CONTENTS

Written evidence reported to the House.
Clauses 64 to 66 agreed to.
Clause 67, as amended, under consideration when the Committee adjourned till this day at Four o’clock.

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The Committee consisted of the following Members:

Chairs: MR ROGER GALE, † MR MIKE HANCOCK, MR JIM HOOD, DR WILLIAM MCCREA

† 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 (Stroubridge) (Con)
† Kendall, Liz (Leicester West) (Lab)
† Lefroy, Jeremy (Stafford) (Con)
† Morgan, Nicky (Loughborough) (Con)
† Morris, Grahame M. (Easington) (Lab)
† O’Donnell, Fiona (East Lothian) (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)
† Wilson, Phil (Sedgefield) (Lab)

Sarah Davies, Mark Etherton, Committee Clerks

† attended the Committee
Public Bill Committee

Tuesday 12 July 2011

(Morning)

[Mr Mike Hancock in the Chair]

Health and Social Care
(Re-committed) Bill

Written evidence to be reported to the House

HSR 34 Council of Deans of Health
HSR 35 Local Government Group
HSR 36 Mrs H M Basson
HSR 37 Association of North East Councils
HSR 38 British Association of Sexual Health and HIV and the Faculty of Sexual and Reproductive Healthcare

10.30 am

The Chair: Good morning, Members. It is nice to be back among friends. I will say first that, as you know, I have bad eyesight and I am not prone to see cups on the tables, so feel free to relax and have a normal existence here. I also suggest that hon. Members remove their jackets if they are hot.

I remind the Committee that the knife falls at 8 o’clock and there is a lot of business in front of us, so we must bear that in mind. If the Whips agree, I intend this afternoon to have a 15-minute break at about 6 o’clock. I hope that is helpful.

Clause 64

FUNCTIONS UNDER THE COMPETITION ACT 1998

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

Liz Kendall (Leicester West) (Lab): Mr Hancock, I am sure I speak on behalf of all hon. Members when I say that, for many reasons, some of which we can say and some of which we cannot, we have missed you being in the Chair. We are glad you are here, and I hope that you are equally glad to be back chairing the discussions on this important Bill.

Today’s debates focus on clauses that go to the heart of the Bill and of Government’s claim that they have made substantial and substantive changes to their plans. Chapter 2 of part 3 contains 12 clauses that explicitly introduce competition law into primary legislation on the NHS for the first time. The clauses give Monitor sweeping powers to conduct investigations into NHS services; to impose penalties and fines on NHS services; to disqualify senior NHS staff in hospitals and other services; and to require national and local commissioners to put services out to competitive tender. The clauses also give the Competition Commission powers to promote competition in all parts of the NHS and to impose penalties on NHS bodies.

Not a single Government amendment has been tabled to the clauses. Let me repeat that: not a single Government amendment has been tabled to the clauses. I believe, and I hope that I will go on to show, that the failure to make any changes, despite what the Government claimed in their response to the Future Forum, still gives Monitor sweeping powers to promote competition in all parts of the NHS, whether or not it leads to benefits for patients, without proper accountability or scrutiny. Lest the Committee fears that I intend to make a long speech on all the clauses, I assure them that I will direct the main thrust of my argument toward clause 64.

The clause gives Monitor concurrent functions with the Office of Fair Trading under part 1 of the Competition Act. It is important to spell out to the Committee exactly what those powers are, so that we are clear about what the Bill introduces. Chapter 1 of part 1 of the 1998 Act prohibits undertakings—I will say what they are in a minute—from reaching certain agreements that prevent, restrict or distort competition; that includes not only fixing prices, but sharing markets. Chapter 2 prohibits undertakings from abusing a dominant position in the market. Undertakings are defined in EU law as entities engaged in economic activity. That is important, because chapters 1 and 2 of part 1 of the 1998 Act are modelled on articles 101 and 102 of the treaty on the functioning of the European Union.

Let us be clear about what it means to give Monitor the same powers as the OFT. First, Monitor may investigate when it has reasonable grounds for suspecting a breach in any of the prohibited areas that I outlined relating to health services in England. Monitor will also have powers to impose remedies or penalties for breaches, including the power to fine undertakings that are found to have broken the law up to 10% of their turnover. Monitor will have the power to fine anything that is considered an undertaking—an NHS service provider—up to 10% of its turnover. In addition, third parties, including competitors, can bring damages claims against such undertakings, so an undertaking may face not only a 10% fine, but damages, too. Individuals found to be involved in cartels may be fined and imprisoned for up to five years, and directors of organisations found to have breached any of those prohibitions may be disqualified for up to 15 years.

Fiona O’Donnell (East Lothian) (Lab): Has my hon. Friend considered the possible impact on the third sector? Large multinational companies might feel that such risks are worth taking, but the risks could frighten the voluntary sector away from engaging in the market.

Liz Kendall: My hon. Friend makes an extremely important point. I was going to come to voluntary sector organisations in a minute, but I shall address them up front, for the record. My noble Friend Lord Beecham asked in a written question whether voluntary organisations and social enterprises will be considered undertakings under the Bill, and the answer was yes. Monitor will have the power to fine not only large private sector companies and NHS hospitals, but small voluntary sector organisations, too. When the Government champion the role of the voluntary sector in the NHS, as they should, perhaps they will make it clear that, under their Bill, the voluntary sector will face such penalties and fines, too.

Owen Smith (Pontypridd) (Lab): Given that my hon. Friend has spelled out that, under these new powers, Monitor will be able to fine undertakings and NHS
hospital providers a significant proportion of their funds, has she spotted anything in the Bill that stipulates that such undertakings ought to hold contingency funds to address such issues, as, for example, a corporation normally would?

**Liz Kendall:** Again, my hon. Friend makes a good point. I have not seen anything in the Bill that states that providers and commissioners of services should keep or set up such contingency funds; however, I know that some NHS providers are already consulting lawyers to figure out what the Bill’s implications will be, including for their finances. As I have made that point on the record, service providers will understand that we are helping them to provide for the bleak future they face under the Bill, even if the Government are not.

**Emily Thornberry (Islington South and Finsbury) (Lab):** At this time, the thoughts of many of us are on the conditions—the separation between the ownership of the property and the running of the social care business—that resulted in disaster at Southern Cross. Does my hon. Friend share my concern that the Bill may pave the way for health providers to be able to separate the ownership of property from the running of a health business?

**Liz Kendall:** Yes, I do share those concerns. There is nothing in the Bill that would prevent service providers from doing precisely that, or prevent private organisations with the same set-up as Southern Cross from providing services in the NHS, thereby raising in the NHS the serious problems that we face with Southern Cross. It is critical that the Government realise that, by opening up the full range of NHS services to private providers without having the regulatory regime necessary to prevent the private equity and leaseholding deals of Southern Cross, they may be creating the possibility of the Southern Cross problems being repeated in the NHS. The Minister of State, the right hon. Member for Chelmsford, who alas will not respond to this debate, gives me one of his trademark quizzical looks. I hope that his fellow Minister will specify which of the Bill’s provisions will prevent that from happening. We have to take that issue seriously.

The powers that Monitor will get under part 1 of the Competition Act are hugely significant. At the heart of our concern is what Monitor will consider to be “sharing a market” or “abusing a dominant position”. Could Monitor consider that a district general hospital that is the only provider of secondary diabetes care occupies a dominant position?

**The Minister of State, Department of Health (Paul Burstow) indicated dissent.**

**Liz Kendall:** The Minister shakes his head. We will explore whether he has a good basis for doing so in a moment. As for sharing a market, if a hospital does a deal with pharmacies, local GP services and district health nurses to provide a whole pathway of care in diabetes, could Monitor consider that to be sharing a market and preventing other competitors from coming in? Again, the Minister shakes his head. I think hon. Members would prefer not to take my word for it or his, but would prefer to take proper legal advice, which we have not received.

I am not arguing, as Ministers have claimed the Opposition have, that the Bill extends the scope of competition law. My argument is that the Bill extends the applicability of competition law to the NHS. It is not just the clauses we are discussing today that will make that happen; so will other clauses, such as those that abolish the private patient cap on foundation trusts, and aspects of the Government’s policy, particularly requiring commissioners to consider any qualified provider for all services, no matter how quickly or slowly this is applied. All those things will guarantee that the NHS will be considered and treated as a full market, and that the providers of NHS services will for the first time be treated as undertakings for the purposes of competition law.

That is the crucial point. In the past, hospital providers have not been considered to be or treated as economic undertakings. When cases have been taken in other European countries, hospital providers have not been considered economic undertakings because of their social purpose and objectives. Their aim is to produce a social good: improving health. My concern is that the Bill will, through the competition clauses, the removal of the private patient cap and the policy of any qualified provider, guarantee that they will be treated as economic undertakings for the first time.

The Minister of State, the right hon. Member for Chelmsford, confirmed this when he told the Committee: “UK and EU competition laws will increasingly become applicable...in a future where the majority of providers are likely to be classed as undertakings for the purposes of EU competition law, that law...will apply.”—[Official Report, Health and Social Care Public Bill Committee, 15 March 2011; c. 718.]

Let us be clear that it applies not only to NHS services—hospitals, community services and others—but to voluntary and third sector organisations, as the Government confirmed in a parliamentary answer to my noble Friend Lord Beecham.

In a previous sitting, I asked whether, in future, commissioners of services might be considered to be undertakings, too. Hon. Members may remember from our many debates in the original Bill Committee that the NHS Confederation and Mills & Reeve—a top 50 UK law firm, according to its website—produced a briefing for primary care trusts and GP commissioners. It states that

“PCTs, in commissioning NHS services, are not...subject to competition law.”

However, the briefing adds:

“Whether or not competition law actually applies to GP commissioning consortia in the future will, however, depend upon their exact form and functions and the precise legislative framework under which they act. Also, competition law is a highly complex area which is constantly developing, with new cases being decided and new guidance being issued all the time. This leads to uncertainty as to its application.”

10.45 am

One does not have to be a lawyer to imagine a scenario in which GP commissioners decide to delegate some of their commissioning functions to the private sector. Consortia will compete for patients, as the Government want them to; they have said that patients
can choose a different consortium, perhaps because it provides different, better, or more services and gets better value for money. We are concerned because of what the Government have said about wanting patients to choose and about commissioning groups competing for patients.

The Government claim that the Bill will not change the current situation and that the real purpose of establishing Monitor as an economic regulator is somehow to prevent competition law from being incorrectly applied to the NHS. As I said last week, however, the Bill guarantees that competition law will apply. The Government are therefore setting up a new regulatory body, Monitor, to protect the NHS from their own Bill and they have failed to answer a simple question: why bother to put these 12 clauses in the Bill if they will not make a difference?

Last week, I asked the Minister of State, the right hon. Member for Chelmsford, whether he had taken legal advice on the implications of the clauses and other parts of the Bill. During the original Bill Committee proceedings, I asked him the same question:

“What has he taken advice on what it would mean for commissioners and providers? If so, will he publish that evidence to the Committee?”

He replied:

“The straightforward answer is yes.”—[Official Report, Health and Social Care Public Bill Committee, 15 March 2011; c. 719.]

In a letter to me—one of many that I have received from the right hon. Gentleman—dated 12 April, he said:

“However, I do not intend to publish legal advice as this is privileged communication to Ministers”.

Yet on 28 April, in an answer to a parliamentary question tabled by my hon. Friend the Member for West Lancashire (Rosie Cooper), who is a member of the Select Committee on Health, the right hon. Gentleman changed his tune, saying that

“no separate legal advice was commissioned by officials on the impact of the Bill on the application of European Union competition law to the national health service.”—[Official Report, 28 April 2011; Vol. 527, c. 602W]

Two questions need to be answered: why did the Minister tell me he had taken legal advice, then say he had not? Secondly, if he has not taken legal advice, why not? This is incredibly important. It does not take a genius to figure out that putting 12 clauses on competition law in a Bill, removing the private patient cap and having a policy of any qualified provider could fundamentally change whether providers and commissioners of services are considered to be undertakings. The right hon. Gentleman should have taken legal advice. Has he done so? Yes or no?

Applying competition law to all parts of the NHS without providing the ability to manage the real consequences of doing so will not help us to meet the challenges that the NHS will face in the years ahead—in fact, it is likely to make meeting those challenges harder. I hope hon. Members will forgive me, even though I have made this point many times before, but two key things need to be done to improve the quality and efficiency of health and health care. First, we need to move some services into specialist centres to improve quality and outcomes, because consultants and other staff there would have greater experience, technical skill and expertise, which would help save more lives, and help more patients survive and lead lives that are free from disability or illness. Secondly, we need to shift many other services out of hospitals into the community and more towards prevention and, crucially, ensure that these services are more joined up with social care. Those are the two key things we need to do if we are to improve care for people with long-term and chronic conditions and take advantage of the technological developments and advances that can make a phenomenal difference to patient care.

**Fiona O’Donnell:** Is the Bill needed to achieve those two aims?

**Liz Kendall:** The short answer is that the Government could have achieved many of their aims without the Bill. They could have cut the number and size of primary care trusts, put the clinicians in control and reduced the size of strategic health authorities. They could have brought in the voluntary and private sector where the evidence showed that it was succeeding. Instead, they have thrown the service up in the air, distracted it and wasted time and resources. In the best-case scenario, competition will be driven into parts of the NHS where it may not work or succeed; in the worst, services will be set against one another when they should be working together.

**Emily Thornberry:** Is my hon. Friend aware that the Prime Minister’s favourite GP, Dr Howard Stoate, has said publicly that the reforms that he has been able to make to his practice have all come about without any legislation and he has come to the considered view that the Bill is unnecessary for forward-thinking, independent GPs like him?

**The Chair:** Tempting though they might be, Dr Stoate’s comments are not before the Committee today, so we should avoid going down that route.

**Liz Kendall:** I am sure the fantastic Hunsard will record my hon. Friend’s point.

Both specialising services into some centres and shifting other services out of hospitals and into the community have major implications for the future of hospital services, particularly district general hospitals. That will have real consequences that have to be properly managed. Simply to leave these huge changes to a full market system without the ability to manage them is a huge mistake. The Government have completely failed to explain how this part of the Bill will help us to achieve those two goals. Why does the Bill have so many clauses that will not help us to achieve those two key aims?

I have used the example of stroke care before and I will do it again, because the example of how the NHS has changed stroke services in London is compelling. NHS London went through a controversial reorganisation of stroke care in the capital to establish eight hyperacute stroke units. Within just five months, those specialist centres more than tripled the number of patients receiving clot-busting drugs to the highest rate of any large city in the world. It is estimated that this will save 400 lives a year, as well as significantly reduce disabilities. The NHS did not need to use competition law to achieve those goals. Indeed, competition law might have prevented those changes from happening as it might have led to the accusation that the hospitals were sharing markets for stroke patients.
It may not suit the Government’s view of the world, but the achievements in London show major service changes can be achieved through effective planning at the strategic level, yet the Bill will remove strategic health authorities—the very organisations that have the capacity and have shown in practice that they can make such changes happen. The Government insist instead that smaller clinical commissioning groups led by GPs will take on the role, but hon. Members will remember evidence given to the original Bill Committee from the Health Foundation that the previous experience of involving GPs in commissioning showed that they had not managed to secure fundamental changes to hospital services. Yes, GPs have managed to improve community services, because they know and understand community services better, but in the current financial climate we cannot afford to double fund hospitals and community services to do the same things at the same time. Difficult decisions must be made.

The Government now say that clinical senates will help clinical commissioning groups to make decisions about major service reconfigurations, but we do not yet know how strategic clinical senates will be or whether they will have the necessary powers to make the large-scale changes necessary. Most important, they do not yet exist. Changes to service provision and improvements to areas of care such as trauma services that are urgently needed to improve outcomes for patients could be happening now. As I have said, the experience in London suggests that 400 lives each year have been saved by the changes they made. Those are lives that could and should be saved now.

The Government seem to have totally forgotten that Ara Darzi led a major review of NHS services, which led to clinicians in every region working together to develop a range of pathways that would improve the outcomes and quality of care. In my region primary care specialists and secondary clinicians have been working together to develop a pathway of care. That has been put on hold. The Government need to understand that all that work, which could save lives and improve care, has been put on hold.

I refer to the review to make the point that the clauses, which are at the heart of the Bill, will not help us to achieve any of the changes that are needed. It astonishes me that instead of getting on and making the changes, the Government are putting through all these clauses, which are at the heart of the Bill, will not help us to achieve any of the changes that are needed. It astonishes me that instead of getting on and making the changes, the Government are putting through all these clauses. Worse still, the Bill creates a plethora of new organisations, which will result in a confused system of responsibility and accountability. It also demonstrates a determination to use competition law as a tool for making changes in the NHS. I believe that the Bill will make the changes that we need harder, not easier to achieve.

I will end my comments with a wider and possibly more philosophical point that is absolutely relevant to clause 64 and its explicit introduction of competition law into primary legislation on the NHS for the first time. I have always believed that we need to give patients more information, more choice and more say over their treatment and care. When people can make choices in all other aspects of their lives, the NHS, like every public service, must respond if it is to retain public support and taxpayers’ money in the long term. Health care is not simply another commodity, however, and patients are not consumers alone. As individuals, patients have a vital role in creating good health and in preventing disease by what they eat, by how much exercise they take and by their sense of mental health and well-being. As Members of Parliament, we are also crucial in determining the future shape of services and how they will be funded. We make the difficult decisions that are necessary to determine how resources should be fairly distributed.

Alongside policies that seek to improve choice and give patients a greater say, we must also address the other side of the equation, namely the responsibilities and duties that patients should be expected to have in return as individuals and as members of wider society. A political choice must be made about the sort of relationship that needs to develop between patients and health services. That relationship can be based on the consumerist model, where the rights of the individual are all-powerful, or above and above those of the local community or society as a whole, or on the citizenship model, where patients have a clear right to choose but also have reciprocal responsibilities.

11 am

The Government have chosen the consumerist model, as the Prime Minister aptly demonstrated yesterday in his speech announcing the public services White Paper, when he compared using public services to buying a mobile phone. He said:

“You go to the shop—only one shop—and there they’re selling one model of phone. You can guarantee the service wouldn’t be what you’d expect, the quality wouldn’t be great...and yet we apply the same tired, old monopolistic thinking across so much of our public services.”

That is a completely inaccurate picture of what happens in health services. More important, health and health care are not like going to buy a mobile phone.

The Minister of State, Department of Health (Mr Simon Burns): Absolutely.

Liz Kendall: The Minister says, “Absolutely.” Perhaps he should tell the Prime Minister not to use that comparison in future.

These parts of the Bill are based on the wrong political philosophy and a wrong understanding of health and health care. The Government would like to portray Opposition Members—I hear the Minister chuntering in the background—as anti-reform. I was proud to serve, in a very minor role, a Government who pushed forward reform and plans that gave patients more of a say. We did not have, however, a fundamentally consumerist model of health and health care. It is wrong for the future, and that is why we oppose the clause.

Grahame M. Morris (Easington) (Lab): I will echo some of the sentiments expressed by my hon. Friend the Member for Leicester West. This is one of the most fundamentally important clauses of the Bill and it is important that we consider its implications very carefully as a Committee. The briefing note provided by the House of Commons library indicated that the clause “would give Monitor concurrent powers with the Office of Fair Trading (OFT) to apply the Competition Act 1998 in relation to the provision of healthcare in England”.

As my hon. Friend indicated, this is in relation to chapter 1, part 1 of the Act, which “prohibits undertakings from reaching agreements that prevent, restrict or distort competition”.

Y ou go to the shop—only one shop—and there they’re selling one model of phone. Y ou can guarantee the service wouldn’t be what you’d expect, the quality wouldn’t be great...and yet we a
It also relates to chapter 2, which “prohibits undertakings from abusing a dominant position in a market. There are similar provisions under EU law”. The NHS Future Forum report told us that competition should be used to secure greater choice and better value for patients. It should be used not as an end in itself but to improve quality, promote integration and increase citizens’ rights. Ministers have tried to sell the idea that, by reforming the role of Monitor, they have dealt with the issue of competition for competition’s sake. I contend that that is a false premise. I understand that Monitor will continue to identify market distortions, and now anti-competitive practices, with the Competition Commission taking appropriate corrective action.

When these clauses were first raised in the Committee, the Opposition asked why they were needed to introduce competition law if the Bill is simply an extension of the previous Government’s reforms over the last 13 years. There can be only one answer: because the Bill does a lot more than that. Since then, the listening exercise found agreement with the Opposition that Ministers had gone too far, promoting competition above patient’s needs. It is another example of the emperor’s clothes, and therefore begs the question why, while Ministers have amended the clauses on Monitor, there have been no amendments to the whole section on competition. The truth is that competition is still being introduced and is being applied to a much greater extent within the NHS. The application of competition law is being implemented in primary legislation, and it is clearly not maintaining the current framework, otherwise it would not have been in the Bill. Is it not possible that we will now be in an even less desirable position in so far as competition is being introduced just as it appeared in the original and, some would argue, discredited version of the Bill, and yet the regulator is being weakened?

I hope that the Minister will answer this question. While Monitor’s duty to promote competition has been turned on its head, or so we have been told, in so far as it must now prevent anti-competitiveness, what change has there been to the extent that competition is being introduced by the Bill? Monitor’s functions are far less important than the fact that competition, and EU competition law, will now be applied to a much greater extent within the NHS. The application of competition law is being introduced by reforming the role of Monitor, they have dealt with the issue of competition for competition’s sake. I contend that that is a false premise. I understand that Monitor will continue to identify market distortions, and now anti-competitive practices, with the Competition Commission taking appropriate corrective action.

There are further questions about whether commissioning groups will find themselves covered by competition laws. In addition to the Competition Act, we have been told that there will be sector-specific regimes. By saying that the principles and rules for co-operation and competition, as conducted by the Co-operation and Competition Panel, will continue, the Secretary of State has sought to sell his reforms as evolution, rather than revolution. We need clarification on that point. On 14 June, the Secretary of State made a statement to the House that I suspect was clouded by the fog of war: “We will keep the existing competition rules introduced by the last Government”—[Official Report, 14 June 2011; Vol. 529, c. 646]. That is the previous Labour Government, so is it fair to assume that the March 2010 rules, which include the “preferred provider” stipulation, are to be kept? From statements in the press and comments in Committee, my understanding is that it is the June 2011 rules, which include “any willing provider”, that will be placed on a statutory footing. I am sure that the Secretary of State would not mislead the Committee or the House, so I invite the Minister to clarify whether the new term “any qualified provider” will be placed on a statutory footing.

Fiona O’Donnell: I appeal to the Minister to find some words of reassurance for the voluntary sector, and for the third sector in general. This is the wrong time to put an extra burden on the voluntary sector, because it is already facing the strain of an increase in VAT and
cuts at local authority level. Understandably, local authorities are protecting their employees' jobs, which I fear will be at the cost of the voluntary sector.

This clause reminds me of "Dr Dolittle". It is a pushmi-pullyu clause. The clause is pushing the NHS in the direction of competition when we need to pull it back towards greater co-operation.

My hon. Friend the Member for Leicester West spoke so eloquently about the challenges that face the NHS. We need centres of excellence to ensure the delivery of the highest standard of care at the right time in a person's illness to give them a better long-term future, but the duty to consult that the Bill places on the NHS might constrain such improvements. At the same time, the NHS needs to devolve into communities to allow it to respond to people's needs, because they will also not be well served.

I hope that the Minister can offer some words of reassurance on how the clause will affect the voluntary sector.

Paul Burstow: It is a delight to serve again under your chairmanship, Mr Hancock.

I will start with the point raised by the hon. Member for Leicester West. The point takes the debate very broadly, but it is important to deal with it straightforwardly. She asked how we would ensure that services were designed and commissioned to reflect the needs of populations and local communities—the people we are here to serve.

We will address the clauses on the health and well-being boards and HealthWatch on Thursday, but the hon. Lady will know from her study of the Bill that, for the first time, it provides a strong statutory basis for joint strategic needs assessments and joint health and well-being strategies, and for the way in which they drive commissioning plans at a local level. At the heart of the debate is the Opposition's fundamental misunderstanding that we want competition to design and deliver services. That is actually the role of commissioning, and we will come back to that later. We have already debated commissioning, but that fundamental misunderstanding is at the heart of the Opposition's persistent pursuit of their concern, which is greatly overstated.

There has been a lot of reworking of history, both in this debate and in some of our previous debates, particularly by the hon. Member for Leicester West. In the past 12 months, more than anything, I have learned that the art of opposition is to forget all that one did in government, which has been aptly and skilfully done in this Committee over the past few months. I want to try to sort out a bit of the reality—

11.15 am

Owen Smith rose—

Paul Burstow: I am not going to put my point yet. There is nothing of substance for the hon. Gentleman to intervene on.

Grahame M. Morris rose—

Paul Burstow: Let me make my points first and set some context.

"Patient choice and contestability are potentially powerful drivers of improved quality and efficiency in the provision of National Health Service services. Involving individuals in decisions about their care and offering people a choice of provider, type of treatment, or the time and location of that treatment, are all characteristics of a high-quality, patient-centred health service.

We must ensure that choice, co-operation and competition within the NHS operate in the interests of patients and taxpayers, and that quality is the organising principle. Achieving these aims depends on having a rules-based approach, clear roles and responsibilities for oversight of the system and effective mechanisms for redress."—[Official Report, 29 January 2009; Vol. 487, c. 25WS.]

I wonder whether hon. Members agree with those propositions? I hope that they do not, because otherwise they are not the propositions of this Government, although we certainly share them. They are the views that were expressed by Ministers, on the record, in Hansard, in the last Parliament. Indeed, they are the words of the right hon. Member for Exeter. The point takes the debate very far from where it was. They are the words of the right hon. Member for Exeter (Mr Bradshaw), who spoke about the establishment of the competition panel, which we have heard so much about, not least because my hon. Friend the Member for Southam drew it to our attention in the earlier stage of this Committee.

The right hon. Member for Exeter said that the competition panel was the NHS's own competition commission. He went on to say that the principles and rules for co-operation and competition “effectively set out the NHS's first ever competition policy.”—[Official Report, 24 February 2009; Vol. 488, c. 66WH.]

Hon. Members have to accept, whether they like it or not, that the Labour party in Government was pursuing a policy of competition in the national health service as an objective of Government policy, as articulated clearly and powerfully by the right hon. Member for Exeter.

Owen Smith: Does the Minister accept that there is a fundamental difference between the co-operation and competition panel—which was not a statutory body but an advisory body to the Secretary of State—and having a body, the OFT and Monitor, in statute, using competition law, to regulate competition within the NHS and to promote it? Does he also accept that, as a Liberal Democrat, he is admirably well placed to know about forgetting what he thought when he was on the other side of the House?

Paul Burstow: I was not around 60-plus years ago, so I am not in a position to have forgotten my party's last time in Government. The answer to the hon. Gentleman's first point is no, and I will set out why in a moment.

The hon. Member for Leicester West raised questions about this clause and a number of others; it is worth rehearsing some of the points, as they set the context in which the clauses should properly be read.

First, Monitor's core duties have been amended, from promoting competition to protecting and promoting patients' interests. When carrying out duties as a sector regulator, it will not be promoting competition for competition's sake. We are absolutely clear about that; I will come back to the questions asked by the hon. Member for Easington in a moment.

We have not amended clauses 64 or 65 for a very simple reason: having said that we would pause, listen and reflect, we have now accepted the recommendations of the NHS Future Forum. They said that the job of dealing with challenges under competition law should best be done by “a dedicated regulator with a greater knowledge of the unique nature of healthcare, including the importance of cooperation
Paul Burstow: I will give way to the hon. Gentleman in a moment, but this answers an important point that I have been asked, and I would like to make sure I answer it. The mere fact that Monitor exercises concurrent powers does not change one iota the applicability of competition law. It is important that we say that, and I will develop the point further in a moment.

I want to come back to the incredible journey that the official Opposition are on—from being a party that was proselytising about the benefits of competition only a year or so ago. As part of that journey, in 2008, when in government, they significantly extended the choice offer around elective surgery. In their manifesto, just a little over 12 months ago, they talked about having a system where people could choose any willing provider who was prepared to operate at NHS prices and NHS standards when it came to elective care. What is that, if not a policy of any qualified provider?

Debbie Abrahams (Oldham East and Saddleworth) (Lab): May I make sure that I understand why we are here? Are we here to scrutinise the Government’s Bill? Is that the purpose of the Committee?

Paul Burstow: We are here to understand the motivations behind the amendments and their purpose. That is what I am doing in setting out these points, which may be uncomfortable. I absolve the hon. Lady because she did not stand on the manifesto that other hon. Members stood on—a manifesto that committed the Labour party to an acceleration of the FT pipeline, to a completion of the implementation of FT status and to a policy of any willing provider. [Interruption.]

The Chair: Order. Can we have a little less backchat? It is difficult to hear what is being said, and it is helpful for the Chair to hear what is going on.

Grahame M. Morris: Thank you, Mr Hancock. In relation to the duties set out on Monitor in this clause and its anti-competitive practices role, can the Minister confirm that under the existing arrangements the NHS was largely exempt? It is classified as a state enterprise under schedule B. The thing that is bringing the weight of competition to bear—obviously, the primary legislation set out in the Bill—is also changing the architecture of the NHS. That will, in effect, subject it to EU competition law.

Paul Burstow: That is a restatement of the question that the hon. Gentleman asked earlier. I will get to it in my own good time as I attempt to respond to all the points that have been made.

Let me start with the points raised by the hon. Member for Leicester West and by her hon. Friends in interventions. I was asked whether providers will need to set up contingency funds in case they get fined; that was another of those scares that some Committee members seem to want to erect in this debate. Fines could be levied only for breaches of the law. Setting up a contingency fund rather suggests that the Opposition would condone organisations infringing the law. It is nonsense to suggest that such a thing would happen.

The Office of Fair Trading, which currently applies competition law in most sectors, has used large fines only for particularly harmful behaviour such as deliberately fixing prices. As we will come on to later, the whole issue of prices and transparency around that is a completely separate matter that is dealt with through the NHS commissioning board, Monitor and the arrangements that the Bill, if it becomes an Act, provides for.

It was then suggested that the sanctions would be too harsh, especially on the voluntary sector. Again, the answer is no. Monitor has a range of sanctions available to it, including accepting undertakings. Later we will come to a clause that specifically stipulates that it can do that. The sanctions would be applied proportionately to the offence and the size of the organisation, in accordance with statutory guidance. Monitor would issue clear guidance to help avoid inadvertent breaches.

I was also asked whether the Bill extends the applicability of competition law and whether it in some way guarantees that providers will become undertakings; that was at the heart of the question from the hon. Member for Easington. In a way, the hon. Gentleman asked the question because he knows the answer; he has heard it before on a number of occasions. Once this place legislates, it is for the courts to determine whether a body is an undertaking.

That is the case now; it was the case before and it will be the case after the Bill is enacted. The Government are simply acting in the environment and legal framework that was established by the Enterprise Act 2002 and the Competition Act 1998—legislation passed by the previous Labour Government.

Owen Smith: This is the heart of the question that we have been debating, about whether competition will see the NHS being broken up. The Minister says that it will be for the courts to decide. Our point, however, is that the context in which the courts will decide will be different once the Bill applies, because there will be more entrants in the marketplace; the nature of what those entrants provide will have changed as a result of lifting the private patient cap and allowing providers to be more commercial. It therefore becomes more likely that the courts will deem them undertakings and that competition law will apply. That is our point, and it is an argument that the Minister refuses to accept.

Paul Burstow: I simply and respectfully say that the journey that the hon. Gentleman seems to suggest began in May last year in fact began many years before. It was part of a journey initiated by Labour in government, and there is nothing that the hon. Gentleman can do to run away from that now. The record is clear. His Government started the process of enabling competition to play a part in the NHS—he may not like that, but Hansard is clear.
Owen Smith: As we have said repeatedly, the fundamental differences are that, first, competition did not have a statutory basis, and secondly, at the end of 13 years of Labour Governments, fewer than 5% of NHS services were provided through the private sector—meaning that courts would have made a judgment in the context of there essentially still being a monopoly state provider. Therefore, undertakings would not have been the description attached to providers. Under the Bill, there will be many entrants into what will be a proper market. They will be deemed as undertakings, and the courts and competition law will apply. That is the difference, and it is not true to describe it as an evolution.

Paul Burstow: The hon. Gentleman can continue to assert his view, but the reality is very different. It is set out clearly in Hansard, in speeches extolling the virtues of competition, made by his right hon. Friend the Member for Exeter, in debates on this subject as recently as 2009. The then Prime Minister did so, too, and the former Secretary of State for Health, Patricia Hewitt, gave a speech saying that “new providers help us to do all the things we want to do: improve the quality of care; increase capacity; support patient choice; drive value for money and promote greater equality...We are working with Ed Miliband, minister for the third sector, to help ensure a truly level playing field.”

The hon. Gentleman now seems to want to resile from that position, but the proposals are clearly part of the previous Labour Government’s legacy. The Bill tries to place how such things will work in future in a clear statutory framework.

The hon. Members for East Lothian and for Leicester West asked about the voluntary sector, and there is the concern about how competition law and procurement law apply to it. Again, this is not a change, because the voluntary sector is already subject to such laws—and, in many cases, such bodies are regarded as undertakings. The only difference that the clause makes is that Monitor, rather than the OFT, would enforce the Competition Act, so an organisation that is expert in and knowledgeable about health care will carry out enforcement, rather than the organisation that can currently do so but does not have that knowledge. The Future Forum rightly recommended a sectoral regulator to enforce the provisions, and the Government have responded to its suggestion.

Owen Smith: Will the Minister give way on that point?

Paul Burstow: I would like to make a little progress—I have been very generous to the hon. Gentleman, as I am sure he would agree. I will be happy to give way later.

A hospital dominating diabetes care was the proposition that the hon. Member for Leicester West wanted to test, asserting that that may be seen as grounds for an intervention by Monitor. It would not, however, if that hospital were part of an integrated pathway for diabetes care, which had been commissioning fairly and openly; Monitor would be unlikely to have grounds for any intervention whatever.

The hon. Lady then asked whether creating a new pathway would amount to the sharing of a market. Providers agreeing to work together to create a new pathway would amount to the sharing of a market, as 2009. The then Prime Minister did so, too, and the hon. Member for Exeter, in speeches extolling the virtues of competition, made by his right hon. Friend the Member for Chelmsford, say one thing and then apparently say something else? I think that that is a complete misreading of what happened. In preparing legislation, Government lawyers will always consider whether the clauses in a Bill are compatible with EU law—which, of course, includes competition law—and human rights law. That is always the case, and has been in respect of the Bill.

Liz Kendall: The issue is not about whether the Bill is compatible with EU law. I asked whether the Bill changes how competition law will be applied to health services in the UK.

Paul Burstow: The only way in which the Bill changes competition law is by inserting the word “Monitor” into the Competition Act and the Enterprise Act. The only way in which the Bill changes anything in competition law is through the addition of that name to the legislation.

I come now to the hon. Member for Islington South and Finsbury’s question about Southern Cross, and how it might be relevant to these issues and to sale and leaseback. The hon. Lady expressed concern for Southern Cross. My concern as a Minister is not for Southern Cross, but the staff and residents of those care homes, and their families. I am sure that that concern is shared across the Committee. We will, undoubtedly, have to learn lessons from the experience of Southern Cross about how the adult social care system is regulated. We must look carefully and critically at the regulatory framework that we inherited, and how it has changed over the last 10 years, to ensure that we have one that is fit for the future.

The Bill does not change the position around sale and leaseback in any way. Foundation trusts and other providers are already able to dispose of property, subject to regulatory controls. That will still be the case under the proposals in the Bill. As is currently the case, foundation trusts would be free to dispose of property

not breach the law if the agreement improved services for the benefit of patients and contained any restrictions necessary for achieving those improvements.
only in line with the terms of their licence. Nothing changes; we maintain the status quo through the licensing arrangement.

Owen Smith: Has the Minister seen the news that St George’s Healthcare Trust has leased 594 of its beds to a Dutch agri-business for £509,000 a year, and is then leasing them back from that business? That seems to be a perfect example of raising money against assets, which is precisely the sort of thing that we are worried about.

Paul Burstow: I have not seen the article. If the hon. Gentleman wants to share it with me, I will have a look at it and perhaps we can discuss it at some other point. [Interruption.] As my hon. Friend the Member for North Warwickshire rightly says, the hon. Gentleman raises a concern about a practice that is occurring now under legislation that was enacted during Labour’s watch.

The Chair: Order. Will the Minister stick to clause 64?

Paul Burstow: I am sorry, Mr Hancock. I am tempted to respond to a cornucopia of delights, but I will resist the temptation.

The hon. Member for Easington has asked a question of questions, which I will come to directly, and the best way to answer them is by reference to Hansard. He asked how things will change as a consequence of the legislation and the amendments that the Government are tabling to address the concerns of the NHS Future Forum. I can do no better than to read from the Committee’s public evidence hearing on the re-committed Bill from 28 June, in which the oft-quoted Dr Bennett said:

“Secondly, it significantly raises the burden of proof on us. If we feel—normally working alongside the commissioning board—that the use of competition is a way of furthering the interests of patients, the burden of proof that that, rather than other ways of furthering such interests, is the right way to go is significantly higher. That is the other key thing that has changed.”—[Official Report, Health and Social Care (Re-committed) Public Bill Committee, 28 June 2011; c. 32, Q68.]

It is important to note that very important contribution from the man who will lead Monitor.

The hon. Gentleman tempted me to revisit my Radio 4 interview and my reference to putting competition back in its box. Again, I can do no better than to quote from the Committee Hansard from the afternoon sitting on 28 June, when my right hon. Friend the Secretary of State for Health was asked the very same question by the hon. Member for Pontypridd. The Secretary of State replied:

“I think we were both very clear that competition is entirely a means to an end. I do not know what David Bennett said earlier, but he may well have been referring to the fact that, strictly speaking, the legislation does not extend the application of competition rules and law in the NHS. To that extent, the legislation does not change because it does not change competition law. What we need to be clear about is that it is in that box.”—[Official Report, Health and Social Care (Re-committed) Public Bill Committee, 28 June 2011; c. 91, Q187.]

The Secretary of State answered the question aptly, and I do not want to add anything to that answer.

Grahame M. Morris: I am grateful to the Minister for being so generous with his time. We have frequently quoted David Bennett and Ministers, but I wonder whether the Minister agrees with this comment from a staunch defender of the Bill, who is a senior partner in Ernst and Young:

“However, it would be quite wrong to see the government’s response as a denial of the competition creed. The Principles and Rules of Cooperation and Competition...will not only remain, but will gain a statutory footing. The Cooperation and Competition Panel will survive, being lodged within the new Monitor. Moreover, the ‘any qualified provider regime’, the subject of so much debate”—

The Chair: Order. In all honesty, Mr Morris, that is going slightly too far from the point. Our colleague in Ernst and Young has no relevance whatsoever to the Bill.

Paul Burstow: I was going to say that that was perhaps an attempt to boost the sales of the Morning Star still further—or some other part of the press.

The Chair: Stick to clause 64.

Paul Burstow: I am desperately trying to do so, Mr Hancock. The hon. Member for Easington also asked me whether the NHS was exempt from competition law as section B services. The NHS has no exemption from competition law, and such exemptions do not apply to other service sectors either. He must be thinking of part B services for the purposes of procurement law. It is important that we draw that distinction for the benefit of those who follow our proceedings. Health care services are part B services, the effect of which is that the full rigour of procurement rules does not apply to such services. There is no change to that provision. The principles of transparency, proportionality and equal treatment apply to the procurement of health care services. I hope that that puts that issue to bed.

I will try to draw the debate about clause 64 to a conclusion. The clause will give Monitor concurrent powers with those of the OFT under part 1 of the Competition Act 1998 in relation to the provision of the health care service. The Bill will not introduce the Competition Act to the provision of health care services for the first time. Competition law has always applied where providers are performing an economic function. The existence of a sectoral regulator does not mean that the courts are more likely to decide that competition law applies. Competition authorities and courts consider the facts on the ground when applying the law, regardless of the institutional arrangements for their enforcement. The existence of a regulator has absolutely no bearing on whether or not competition law applies.

I will end by saying that we decided to pause the Bill and to engage an independent organisation of professionals and others from within and outside the NHS, and they concluded:

“Under current rules, any challenge under competition law would be for OFT to deal with. However, we think that this job would be best done by a dedicated regulator with a greater knowledge of the unique nature of healthcare”.

The Government agree, and that is what we are doing with this group of clauses, on which we will spend most of the rest of today, and our purpose is to ensure that we safeguard the NHS against competition being applied
disproportionately. This group of clauses is all about that safeguarding and not about the various agendas that Opposition Members tend to suggest, which are just another part of the fantasy.

**Liz Kendall:** That was a good attempt by the Minister to deflect attention from the Bill. He shimmied almost as effectively as the Secretary of State for Business, Innovation and Skills did on “Strictly Come Dancing”. However, he gave the game away in his final comment, when he said that “Competition law has always applied wherever providers are performing an economic function.” The point is that health care providers have always been considered as carrying out a social function. The Bill changes that, and the Minister knows it.

The Minister has failed to answer four simple questions. First, why introduce 12 clauses in part 3 of the Bill if they make no difference? The Minister said that chapter 2 simply inserts Monitor into the Competition Act 1998. It does not. Has he read it? There are 12 clauses. If they do not make a difference, why are they in the Bill? Secondly, why give Monitor concurrent powers with the OFT if it will not use them? What is the point, unless Monitor uses them to conduct its functions? Thirdly, if it is really the role of commissioners to promote competition, as the Minister has said, why set up Monitor at a cost of up to £320 million over four years and give the Competition Commission a role in the NHS for the first time? Fourthly, why does clause 66 state that the core duties of Monitor, which the Minister says that the Government have amended, do not need to apply when it is carrying out its functions under the 1998 Act and the Enterprise Act 2002? That is the key point.

Finally, just in case anyone had any doubt and to clarify for the record, the Committee is about assessing the Government’s policy. I would swap places in a heartbeat, so that our policy could be assessed, but that is not the point of the Committee. When we were in government, we brought in different providers where they could increase capacity in the NHS or provide some challenge where services needed to improve. We did not enshrine competition law in the NHS, nor did we propose to do so. We always had the ability to manage the real consequences of having competition and choice in the system, particularly with district general hospitals through the existence of strategic health authorities and primary care trusts, which the Government are removing. We also had clear national standards, or targets, so that patients did not lose out in the system. I would proudly defend our record in government on the NHS.

11.45 am

**Dr Daniel Poulter** (Central Suffolk and North Ipswich) (Con): If we open up the NHS to different providers, competition law, which the hon. Lady is concerned about, will automatically apply. According to her argument, the previous Government opened up the NHS to competition law.

**Liz Kendall:** With the greatest of respect to the hon. Gentleman, that has not been the case in other countries; providers were not considered to be economic undertakings because they had a social function and because there was not a full market. The Bill will change that. If Government Members do not believe that that is the case, they should ask themselves why the clauses are in the Bill and why lawyers are making a great deal of money from advising commissioners and providers in the public and private sectors.

**Paul Burstow:** The hon. Lady and I agree that there should be no cherry-picking in the NHS, but will she clarify whether she is cherry-picking from the recommendations of the NHS Future Forum? Does she agree with concurrency, as recommended by the Future Forum, or not?

**Liz Kendall:** I am assessing whether the Government’s amendments meet their promises to the Future Forum. I do not believe that they do. It is only by scrutinising the legislation that we can see whether the Government have made good on their so-called promises to the Future Forum. I do not believe that they have, which is why we oppose the clause.

**Question put.** That the clause stand part of the Bill.

The Committee divided: Ayes 12, Noes 10.

**Division No. 16**

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<td>Brine, Mr Steve</td>
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**Question accordingly agreed to.**

**Clause 64 ordered to stand part of the Bill.**

**Clause 65**

**Functions under Part 4 of the Enterprise Act 2002**

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

**Liz Kendall:** Clause 65 gives Monitor the functions that the OFT has under part 4 of the Enterprise Act 2002 in respect of health services in England. The clause will allow Monitor to make what are called “market references” to the Competition Commission if it has reasonable grounds to suspect that any feature of a market would prevent, restrict or distort competition. Not only Monitor will be looking at health services in England; the Competition Commission will, too. The primary purpose of the Competition Commission is to promote competition, but, as far as I am aware, it has no experience, skill, knowledge or expertise in health and health care.

I want to raise a key issue about this clause, as I did in the original Committee. What will be covered as a market under this clause? Could a whole local area be considered a market? For example, suppose that only one district general hospital provides diabetes care in a local community in which there are no other providers
and either another provider challenges the situation or Monitor decides that the current set-up restricts competition. Could Monitor refer that to the Competition Commission? David Bennett gave precisely that example in one of his many productive interviews before progress on the Bill was paused.

Owen Smith: In respect of that example, Ministers and David Bennett have pointed out that there will now be a higher burden of proof on Monitor to demonstrate that integration in the service is not in the interests of competition or of patients. Can my hon. Friend imagine any circumstances in which the OFT and Monitor will not view that it might not be in the interest of patients, because there is collusion and only one service is being provided?

Liz Kendall: My hon. Friend is right to raise the issue of burden of proof, and I would be grateful if the Minister explained in simple, layman’s terms what the burden of proof would be.

I would also like to ask the Minister whether one of the national services that the NHS board—NHS England—commissions would be considered a market. That includes, for example, specialist renal services or kidney treatment. If Monitor decides that only NHS providers will deliver those services and a private provider from this country—or indeed from other European countries, which could happen under the Bill—offers to provide better renal or kidney services, will Monitor be able to refer those services to the Competition Commission?

On 17 March, during the last Committee, the Minister, the right hon. Member for Chelmsford, told me in response to my question about what a market could cover:

“That would cover a national market for specialised services—for example, a regional market for elective hospital care, or a more local market for long-term conditions.”—[Official Report, Health and Social Care Public Bill Committee, 17 March 2011; c. 874.]

Why have the Government done nothing to change the power that Monitor gets under clause 65, which is about not only Monitor’s role but the role of the Competition Commission? The Minister speaking today has made much of the Government’s decision to amend Monitor’s core duties, but nothing in the Bill changes how the Competition Commission will act in relation to the NHS.

Owen Smith: I am prompted to intervene because my hon. Friend’s point about renal care is pertinent. The concern that she raises is borne out by the Government’s own words. Point 5.15 of the Government’s response to the Future Forum states:

“Monitor will be limited to tackling specific abuses and restrictions that act against patients’ interests, to ensure a level playing field between providers. For example, Monitor could take action against a provider seeking to frustrate patient choice, or colluding with another provider not to offer patients home-based treatments.”

Renal care is one example where hospitals often insist, for good reasons, on patients’ coming into hospital for dialysis, but they are now being challenged by home care providers that offer to provide dialysis at home. Would Monitor be able to deem the provision of such a service in hospital to be collusive and force hospitals to employ other providers to provide it at home?

Liz Kendall: My hon. Friend has asked an extremely good question, which I hope the Minister will answer. To clarify, I would like the Minister to tell us which services could be considered a market under this clause. In addition, what knowledge, expertise or experience does the Competition Commission have in health care that would put it in a reasonable position to judge the very real impact on local hospital services of a reference under this clause?

Paul Burstow: By way of beginning my response, I should say that I do not think that we have an answer about something; perhaps at some point, as we proceed through these clauses, which effectively lay the foundations for concurrency, we will hear whether the hon. Lady or her hon. Friends accept the very clear, specific language used in the NHS Future Forum. It would be genuinely interesting to know whether the hon. Lady had a view on that.

Liz Kendall: It is not my job.

Paul Burstow: The hon. Lady suggests that it is not her job. I think the job of the Opposition is not just to have—

Liz Kendall: Not in this Bill Committee.

The Chair: Order. You have made the point.

Paul Burstow: I have made the point, absolutely, Mr Hancock.

The Chair: Let us leave it there for now, shall we? Just move on. They are not going to respond.

Paul Burstow: I think that the hon. Lady still ought to respond. There was a good deal of sedentary chuntering, Mr Hancock.

The Chair: You are not going to get the answer you want, so let us move on.

Paul Burstow: The clause gives Monitor powers to make market references to the Competition Commission if it has reasonable grounds to suspect that features of the market restrict, prevent or distort competition. An example of when Monitor might use the power would be if a number of providers introduced systems that made it difficult for patients to choose providers or move between them, or made it more difficult for potential new providers to offer services to patients. I will come to specific points in a moment. The Competition Commission would investigate and, if it found an adverse effect on competition, it would determine remedies to address this, which are set out in competition law.

Monitor would have concurrent powers with the Office of Fair Trading to undertake this function, so the Bill requires that these bodies consult each other when first exercising this function in relation to a particular issue and not to make the reference if the other body has already done so. That includes investigation powers, which Monitor can use to decide whether or not a reference should be made.

The investigation powers include the power to require the production of documents or certain information, or to require a person to give evidence. Failure to do so
intentionally, or without reasonable excuse, would be an offence. In practice, however, Monitor is likely to have a lot of the information that it would typically need when considering a reference—information that the OFT may not have. That is the basis on which this power is included in the Bill. Monitor would also have the power to accept undertakings in lieu of a reference.

As with clause 64, the clause does not create a new power: these powers already exist, and that is what concurrency is all about. The Bill simply provides Monitor with the powers that currently rest with the OFT, which they could use in all the scenarios that the hon. Member for Leicester West and the hon. Member for Pontypridd rehearsed. The powers that could already be used in regard to the NHS can now be exercised by a sector-specific expert regulator, in the form of Monitor. We want to create a single regulator for that very reason and in respect of the NHS Future Forum’s recommendation to the Government.

The hon. Lady asked me to explain what a market might be for this purpose. I simply refer her to the *Hansard* report from the Health and Social Care Bill Committee on 17 March 2011, column 874. There she will find the very clear exposition that she received from the Minister, my right hon. friend. Friend the Member for Chelmsford. Nothing has changed since then, so I will not repeat it today and accidentally get it wrong.

Mr Kevin Barron (Rother Valley) (Lab): The Minister keeps repeating the mantra that the OFT could do this now. I questioned the Secretary of State on that point, and when challenged he eventually said that yes, they could, but they never had. What has changed to require these powers in the Bill when they have never been used before?

Paul Burstow: The change is the one articulated very clearly by the NHS Future Forum, which sees this as a further safeguard against the disproportionate use of competition law. That is the recommendation, and that is why I was interested to understand—[Interruption.] I note much laughter and mirth from the Opposition when it comes to a reference to what the NHS Future Forum had to say. They find it funny; I do not. It is a very sensible and logical answer.

Dr Poulter: Does my hon. Friend agree that it is disingenuous of the Opposition to raise this issue on competition law when in government they introduced the possibility in legislation? By introducing Monitor, we are making things much more open, clear and transparent for the benefit of patients.

Paul Burstow: My hon. Friend makes an important point. Although the mantra is that there was no legislation, there was the Enterprise Act 2002 and the Competition Act 1998. Those were the pieces of legislation that apply. [Interruption.]

Let me answer some of the hon. Lady’s questions, as that is probably what she would hope I would do. What is the burden of proof? That was the hon. Member for Pontypridd asked. In respect of seeking to intervene under competition law, the burden of proof would be on Monitor, the Office of Fair Trading or the Competition Commission to demonstrate that an arrangement was anti-competitive and acting against patients’ interests. I hope that that helps.

12 noon

Could Monitor force hospitals to stop providing dialysis? That was another spectre raised to haunt the Committee for a few moments. As long as it has demonstrated that the commissioning route provides for services that have been commissioned on a fair and open basis, the answer is no. This is not to do with competition, but with how commissioners commission services, how care pathways are put together and how we make sure that Monitor does not get in the way of that. That is why we are amending the Bill to make Monitor an enabler of integration, not a block to it.

Mr Barron: The Future Forum said:

“Under current rules, any challenge under competition law would be for OFT to deal with. However, we think that this job would be best done by a dedicated regulator with a greater knowledge of the unique nature of healthcare, including the importance of cooperation through clinical networks and the benefits of integrating services to improve quality.”

Does the Minister not believe that the clause undermines that?

Paul Burstow: No, I do not. We have these powers because they are all about the concurrent exercise of existing powers under the Enterprise Act and the Competition Act.

Owen Smith: Will the Minister give way?

Paul Burstow: I was going to answer the hon. Lady’s question about the application of part 4 of the Enterprise Act.

Owen Smith: A moment ago, in response to my question about whether non-provision of renal dialysis at home might be deemed to be anti-competitive, the Minister said that Monitor could not intervene in that instance, as long as the awarding of the contract commissioning was shown to be fair and transparent. How does that square with what the Government say at 5.15 of the response:

“Monitor could take action against a provider seeking to frustrate patient choice, or colluding with another provider not to offer patients home-based treatments.”

It does not say there that as long as it was transparent in its non-provision of home-based treatments, Monitor would not be able to do something about it. It simply says that if it engaged with a provider that did not provide the service when another provider was offering home-based treatments, that might be deemed anti-competitive and not in the interests of patients. Could the Minister explain that contradiction?

Paul Burstow: The hon. Gentleman may not have speed-read all the way through. There may well be the part that I referred to in my response to his earlier question and, given the Opposition’s role in scrutinising the Bill, he should be pleased that I have set out the Government’s position even more clearly. We have offered further clarification.

I was asked about the application of part 4 of the Enterprise Act and what a market was. I have partly answered this, but I will now stray a bit further. Clause 65 makes no change to the application of part 4 of the Enterprise Act 2002. The Bill simply gives Monitor the power that the OFT already has to make market references to the Competition Commission. A market could cover
only a part of England. In considering what amounts to a market, Monitor or the OFT would apply normal principles to reach their conclusions.

Owen Smith: Will the Minister give way on that point?

Paul Burstow: As I gather my thoughts to read the next answer, let me give the hon. Gentleman an answer to the next point and then I will take another intervention. My answer relates to one of his questions. What does burden of proof mean?

Owen Smith: We have done that one.

Paul Burstow: I give way to the hon. Gentleman.

Owen Smith: The Minister said that a market could constitute only a part of England. That makes the point that we have been trying to impress on him. If that included the whole of England that would be truly dreadful, because it would imply that anybody offering to provide any services anywhere in England and not being allowed to do so was somehow being prevented or restricted in respect of competition law. Even in a local area, surely the Minister sees the point that that could result in Monitor’s deeming standard activities—GPs contracting with a hospital, as they have always done, to provide services—in a local health market to be anti-competitive and collusive, and therefore intervening. That is the issue that we see as a problem.

Paul Burstow: We do not accept that that is a problem, because we do not believe that that is what the Bill does. The evidence is that such references have not occurred, as was mentioned earlier. There is a clear difference between colluding with other providers to deny patients choice or home-based treatment—the hon. Gentleman’s specific point—and responding to pathways of care, which commissioners have procured in a way that is open and fair. That comes back to the point that I made earlier, and to the point here that commissioners are the responsible part of the new architecture that the Bill puts in place for redesigning services and leading the effective delivery of services.

I have set out the rationale for the clause and responded to the hon. Lady’s questions. I hope that the clause stands part of the Bill.

Liz Kendall: The Minister did not reply to my crucial question: what experience, knowledge or expertise does the Competition Commission have in health and health care if Monitor has the power to refer markets, including only a part of England, to the Competition Commission?

The Chair: Would you care to answer that, Mr Burstow?

Paul Burstow: I think that we have finished.

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

Division No. 17]

AYES

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

Byles, Dan

Leffroy, Jeremy
Morgan, Nicky
Poulter, Dr Daniel

Pugh, John
Soubry, Anna
Sturdy, Julian

Owen Smith: What might that mean in practice? If a GP regularly refers his patients to the local hospital, or recommends to certain providers.

The Committee divided: Ayes 12, Noes 10.

AYES

Lefroy, Jeremy
Morgan, Nicky
Poulter, Dr Daniel
Liz Kendall: I beg to move amendment 233, in clause 66, page 81, line 5, leave out subsection (2).

I want to make two specific points about clause 66 and then I shall address the amendment. I want to remind hon. Members of the specific and significant powers given to Monitor under clause 66. Subsection (4) gives Monitor the power to disqualify directors for competition infringements if they are in breach of the Competition Act 1998. On 17 March, I asked the Minister, the right hon. Member for Chelmsford, to clarify to whom the provisions apply. He said:

“It applies to directors of companies and those in equivalent positions, such as senior staff in NHS providers who perform a director-like role.”—[Official Report, Health and Social Care (Re-Committed) Public Bill Committee, 17 March 2011; c. 876.]

That needs to be clearly on the record, so that NHS staff in primary, secondary and community care can be clear about it.

One consequence of the Bill is that if the bodies involved are found to have done something that Monitor considers has restricted competition—for example, sharing markets or having a dominant market position—they could be disqualified from working in the NHS for 15 years. If a clinician—a GP, hospital doctor or nurse—is a senior member of staff in an NHS service, will they be covered by this power? That is the first set of issues. If the Minister says, “Oh well, they’re not going to use these powers anyway,” why have them in the Bill? That is the question that he continues to fail to answer.

Hon. Members may remember that the Government tabled a new set of amendments at our previous sitting to give Monitor the power to conduct investigations where it has “reasonable grounds” to suspect that any commissioners have failed to comply with the prohibitions on anti-competitive conduct. The other Minister—the right hon. Member for Chelmsford; it is so complicated to say that all the time—gave a specific example of how Monitor could become aware of a “pattern of service provision” that suggested that patients were being directed to certain providers.

What might that mean in practice? If a GP regularly refers his patients to the local hospital, or recommends that they go there, for diabetes care—as you may gather, Mr Hancock, I am very concerned about diabetes care—would that be considered anti-competitive?

Amendment 233 is extremely important. It would delete subsection (2), which says that Monitor’s general duties—we spent last week discussing them, and the
The Government said they had changed them and that Monitor would not promote competition, but prevent anti-competitive behaviour and promote integration—need not apply when Monitor carries out its functions in relation to the Competition Act 1998 and the Enterprise Act 2002.

If the Government really want Monitor to abide by and be driven by its new duties, why does subsection (2) say that those duties need not apply when it exercises its functions under those two Acts? The Government should support amendment 233 so that they can make real their claim to have changed Monitor’s role in the Bill. I look forward to Government Members’ voting with us.

Mr Barron: I understand that we can have a general debate on the clause at the same time as a debate on the amendment, Mr Hancock.

The Chair: It is a stand part debate as well.

Mr Barron: Thank you very much.

I want to reiterate what I said in an intervention on the Minister about the clause. The explanatory notes say:

“Subsection (1) states that the concurrent nature of Monitor’s powers means that there could be no valid objection that its actions under these powers should have been carried out by the OFT.”

As I read that, the Office of Fair Trading can—if asked to, presumably—take a decision that cannot be objected to. I want to draw a parallel—I said this earlier, but I will put it on the record once again—with what is in the Future Forum’s “Choice and Competition” report. The report recommends maintaining “the provisions to give Monitor concurrent powers with the Office of Fair Trading. Under current rules, any challenge under competition law would be for OFT to deal with.”

We assume that that is what subsection (1) deals with, and that a decision cannot be reversed—presumably, the OFT decides, and that is it.

12.15 pm

The Future Forum report continues:

“However, we think that this job would be best done by a dedicated regulator with a greater knowledge of the unique nature of healthcare”.

That seems to be at odds with where the power lies. The Future Forum was clear that it was deeply concerned about the interaction of competition law, which is a point that we have heard many times, including in evidence to the Committee. It begs the question of why the clause and the previous two clauses remain in the Bill unamended, if the Government are trying to assuage people’s fears that competition law and not the health service will decide on the shape of local health services. Surely, that was what the Future Forum meant. It is added through the additionality gained from a sector-specific regulator that has knowledge of the sector, which is why the NHS Future Forum saw the advantages of that as a safeguard against the disproportionate use of competition. In essence, that was the Commission’s argument, so the right hon. Gentleman’s view seems completely unsustainable if taken alongside the whole of the Future Forum’s proposals.

As the Future Forum stated:

“Under current rules, any challenge under competition law would be for OFT to deal with... However, we think that this job would be best done by a dedicated regulator.”

The amendment relates to how Monitor would exercise its concurrent functions. Subsection (2) means that when Monitor is carrying them out, its main duties and the matters to which it must have regard would not apply—the concern that the hon. Member for Leicester West raised—unless the OFT also took account of any particular duty or matter. That is the important point. There is a clear public interest test that Monitor would apply in this context when exercising concurrent powers, and it would, of course, exercise that public interest test equipped with its sector-specific expertise and knowledge. That is the point that hon. Members who do not wish to have Monitor exercising concurrency seem to miss, because without concurrency, we leave the NHS open to the OFT, which does not have that expertise.

Mr Barron: That seems to completely contradict what the explanatory notes say about subsection (1). I repeat that “the concurrent nature of Monitor’s powers means that there could be no valid objection that its actions under these powers should have been carried out by the OFT”.

Does that not give power to the OFT? The Future Forum wanted to ensure that the OFT did not have such powers and that the sector regulator had them. What does it mean?

Paul Burstow: I am working my way through my response to the debate, and I hope that by the end of it the hon. Gentleman and others who follow our proceedings will feel that they have had further illumination.

There seems to be an implication in what the hon. Gentleman has just said that in some way, the OFT exercises power over Monitor. It does not. These are two bodies that in statute would have concurrent powers and specific duties to co-operate, which we will come on to.

Tom Blenkinsop (Middlesbrough South and East Cleveland) (Lab): My right hon. Friend raised clause 66(1), which clearly states that no objection can be made by Monitor. Therefore, the specific regulator cannot make any objection to the non-sector specific regulator.

Paul Burstow: By mistake, the hon. Gentleman makes my very argument about the need to have concurrent powers. We need to allow Monitor to exercise powers in this area and therefore to act as a shield against the disproportionate use of competition law by an uninformed regulator, which is exactly why we need concurrency. That is why the NHS Future Forum drew that conclusion.
after spending considerable time sifting through the evidence and listening to many people with expertise beyond this Committee.

Tom Blenkinsop: Clause 66(1) states that Monitor cannot make an objection. If the OFT were to rule that there has to be a minimum or a top level of percentage market procurement by the NHS, it can rule on that and Monitor cannot object.

Paul Burstow: The point that the hon. Gentleman is missing is that that is the current position. Competition law and the OFT’s powers already apply. As much as hon. Members may not like that—[Interruption.]

The Chair: Order.

Paul Burstow: That is the position. Let me try to deal with some of the questions asked and come back to some of the other points.

On the amendment itself, the OFT and Monitor would not investigate commissioners because they are unlikely to be considered undertakings. We debated that issue at length the last time the matter was dealt with. The second issue is about competition legislation setting a significant threshold in terms of the sort of practices that are to be regarded as anti-competitive. Chapter I of the Competition Act 1998 and article 101 of the treaty on the functioning of the European Union prohibit agreements between undertakings that prevent, restrict or distort competition or that are intended to do so and that affect trade in the UK or the EU.

The agreements likely to be prohibited include those by providers that, for example, fix the prices to be charged for goods or services, limit production, carve up markets, make a contract conditional on factors that have nothing to do with the subject of the contract or that discriminate between customers. Examples of such discrimination could be charging different prices or imposing different terms where there is no difference in what is being supplied. The legislation also covers cartels, which are agreements between businesses not to compete with each other.

Chapter II of the Competition Act 1998 and article 102 of the treaty on the functioning of the European Union prohibit a business that holds a dominant position in a market from abusing that position. A dominant position in a market means that a business is generally able to behave independently of competitive pressures, such as other competitors in that market. Conduct that may be considered an abuse by a business in a dominant position includes charging excessively high prices, limiting production, refusing to supply an existing long-standing customer without good reason, charging different prices to different customers where there is no difference in what is being supplied or making a contract conditional on factors that have nothing to do with the subject of the contract.

Those practices are a very long way away from providers co-operating to provide continuity of care along a care pathway. They are deliberate and serious attempts to manipulate a market to extort unjustified profits, which are already prohibited. The OFT already has the power to investigate them under current legislation. They are not in the public’s interest and they are not in patients’ interests either. It is also relevant that, under competition law, market distortions may be permitted if they are beneficial to users. That could go back to a question in our earlier discussions. However, in general, anti-competitive practices by providers, if they were to occur in health care markets, would not be in the best interests of patients because they could restrict choice and stop the NHS getting value for money for the taxpayer in the first instance.

The Future Forum concluded that Monitor should have concurrent powers with the OFT because, in looking at potentially anti-competitive practices, it would be able to bring to bear its knowledge of health care, including the importance of co-operation through clinical networks and the benefits of integrating services to improve quality. The Government agree. We think that that is absolutely right.

Tom Blenkinsop: I come back to subsection (1). Quality is not even a part of it. It is about market share, and how Monitor cannot object to the OFT applying market share rules. It has nothing to do with quality.

Paul Burstow: I will come to subsection (2), the heart of this debate, and the hon. Lady’s amendment. She asks that subsection (2) be removed from the Bill. The effect of deleting it would be to say that, although Monitor exercises concurrent powers, it should do more than exercise specialist knowledge. In our view, the provision is not necessary, because the patient’s interest can in any case be taken into account, as can the nature of NHS health care.

Moreover, removing subsection (2) would create uncertainty. If either of the two regulators can exercise powers, they must do so on the same basis. Otherwise, the determination in a particular case could differ depending on which regulator considered it. For that reason, concurrency is necessary, as it would remove that uncertainty. Accepting the Opposition’s amendment would create uncertainty and confusion, as it would not be clear what the regulator would take into account when considering whether a particular practice was in breach of the legislation. By creating Monitor as a sector-expert regulator, we are strengthening protection in the NHS.

Fiona O’Donnell: The Minister has spoken in general and glowing terms about Monitor. Will he give us the benefit of an example of a situation in which Monitor would reach a different conclusion from the OFT?

Paul Burstow: It is a good hypothetical question. The hon. Lady, who is listening carefully to my response, was not on this Committee during its first round of consideration of the Bill. One of the bitter lessons that my right hon. Friend learned on behalf of the Government Front Bench was that examples were asked for not to elucidate but to ensnare and entrap. We will avoid them for that reason. Let me give answers to some of the other questions, because—[Interruption.]

The Chair: Order. A question was asked, and the Minister responded in his own way. He is now trying to answer other questions that have been posed. Let us give him the opportunity to answer the questions that Ministers have asked.
Paul Burstow: Thank you—

Fiona O'Donnell: Will the Minister give way again?

Paul Burstow: I have only just got up. I would like to make some progress, if I may. I will gladly give way to the hon. Lady later in order to move the debate on.

A question was asked about the role of promoting competition, and the concern that other regulators might have no expertise. The issue was touched on earlier, but it is worth putting the answer on the record now. The concern was about the expertise—or the lack of it, as some asserted—of the Competition Commission. It is worth saying that promotion of competition is not an objective of the Competition Commission. That is not set out explicitly in legislation, and it is not its stated legal purpose. The OFT could concurrently refer a health care market to the Competition Commission. We will, I am sure, return later to the issue of expertise.

The hon. Member for Leicester West asked why the Bill gave powers to disqualify directors. The OFT already has powers in that area and can apply to disqualify directors for breach of competition law, including directors of foundation trusts. The Bill simply covers those powers to be exercised by a sector-specific regulator, Monitor. It gives Monitor concurrent powers.

Liz Kendall: Can the Minister give an example of a hospital in this country or abroad that has been considered an economic undertaking?

12.30 pm

Paul Burstow: To be helpful to the Committee, rather than giving a brusque off-the-cuff response, I will write to the hon. Lady to give her a proper answer to her question. I hope that will be helpful to her and her hon. Friends.

Questions have been asked about subsection (1). That subsection means that a decision reached between Monitor and the OFT as to who is best placed to make a case cannot be challenged by a third party. That is the purpose of that part of the clause. Such a decision must be taken in accordance with concurrency regulations. The hon. Member for Leicester West asked whether GPs regularly referring patients to hospital for diabetes care would be considered anti-competitive. I believe that Leicester has a high level of diabetes, so I understand that she has a constituency interest as well. The answer to her question is, no. Monitor will have power to intervene only in conduct that restricted patient choice or competition against patient interest. The answer is very clearly, no.

Owen Smith: Will the Minister give way?

Paul Burstow: Not at this point. I want to answer some questions because I would hate to forget to do so.

I was asked whether if a clinician is a senior member of staff, they could be disqualified. To be specific, the answer is, yes, in certain circumstances, but only in respect of being a director or in an equivalent position. It is important to make it absolutely clear that it is not just any member of staff, but members of staff who are exercising particular positions. The provision applies only if they have been shown to have breached the law and are deemed unfit to hold such an office as a consequence.

Tom Blenkinsop: I thank the Minister for his response to the questions about subsection (1), but subsection (2) says that Monitor must have regard to “carrying out of its functions by virtue of section 64 or 65.” Therefore, any agreement that Monitor comes to with the OFT and the decisions it makes must pay explicit regard to sections 64 and 65, which cover the Competition Act 1998 and the Enterprise Act 2002.

Paul Burstow: The hon. Gentleman refers to Acts for which we are attempting to give concurrency. We are responding to the argument made by the NHS Future Forum that concurrency is the best way to safeguard the NHS from the disproportionate application of competition law. The Government agree with that, and that is why we are retaining the clauses and making other changes to the role of Monitor, particularly the discharge of its licensing proposals. Having dealt with, I think, all the questions, I hope that I have made progress, that the clause stands part of the Bill and that the amendment is rejected.

The Chair: I call Liz Kendall to respond to both the amendment and the question on clause stand part.

Liz Kendall: I know that the Minister does not have direct responsibility in his day job for this aspect of the Bill because he is responsible for social care, but, with the greatest respect, I do not think it is good enough for him to work his way through the debate hoping to come up with an answer at the end or not answering the question of my hon. Friend the Member for East Lothian that, “unless the OFT takes a particular public interest point”. At best, it is unclear whether the legislation gives the OFT the ability to make a different decision from Monitor, and, as we will see in later clauses, it is clear that the Competition Commission also has a role. At worst, as my hon. Friend said, they are trying to cover up the fact that the OFT and the Competition Commission have additional roles. It is not pure concurrency.

Liz Kendall: I absolutely agree with my hon. Friend. On the one hand, the Government insist that Monitor has been given concurrent powers with the OFT, but in the next breath the Minister said—I hope I quote this accurately, but Hansard will have recorded it if I am wrong—“unless the OFT takes a particular public interest point”. At best, it is unclear whether the legislation gives the OFT the ability to make a different decision from Monitor, and, as we will see in later clauses, it is clear that the Competition Commission also has a role. At worst, as my hon. Friend said, they are trying to cover up the fact that the OFT and the Competition Commission have additional roles. It is not pure concurrency.

John Pugh (Southport) (LD): Is not the answer to the question of the hon. Member for East Lothian that, when it makes an appropriate decision as a regulator, Monitor can properly take into account the need to have integrated services, which is not in the remit of the OFT? In some circumstances, therefore, Monitor will make slightly different decisions if asked to do so.
Liz Kendall: What is not clear from the Bill is who has the final say and whose decision holds sway. We also see that in later clauses about the Competition Commission’s role in reviewing the development of competition in the NHS. Later on, we see it in the role of setting prices, which my hon. Friend the Member for Pontypridd will talk about. It is unclear. If there is a dispute between Monitor, the NHS commissioning board and providers about how a price can be set, the matter can be sent to the Competition Commission for arbitration. Who has the final say? The Bill is not clear. To suggest that Monitor is given concurrent powers to those of the OFT or the Competition Commission is simply incorrect.

Paul Burstow: The hon. Lady has moved on a bit from the point that I wanted to clarify and correct. I was making the point that, as the clause is about disapplying certain main duties of Monitor when it carries out its functions, the OFT and, by extension, Monitor still apply a public interest test. The difference is that Monitor, as a sector-specific regulator, is informed by its expertise in health care when it applies the test.

Liz Kendall: I am grateful to the Minister for his attempt to clarify the Bill.

Mr Burns: It was rather good.

Liz Kendall: The right hon. Gentleman says that it was rather good. I am sure that he is grateful that he is not sitting in the Minister’s position at the moment and trying to explain the issue.

What additional powers the OFT has here is unclear in the legislation. Later on, we will see that it is unclear whether the Competition Commission also has different powers and who will have the final say or make the final decision. It is wrong that Monitor does not have to pay regard to its general duties when exercising its functions under the Competition Act 1998 and the Enterprise Act 2002, so I want to push amendment 233 to a vote.

Question put, That the amendment be made.

The Committee divided: Ayes 10, Noes 12.

Division No. 18]

AYES

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Question accordingly negatived.

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

The Committee divided: Ayes 12, Noes 10.

Division No. 19]

AYES

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Question accordingly agreed to.

Clause 66 ordered to stand part of the Bill.

Clause 67

Requirements as to procurement, patient choice and competition

Amendment made: 158, in clause 67, page 82, line 7, leave out paragraph (c) and insert—

‘(c) do not engage in anti-competitive behaviour which is against the interests of people who use such services.’—

(Paul Burstow.)

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

Debbie Abrahams: By opening up competition under the guise of increasing patient choice and clinician-led commissioning, the clause epitomises what the Government are trying to do with the NHS. In spite of the weak evidence, they are trying to convince us that a competitive market health system is the way to improve quality of health care or, to paraphrase, it is the Government’s preferred way to deliver health care. The current Secretary of State made that clear in a speech to the NHS Confederation in 2005. He said:

“So the first guiding principle is this: maximise competition. There are, of course, potential benefits from privatisation in terms of access to capital, flexibility, and creating new markets; but private sector ownership is a secondary consideration to competition, which is the primary objective.”

He then explained that in order to maximise competition, we need to maximise the number of providers and purchasers in the system. He continued:

“To make markets work requires not only a plurality of competing suppliers, but willing and active customers.”

He went on to say that the NHS needed “more consumers rather than fewer.”

In another key statement, the right hon. Gentleman said:

“The statutory formula should make clear that choice should be exercised by patients,”—

this is fundamental—

“or as close to the patient as possible, thereby maximising the number of purchasers and enhancing the prospects of competition.”

That explains why the Government are transferring power and financial decisions to GP commissioners. The commissioners are closest to the patient and GP
commissioning will help to increase competition and the number of purchasers through greater choice in the system, especially if it is driven by the private framework for procuring external support for commissioners. That also explains the patient-held budgets policy. The Government want a system in which the number of both purchasers and providers are maximised, creating a citizen consumer competitive market to drive forward the forces of “creative destruction” on the NHS.

Unfortunately, creative destruction causes constant entry and exit from the market, which is prohibitively expensive in health care because of the costs of medical infrastructure, technology and staffing. In a single payer system with a fixed budget, such as our NHS, that will inevitably lead to financial meltdown. The only way to avoid that is by getting extra capital into the system, and this is where we come to the heart of it. The Bill achieves that in a number of ways. First, foundation trusts can borrow money from the City to invest. They will have to repay that by treating more NHS patients and more private patients; that will be aided by the abolition on the cap on private patients' income for foundation trusts. Secondly, there will be an increasing demand for health care insurance as waiting lists go up. We are seeing that already under the so-called efficiency measures. Thirdly, a new insurance market will be set up for top-ups and co-payments. Fourthly, we fear that this will also lead to direct patient charges.

12.45 pm

Because the NHS budget is fixed, the drive for excess capacity and a consumerist approach to health care will have a rapid draining effect. That will result in clinical commissioning consortia increasingly becoming rationing bodies, driving up waiting lists and reducing the number of core NHS services. It will drive foundation trusts into further debt burdens, forcing closures, mergers and private management takeovers. That is why the clauses are in the Bill. Despite what Ministers have said in the past, we are already seeing the beginning of that in increasing waiting lists. In fact, the process is crucial to stimulating the private health care insurance and provider industry. That is why we argued strongly for the retention of the exact phrasing of the Secretary of State's duty to secure and provide a comprehensive health service.

Although the Government have supposedly made concessions that recognise that the public would not accept an attempt to privatisate the NHS, as the utilities were privatised by a previous Tory Government in the 1980s, they have changed tack, not direction. The quality, innovation, productivity and prevention programme allows politicians to say that the NHS will continue to improve and work better. This is a disaster for our NHS, which is actually a very expensive in health care because of the costs of medical technology. The Secretary of State clearly set out his vision in 2005. He believes that the market requires not only plurality but willing and active consumers. He believes that maximising competition is the primary objective, that a strong pro-competitive regulator, Monitor, is needed, and that there should be a regulatory regimen geared towards maximising competition or, where competition is absent or limited, enforcing contestability. He believes that the market requires not only plurality of competing providers, but willing and active consumers. It is clear that a single payer system, our NHS, cannot survive these policies. In fact, the whole point is to move away from that idea and the Bill will certainly see to that. This is a disaster for our NHS, which is actually a very efficient system. We need proper accountability and collaboration, not this competitive market system that is being introduced.

Mr Burns: I find that last statement extraordinary. It was the hon. Lady's party, which was in power until last year, that imposed that programme. In recognition of the situation, we have allowed the NHS to take four years instead of three to make the savings, so that it can reinvest every single penny in front-line services.

Debbie Abrahams: With all due respect, the scale and pace of the Minister's proposals—I will come on to this—far exceed what the Labour Government set in train.

We have said all along that the Bill is a privatisation measure. Dr Lucy Reynolds, who submitted evidence to the Committee, says:

“I worked as a privatisation adviser in the 1990s, and I can recognise a privatisation law when I see it. That's what this is, and, even more disgracefully, it is nothing but that. It does nothing constructive for the NHS at all, just removes its protections against being pillaged and weakens patients' protections against being harmed.”

The Bill is designed to make the NHS fail and drive the need for private investment in our health service. Taxpayers will pick up most of the bill, but get less and less for their money. Additionally, English citizens will increasingly have to consider taking out health care insurance policies. The most vulnerable in society will be the most adversely affected because of the inverse care law.

Finally, opening up the NHS to EU competition law will dramatically increase the amount of capital available to our health service, but, ultimately, that capital will flow back to the investors as profit, at the expense of the UK taxpayer, private health care insurance payments, and so on. That will only increase income and health care inequalities, which are both known to damage economic growth. As I have asked throughout our deliberations, how can the Secretary of State justify the Bill? How does this clause relate to clause 3 and his duty to reduce inequality? It is a paradox.

The Secretary of State also mentioned EU competition law in his 2005 speech, saying:

“A vital aspect of our relationship with Europe should be to encourage the EU to be concerned with promoting competitive markets. Although we don't want the EU to intervene directly into domestic legislation, I see no difficulty with encouraging EU trade in services, by ensuring that a strong market orientated regulatory framework is in place in each Member State. And it will come, I dare say, for the education and health in the future—as it did for Telecoms in the recent past. I see good reason to plan positively for it, rather than ignore it.

The time has come for pro-competitive reforms in public services including health and education.”

The Secretary of State clearly set out his vision in 2005. He believes that maximising competition is the primary objective, a strong pro-competitive regulator, Monitor, is needed, and that there should be a regulatory regimen geared towards maximising competition or, where competition is absent or limited, enforcing contestability. He believes that the market requires not only plurality of competing providers, but willing and active consumers. It is clear that a single payer system, our NHS, cannot survive these policies. In fact, the whole point is to move away from that idea and the Bill will certainly see to that. This is a disaster for our NHS, which is actually a very efficient system. We need proper accountability and collaboration, not this competitive market system that is being introduced.

Mr Barron: I do not wish to delay the Committee, but I would like to ask a question. Subsection (2) enables the making of regulations that will capture only contracts that are primarily for services, not procurement. I do not know whether that is any great change for the NHS, but that is what it is designed to do. Subsection (3) states:

“Regulations under this section may, in particular, impose requirements relating to”—

two areas. One area, in paragraph (b), is:

“the management of conflicts between the interests involved in commissioning services”.


The potential for clinical members of commissioning consortia to commission services effectively from themselves has been well trawled through by the Committee. Safeguards have been written into the Bill in relation to that. The other area, in paragraph (a), is: “competitive tendering for the provision of services”.

That strikes against a lot of the disquiet in the Future Forum about the intention behind the Bill. Will the Minister explain exactly what type of competitive tendering there will be and what it will be based on? Presumably, we are talking about services within and without the NHS. What regulations do the Government have it in mind to lay out the detail? That would be useful for the Committee to know.

Tom Blenkinsop: I have a similar point relating to the reference in the clause to “competitive tendering for the provision of services”.

As I understand it, it is the Government’s intention to apply similar rules that were applied by the Labour Government in terms of best value principles for non-tariff services. May I mention in passing, because it may help the hon. Member for Oldham East and Saddleworth, that not only were the £20 billion efficiency cuts introduced by the previous Government, but the previous Chancellor of the Exchequer defended them at the Treasury Committee and said that they were entirely doable? I can send her the reference if she would like me to.

Tom Blenkinsop: I draw the Committee’s attention to subsection (1), which refers to regulations to ensure that commissioners “do not act in a manner that would…prevent, restrict or distort competition in the provision of health care services for those purposes.”

and that:

“protect and promote the rights of patients to make choices”.

Again, there is no mention of quality. The provision is again subservient to clauses 64 and 65—the coterminosity of the OFT and Monitor acting together, making decisions based primarily on clauses 64 and 65, which bring in the Competition Act and the Enterprise Act. Quality is not even mentioned in the clause.

Nicky Morgan (Loughborough) (Con): May I draw the hon. Gentleman’s attention to that fact that I think the Committee has just amended subsection (1)(c), so that it now refers to regulations to ensure that commissioners “do not engage in anti-competitive behaviour which is against the interests of people who use such services.”

The revised wording, as I understand it, talks about the interests of the people using those services.

Tom Blenkinsop: It still does not mention quality.

Tom Blenkinsop: My hon. Friend makes a good point. Again, we have absolutely no definition, and I hope the Minister will be able to give us an answer on this point.

What I am concerned about is that quality is not even mentioned. How does that relate to promotion or even advertising? A patient’s choices could be based on advertising by a private company that is seeking that patient’s choice. That does not necessarily mean that the patient is making a decision based on information about quality; rather, it is based on private sector advertising.

Liz Kendall: I shall touch on a point that was eloquently made by my right hon. Friend the Member for Rother Valley. We are all concerned about subsection (3)(a). As he correctly said, it suggests that regulations could be passed to impose requirements on the NHS board—on national services, therefore—and on local commissioners to put services out to competitive tender, but it is not clear what that will cover. As my hon. Friends may remember in the original Bill Committee, we tabled amendment 492, which would have deleted subsection (3)(a) to ensure clarity. The hon. Member for Southport may remember that he voted against that amendment.

It is not right for the Secretary of State to have the power, as he could under subsection (3), to use regulations to force—the clause uses the words “impose requirements”—the NHS board, which will be responsible for commissioning £20 billion-worth of services, as well as local commissioning groups to put services out to competitive tender. If that is to happen, it should be up to clinicians, commissioners and patients, not the Secretary of State. That is why we tabled the amendment, but, unfortunately, the Government voted against it. I ask the Minister now to do what the Minister of State, Department of Health, the right hon. Member for Chelmsford, was unable to do last time, and clarify which services the provisions cover.

The Chair: Mr Burrow, it would be very nice if you could conclude by 1 o’clock.

Paul Burstow: Although I might please you if I did that, Mr Hancock, I would probably be doing a disservice to the debate. I need to make sure that I respond properly.

The Chair: I say that only because I understand that, this afternoon, you will be answering a question on the Floor of the House that may be relevant.

Paul Burstow: That is a matter for business managers and not us.

Let me deal with some of the points that have been raised, starting with those raised by the hon. Member for Oldham East and Saddleworth. Her comments seemed to move us into some sort of twilight world, or alternative universe, where the Labour party’s conspiracy theories were writ large; they seemed to be the perfect rehearsal of a conspiracy theory. [Interruption.] From
a sedentary position, other Members say, “We’ll see,” which rather underlines the point that we are talking about a conspiracy theory.

The hon. Lady talked about efficiency measures. My hon. Friend the Member for Southport rightly drew attention to the evidence, and indeed the stout defence, given in respect of the QIPP programme, which the Labour Government identified as necessary. They identified the £15 billion to £20 billion of savings as an absolute necessity and they commenced the work to get the programme under way. It does not behove the hon. Lady to imply that the coalition has cooked up that programme since it came into office and inherited the present challenge. We are working through the programme to redesign services to ensure that they actually deliver better value for the taxpayer and quality outcomes for the individual. I am sure that the hon. Lady accepts that those measures emanated from the Labour Government.

Debbie Abrahams: Both Ministers have talked throughout the debate, and throughout the re-committed Bill phase, about context. The Bill is exacerbating the problems by adding to the efficiency savings that the NHS is having to undertake, which is totally inappropriate. I agree with the Minister about context, and, in this case, the context is inappropriate.

Paul Burstow: I still do not agree with hon. Lady’s contention, but she has at least come nearer to a rhetoric that is related to the real world and that contrasts with the unreality of her original propositions. I look forward to returning to the issue later.

1 pm

The Chairman adjourned the Committee without Question put (Standing Order No. 88)

Adjourned till this day at Four o’clock.