Conflicts of interest in the post Lansley NHS—from a regulated to an unregulated healthcare market?

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The common perception of the UK government's recent proposals on reforming the NHS announced in the recent Queen's Speech is that it represents the moment when the government finally turned its back on private sector involvement in the NHS and overturned the market-based orthodoxy in health policy which stretches back almost three decades to the internal market reforms of the early 1990s.

This interpretation, however, is flawed as it fails to recognise the extent to which market-based provision is now deeply embedded in England's health and social care system, and wrongly assumes that the changes to the NHS's institutional structure proposed in the white paper will bring about a radical shift in the role of the private sector in the delivery of healthcare.

The overall percentage of NHS expenditure which is used to buy healthcare from an array of private providers —excluding GPs—is currently around 18%, or £21 billion a year. At the local level clinical commissioning groups (CCGs)—the bodies which currently purchase healthcare services on behalf of their local populations —spend on average around £1 in every £6 purchasing healthcare from outside the NHS: many are now spending over a fifth of their budget on private providers.

Prior to the pandemic almost one in three NHS funded hip replacement operations took place in private hospitals, and almost all provision of care home and home care services—which the white paper wants to see integrated with NHS care—is now provided by private providers.

Add in the fact the NHS has recently outsourced £10 billion worth of clinical services to be provided by private hospitals over the next four years and it is clear that the current government remains highly committed to providing new market opportunities for multi-national healthcare companies, irrespective of the proposal in the white paper to remove the legal requirement on the NHS to put services out to competitive tender.

If buying health and social care services from market-based providers will continue to be a major feature of the English healthcare system, the question arises what type of market this will be, and how it will be regulated, particularly when the reforms are being sold on the basis that much of the architecture underpinning the market will be stripped away.

The white paper proposes three major changes to the NHS market framework introduced by the 2012 Health and Social Care Act.

1. A clear distinction between those buying healthcare for their local populations and those providing them—the purchaser provider split—will no longer exist. The purchasing bodies CCGs set up under the 2012 Act will be abolished and decisions taken about who will provide services will transfer to a loose and relatively informal collaboration of different NHS bodies and local authorities known as Integrated Care Systems (ICS)
2. Public procurement rules governing the tendering and awarding of contracts for services will no longer apply to NHS bodies with an unspecified" provider selection regime" being put in its place
3. Economic regulation of the market in the form of price setting and the application of competition law to purchaser and provider behaviour will also be significantly watered down.

But it is not possible to remove the regulatory framework for a multi-billion pound healthcare market and put nothing in its place—as the white paper intends to do—without creating serious risks to the integrity of the service.

One major area of concern are the institutional arrangements for Integrated Care Systems, which are likely to foster an array of conflicts of interest, with the potential to seriously undermine the probity and transparency of local decision-making.

While exact institutional arrangements for ICS's appear to be left for local elites to determine, it is expected that provider organisations—such as NHS Trusts, GP confederations, and potentially private sector providers —will sit on the boards of ICS's and will determine between themselves which of them are to provide which services, and on what terms. This will inevitably mean that those organisations who issue contracts for the provision of local healthcare services will also be involved providing them, thus institutionalising conflicted interests at the heart of the new NHS structure.

The National Audit Office raised significant probity concerns about this model of healthcare commissioning in 2015 after a decision by NHS England to allow CCGs—which are in effect GP membership organisations—to purchase primary care services from their own members. The NAO found that this created major conflicts of interest and "a risk that commissioners may put, or be perceived to put, personal interests ahead of patients' interests."

Research for Transparency International found that this risk was indeed significant. In 2019, £1.5 billion was paid by CCGs to companies associated with their own board members to provide primary care services—an institutionalised conflict of interest that would not be tolerated anywhere else in the UK public sector.

In addition to concerns about how contracts are awarded, the problems of institutionalised conflicts of interest within ICS's are likely to emerge if locally commissioned healthcare services fail to deliver—how providers who are represented on the boards of an ICS will be held to account in the event of a contractual breach or a service failure for which they are responsible is an issue on which the white paper remains silent.

This accountability gap at the heart of the proposed reforms is likely to be made worse by the removal of the public sector contract regulations from the NHS, regulations which require contracts to be subject to open competition and which explicitly prohibits conflicts of interest between contracting parties.

The proposed loosening of competition law in relation to providers of NHS services is also problematic, particularly as growing numbers of multi-national healthcare companies are seeking to gain a foothold in the UK market, including in the provision of primary care services.

While media reports have covered the recent purchase of 37 GP practices in London by the US Healthcare corporation Centene, making it the largest corporate provider of GP practices in the English NHS, little attention has been paid to the fact that, according to the Competition and Markets Authority Centene also owns "at least" 25% of the Circle Group, which is now the largest private acute hospital provider in the UK, following its takeover of BMI last year.

Like most of the private hospitals in the UK, the hospitals acquired by Circle generate a large proportion of their income (around 40%) from treating NHS patients who are referred to their hospitals by GP practices, so it is an astute move by Centene to have secured a significant financial interest in both the primary and secondary care parts of the NHS market

However, such an arrangement again holds out the possibility that conflicts of interests may arise and raises further questions about how to prevent the decision-making of clinicians from being influenced by financial considerations, particularly those working in the increasingly corporatised primary care sector.

As long as the NHS relies on private companies to deliver NHS services it will require a highly effective form of market regulation to protect it against the well-documented tendency of for-profit healthcare companies the world over to fix prices, generate illegitimate income through fraud, engage in collusive and monopolistic behaviour, and win public sector contracts through cronyism.

Simply shifting the policy goal of the NHS from competition to collaboration will not mitigate these risks. Parliament will need to consider ways in which it can amend the proposed reforms to introduce a new form of market regulation which is effective in protecting the public interest.

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The claims made in the blog by David Rowland (BMJ Opinion May 28th 2021) are that private companies will have a powerful influence over the allocation of NHS funding and that this will cause conflicts of interest and also facilitate further private sector penetration of the NHS.
Some background to the relevant parts might assist.
A White Paper and proposals for a new NHS provider selection regime foreshadow a Bill to be published soon. The Bill seeks to put into law what has already largely happened. Compulsory tendering for NHS funded services within a market system will end. And, NHS structures in England will be redefined around 44 Integrated Care Systems (ICS). This follows what the NHS in Scotland and Wales did years ago.
Within ICS's, NHS Boards will bring together the various fragmented parts of NHS services for a defined area, returning us to something like the Health Boards of 3 decades ago, before the era of markets and competition. This does give rise to huge conflicts of interest but between competing NHS vested interests – like the acute sector versus the rest.
Ironically the past 10 years has seen NHS services "commissioned" by CCGs made up of GPs who are for-profit 'independent' contractors! This was not pointed out in Rowland's blog.
Again, following our devolved neighbours, ICS Partnership Boards will sit above NHS and local authorities to promote coordination in service planning for a defined area (population). If this sounds familiar it is because we currently have Health and Wellbeing Boards with basically that

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