



Unite Briefing

Health and Social Care Bill: Combined Impact Assessments

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The Combined Impact Assessments contain a huge range of further information and data to explain the legislative impacts and intentions of the Bill.

As of Thursday, January 27th, the Impact Assessments had not been provided to the Vote Office in the House of Commons, despite Second Reading on the following Monday.

However, Unite has examined the CIAs and found them to reveal that:

- A pure market ethos is to transcend the ethos of the health service – but it is to be helped to ascendancy by a lenient regime and assistance with costs.
- Despite the Coalition Agreement’s pledge to “stop the centrally dictated closure of A&E and maternity wards, so that people have better access to local services”, the government’s proposals will mean hospitals will have to close – even where there are mass redundancies or health needs will not be met
- MPs and local campaigns will have no powers to prevent closures
- The government wants the changes completed by 2014. In short, the government may be prepared to let NHS hospitals go in to administration in order to meet a political timetable.
- The government does not want failing hospitals to be saved – because this will intrude on the market they are seeking to enforce.
- Despite the Health Secretary’s recent claims to the Commons that the market will not be rigged in favour of a private provider, it is clear that they will be helped to gain and maintain a prominent place in the new market.
- A private sector acute provider (e.g. a hospital) is found to have a cost base 14% higher than the NHS equivalent. But the NHS would be forced to subsidise private health companies competing with Foundation Trusts in order to make up for their extra costs, specifically including tax – taxpayers will, quite literally, pay their tax back.
- The Bill undermines the supposed ring fence around the NHS budget, because private health companies would be paying tax to the Treasury, but the NHS would then have to refund it.
- By the government’s own admission, the NHS is an economically cost-effective model compared to private providers. Public investment is more efficient than private. However, the government views this as a problem because it may prevent the development of a market in health care it seeks.

Hospital Closures: Markets versus Democracy

One of the most significant issues dealt with by the IA is the necessity of “provider failure” for the market to function properly – and the corresponding need to deliberately and explicitly exclude elected representatives from any decision making about health care providers in their area.

In particular, **it makes clear that local hospitals will have to close** – and that **the local MP (or council) must not be allowed to have any way of preventing this.**

The theoretical base for this is made clear in the opening passages of the Impact Assessment of Policy Option B, which states that *“competition works best where good providers can ... enter new markets, and poor providers are forced to contract or exit markets”*. [B4, p33]

The document continues that under the current system *“there is significant risk ... of political lobbying having undue influence on decision-making. This provokes suspicion of failing providers being inappropriately supported through public funding to avoid politically unpopular hospital closures or service reconfigurations.”* [B6, p34]

The introduction concludes that a new system must be *“free from political influence”* in order to *“enable provider entry and exit to a greater degree and more intense competition between providers”*. [B8]

It goes on to complain that “provision remains within NHS Trusts which are accountable to government” [B11] and that the NHS “hampers provider entry and exit” [B17] and a new system must involve “forcing out inferior providers” [B12]. It makes clear that the Bill “will address these problems and in future, we should see ... higher levels of exit” [B18].

These sentiments are repeatedly emphasised throughout, with references to forced exit by providers (a bureaucratic phrase that is only occasionally translated in to the reality of NHS Trusts going bust or departments closing) appearing 15 times in the first 14 pages.

The evidential base in Part C makes clear that, unless some providers “exit” the market, the changes will not produce the benefits that are anticipated. Almost all of the studies cited in paragraph B25 as proving that competition drives efficiency and productivity gains make explicitly clear that this is because weaker competitors will fail and thus exit the market.

This case is explained again in the government’s conclusions [B112, p53]:

For competition to work effectively, less effective providers must be able to contract or exit the market entirely; historically, local and political objections have constrained the contraction of poorer providers. International experience confirms that the state finds it politically hard to step away from underwriting deficits and to allow hospitals to fail. This presents a strong case for regulatory independence and freedom from political interference.

The final section on Risks and Assumptions is similarly stark [B149, p60]:

Successful providers will be able to expand as they attract new patients or win new contracts. However, some providers will struggle to attract patients or win contracts. These providers will need to restructure their services and those who are unable to improve the quality and efficiency of their services may fail. There is a risk that this could lead in inequalities in access to services or disruption to the continuity of essential services.

In case there is any doubt about the practical meaning of this, the document goes on to cite the Dutch Health Ministry’s rescue of a local hospital that faced bankruptcy and closure. The Dutch Health Minister decided that a bankruptcy would interrupt continuity of care because there was no competitor immediately available to take over the hospital – a decision that the UK government appears to cite as a warning of how to get it wrong. [Footnote, p53]

The government outlines plans, contained in the Bill, to “address these weaknesses” so that the “taxpayer will be protected from political pressure to rescue providers” [B114] by a regulatory system “free of ministerial influence, to ensure that political imperative does not stifle the development of a market structure more conducive to competition.” [B58]

Clearly, it is a source of great frustration to the government that people behave as citizens – pressuring their representatives to maintain local NHS services – rather than as consumers willing to let the weak go to the wall. Therefore, they must essentially be protected from themselves.

The government’s statement that “public funds will not be used to support unviable providers in the long term” is rather revealing given that the entire system is based on public funds and that the purpose of the NHS is provide services that would be “unviable” in a true free market.

The government does acknowledge that there are cases where the failure of a provider would lead to the closure a service that it is desirable to retain for healthcare reasons.

But, as outlined above, **they are extremely clear that democracy cannot over-ride the diktats of the market.** The government makes clear that the existing “unsustainable provider regime” set out in the Health Act 2009 provides too much “ability for political interference”.

They have, therefore, created a new “failure regime” where key services will be “designated” by the unelected and unaccountable regulator, Monitor, which will also have sweeping powers to determine the criteria for which services are designated.

The supporting documents do, however, set out that the criteria are “likely to focus on identifying where a provider is the only provider or one of very few providers in a local area” and that the only “justification for additional regulation” is the “the need to maintain patient safety in the absence of other providers”. [Box 2: Provider Failure Regime, p. 54]

The criteria, therefore, are likely to be somewhat restrictive. **In particular, the government seems to have created a bias towards rural areas (where are many Tory seats) where there are less likely to be alternative providers and against large cities (more Labour seats) where there are more likely to be other hospitals or services available.**

Certainly, the language of the government's policy proposal does not seem to hold out much prospect that all existing NHS Trusts, let alone other existing NHS services, will be designated. These might, therefore, be allowed to "fail" without even a requirement for continuity of service.

Where a service is designated, a special administration regime will apply. **Monitor will apply to the courts to appoint a "special administrator", who will be a "qualified insolvency practitioner" rather than a healthcare professional.** [B115, p54]

They will be responsible for ensuring that the designated services continue (it is unclear what will happen if, for example, only certain departments of a hospital are designated but that the entire Trust fails) and to develop plans to ensure their continuity in future.

This will include the responsibility to establish funding arrangements to finance that provision. However, the regulator will create a "risk pool" system for this, in which any designated service will effectively pay an insurance premium to a scheme (which the document states will be a "financial institution", presumably private sector) that will then pay out to finance the provision of services where a provider has failed.

In the longer term, however, the options available to the administrator will be "transfer, rescue or tendering for alternative provision". [Box 2]

The IA does not spell out what this means, but it appears to suggest that if an NHS Trust providing designated services were to enter special administration, and that it could not be rescued by the administrator and no other Trust would take it over, then the administrator would open it to competitive tendering and a private company could do so instead.

This is supported by a statement in the final section on "Risks and Assumptions", which highlights the risk that a designated service might continue in administration for an extended period, draining the risk pool and forcing up premiums across the system. This will be mitigated by the regulator forcing administrators to "invite tenders from possible substitute providers in order to find the most cost-efficient substitute". [B150]

The legal ownership of Foundation Trusts is slightly unclear, though there is legal opinion that they are owned by their members, i.e. staff, patients and the general public in their catchment area.

The special administration regime appears to leave open the possibility that these assets could end up in private hands where a Foundation Trust fails, even where it is designated.

Furthermore, the risk pool arrangement does create some disincentive for designation as it means that the service provider has to pay the premium. These costs may be passed on to the commissioning consortia, but that may disadvantage a designated service in bidding for patients and this may also dissuade commissioners from applying for designation.

In listing the "expected benefits" of this system, the paper contradicts its own argument by acknowledging the "possibility of more failure cases" but saying that "greater failure rate" is "not necessary to produce benefits" as "the threat of overall failure will produce benefits without providers necessarily failing". [Expected benefits: Intermediate Outcomes, p. 55]

The conclusions, set out in Section E, also do not match the government's own evidence for its own policy, stating that they "do not expect large-scale provider failure, especially amongst larger providers", explaining that instead they will be forced to "restructure" and "exit service areas where they are relatively inefficient".

In short – where your local NHS Trust is in trouble, you can expect mass redundancies and departmental closures, but that will be a sign of success rather than failure.

The practical significance of this policy is that the innumerable MPs who campaigned on saving their local hospital cannot in all honesty vote for this Bill, knowing that in so doing they are voting for a measure that is purposely and expressly designed to prevent them having any such say in future, and will potentially lead to the very outcome that they so vociferously campaigned against.

This is particularly ironic given that the two coalition parties were especially notable for campaigning against closures and reconfigurations while in opposition and during the election. **The Coalition Agreement also pledged to “stop the centrally dictated closure of A&E and maternity wards, so that people have better access to local services.”**

But this goes to the heart of the government’s ideological approach – it is not that they object to services closing, but that it was the state that decided to do so and not the market. The government’s own case makes it clear that they believe that the market cannot work alongside democracy – and it is the market that will rule.

Private companies: get your tax back

Perhaps the most extraordinary proposal made within the Impact Assessment – though never put before Parliament in clear terms and on its own merit – is the envisaged solution to the supposed problem of “market distortions”.

The government’s Impact Assessment outlines a major problem with the proposed market in healthcare: “Providers currently face different cost conditions purely because of their organisational type. These arbitrary cost advantages for particular provider types are referred to as ‘fair playing field distortions’.” [Para B51, p42]

The government fears that the differing costs of potential providers will prevent a market developing, especially if “distortions are enshrined in national tariffs” and thus a provider with higher costs could not match the price that another provider could offer a treatment at. In particular, the government’s concern is that tariffs are “set on the basis of cost data provided by NHS organisations” not the private sector. [B52]

The IA then cites a KPMG study (Fair Playing Field Report, 2009, KPMG for Dept of Health) that quantified some of these “distortions”. It concludes: “The majority of quantifiable distortions work in favour of NHS organisations”. [B55]

The study identified the three most significant “distortions” as:

- Tax: private health providers have to pay Corporation Tax while the NHS does not; and they cannot recover all of their VAT costs
- Capital: public investment is much cheaper than private borrowing
- Pensions: the private sector cannot access the NHS pension scheme, which would make it more expensive to provide equivalent benefits to staff

The study estimated that because of these, **a private sector acute provider (e.g. a hospital) had a cost base 14% higher than the NHS equivalent.** Only those distortions working in favour of the NHS rather than the private sector appear to have been measured.

The IA also provides a slightly more detailed summary of these and other potential “distortions”. [Table B1: Fair Playing Field Distortions, p43]

There is an alarming reference to “labour terms and conditions”, suggesting that the “statutory protections offered to NHS staff tend to restrict workplace mobility and can make it very expensive to make staff redundant, which impacts the costs of NHS providers” – however, this leads it to conclude that this is a disadvantage to the NHS, rather than advantage in attracting staff.

There is also an *intriguing section on the “Cost of Capital”, in which the government admit that public investment is far more efficient than private borrowing – though they again view this as a problem rather than an argument for publicly-funded investment instead of creating private markets.*

It also notes that “NHS providers with PFI schemes are disadvantaged relative to NHS providers who do not have such schemes due to higher costs of capital”.

There is also a potentially significant admission under the section entitled “Cross-subsidy in tariffs”, which notes that emergency admissions are “perceived to be systematically under-funded” and that other tariff income is therefore used by NHS Trusts to cross-subsidise the overheads involved; that “NHS hospitals treat more complex patients than private hospitals ... as they have to accept all elective referrals regardless of cost”; and that “private providers can have referral criteria” which allow them to effectively take the easiest patients and treat them at the average cost, while NHS providers must treat the more expensive patients at the same overall price. It is noted elsewhere that these factors are “difficult to quantify” and no attempt is made to do so. [B56]

The section concludes that “a better understanding” of variable costs is needed but that so is unspecified “action to make the playing field fairer”. [B59] There is also a hint of what this might mean in the observation that “distortions would not affect competitive neutrality and efficiency ... if prices differ to neutralise competitive (dis)advantages.” [B53]

In summary, the NHS is, by the government’s own admission, an economically cost-effective model compared to private providers, and public investment is more efficient than private. However, the government views this as a problem because it may prevent the development of a market by disadvantaging the private sector – and the development of a market is more important than value for money. This appears to leave open the question of the government’s solution to this perceived problem.

Their proposals for doing so have been slipped quietly in to an apparently unrelated section on the powers of Monitor, the economic regulator [B108]:

The regulator will also be tasked with publishing advice to Government and NHS Board on barriers to competition / fair playing field ... and to propose / implement recommended solutions. For example ... the tariff methodology could be developed in such a way as to move towards a fairer playing field by **setting different prices for different providers in order to recognise difference levels of implicit subsidies.**

In other words, **the NHS would be forced to subsidise private health companies competing with Foundation Trusts in order to make up for their extra costs, specifically including tax – we would quite literally pay their tax back.**

Similarly, they would need to be compensated for their higher borrowing costs – presumably the tariff might need to vary year-to-year depending on the state of the lending market.

They would also receive a bonus in respect of the NHS pension scheme – though they would not, of course, have to pass this on to their staff.

On the evidence presented in the Impact Assessment – though this seems to be selective and entirely focused on those factors that benefit the NHS rather than private health – this would mean a 14% premium paid to private providers for the same procedure over that paid to an NHS provider.

This would not be paid by commissioners (as it would obviously act as a disincentive to commission from the more expensive private provider) but would come from a central NHS pot. A legal opinion from Hempsons suggested the “most likely scenario” was “a system whereby commissioners paid the same tariff rate to NHS and private providers, but the 14 per cent was subsequently deducted from NHS providers and placed in a central pot to fund their state subsidised benefits.” **An opinion from Beachcroft largely concurred but suggested that an alternative might be that Monitor would force “a reduction in the value of NHS pension scheme benefits”.** [HSJ, 25 Jan 2011]

Among the many obvious problems with this approach, **it undermines the supposed ring fence around the NHS budget, because private health companies would be paying tax to the Treasury, but the NHS would then have to refund it.**

It also seems to suggest that statements made by Andrew Lansley to the Commons are rather misleading. Replying to Shadow Health Secretary John Healey, he said:

Let me tell him that the one thing we will not do with the private sector is rig the market so that private companies get contracts and guaranteed money whether or not they treat patients. We are not going to give them 11% more money than the NHS would get for doing the same work. [HC Deb 148, 25 Jan 2011]

Lansley was referring to the Independent Sector Treatment Centres, which were paid regardless of how many patients they treated. **Nonetheless, the government's own Impact Assessment makes clear that ministers are proposing precisely to pay private companies more money than the NHS would get for doing the same work.**

Ministers have not only hidden this proposal from Parliament, they have sought to misdirect MPs in suggesting that they would not take this approach at all.

Of course, this decision would be made by Monitor – the Impact Assessment's reference to advising the government is somewhat misleading as the Bill gives the regulator the ultimate power over pricing, and it need only consult. Nonetheless, the government seems to be giving the regulator a very clear steer as to how ministers wish to see it fulfil its duties.

This proposal is revealing of how the government conducts itself, but also its ultimate goals in shaping public services. In a choice between boosting the bottom line of big business or getting value for taxpayers' cash, there is clearly no contest.

Price competition

The Impact Assessments appear to betray a confused approach on the issue of price competition. A central plank of the justification for the vast corporate subsidy outlined in the government's proposed solution to "fair playing field distortions" (above) is that competition must be on quality, which is why differing cost bases must in some way be equalised. Similarly, the government also expects Monitor to promote "pricing to support new entry" [B97] and has deliberately been given "the freedom to set prices that enable competition and new entry" [B102] which again suggests that the main aim to push competition rather than efficiency, by boosting private profits.

Their justification for this is that it will improve quality. The IA states this fairly clearly in Section A [para B13]:

In health, there is strong evidence that competition with fixed prices leads to improved quality. Where competition is based on price and quality, and where quality is not transparent, there is a risk that price is driven down at the expense of quality

This was also a clear conclusion from the two main studies of public service "markets" that are cited in the Impact Assessment: *The Proper Scope of Government: Theory and an Application to Prisons* (Hart, Shleifer and Vishny, 1997, Quarterly Journal of Economics) and *Choice and Competition in Public Services: A Guide for Policy Makers* (Frontier Economics for Office of Fair Trading, 2010), even though both are positive about markets in general.

Indeed, the latter clearly finds (p50) "good evidence that price competition in health can drive down quality" and goes on (Key Findings, p54) to conclude that in "public sector markets, in particular health, it is preferable for institutions to compete on quality with a given price, and not on price."

But Monitor's pricing remit includes "powers to decide where to introduce price caps ... rather than fixed prices". [B100] The Bill allows Monitor to set a maximum price for treatments rather than either a national tariff or a framework for local price setting. The Impact Assessment also seems to expect that the "more diverse provider base should lead to more effective cost containment" and "reduce pressures on the NHS budget", that "providers will have a greater incentive to constrain costs" and this will "support future reductions in centrally administered prices relative to ... a less competitive system." [B20]

Indeed, the Impact Assessment seems to point Monitor in multiple directions when it comes to pricing, with "the reasonable cost of providing a service", the "need to generate efficiency savings", "regard for equity", "overall budget constraint" and the "primary duties to promote competition" all cited just in the space of one paragraph [B102] despite the fairly obvious contradictions between these criteria.

The evidence base

There are only two studies that examine the theory of markets in public sector cited in the Evidence Base section of the Impact Assessment, which are mentioned above. It should be noted that the OFT report made clear that it did not take a policy stance or draw such a conclusion from its study; it also concluded that "a key issue is around the exit of poor performing providers" which reinforces the point that the government's own evidence indicates that a degree of failure is built in to the new system.

The government cite a wide range of other studies in this section [B24-28]:

- Nickell (1996) is a well known study, but looked at private sector companies in private sector markets – and again concluded that the largest single factor was “the level of entry and exit”
- Djankov and Murrell (2002) considered transition economies
- Ahn (2002) was a meta-review of other studies, but these were of conventional private sector markets
- Barnes and Haskell focused entirely on plant level production in manufacturing, and again its conclusions focused on the need for poor performers to “exit”

DTI Economics Paper Number 9 reviewed six markets that had been de-regulated or regulated to prevent anti-competitive behaviour – these were in markets such as passenger flights and replica kits, and were “not selected randomly but on the basis that benefits were likely to be found” so had a (deliberate) selection bias; it also concluded that the benefit of the new competition was in price falls

The government seem to take it as a given that what works in normal private sector markets can be imported wholesale in to the NHS. They have, of course, also selectively cited studies that support their case.

The IA also ***considers those services that will go to competitive tendering rather than choice-based competition, citing studies for the World Bank in to bus services and by Domberger and IFS in to refuse collection.*** However, the document acknowledges itself that [B36]:

...the significant benefits are in part due to the ease of specifying the service to be operated – for example for buses, so many buses per hour, a specified route and number of stops, and so on. Moreover in both cases, it is relatively easy to monitor contractor performance and to transfer assets to a new operator if performance is unsatisfactory. This will be the case for some health services, but by no means all.

If anything, this seems a rather optimistic view – there cannot be too many health services that are comparable to buses, even if this rather limited evidence is itself taken at face value.

One other report is covered in considerable detail, with an entire section devoted to it. That report (*Refusing Treatment: the NHS and Market-Based Reform*) is by centre-right think-tank Civitas, though its political leaning is not acknowledged, despite the Impact Assessment being carried out by the civil service.

That the major study cited in a government Impact Assessment is one report issued by a political think tank may suggest that the evidence base is, in fact, somewhat lacking.

Furthermore, as the IA admits, the report itself “highlights some of the risks inherent in greater use of competition” and cited evidence that “collaboration is suffering and that high quality care is being undermined”. [B44]

Nonetheless, the following eight paragraphs quote selectively from the report to justify the government’s overall approach. The document neglects to include many conclusions from Civitas that do not reflect the government’s policy – for example, the rather major difference that the report opposes the replacement of Primary Care Trusts with GP Commissioning Consortia.

Nor has the government taken any heed of more recent Civitas conclusions criticising their approach. For example – given that we considering an Impact Assessment, in which risks are meant to be identified and addressed, a recent Civitas commentary on the government’s NHS proposals by Sir David Varney concluded:

The crucial point is the White Paper does not focus on the potential risks the reforms create and how these risks might be mitigated. Instead, the document appears to believe that noble ends will suffice. It pays little attention to the history of NHS re-organisations, nor does it have much time for reflection on lessons learnt.

McKinsey: decimating the NHS?

One other study is mentioned, though not properly cited, within the Impact Assessment covering both primary (Appendix A) and secondary (Appendix B) markets. That is a **2009 study of the NHS by McKinsey, which is cited to suggest that the government’s programme could achieve**

recurrent annual efficiency gains of £13-15bn within 3-5 years. [A40; B37] This report had been rejected by Labour health ministers, who briefed that it was commissioned by a senior DH official who then left to work for KPMG, without ministerial authority.

The report proposed measures such as 137,000 redundancies - a 10% reduction in the NHS workforce, mostly clinical staff, and an £8.3bn privatisation of hospital estates. Ministers said at the time that all other evidence suggested more, not less, clinical staff were needed.

The reaction of then Shadow Health Secretary Andrew Lansley was instructive – he attacked “secret plans for swingeing cuts” and which would “take an axe to the hospital budget rather than to the bloated health bureaucracy. Only a fifth of job cuts would be within the bureaucracy, meaning the vast majority would be frontline NHS staff.”

Deadline 2014

The Impact Assessment highlights one particularly risky element of the government’s plans – **setting an arbitrary date of 2014 by which all NHS Trusts must become Foundation Trusts.**

The IA warns that “in bringing forward the date, the costs to some organisations of meeting the standards required may be higher than would otherwise have been the case.” [B90]

There will be some concern that this is a political timetable designed around the electoral cycle rather than genuine reasons of public policy - the 2014 end date would mean that this change occurred before the general election.

This is particularly concerning given that it, by the government’s own admission, this is likely to incur extra costs for some NHS Trusts – money that could otherwise have been spent on healthcare. It is also likely to be **those NHS Trusts that are already in the weakest financial position that are hit the hardest.**

This risk is highlighted again in the final section on “Risks and Assumptions”, which warns that “there is a risk that organisations that currently do not meet FT authorisation criteria will be forced to incur higher costs than would otherwise be expected”. The meaning of this is made starkly clear [B151, p60]:

If it proves to be necessary for some organisations to exit the market to ensure essential services are sustainable, the adapted unsustainable provider regime and the new provider failure regime (described in Section D) will provide mechanisms by which provider failure can be appropriately managed

In short, the government may be prepared to let NHS hospitals go in to administration in order to meet Lansley’s political timetable. This will be especially concerning for current NHS Trusts that do not meet FT authorisation criteria because for many this will be precisely because they are struggling financially and may not survive in the market. This Assessment seems to imply that some of them may not even survive for long enough to fail in the face of competition – even the very attempt to prepare them may be too much.

However, the Impact Assessment reveals that the government do have an alternative policy option [B151]:

If necessary the Secretary of State could seek Parliamentary approval to change the date. This proposal is not mentioned or explained any further. There has been no indication that there would be any flexibility in this date from ministers, and it is specified on the face of the Bill [Clause 164 (2)] though sub-section (4) allows the Secretary of State to vary it by statutory instrument. We have any information on what circumstances would need to arise for this power to be used. This seems to raise more questions for ministers than it answers.

Intrusive Monitoring

The Impact Assessment outlines some details of the government’s view on how Monitor might develop and perform its functions that are left open in the legislation itself and the preceding White Paper.

Particularly noteworthy is its ability to [B107]:

...require the incumbent to grant access to its services to other providers (e.g. operating theatres, diagnostic scanning) at predetermined prices.

The incumbent will almost always be (at least for the near future) an NHS hospital. The government therefore anticipates that NHS hospitals will be forced to share operating theatres, brain scanners, and presumably any other facility, with private health care providers, perhaps on some kind of rota system.

Again, this proposal is light on detail and the potential risks and problems with such an approach are not shared. It is unclear whether there has been any clinical input in to this consideration, but it seems obvious that there might be serious practical concerns about the impact such a right of access would have on the provision of healthcare.

It also raises concerns about how prices could be determined for such an arrangement, given the government's own admission elsewhere in the Impact Assessment that it is extremely difficult to establish a fair price for services in a large NHS hospital where there will inevitably be a complex pattern of cross-subsidies due to the overheads and requirement to take all emergency admissions. **This could lead to the private provider effectively profiting from the NHS by using their facilities but without paying for the wider costs that the NHS Foundation Trust would have to bear.**

There is also more detail about Monitor might enforce competition on the commissioners of services, i.e. the GP consortia.

The government is concerned that GPs might prefer to commission from their NHS hospital rather than private competitors. A solution to this problem is suggested. Monitor will be expected to [B108]:

Implement remedies in the event that it upholds complaints by providers and potential providers (new entrants) that commissioners are unfairly favouring incumbents...

In short, if local GPs try to help their local NHS hospital survive, then a private provider might pursue a complaint with Monitor for anti-competitive behaviour. If upheld, Monitor would have "remedies" in competition law, which presumably would involve levying a fine on the consortium or even hauling GPs in to court.

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