# Protecting the NHS from Destructive ‘Reform’


## The Need for Amendment to the Health and Care Bill

*Fact Pack v1.6*

# Contents

# Executive Summary: Why the Health & Care Bill needs amendment


Many individuals and organisations[1] have commented on the Health & Care Bill

We and they acknowledge positive aspects to the Bill – most notably that integrating Health and Care, if done well, could be beneficial

But also there are reasons for grave concern about some of its provisions. Most importantly, the Bill gives Ministers extraordinary powers without corresponding duties and with greatly reduced scrutiny.

These concerns are heightened by the number of senior members of the Conservative party and the Government who have publicly stated – and demonstrated – that they do *not* wish to continue with the NHS in anything like its current form (see slides 9-10 for examples). And fellow members of the Conservative party have warned us about their intentions. As John Major famously said:

> *"The concept that [they] would care for the National Health Service is a rather odd one: Michael Gove wanted to privatise it; Boris wanted to charge people for using it; and Iain Duncan Smith wanted a social insurance system. The NHS is about as safe with them as a pet hamster would be with a hungry python."*

Given that so many senior and influential Conservatives have been open and clear about their motives, we should take seriously the mounting evidence that this Bill, as currently drafted, could become an important enabler of the deconstruction of the NHS that so many of us know and love.

The purpose of this paper is to highlight the risks of allowing the Bill to pass unamended.

The **motives** of several members of this government are clear. We can now establish which parts of this Bill might provide the **means** and the **opportunity** to achieve their objective. Our aim is to provide evidence in the following pages to substantiate our concerns – and to provide facts, figures and qualitative information which may be useful to MPs and organisations campaigning to protect the NHS.

Our hope is that everybody who cares about the NHS and its ability to look after the needs of ordinary families across the UK will work together to moderate this Bill and ensure that it does not become a historical landmark in the dismantling of one of our national treasures.

The following chart sets out our key concerns about the Bill – and how they might be resolved

[1]Including: The British Medical Association, The NHS Confederation, The Kings Fund, The Lancet, The Nuffield trust, Professor Allyson M Pollock & Peter Roderick

# Executive Summary 2: The Bill – Concerns and proposals

| Provisions of the Bill that concern us | Why we are concerned | What we propose |
|---|---|---|
| Removal of statutory duty to arrange provision of secondary (i.e. hospital) medical services – leaving only a power to do so.<br>The reasons for this measure are not explained. | This removes/reduces existing patient rights to challenge in court the non-provision of services. With proposed new payment rules this might lead to new categories of services having to be paid for. | Reintroduce a **duty on the Health Secretary** to provide a high quality health and care service, free at the point of use for all UK citizens. |
| Removal of the obligation for public tendering for NHS services and allows ministers to circumvent normal procurement rules. | This removes scrutiny and transparency over the awarding of contracts. Raises the possibility of corruption at worst and ineffective procurement at best. | Make the NHS the **default option** for contracts. Competitive tenders to be retained where in-house provision is not available or clearly inappropriate. |
| Provision to enable private companies to sit on ICS Boards (no maximum representation) However, Local Authority representation on ICS Boards is strictly limited | Corporate providers have a legal duty to serve their shareholders' interests by influencing key decisions and policies; these may well be misaligned with those of patients and taxpayers. | Keep **governance** under the control of those whose fiduciary duty is to patients and to the NHS rather than to shareholders. |
| Provision of new & considerable powers to Health Secretary to amend /abolish existing bodies, create new NHS trusts and to intervene in reconfigurations of NHS. | If Health Secretary wishes to progressively denationalise the NHS, this gives him means and opportunity to do so | **Withdraw this provision** and ensure that Parliament retains control over all significant restructures of NHS |
| Gives ministers greater control of patient data. | Confidential patient data has huge commercial value | **Impose strict protections** on patient data |
| ICBs will only have a "core responsibility" for a "group of people" | This evokes the US definition of a health maintenance organization which provides basic and supplemental health services | **Clarify / reword section 14Z31** to avoid the possibility of this section facilitating a drift towards the NHS being reduced to a basic safety net for the uninsured/ poor |

*Source*: *Health and Care Bill: BMA demands greater protection for patients and NHS*; *Prof Allyson M Pollock and Peter Roderick*

# Introduction to this document


- The Government's Health & Care Bill focuses on shifting control over the NHS in England to:
  - **An Integrated Care System** – via Integrated Care Boards, which will take charge of the commissioning and provision of NHS services in the area they cover
  - **Ministers** – who will have for example increased ability to sidestep normal commercial procedures and alter organisational structures
- While The Bill has some potentially positive features, it also poses **grave risks to the efficiency, effectiveness and accessibility of the NHS,** if it passes unamended. Patients and taxpayers will suffer, even if private healthcare companies benefit
- We are also concerned that some members of Government (see slides 9-10) are motivated to denationalise the NHS and/or replace it with a US style insurance system – leaving a basic service as a fallback for the poor and/or uninsured – and that some of the Bill's provisions may have been covertly drafted to enable that change
- This resource pack contains facts, figures and qualitative information which may be useful to MPs and organisations campaigning to protect the NHS

# Key concerns about the new Bill


**We could end up with a system that works as badly as the US system** – which would cost many patient lives as well as having a huge financial cost.

**Efficiency:** As **taxpayers**, we care about **efficiency** – the NHS should deliver good outcomes as cheaply as possible.

As **patients**, we care about both **effectiveness** and **accessibility**.

**Effectiveness** is crucial because we want the NHS to have a positive effect on our health. We need it to have the powers and resources necessary to provide a high-quality healthcare system.

**Accessibility** is vital because, if we cannot reach or afford healthcare when we need it, our health – or even our lives – is at risk.

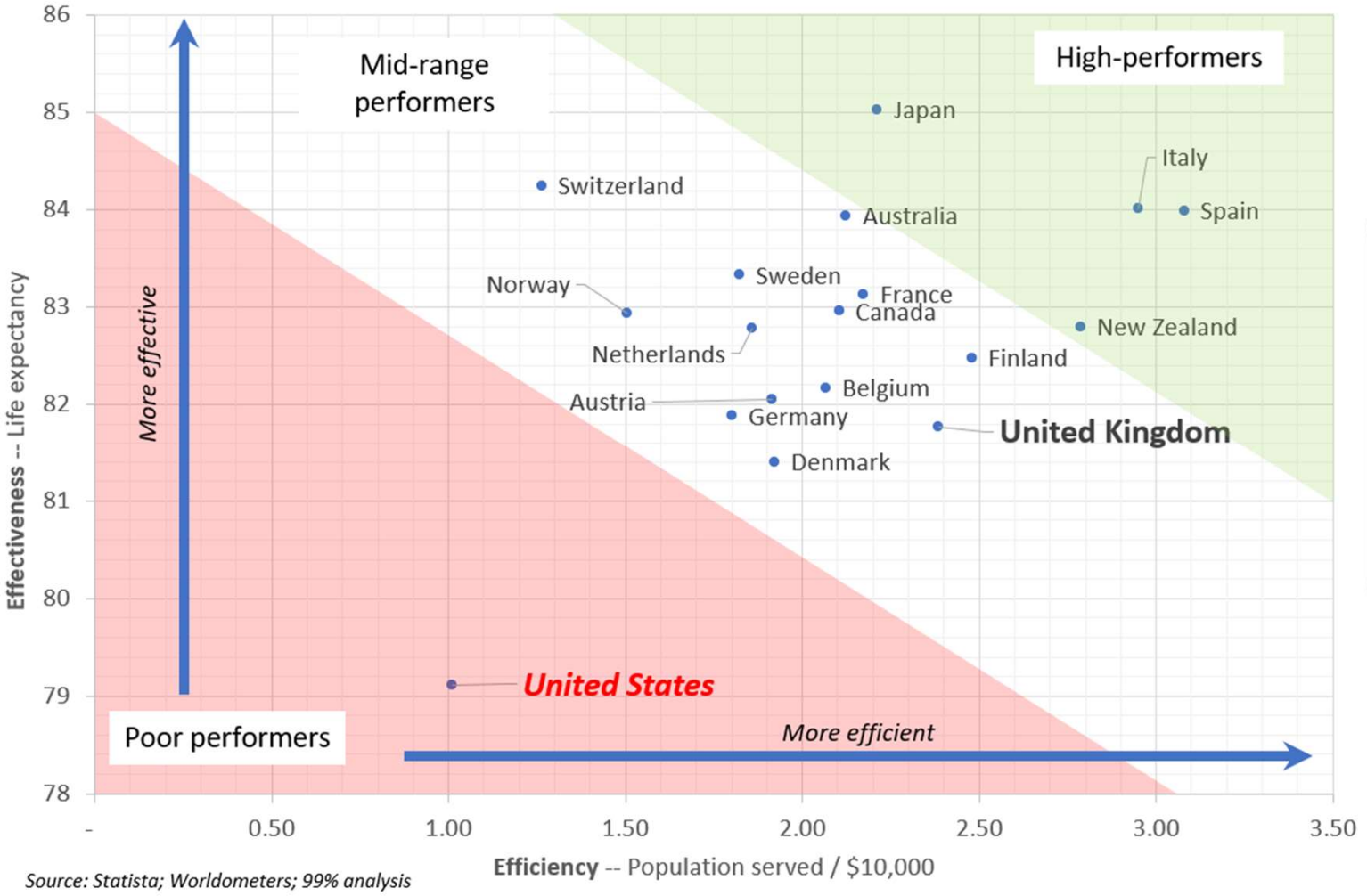
The Bill does not ensure negative changes, but it would *enable* changes which would be negative on all three dimensions – hugely damaging to most of the UK population.

For example, The Bill allows private sector healthcare providers to sit on the Integrated Care Boards – and this is already starting to happen.

Company directors have a fiduciary duty to take decisions in the interests of the members (shareholders) of the company. Where this is in conflict with patient interests, **they must side with shareholders.**

This will create profit opportunities at the expense of efficiency and effectiveness

# We could end up with a system that works as badly as the US system, the poorest performer for patients and taxpayers




*Source: Statista; Worldometers; 99% analysis*

The US is clearly the poor performer; and yet it has been the model for many recent and proposed changes in the NHS.

There **are** countries whose systems perform better than the UK's, and learning from these could be valuable.

But the UK currently has a mid-performing healthcare system in terms of both efficiency and effectiveness – **any move towards a US system would reduce its performance on both dimensions**.

That is what this Bill, unamended, threatens.

# But, commercially, the size of the prize from going down the US route is astronomical – a $28 billion profit opportunity


| Country | Public spend per person on Healthcare (US $) | Private spend per person on Healthcare (US $) | Per person profit opportunity from US model (US $) | Population | Size of the Prize from adopting US model (US$ billion) |
|---|---|---|---|---|---|
| Japan | 3,801 | 718 | 431 | 126,476,461 | 55 |
| Germany | 4,695 | 856 | 418 | 83,783,942 | 35 |
| United Kingdom | 3,320 | 872 | 416 | 67,886,011 | 28 |
| France | 3,626 | 974 | 406 | 65,273,511 | 26 |
| Italy | 2,545 | 847 | 419 | 60,461,826 | 25 |
| Spain | 2,293 | 955 | 408 | 46,754,778 | 19 |
| Canada | 3,341 | 1,412 | 362 | 37,742,154 | 14 |
| Australia | 3,190 | 1,518 | 351 | 25,499,884 | 9 |
| Netherlands | 4,354 | 1,032 | 400 | 17,134,872 | 7 |
| Belgium | 3,740 | 1,100 | 393 | 11,589,623 | 5 |
| Sweden | 4,603 | 884 | 415 | 10,099,265 | 4 |
| Austria | 3,957 | 1,270 | 376 | 9,006,398 | 3 |
| Denmark | 4,374 | 831 | 420 | 5,792,202 | 2 |
| Finland | 3,017 | 1,017 | 402 | 5,540,720 | 2 |
| Norway | 5,664 | 983 | 405 | 5,421,241 | 2 |
| Switzerland | 5,038 | 2,881 | 215 | 8,654,622 | 2 |
| Ireland | 3,879 | 1,650 | 338 | 4,937,786 | 2 |
| United States | 4,860 | 5,032 | - | 331,002,651 | - |

The risk for the UK is that commercial demands for profit will trump both **patient needs** for accessible and effective healthcare and **taxpayers' expectations of efficiency**.

Note: profit opportunity is based on lifting private sector spend to US levels and assuming 10% operating margin
*Source: Statista; Worldometer*

# And it is clear that some very influential members of the Conservative party would like to see such a change (1)


- *"As living standards rise, individuals are likely to demand more and better healthcare. There is some social gain from improved healthcare, but it is mainly a matter of individual wants and choices. Hence it is arguably* ***not appropriate for public finance****, and puts a strain on the Exchequer by distorting choices and* ***shifting the burden from consumer to taxpayer****. Public health services also tend to be led by producers rather than consumers. It is therefore worth considering whether, over a period, the* ***provision of healthcare for the bulk of the population could be shifted from the state to privately owned and run medical facilities.*** *Those who could not afford to pay would then have their charges met by the state, via some form rebating reimbursement. This would mean leaving to individuals how far they insured against facing high costs of healthcare, and it would be important to monitor the growth of private health insurance over the intervening period. Given that the state would in the last resort meet the costs of necessary healthcare, there could be a danger of underinsurance by a large part of the working population, and thought therefore might have to be given to* ***a scheme for compulsory private insurance****."* – **Cabinet Paper**, 1982
- *"A system of this sort would be fraught with transitional difficulties. And it would be foolhardy to move so far from the present one in a single leap. But need there be just one leap? Might it not, rather, be possible to* ***work slowly from the present system toward a national insurance scheme****? One could begin, for example, with the establishment of the NHS as an independent trust, with increased joint ventures between the NHS and the private sector; move on next to use of 'credits' to meet standard charges set by a central NHS funding administration for independently managed hospitals or districts; and* ***only at the last stage create a national health insurance scheme separate from the tax system****."* – **Oliver Letwin and John Redwood**, 1988

*Sources*: https://discovery.nationalarchives.gov.uk/details/r/C13318082 ; https://consortiumnews.com/2021/07/14/sicko-uk/

# And it is clear that some very influential members of the Conservative party would like to see such a change (2)


- *"The problem with the NHS is not one of resources. Rather, it is that the system remains a centrally run, state monopoly, designed over half a century ago. … We should fund patients, either through the tax system or* ***by way of universal insurance****, to purchase health care from the provider of their choice.* ***Those without means would have their contributions supplemented or paid for by the state.****" "Our ambition should be to break down the barriers between private and public provision, in effect* ***denationalising the provision of health care in Britain****"* -- An Agenda for a New Model Party (2005) – authors include: **Michael Gove, Jeremy Hunt, Jesse Norman, Kwasi Kwarteng, John Penrose, Daniel Hannan** and 18 others.
- **Sajid Javid**, the current Health Secretary and the sponsor of the Bill, has made no secret of his devotion to the ideas of Ayn Rand. This is important, since Rand's views on healthcare are radically different from those of most people in the UK health system: as her biographer put it, *"Rand derided 'humanitarian' projects that, as she saw it, 'were to be imposed by political means–that is, by force–on an unlimited number of human beings. 'Medicare' is an example of such a project,' she said. 'Isn't it desirable that the aged should have medical care in times of illness?' Its advocates clamor. [That] hides such facts as the enslavement and, therefore, the destruction of medical science, the regimentation and disintegration of all medical practice."* The Ayn Rand Institute clearly states its position that **Healthcare is not a right**. That our Health Secretary, the man in charge of the NHS, appears to share these views is, in itself, a cause for concern.
- *"The concept that [they] would care for the National Health Service is a rather odd one: Michael Gove wanted to privatise it; Boris wanted to charge people for using it; and Iain Duncan Smith wanted a social insurance system. The NHS is about as safe with them as a pet hamster would be with a hungry python." –* ***Sir John Major,*** 2016

*Sources*: https://whatwouldvirchowdo.files.wordpress.com/2015/09/direct_democracy___an_agenda_for_a_new_model_party.pdf ; https://ari.aynrand.org/issues/government-and-business/individual-rights/health-care-is-not-a-right/ ; https://www.theguardian.com/politics/2016/jun/05/john-major-nhs-risk-brexit-pythons-johnson-and-gove

# Key concerns about the new Bill


**We could end up with a system that works as badly as the US system** – which would cost many patient lives as well as having a huge financial cost.

**Efficiency** could be badly hit by loss of economies of scale, lack of competition, underfunding and increased privatisation

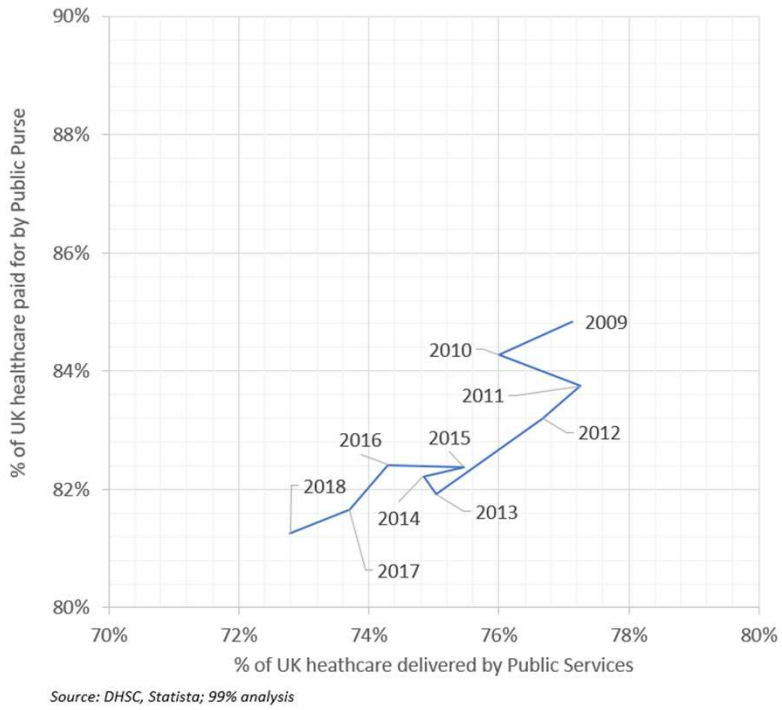
- The trend towards privatisation can drive up costs
- Underfunding decreases efficiency and performance
- Economies of scale could be lost – to the benefit of providers but not of patients or tax-payers
- Lack of competition among private suppliers could crowd-out the best and raise prices

**Effectiveness** could be reduced by the knock-on effect of underfunding leading to rationing, and by ignoring human needs

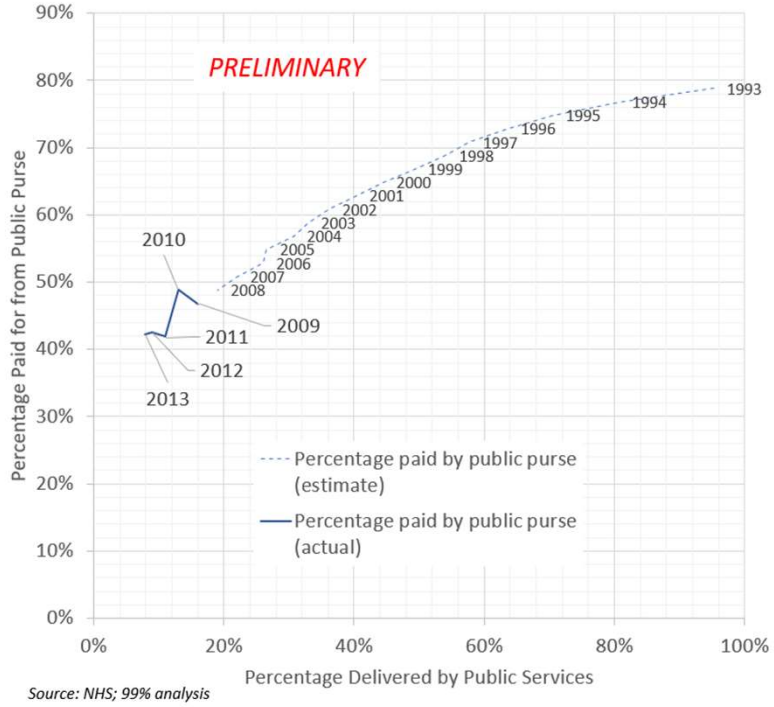
**Accessibility** could be reduced by further underfunding, by inappropriate use of technology and by stealth charging

# There has been a great deal of covert privatisation, especially in the Care sector …

Since 2009, Healthcare has been increasingly funded and delivered by the Private Sector




Since 2009, and probably much longer, Social care has seen a steady transfer to the Private Sector



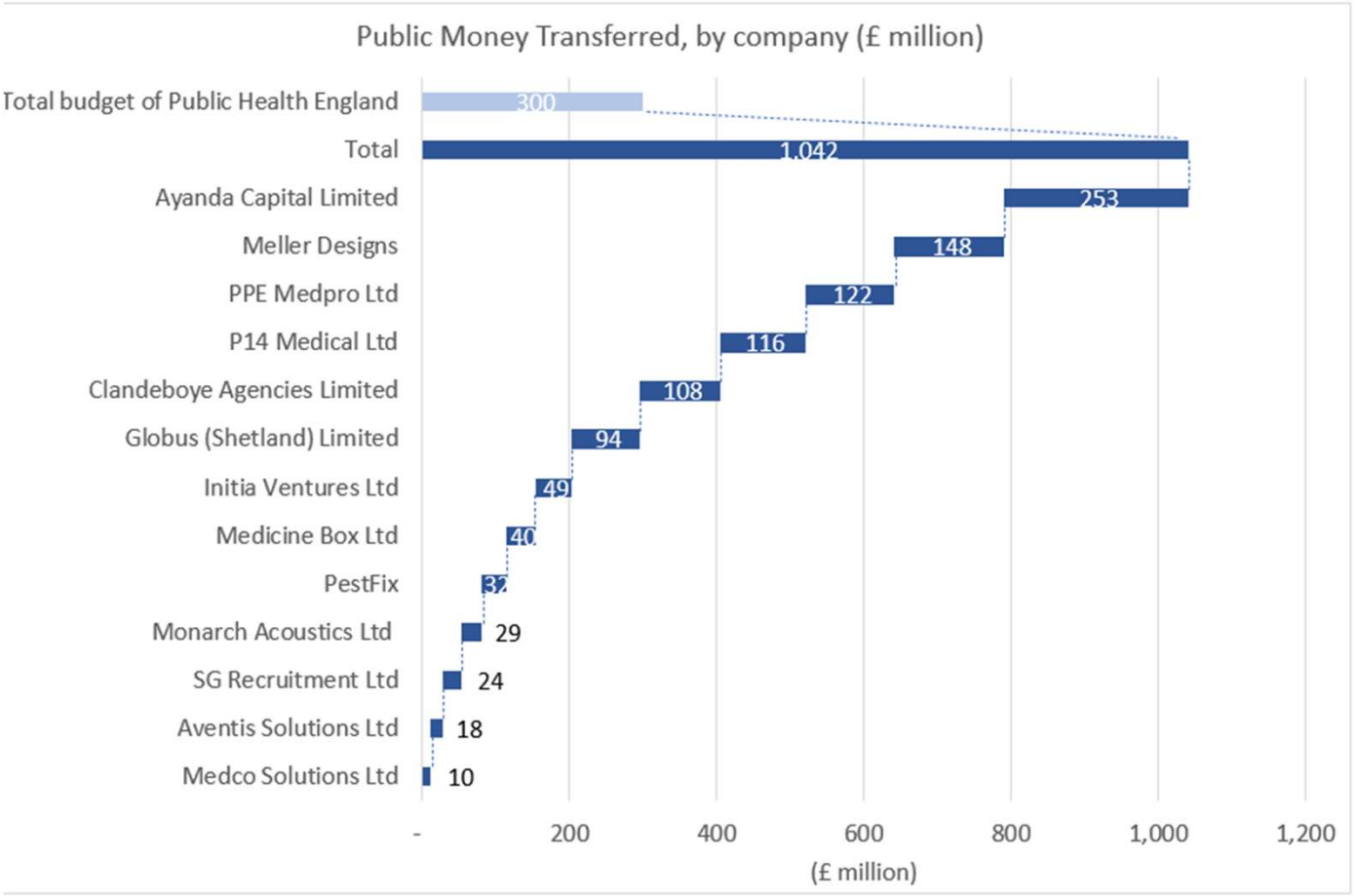

**Note**: the axes on the RH chart refer to slightly different issues: the % paid for from the Public Purse refers to all adult social care expenditure; the % delivered by Public Services refers to the number of contact hours of home care provided

# … driven by legislation over at least 30 years


| | |
|---|---|
| **1990** | NHS & Community Care Act: Purchaser/provider split. Made hospitals into budget holding trusts independent of Regional Health Authorities |
| **1990-97** | Private Finance Initiative (PFI): Private companies building hospitals, incurring huge and increasing debts to hospital trusts. |
| **2002** | Attempted upgrade of NHS IT system by several private companies - complete failure and abandoned. |
| **2003** | Health & Social Care Act: Under Alan Milburn. NHS Foundation Trusts formed |
| **2004** | Changes to the GP contract allowing private companies to provide GP services |
| **2012** | Health & Social Care Act: Under Andrew Lansley. 'Clinical Commissioning Groups' (CCG) replaced publicly accountable Primary Care Trusts and Strategic Health Authorities. Public Health taken out of the NHS. Removed duty of Sec. of State to provide a health service. Funding for Mental Health became more complex. As a result, Hinchinbrooke Hospital – run by private companies – collapsed. (NHS picks up the tab.) |
| **2013** | 'NHS England' replaced NHS Commissioning Board. CEO Simon Stevens, ex United Health, largest health company in USA |
| **2015** | 'Five Year Forward View': introduced 'Sustainability & Transformation Plans' (STPs) meant to integrate health and social care.<br>'Integrated Care Systems' (ICS) to facilitate private companies bidding for NHS contracts. CCGs struggle to manage the financial and organisational complexity. As a result, by 2018, record £9.2 billion was handed to private providers such as Virgin Care, and the Priory mental health group. |
| **2019** | 'Primary Care Networks' (PCN): Local GP surgeries formed into large super practices, ready for private takeovers. As a result >500 practices owned by US giant Centene |
| **2020** | Supply of PPE outsourced to private companies; Test & Trace system private, (ignoring expertise of Local Authority Public Health staff.) |

*Source: J Niechal research*

# Lack of competition among private suppliers could crowd-out the best and raise prices




During the pandemic, the government made extensive use of emergency procurement rules to avoid having to use open competition. Over £1 billion of taxpayers' money went on these transactions.

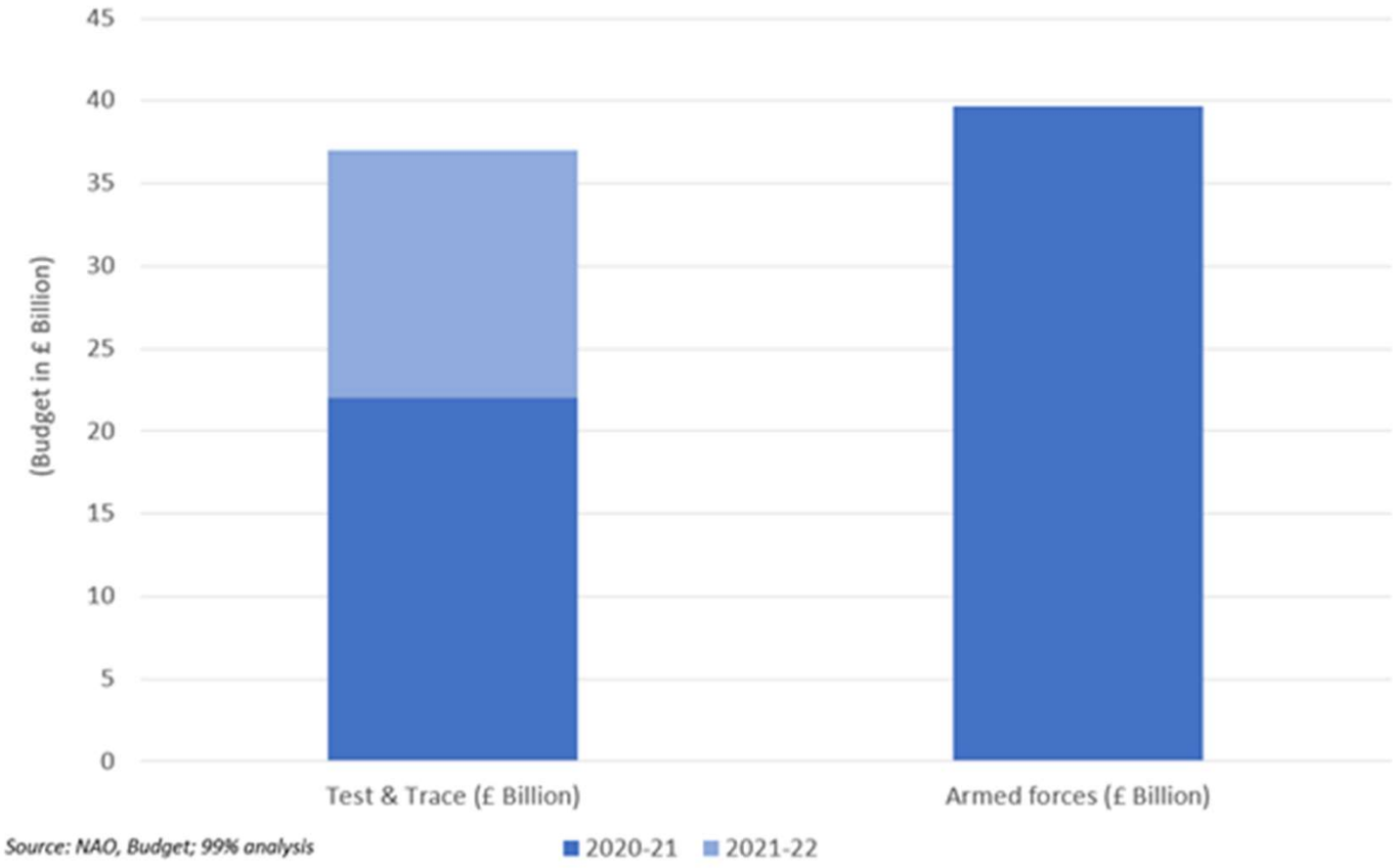
The result was that many **capable suppliers were ignored** while VIP contacts of ministers secured large contracts – in several cases without providing anything usable in practice.

This is (at best) a huge waste of public money and efficiency loss to the NHS.

**The Bill will enable more of this.**

*Sources: See Appendix 2*

# Even more concerning is the £37 billion of taxpayers' money which was allocated to the so-called NHS test & trace system



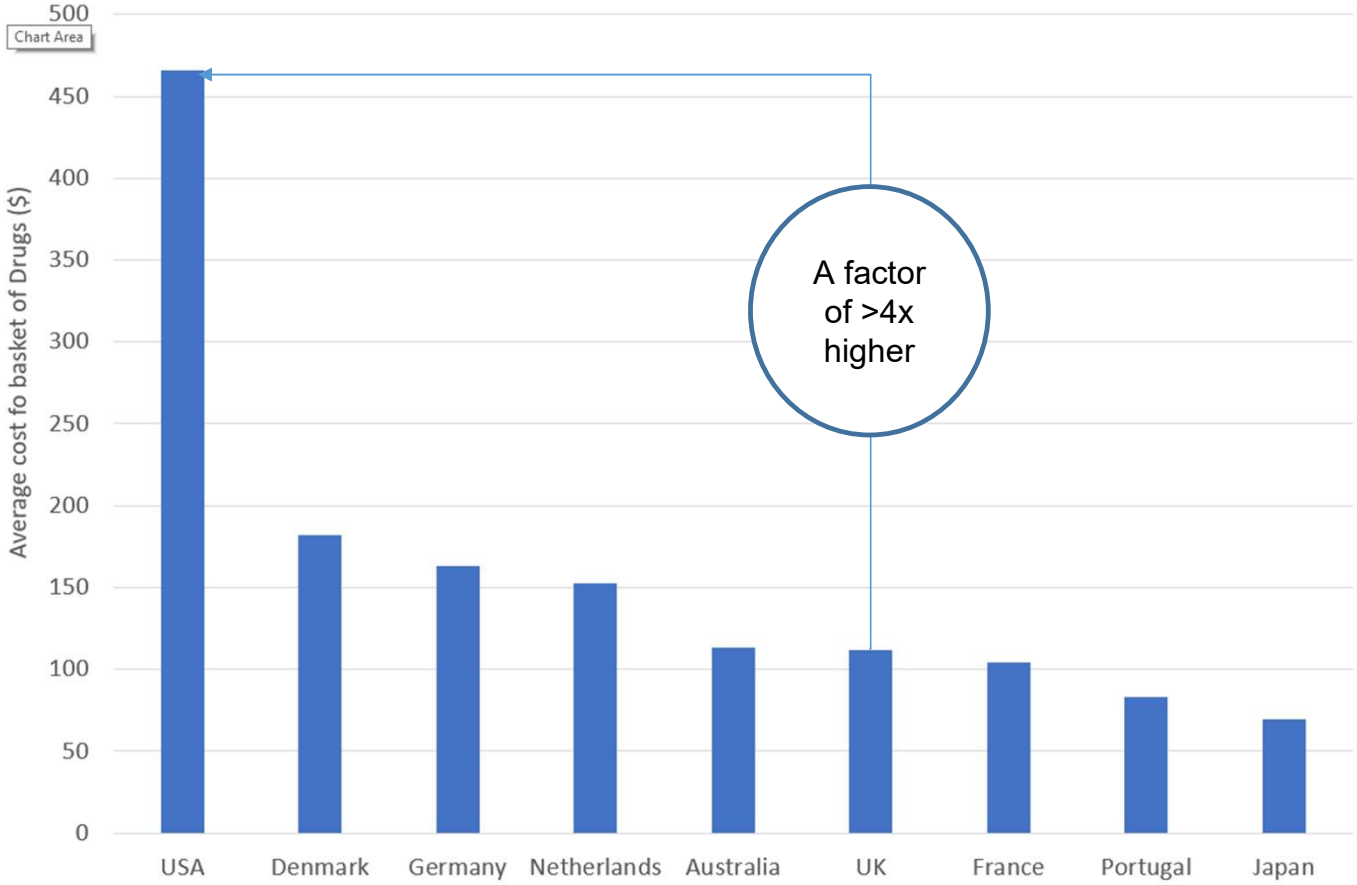

*Source: NAO, Budget; 99% analysis*

According to the National Audit Office, the so-called '[NHS test and trace]' system has almost the same budget allocated over two years as all three armed forces do for one year. Most of it has gone to the private sector; it has little to do with the NHS in reality.

And it has failed to meet all its targets.

**Shifting huge sums of money to the private sector without competition will be quite legal if the Bill is unamended**.

# Economies of scale could be lost in purchasing – to the benefit of providers but not of patients or tax-payers




The NHS (like most systems) uses its monopsony buying power (it is by far the biggest buyer) to keep drug prices low.

In the US, drugs are bought (largely) by insurers with much less bargaining power.
To secure a US trade-deal, the government may give way on this point.

Our drugs bill today is around £17 billion; if we paid US prices, it would be around £71 billion.

Either taxpayers would have to provide an extra £54 billion to drug company profits or further rationing would be needed.

*Source:*
*https://waysandmeans.house.gov/sites/democrats.waysandmeans.house.gov/files/documents/U.S.%20vs.%20International%20Prescription%20Drug%20Prices_0.pdf*

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**Efficiency** could be badly hit by loss of economies of scale, lack of competition, underfunding and increased privatisation

**Effectiveness** could be reduced by the knock-on effect of underfunding leading to rationing, and by ignoring human needs

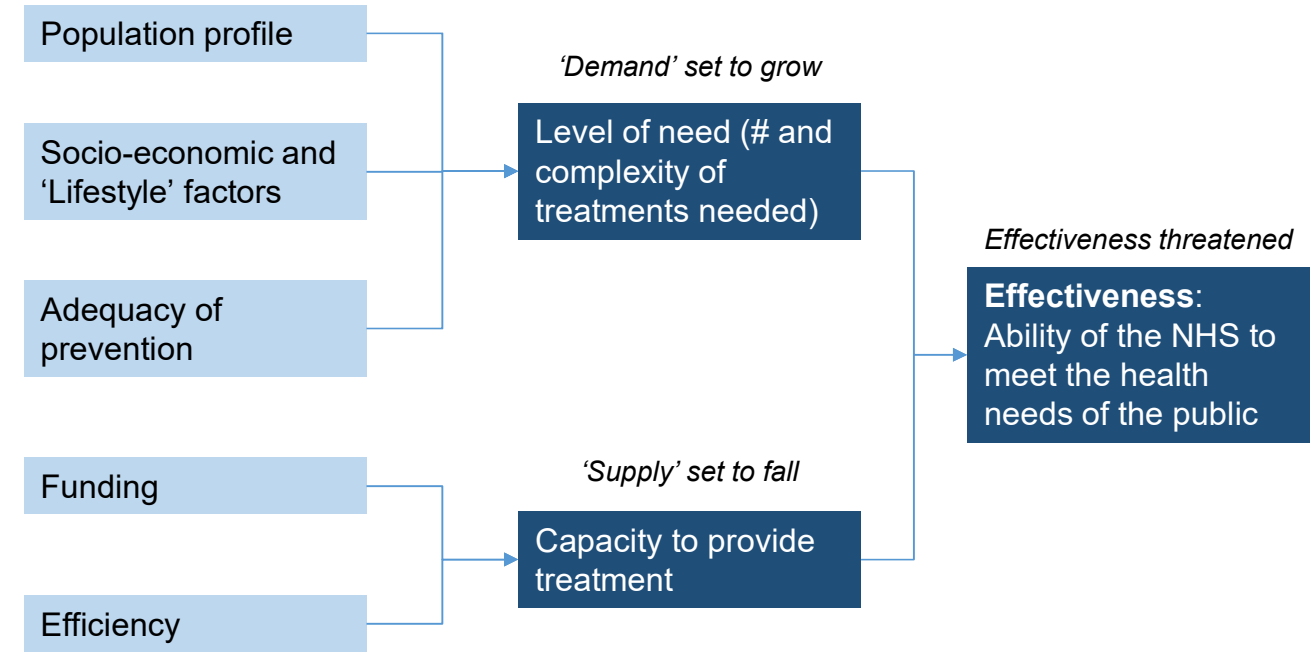
- Effectiveness depends on having the capacity to meet patient needs, driven by funding and efficiency
- Effectiveness requires meeting the needs of patients not just of their conditions
- Effectiveness also requires stability – reforms now would worsen NHS morale at a crucial time

**Accessibility** could be reduced by further underfunding, by inappropriate use of technology and by stealth charging

# Effectiveness depends on having the capacity to meet patient needs, driven by funding and efficiency…

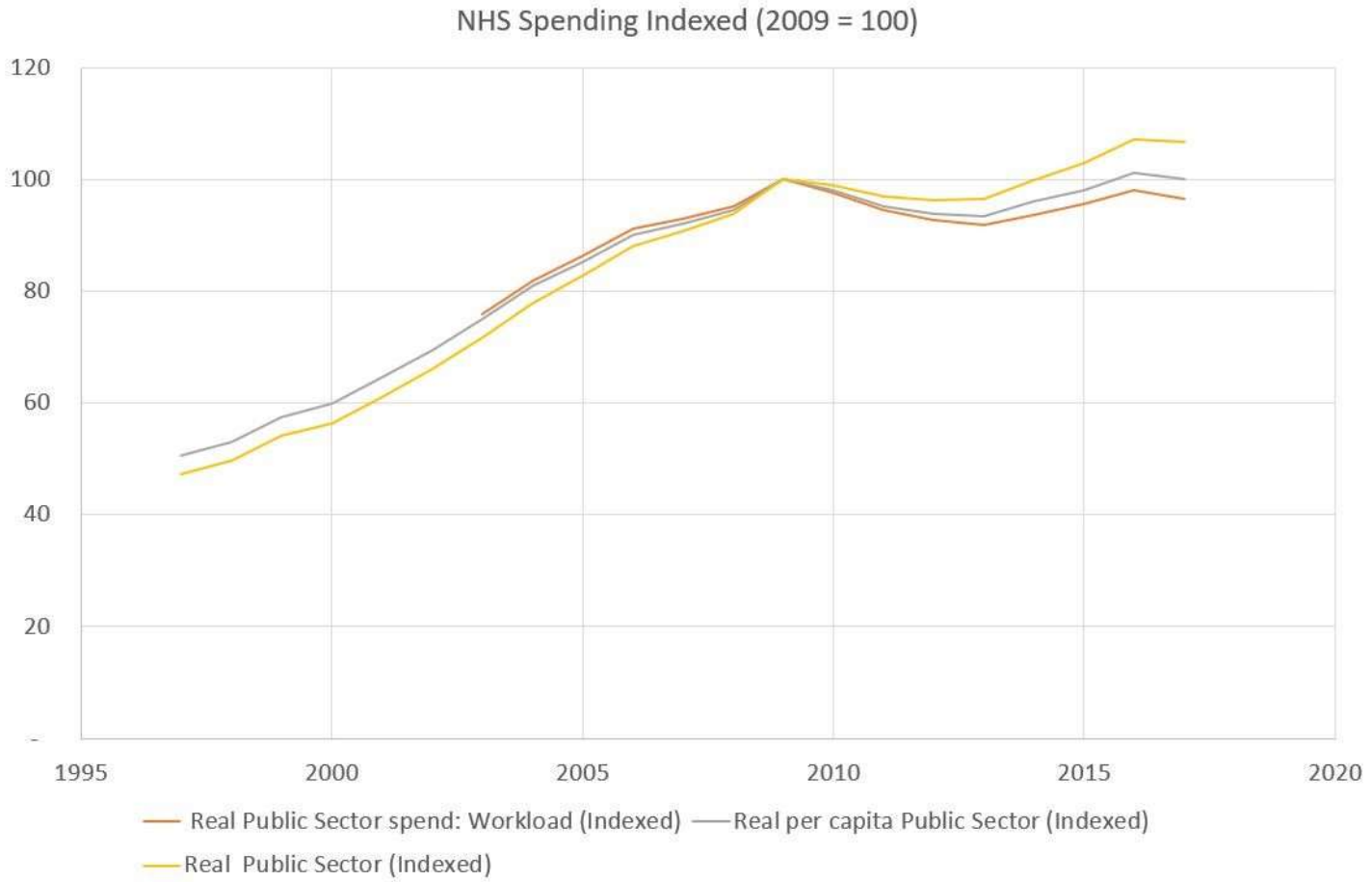
**Situation**

- ✗ Population growing at ~1% per annum, and aging
- ✗ Environmental degradation and rising deprivation both strongly linked to health issues
- ✗ Reduction in investment in prevention
- ✗ Sustained underfunding, not addressed by Bill
- ✗ Efficiency reduced by approach to privatisation




… the proposed Bill will address none of these issues positively, and may **seriously exacerbate some**

# The NHS has been systematically underfunded since 2010…




Until 2010, NHS spending rose in line with need – taking into account inflation, population growth and age profile as well as increases in morbidity.

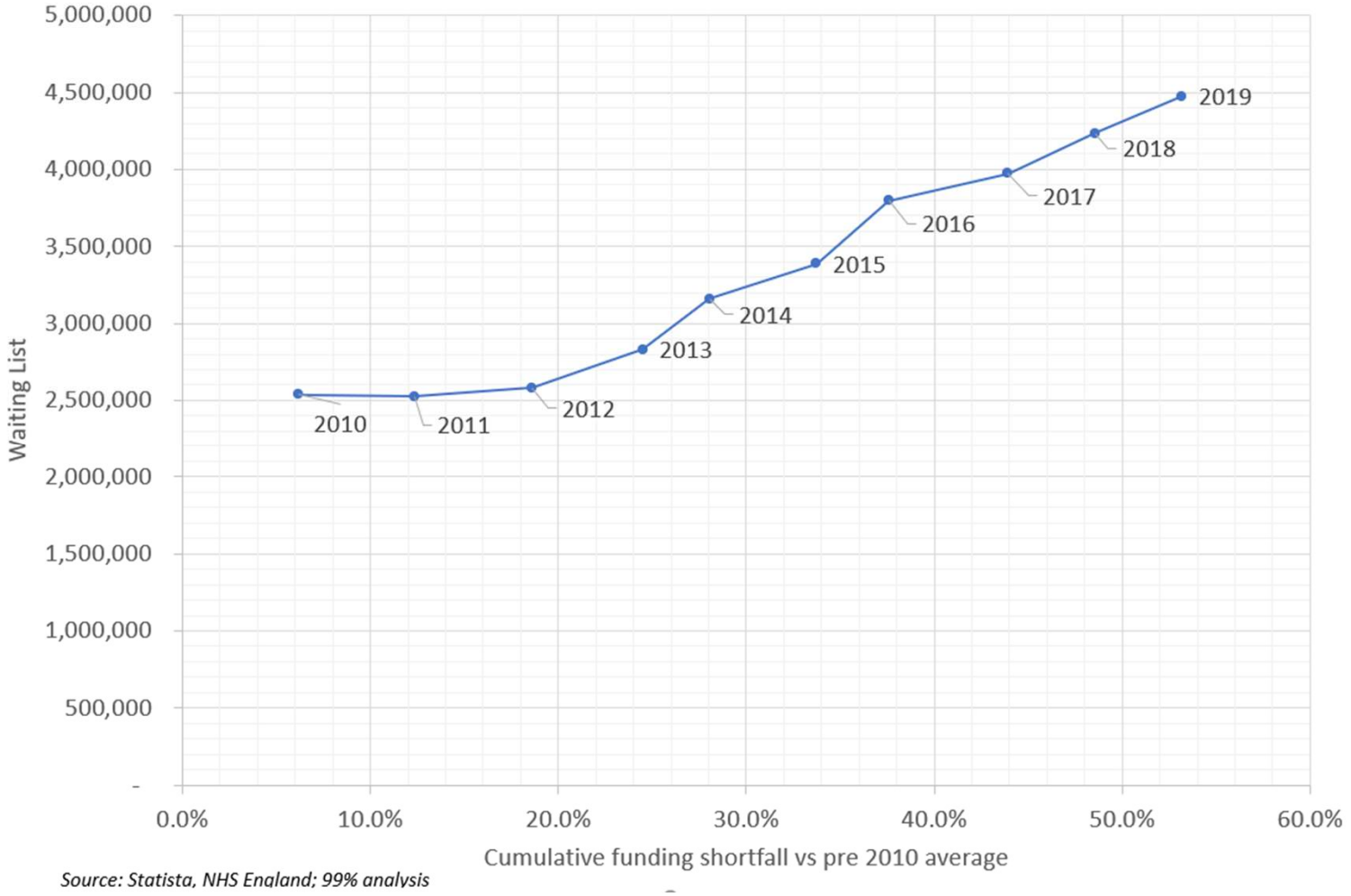
Since then, it has failed even to keep pace with population changes.

As a result, NHS capacity cannot keep pace with need and performance has declined.

This has created the supposed 'need' for reform.

*Source: Office For National Statistics; 99% analysis*

# Underfunding has decreased effectiveness




*Source: Statista, NHS Enaland; 99% analysis*

Slide 19 showed how NHS funding has failed to rise with workload.

As a result, NHS capacity cannot keep pace with need and performance has declined.

This underfunding has also created staff shortages and a serious morale issue.

Some have pointed out that a strategy of underfunding would be consistent with a desire to replace the NHS.

# Effectiveness requires stability – reforms now would worsen NHS morale at a crucial time


The British Medical Association recently surveyed consultants and found:

*"Over 80% of consultants believe the [most recent pay] award is either inadequate or completely unacceptable, with **more than 70% stating that their morale had declined as a result**. A staggering 91% believe it shows the Government does not value the work consultants have done and will be expected to do in the future.*

*Given that the **estimated take-home pay of the average consultant has fallen by over 28% in real terms** since 2008, it comes as no surprise that consultants in England have lost faith in the pay setting process. Our pay is supposed to be determined independently by our pay review body, the DDRB. Indeed, its original founding principles were to provide an independent mechanism to avoid disputes between the Government and the profession, and to ensure our standard of living was not depressed by 'arbitrary government action'.*

*Yet despite this we have been exposed to government-imposed pay freezes and pay caps of 1% for an eight-year period between 2010/11 and 2017/18."*

Nurses and other NHS staff have faced similar issues.

Coupled with the enormous load (and build up of waiting lists) caused by COVID, now would be a dangerous time to begin another major re-organisation.

*Source: BMA survey of consultants; https://www.rcn.org.uk/get-involved/campaign-with-us/fair-pay-for-nursing*

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**Accessibility** could be reduced by further underfunding, by inappropriate use of technology and by stealth charging

- Stealth charging reduces accessibility
- Underfunding can reduce accessibility
- Inappropriate use of technology reduces accessibility for the vulnerable
- Integrated care could be a Trojan Horse

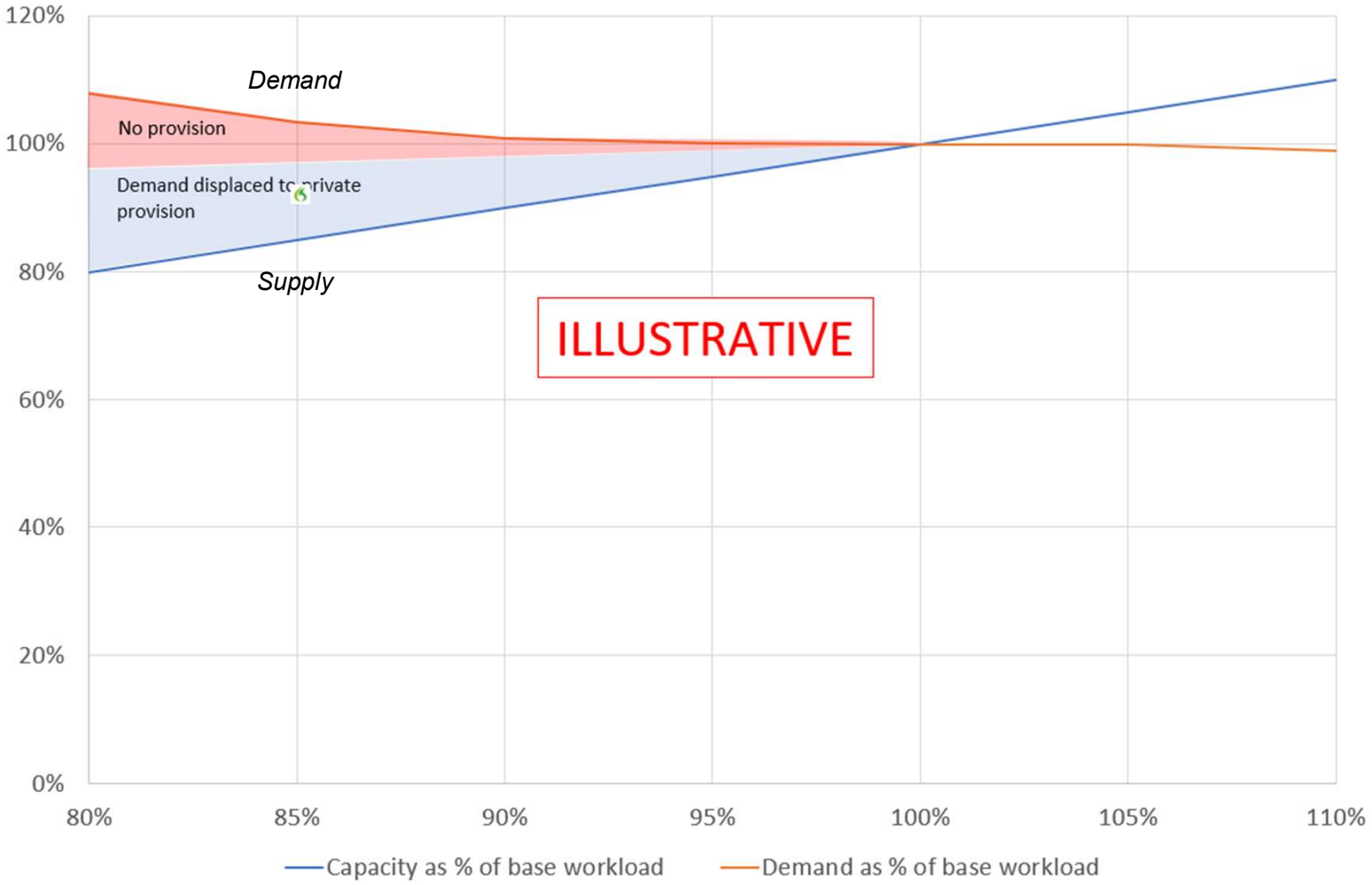
# Stealth charging has gradually reduced availability of healthcare…


| Issue | Description | Phased out from |
|---|---|---|
| Prescriptions | Being able to get free prescriptions for medicine | 1952 |
| Opticians | Free eye tests and glasses for all | Until 1989 |
| Dentistry | Being able to receive dental treatment on the NHS | Decreasingly available since 2006 |
| OTC medicines free on NHS | Having over-the-counter medicines prescribed by the Doctor | No longer prescribed: 2018 |
| Drugs free on NHS | Prescription-only medicines | Still largely free of charge |
| GP visits | Being able to visit a Doctor when you are ill | Still free of charge |
| Major surgery | Having serious surgical interventions provided | Still free of charge |

…and for Social Care, the picture is even worse – hence the constant promises of a plan to resolve the crisis.

Sources: https://inews.co.uk/news/health/nhs-medicines-prescription-no-longer-free-full-list-210284; https://www.theguardian.com/society/2011/oct/04/nhs-charging-operations-york; https://www.huffingtonpost.co.uk/entry/nhs-treatments-no-longer-offered-patients-risky_uk_5b372ddce4b007aa2f803e5a ; https://en.wikipedia.org/wiki/NHS_dentistry ; http://news.bbc.co.uk/1/hi/uk/308184.stm

# Underfunding also reduces accessibility – as well as forcing people to go private if they can




Underfunding damages people's health if they cannot afford to go private, and their wealth if they can.

But if your objective is to see *"whether, over a period, the provision of healthcare for the bulk of the population could be shifted from the state to privately owned and run medical facilities"* then it is an effective strategy.

# Patients want to be treated as people, not just bundles of symptoms


"I feel cared for because the specialist nurses treat me like a human being rather than a number, a patient."

*-- Patient A*

"My experience has mainly been fighting for things. However this GP [genuinely listens]. [With him] I feel consulted, valued, and not ignored."

*-- Patient B*

"I have fallen over and broken my bones many times. When I broke my hip I heard the Sister saying 'You have to be gentle with her, she is in a lot of pain.' She was kind, not just matter of fact."

*-- Patient C*

"Dr X was the first person who was reassuring. Before him, we were at A&E and a doctor looked at my wife and said 'I think you have MS.' I fainted and ended up in the bed next to my wife! … Although Dr X was always very polite to me, he always talked to my wife (the patient), treating her as the most important person in the room."

*-- Patient D*

*Source: Project interviews with patients*

# Effectiveness and accessibility require the sensitive use of technology


### Technology is often efficient but not always effective or accessible

"Once, I went [to hospital] with suspected eye cancer (which turned out to be benign). I had had a long journey and was holding it all together. I did not want to have to deal with technology. But there was a check-in machine at the hospital.

Fortunately a nurse came with a lovely smile; she was so [kind] and reassuring, she made me feel okay about things. That is what you *need* when you are trying to hold it together – when you go to hospital you could have cancer, *et cetera*. People's [kindness] transforms a horrible experience into a pleasant one."

*– Patient A*

### Used correctly, Technology can aid communication

"Zoom helped connect my aged mum to a specialist after a fall. That was great."

*– Patient B*

"In terms of administration side, I see two different departments now: Rheumatology and Orthopaedic. These departments never talked. It took 2 years for me to be diagnosed because they did not talk. If they had been communicating this would have not taken so long. Now they communicate with each other (the two departments) all the time. And it works."

*– Patient C*

"As a cancer patient I've rarely had good experience with admin, though it's getting better with the new patients' website, patientsknowbest.co.uk. You can access blood tests, also appointments and past medical history.

*– Patient D*

"When I left hospital, I needed regular doctors' consultations and therapy and assessments. In the early weeks of independent living I had mobility problems. When the pandemic came, social distancing was a blessing. As contact was by phone or Zoom, I didn't have to go on buses or trains with crutches."

*– Patient E*

*Source: Project interviews with patients*

# Integrated Care could be a Trojan Horse


| Options for Funding Care | | Impact on top 1% | Impact on median household |
|---|---|---|---|
| Largely self-funding (as now) | ~1 in 10 get Dementia and need nursing care; most have to self-fund at a cost of ~£40k per annum | Finding ~160k is a serious issue, but represents only ~2% of net worth | Finding ~£160k means wiping out >50% of net worth |
| Compulsory Insurance | An annual premium starting at ~£400 per person over a 40-year period would cover 4 years of care for those who need it. £800 for a two-adult household. | Finding £800 per annum represents 0.3% of disposable income | Finding £800 per annum represents 2% of disposable income |
| Government funded | An annual cost of ~£20 billion is around 1% of GDP. | Distributional impact depends on funding approach adopted – could be progressive if funded by progressive taxation – **funding via NI is regressive** | |

Government funding is clearly the fairest way to tackle the care crisis.

But the government could use it as an opportunity to introduce an initially voluntary, ultimately compulsory insurance scheme. See the Elderly Social Care (Insurance) Bill and slide 9.

Once in place, this could be extended to fund much of healthcare, as in the US

**Note**: For comparison, the government spent £37 billion on the so-called NHS test & trace system; estimates of tax avoidance and evasion range from ~£7bn per annum to over £80bn *per annum.* A full discussion of affordability is in Chapter 12 of 99%

*Source*: Office for National Statistics

# **Conclusion**: The Bill gives ministers powers to make things worse, but no tools for improving the NHS – it must be amended

| What the Bill *does* | What it *should* do |
|---|---|
| The Bill removes the obligation for public tendering for NHS services and allows ministers to circumvent normal procurement rules. | The Government should protect the NHS from unnecessary and costly private sector involvement, and ensure scrutiny and transparency over the awarding of contracts. The most effective way of doing that is to **make the NHS the default option for NHS contracts** and to tender competitively where this is not possible. |
| The legislation leaves open the possibility for corporate healthcare providers to gain seats on ICS boards which represents a clear conflict of interest, and gives them undue influence in decision-making. | Keep **governance** under the control of those whose fiduciary duty is to patients and to the NHS rather than to shareholders. |
| There will no longer be a statutory duty on any body to arrange provision of secondary (i.e., hospital) medical services – only a power for ICBs to do so.<br><br>Gives new and considerable powers to amend or abolish existing arm's length bodies, create new NHS trusts and to intervene in reconfigurations of the health service. | Reintroduce a **duty on the Health Secretary** to provide a high quality health and care service, free at the point of use for all UK citizens.<br><br>Introduce a **statutory duty on the ICBs** to ensure provision of secondary medical services<br><br>Ensure **adequate funding** to meet the needs of the population. |
| Gives ministers greater control over patient data. | Impose **strict protection on patient data** unless totally anonymised (not merely de-personalised) especially when given or sold to commercial organisations. |

**Enable accelerated privatisation of UK healthcare**

**Fund and fix the NHS**

*Source: 99%; British Medical Association [Health and Care Bill: BMA demands greater protection for patients and NHS]; [Prof Allyson M Pollock and Peter Roderick]*

# If we were to drift towards the US system, the impact on UK citizens would be devastating

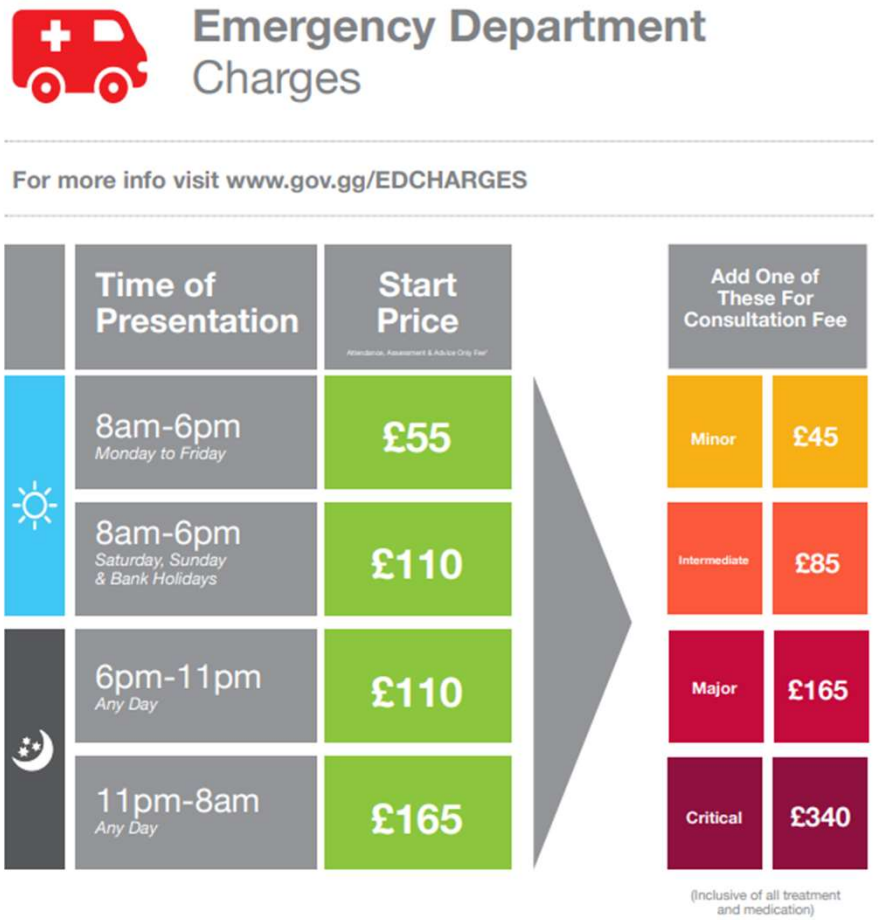

| Procedure | Average $ cost without Insurance (lowest) | Average $ cost without Insurance (highest) |
|---|---|---|
| Ambulance | 400 | 1,200 |
| Air ambulance | 2,000 | 200,000 |
| ER (accident and emergency) visit | 150 | 3,000 |
| MRI test | 1,000 | 5,000 |
| X-ray | 150 | 3,000 |
| Blood test | 100 | 3,000 |
| Cholestrol test | 50 | 200 |
| Breast cancer | 15,000 | 300,000 |
| Brain cancer | 50,000 | 700,000 |
| Labour and delivery | 9,000 | 17,000 |
| C-section | 14,000 | 25,000 |
| Post-partum checkup | 100 | 200 |
| Hip fracture | 13,000 | 40,000 |
| Sprained or broken ankle | 2,500 | 35,000 |
| Appendecectomy | 10,000 | 35,000 |
| Cataract surgery | 7,200 | 12,000 |

Even with insurance, the costs are high:

- In 2019, annual premiums for health coverage for a family of four averaged $20,576
- In addition to the premium, you also have to cover deductibles: $1,655 is the average general annual deductible for a single worker on an employer plan
- **The number one cause of US personal bankruptcies is medical costs**.

*Source*: https://www.internationalinsurance.com/resources/healthcare-costs-in-the-usa.php ; https://www.investopedia.com/how-much-does-health-insurance-cost-4774184 ; https://ajph.aphapublications.org/doi/abs/10.2105/AJPH.2018.304901?journalCode=ajph&

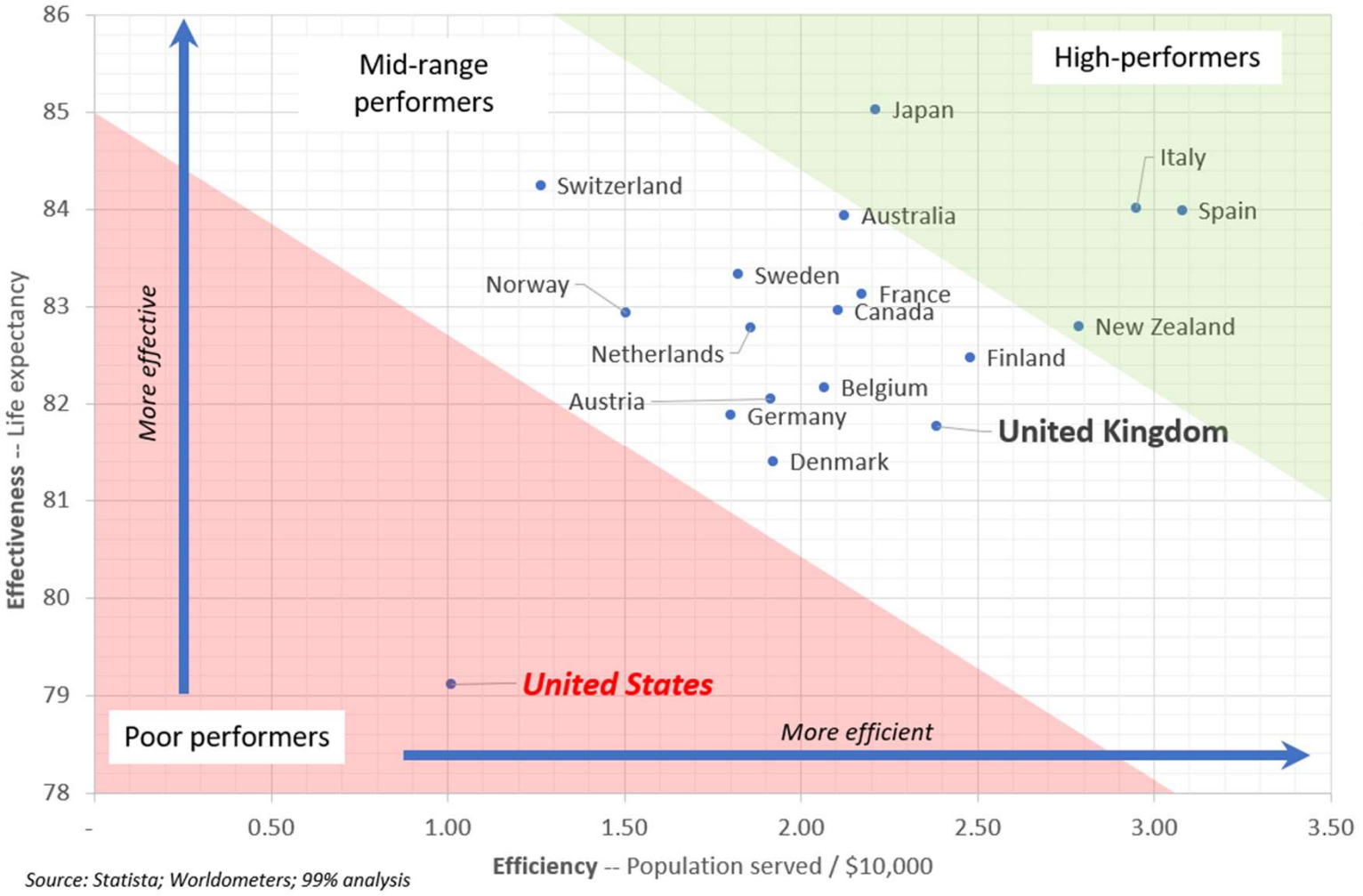
# The idea that this could not happen in the British Isles is false: on Guernsey with its low-tax regime, things are not cheap




A visit to Accident and Emergency on a Saturday evening could easily cost a patient £275 – no problem for high earners, whose tax is commensurately lower, but potentially ruinous for those on low incomes.

*Source*: https://www.gov.gg/CHttpHandler.ashx?id=113643&p=0

# Final reminder: we do not want to move in the direction of the US system




*Source: Statista; Worldometers; 99% analysis*

The US is clearly the poor performer; and yet it has been the model for many recent and proposed changes in the NHS.

There **are** countries whose systems perform better than the UK's, and learning from these could be valuable.

But the UK currently has a mid-performing healthcare system in terms of both efficiency and effectiveness – **any move towards a US system would reduce its performance on both dimensions**.

That is what this Bill, unamended, threatens.

# Appendices

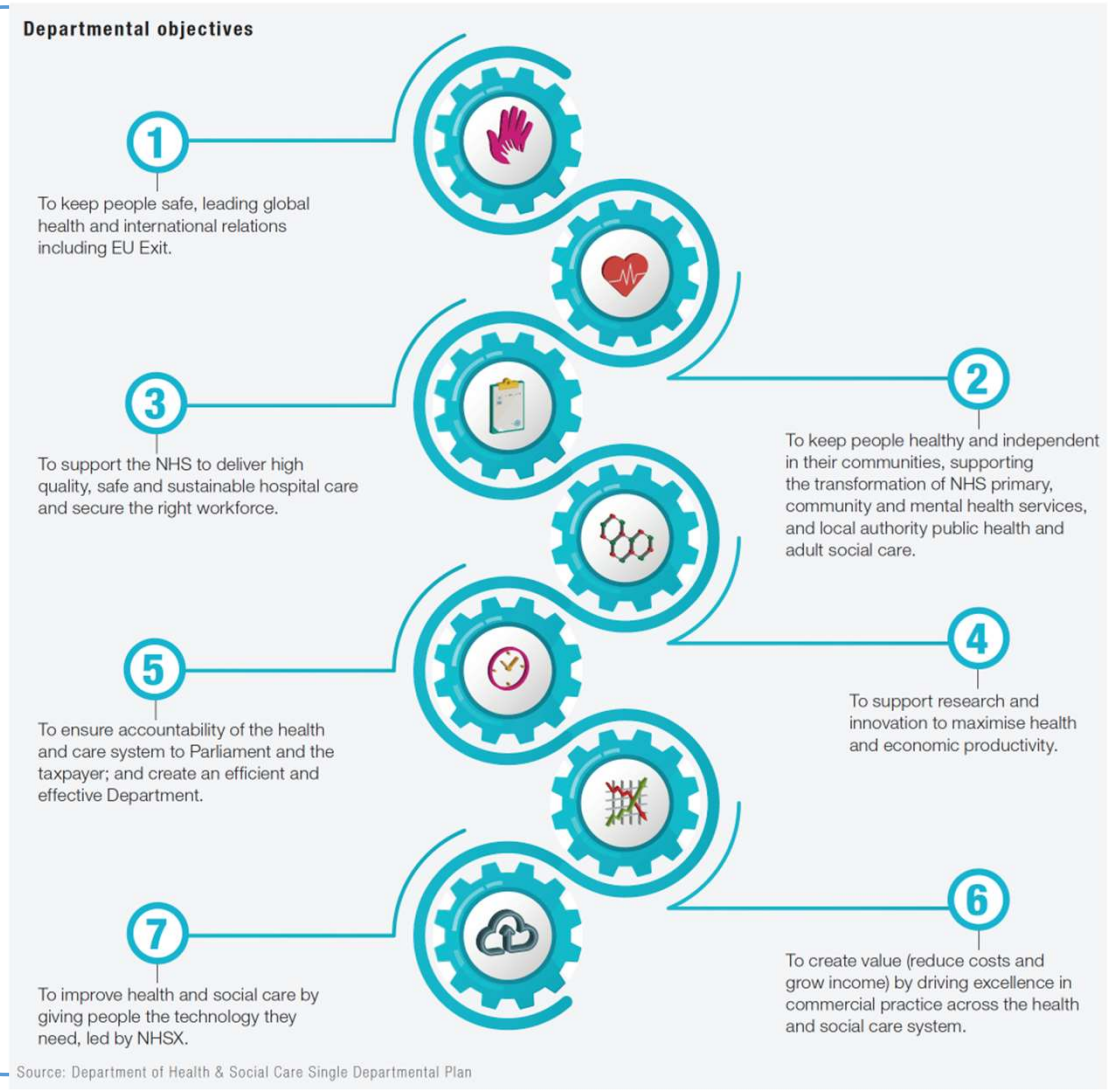

1. Current organisation and funding of NHS England
2. Suspect PPE deals
3. Key points of the Bill
4. Key Dynamics of the healthcare system

# 1. Current organisation and funding of NHS England


- Overview of the scale and scope of health and social care services in England now
    - Who provides
    - Who supports
    - Who governs
    - How does ‘the system’ work
    - How much does it all cost, and who funds it
- How levels of demand (and funding) have changed in the recent past and the expected future
- Summary of the state of care pre-pandemic (CQC and NAO views)

# DHSC manages funding and oversight of health and social care…

DHSC has seven specific objectives in relation to population health, its management and improvement




*Source: NAO Departmental Overview: Department of Health & Social Care 2018-19*

# Health & Care – a complex network of agencies…


**Department of Health & Social Care**
Funding for health. Accountable to Parliament for health and adult social care

**Ministry of Housing, Communities & Local Government**
Funding for local government. Accountable to Parliament for overall funding to local authorities

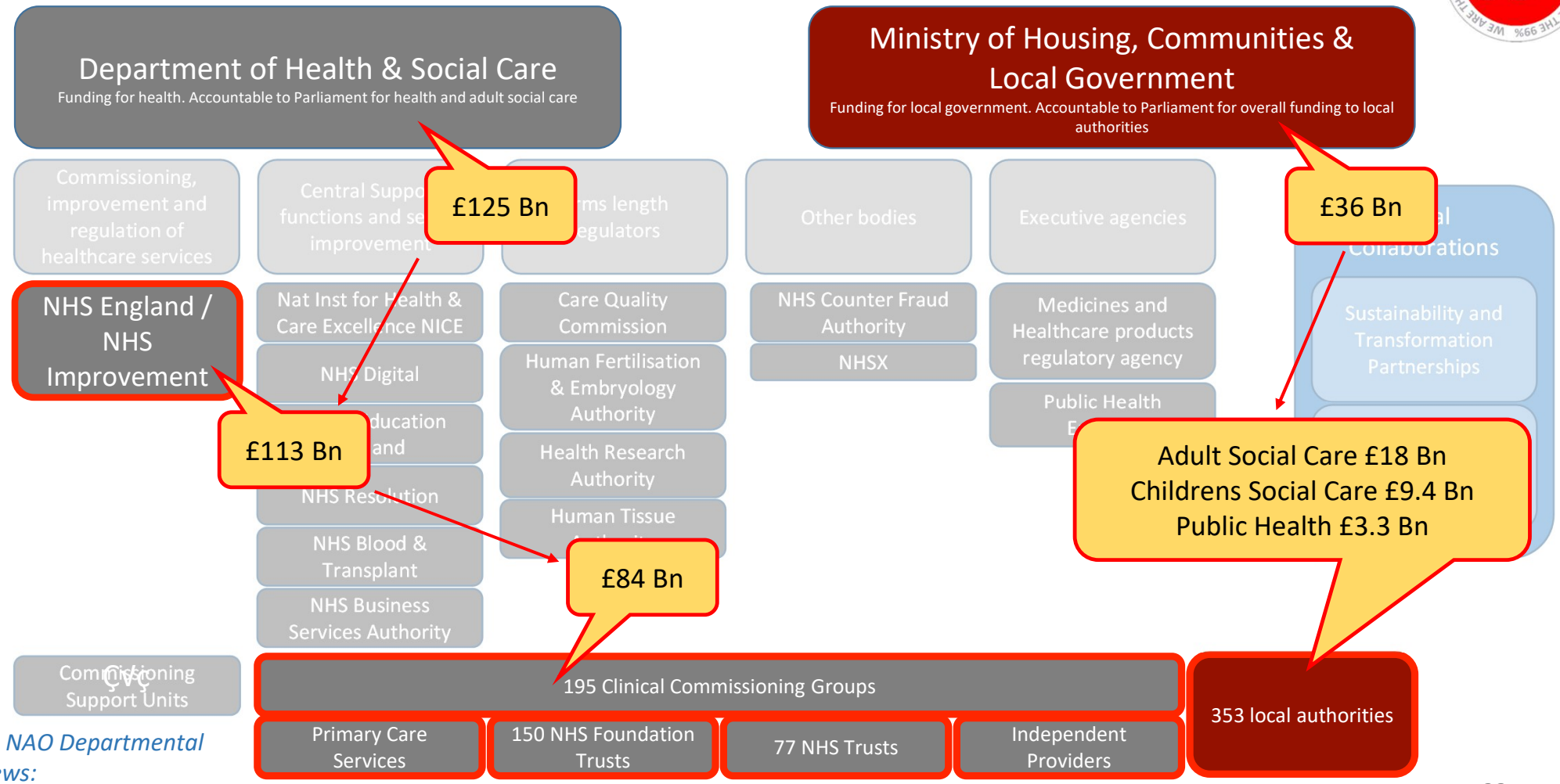
| Commissioning, improvement and regulation of healthcare services | Central Support functions and sector improvement | Arms length regulators | Other bodies | Executive agencies |
|---|---|---|---|---|
| NHS England / NHS Improvement | Nat Inst for Health & Care Excellence NICE | Care Quality Commission | NHS Counter Fraud Authority | Medicines and Healthcare products regulatory agency |
| | NHS Digital | Human Fertilisation & Embryology Authority | NHSX | Public Health England |
| | Health Education England | Health Research Authority | | |
| | NHS Resolution | Human Tissue Authority | | |
| | NHS Blood & Transplant | | | |
| | NHS Business Services Authority | | | |

**Local Collaborations**
- Sustainability and Transformation Partnerships
- Integrated Care Systems

| | | | | | |
|---|---|---|---|---|---|
| Commissioning Support Units | 195 Clinical Commissioning Groups | | | | 353 local authorities |
| | Primary Care Services | 150 NHS Foundation Trusts | 77 NHS Trusts | Independent Providers | |

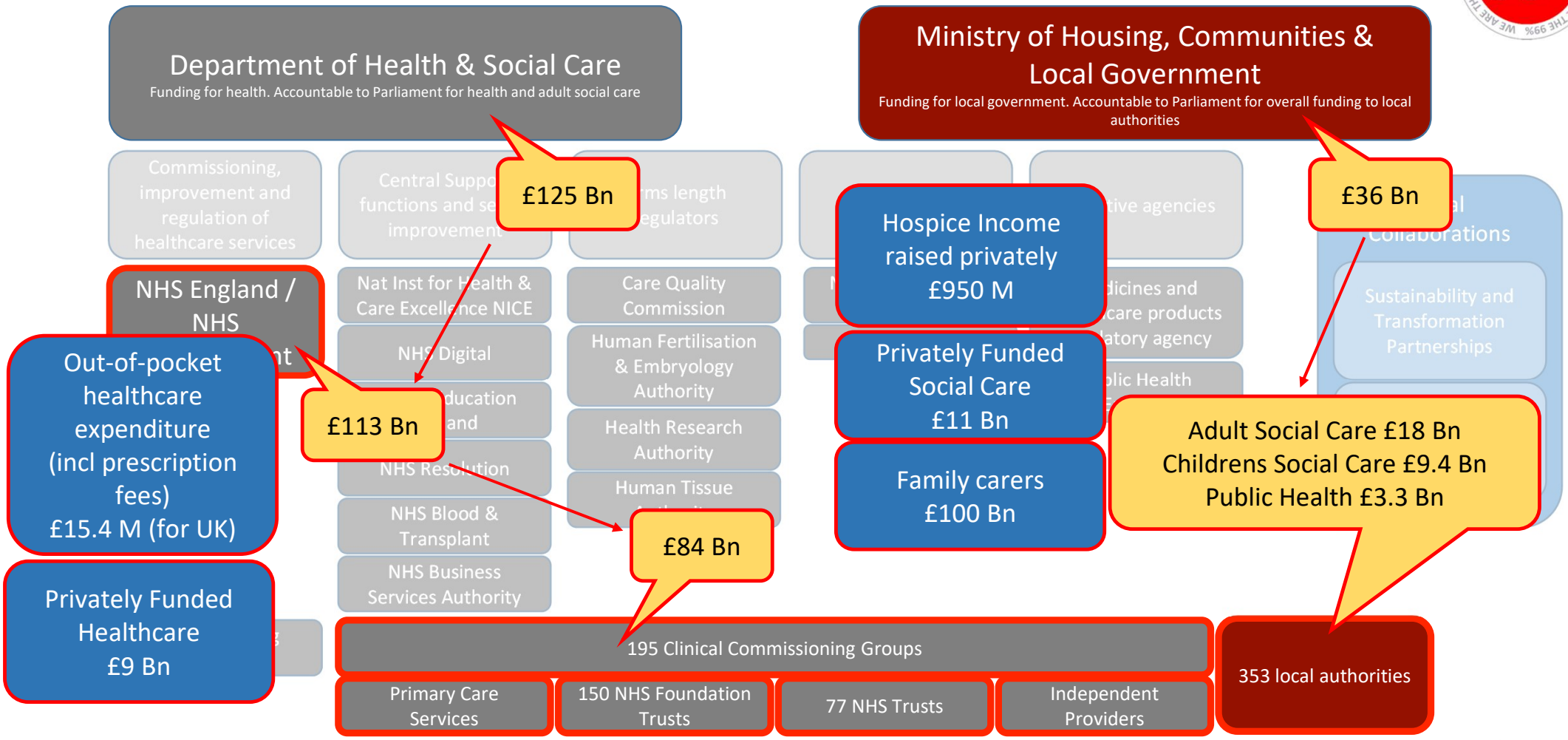
*Source: NAO Departmental Overviews: DHSC / DHCLG 2018-19*

# … with substantial public funding



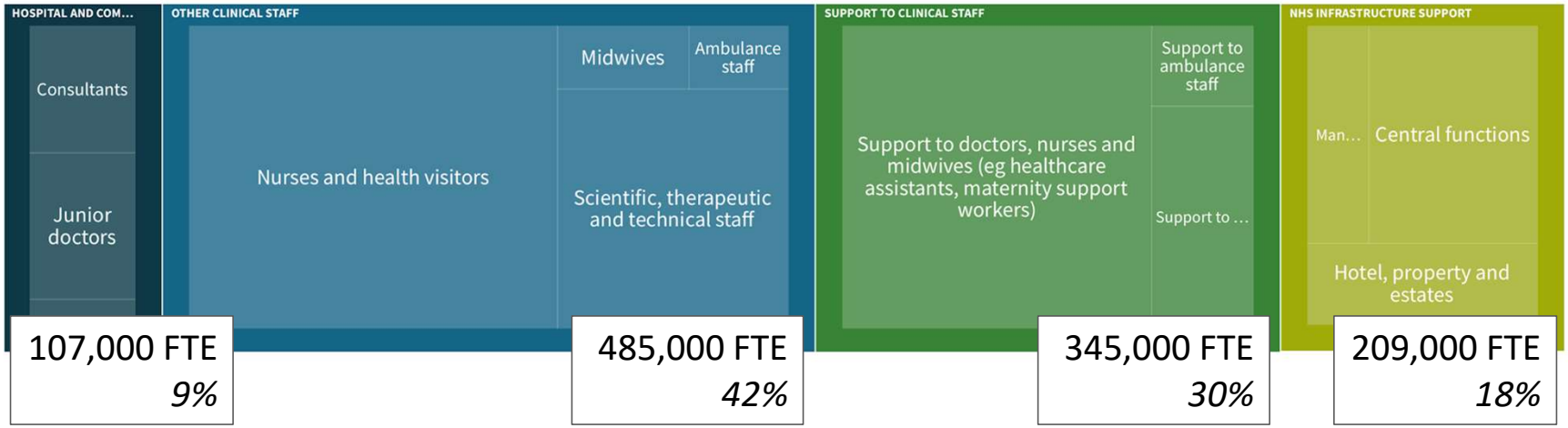

*Source: NAO Departmental Overviews: DHSC / DHCLG 2018-19*

# … supplemented by private money




*Sources: NAO Departmental Overviews: DHSC / DHCLG 2018-19: ONS Healthcare Expenditure, UK Health Accounts 2018: re-check other sources:*

# NHS is the UK's largest employer – 1.4 M people

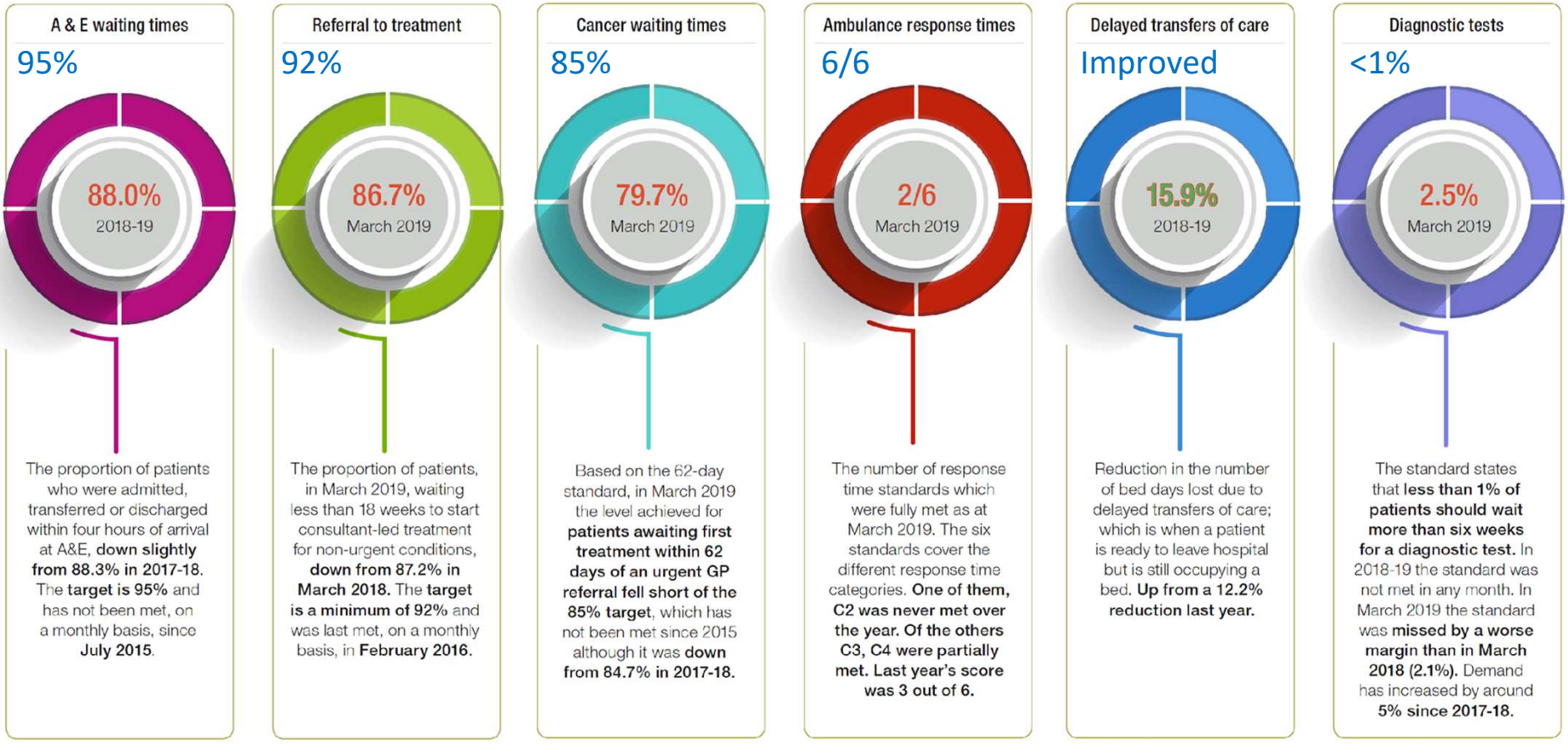



Other significant groups are also key to the delivery of health and social care:

- Primary Care: GPs - 42,000
- Adult Social Care - employs ~ 1.5M people in regulated locations, and in domiciliary settings

* Sources: Kings Fund 'NHS in a Nutshell': NAO The adult social care market in England *Not in the numbers above because not directly employed by the NHS

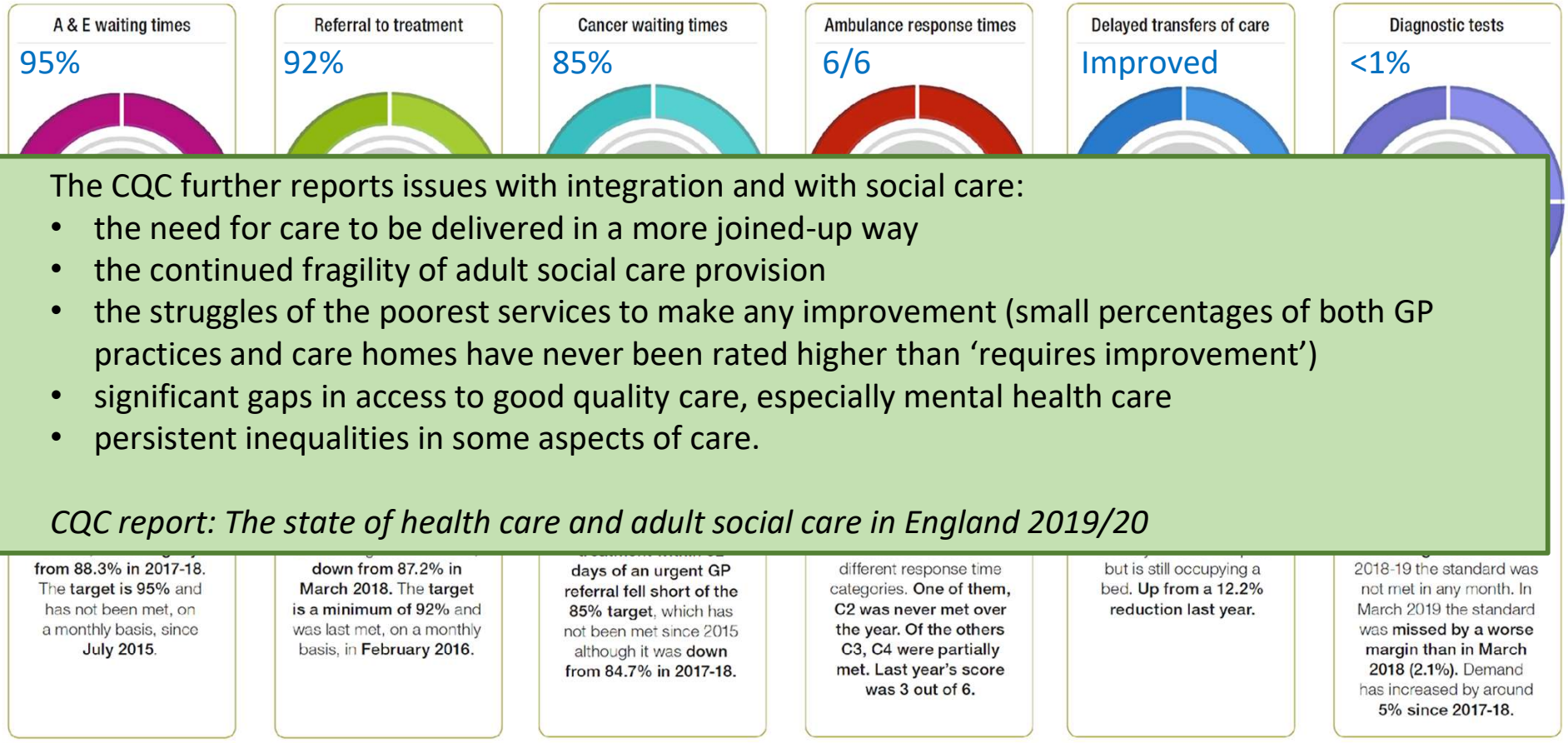
# But there are continuing shortfalls against target delivery




*Source: NAO Departmental Overview: Department of Health & Social Care 2018-19*

*Pre-pandemic numbers*

# But there are continuing shortfalls against target delivery




The CQC further reports issues with integration and with social care:

- the need for care to be delivered in a more joined-up way
- the continued fragility of adult social care provision
- the struggles of the poorest services to make any improvement (small percentages of both GP practices and care homes have never been rated higher than 'requires improvement')
- significant gaps in access to good quality care, especially mental health care
- persistent inequalities in some aspects of care.

*CQC report: The state of health care and adult social care in England 2019/20*

*Source: NAO Departmental Overview: Department of Health & Social Care 2018-19*

*Pre-pandemic numbers*

# Challenges are consistent with shortfalls in capacity across most areas


Including, for example:

- 84,000 FTE vacancies across the NHS (7%) – of which 38,000 are for nurses

- GPs – currently estimated to be short by ~2,500 (6%)
  - with gap likely to increase to 7,000 within 5 years

- Adult Care sector reports a vacancy rate of ~7%
  - But there is a more complex picture of provision with some 7.3 M individuals providing care for family or friends.
  - 1.1 M of these (as at May 2020) were entitled to Carer's Allowance, although only 780,000 were receiving it.

* Sources: Kings Fund 'NHS in a Nutshell': NAO The adult social care market in England e-check other sources: *Not in the numbers above because not directly employed by the NHS

# There are a number of indications of future capacity pressure


In healthcare:

- 84,000 FTE vacancies across the NHS (7%) – of which 38,000 are for nurses
- Widespread reporting of 'burn-out' of front-line staff as a result of the pandemic, with concerns that a significant level of staff losses will follow

- GPs – currently estimated to be short by ~2,500 (6%) with gap likely to increase to 7,000 within 5 years
- Concern that, even if medical schools are able to recruit more students, the lead time to qualifications means a 3-4 year lag in improving capacity
- Financial and other pressures on GP practices are creating pressure for some structural changes (federation / consolidation / ownership)

* Sources: Kings Fund 'NHS in a Nutshell': NAO The adult social care market in England e-check other sources: *Not in the numbers above because not directly employed by the NHS

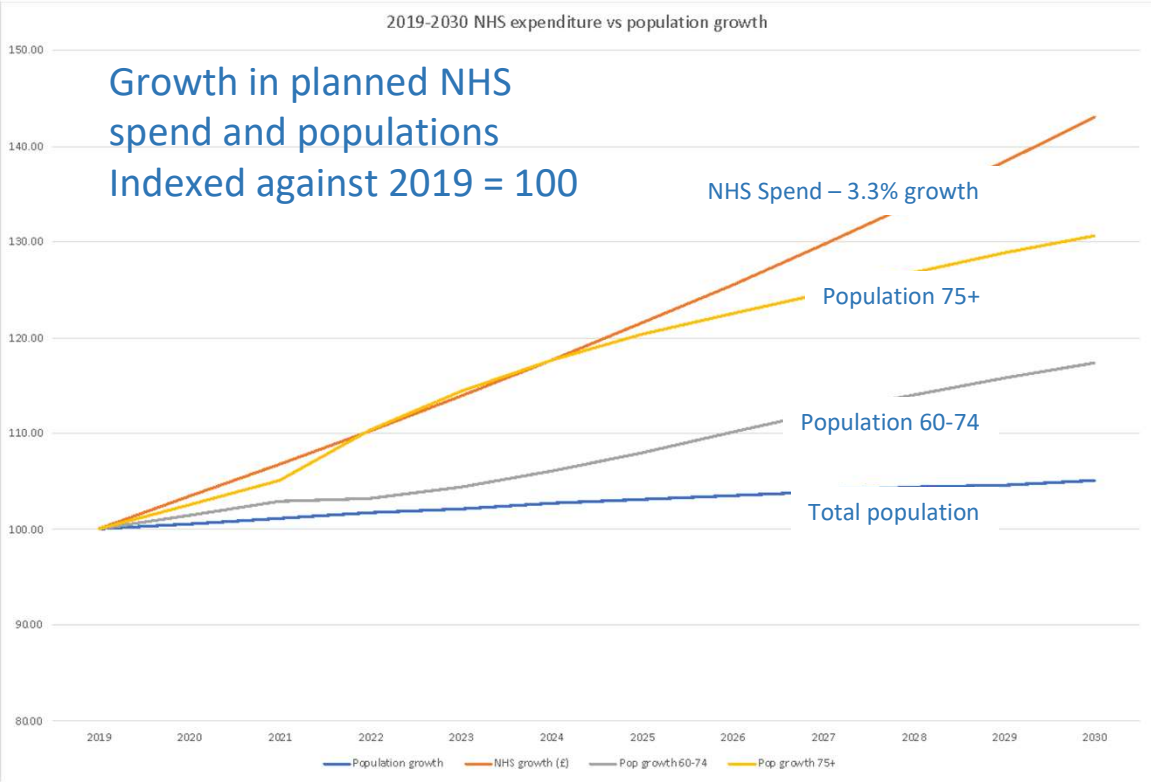
# There are a number of indications for future capacity pressure


And in social care:

- Adult Care sector reports a vacancy rate of ~7%: but there is a more complex picture of provision with some 7.3 M individuals providing care for family or friends.
- The financial sustainability of care homes has been under pressure for some time, partly because of funding pressures on Local Authorities.
- There have been some large-scale casualties
  - Southern Cross in 2011
  - ”Quarter of UK care homes 'at risk of closure’” – reported by BBC in 2016
  - “in 2019, the market saw two care home closures for every opening” (CSI Market Intelligence Report Feb 2020)
- Burn-out issues (following the pandemic) are reported from the sector, which has taken a substantial burden of the events of 2020-21

* Sources: Kings Fund ‘NHS in a Nutshell’: NAO The adult social care market in England e-check other sources: *Not in the numbers above because not directly employed by the NHS

# Spend will continue to increase, BUT…




Whilst these figures seem to indicate that spend will be in line with the needs of the growing and ageing population, they conceal gaps, risks and issues:

- Increasing proportion of elderly population will increase demand for both health and social care
- The '3.3%' settlement in the NHS Long Term Plan does not cover other important aspects of spend (hospital deficits, maintenance backlog, workforce shortages) – 'catch-up' from historical underspending
- Plans and settlements post-pandemic are as yet unclear – as is impact of 'burn-out' of staff creating higher-than-typical churn. Likely to be further exacerbated by pay settlements that do not adequately recognize front-line efforts during the pandemic
- Future plans for Social Care are entirely unclear. No significant indications from Queens Speech (May 2021)

Sources: Health Foundation 'H&SC Funding Priorities for the next government' Nov 2019: other sources to be quoted…

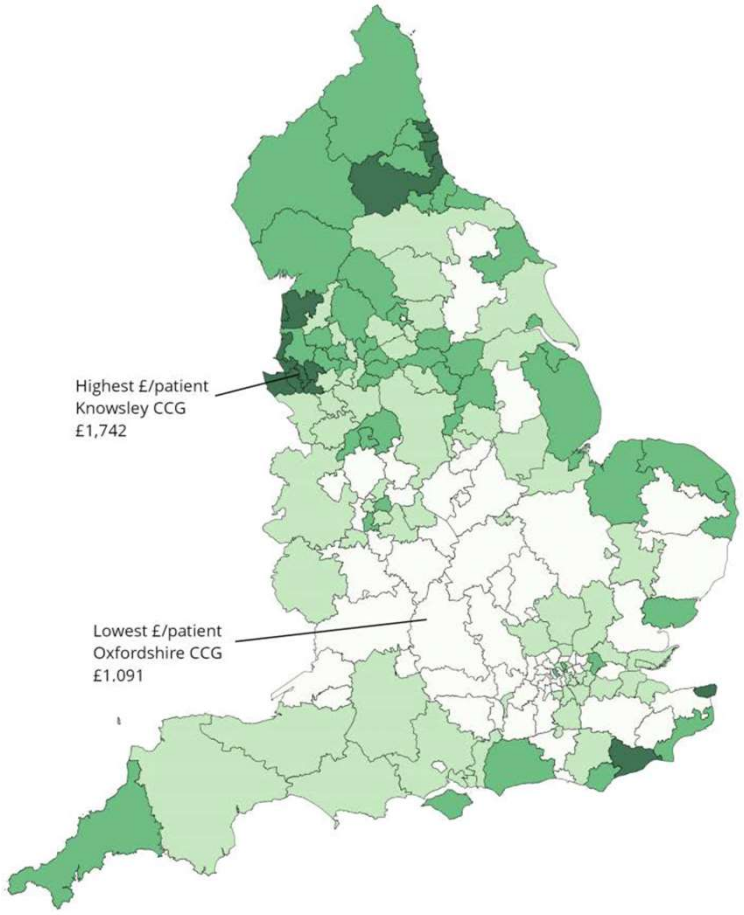
# Regional health inequalities are recognised in funding allocation

Clinical Commissioning Groups are funded according to a funding formula which factors in both needs and costs within the local areas:

- Population
- Age, health status and deprivation levels of the local population
- Staff, land and building costs

Average CCG allocation per registered patient was £1,318 in 2018/20:

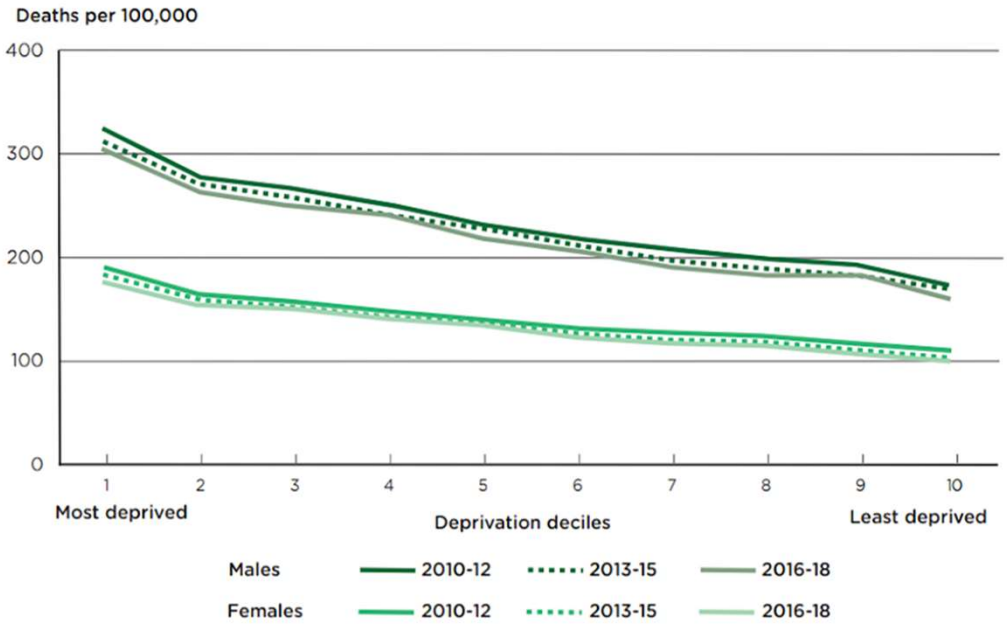
- Lowest in Oxford - £1,091 / patient
- Highest in Knowsley - £1,742 / patient




*Sources: House of Commons Library Briefing Paper CBP-8399 / Marmot Ten Years on report*

# Healthcare & Inequality Trends

Figure 2.17. Mortality rate from causes considered preventable, deprivation decile and sex, England, 2010–12 to 2016–18




**Source:** Based on PHE, 2019 (18)

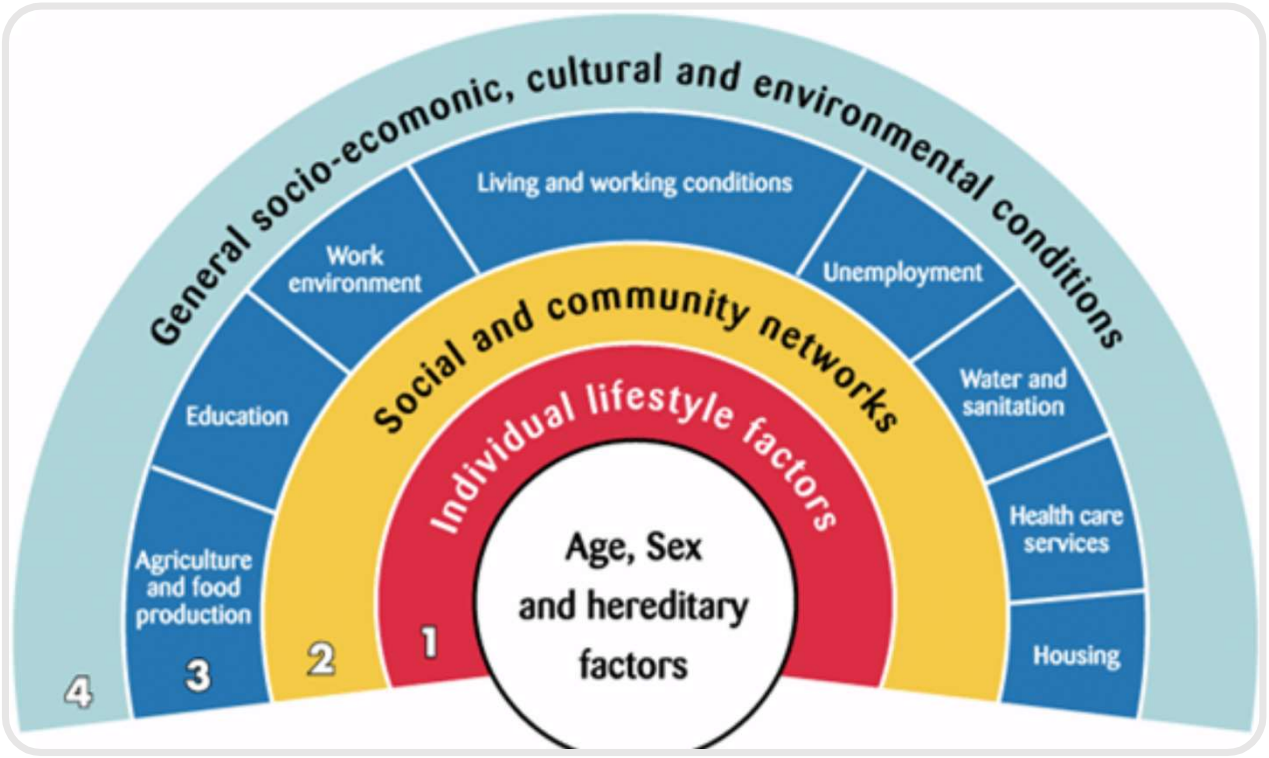
**Inequalities in avoidable deaths increased markedly between 2010 and 2017 in the most deprived areas.**

**Government spending declined by seven percentage points between 2009/10 and 2018/19.**

**Growing inequalities in life expectancy between the North and South.**

**Spending on housing and community amenities has been significantly reduced.**

# Deprivation, affluence and gender….




**Poorer people under-use health care according to relative need.**

**Women are expected to live longer than men at any given deprivation level.**

**Those in the most affluent 5th of areas had longer life expectancies but lower lifetime hospital costs.**

**Deprivation has a bigger impact on life expectancy than geographical location.**

…all drive differences in costs and outcomes

# Inequality: the picture shows

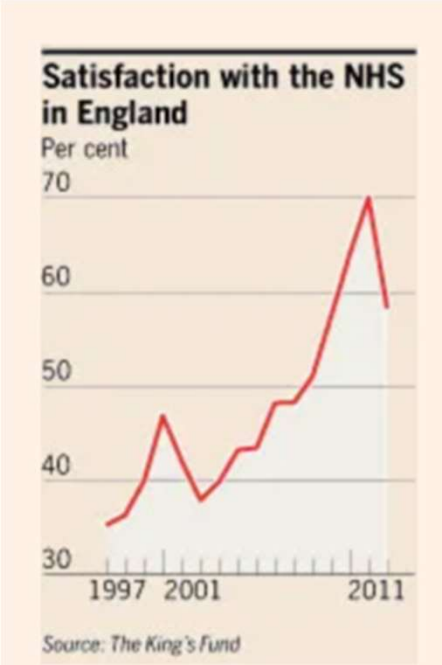

- Socioeconomic inequality cost the NHS in England £4.8 billion in 2011/2012 as a result of excess hospital admissions.
- Costs associated with different population groups seem to be primarily driven by **volumes** of hospital usage rather than differences in **types** of hospital usage across the life course
- Health care costs at any given age are higher for those more deprived neighborhoods than those in more affluent neighborhoods.

# ….but there are unanswered questions


- How do multiple inequalities (eg gender / ethnicity / class) interact to produce lifetime healthcare costs for different socioeconomic groups?
- Ethnicity is not included on death registration so we cannot fully understand health disparities here.
- Reasons for health inequality have not been considered enough from a qualitative angle.
- Not enough data on the demographics of private patients.

# Disruptions….

- The snapshot in the previous slides in this deck is drawn from material that pre-dates the impact of Covid-19, so we need to think about how to reflect that as we develop our fuller responses to the White Paper proposals
- The last major disruption to the way that health care is funded and provided was the Lansley reforms (2012), which had a significant impact on satisfaction
- There has been continued ‘adjustment’ since then, with the impression of tactical ‘tinkering’ as agencies change roles, are combined (NHS Digital/NHS X: NHS England/NHS Improvement) or removed (Public Health England).

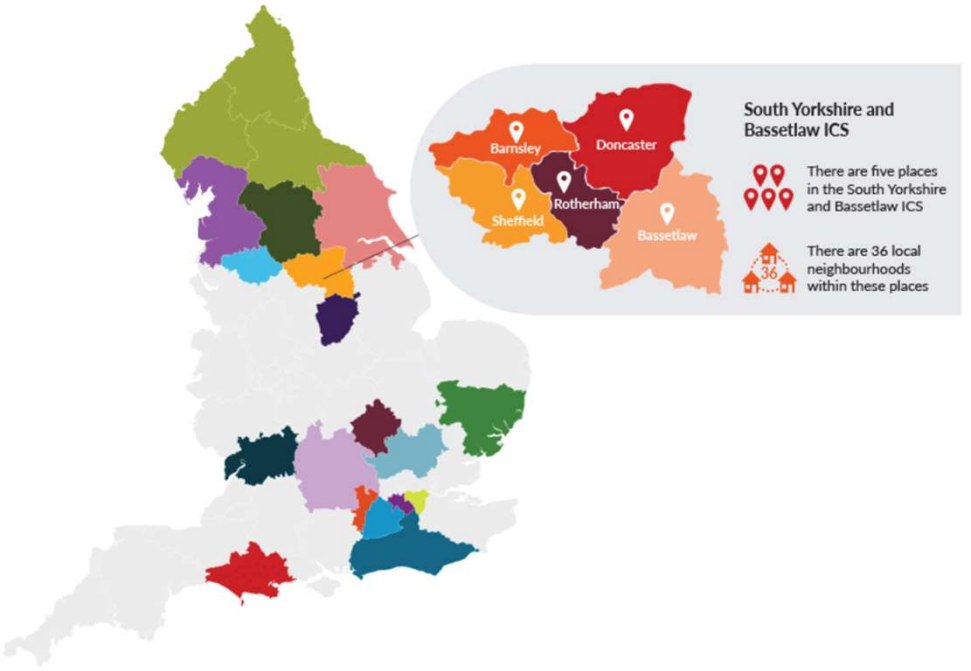



https://www.ft.com/content/e7b5c638-b3c7-11e1-a3db-00144feabdc0

# Migration to ICSs

- Currently ICSs have been established in 18 areas (*coloured in main map*).
- The rest of England is covered by 24 STPs, all of which have been working to strengthen partnerships so that they can take on the greater roles and responsibilities of an ICS.
- The NHS long-term plan set an ambition for all areas of England to be covered by an ICS by April 2021.
- Inevitably, the development of ICSs took a back seat as local and national health and care leaders focus their efforts on responding to the Covid-19 outbreak.
- In the Kings Fund explainer, they take stock of how local systems were developing before the outbreak….
- Note that in addition to the. Kings Fund material we also have comments from BMA and others

**Map 2 An example of the places and neighbourhoods within an ICS**




*Source: https://www.kingsfund.org.uk/publications/integrated-care-systems-explained*

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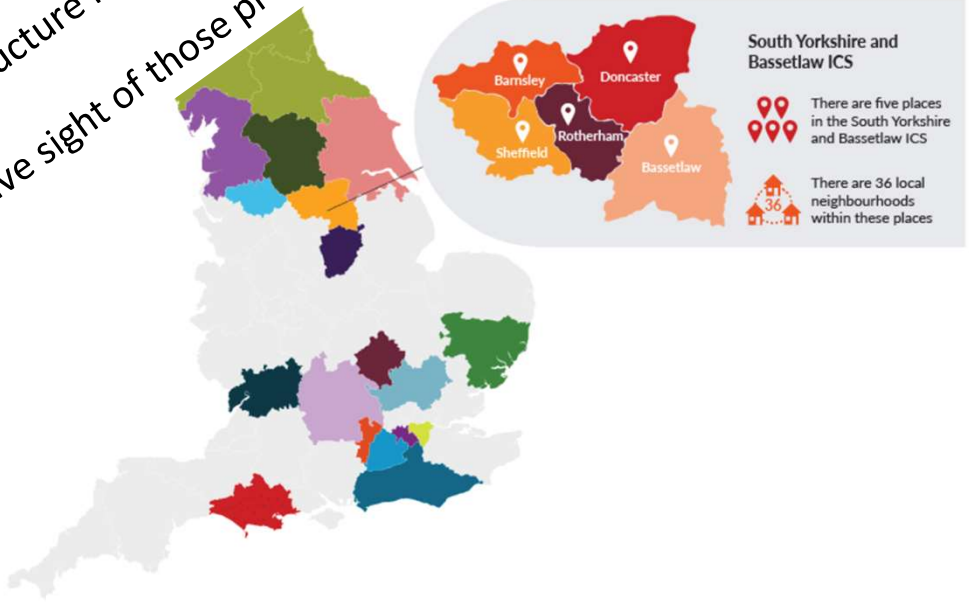
- In the Kings Fund explainer of how local systems were responding to the outbreak….
- Note that in addition to Kings Fund material we also have commentary from BMA and others

Further detail on the proposed migration to ICS structure is expected in June 2021

This section to be updated once we have sight of those proposals

Map 2 An example of neighbourhoods within an ICS




*Source: https://www.kingsfund.org.uk/publications/integrated-care-systems-explained*

# The White Paper has provoked concerns…


… many of which are shared among groups interested in ensuring a successful and continuing future for the NHS and for health and care in England

A ‘starter for ten’ of those concerns is shown on the next slide.

Our next task is to look at the White Paper, and to consider the impact - positive, negative or both – of proposed policy changes on important areas of performance from the perspective of the patient.

# Issues and concerns – to be explored


- Increased scope for privatisation and deregulation of the market (Drift towards a US-style healthcare system, with danger of focus on provider profit not patient healthcare)
- Private companies potentially represented on ICS boards and at the heart of NHS management
- Lack of transparency, reduced accountability to local authorities and loss of voice for local communities
- Unexplored implications for social care
- Major potential impacts on staff, including loss of nationally agreed pay, terms and conditions; flexible working across locations and job roles; and professional deregulation
- Reduced access to face-to-face appointments and increased reliance on digital apps
- Confidential patient data – which has huge commercial value and potential for future misuse - in the hands of multinational corporates
- Challenges of change (culture / leadership / bureaucracy / process / complexity / governance)
- 'Now is not the time' for major re-engineering: still need to recover from pressures of the pandemic

Extracted from 'WeOwnIt' website – May 2021; with modifications

# Issues and concerns – to be explored


| | | |
|---|---|---|
| *What are the strengths / weaknesses / unanswered questions in the White Paper?* | *How will it tackle decentralisation?* | 1. Greater government / ministerial control could increase centralisation and reduce accountability |
| | *How will it ensure efficiency?* | 2. Weakening of competition rules could reduce efficiency |
| | | 5. The 'purchaser/provider' split – conflict of interest / impact on governance |
| | | 3./6. Alignment of service and capacity to population health needs could be weakened by the 'purchaser/provider' split – conflict of interest / impact on governance |
| | | Increased scope for privatisation and deregulation of the market (Drift towards a US-style healthcare system, with danger of focus on provider profit not patient healthcare) |
| | | Private companies potentially represented on ICS boards and at the heart of NHS management |
| | *How will it ensure effectiveness?* | 7. Ultimately, there is a risk of both underfunding and mis-spending because of lack of auditability and cotrols |
| | | 4. Health and Social Care integration could be beneficial subject to the above points being addressed |
| | | Unexplored implications for social care |
| | | Lack of transparency, reduced accountability to local authorities and loss of voice for local communities |
| | | Reduced access to face-to-face appointments and increased reliance on digital apps |
| | *How will It sustain privacy of patient data?* | Confidential patient data – which has huge commercial value and potential for future misuse - in the hands of multinational corporates |
| | *Is this the right time for major change?* | Challenges of change (culture / leadership / bureaucracy / process / complexity / governance) |
| | | 'Now is not the time' for major re-engineering: still need to recover from pressures of the pandemic |
| | | Major potential impacts on staff, including loss of nationally agreed pay, terms and conditions; flexible working across locations and job roles; and professional deregulation |

# 2. Suspect PPE deals


| Company | Comment | Supply | Value (£ million) | Source |
|---|---|---|---|---|
| Medco Solutions Ltd | Newly formed | Facemasks | 10 | https://ted.europa.eu/udl?uri=TED:NOTICE:209357-2020:TEXT:EN:HTML&src=0 |
| Initia Ventures Ltd | Business Support Services | PPE | 48.84 | https://ted.europa.eu/udl?uri=TED:NOTICE:293536-2020:TEXT:EN:HTML&src=0 |
| Monarch Acoustics Ltd | Shop and office furniture | PPE | 28.8 | https://ted.europa.eu/udl?uri=TED:NOTICE:307294-2020:TEXT:EN:HTML&src=0 |
| Medicine Box Ltd | £6,000 net assets in March 2020 | PPE | 40 | https://ted.europa.eu/udl?uri=TED:NOTICE:293548-2020:TEXT:EN:HTML&src=0 |
| P14 Medical Ltd | Negative net assets | PPE | 116.013 | https://ted.europa.eu/udl?uri=TED:NOTICE:293540-2020:TEXT:EN:HTML&src=0 |
| SG Recruitment Ltd | Recruitment; turnover <£600k | PPE | 23.889 | https://ted.europa.eu/udl?uri=TED:NOTICE:293541-2020:TEXT:EN:HTML&src=0 |
| PestFix | Pest control business | Surgical gowns | 32 | https://www.thetimes.co.uk/article/108m-ppe-contract-was-given-to-small-pest-control-company-7vw0295rr |
| Aventis Solutions Ltd | Wholesale of pharmaceutical goods | PPE | 18.48 | https://ted.europa.eu/udl?uri=TED:NOTICE:309296-2020:TEXT:EN:HTML&src=0 |
| Clandeboye Agencies Limited | Wholesale of Sweets | PPE | 108 | https://goodlawproject.org/news/ppe-supplied-by-a-sweet-wholesaler/ |
| Ayanda Capital Limited | Private equity and currency trading | PPE | 252.5 | https://inews.co.uk/news/health/government-ppe-contract-private-equity-tax-haven-494587 |

# 3. Key points of the Bill


**If Parliament enacts this Bill without amendment:**

- there will no longer be a statutory duty on any body to arrange provision of secondary (i.e., hospital) medical services – only a power for ICBs to do so;
- ICBs will only have a "core responsibility" for a "group of people" in accordance with enrolment rules made by NHS England, evoking the US definition of a health maintenance organisation which provides "basic and supplemental health services to its members";
- it will be possible for ICBs to award and extend contracts for health care services of unlimited value without advertising, including to private companies;
- private health companies will be able to be members of ICBs, their committees and subcommittees, which will plan NHS services and decide how to spend NHS money;
- NHS England will have new powers to impose limits on expenditure by NHS trusts and NHS foundation trusts;
- integrated care partnerships will be set up as joint committees of local authorities and ICBs to draw up integrated care strategies, with no restrictions on membership and without clear transparency obligations;
- payments will be determined by NHS England after consultation with providers, including private providers, and can distinguish between different types of providers, different groups of patients and different types of services;
- local authority representation on ICBs will be limited to one member covering (usually) several local authorities, whilst the more local 'place-based' ICB committees will not have power to determine their budgets;
- local authority powers to refer reconfigurations will be affected because the Secretary of State is to be given new intervention powers, but exactly how is unclear.

*Source: Prof Allyson M Pollock and Peter Roderick*

# 1. There will no longer be a statutory duty on any body to arrange provision of secondary (i.e., hospital) medical services – only a power for ICBs to do so


- Clause 15 – Commissioning hospital and other health services; NHS Act 2006, ss. 3 & 3A
- The government had a qualified legal duty to provide hospital medical services "throughout England" from 1946 until 2012. Under the Health and Social Care Act 2012, this duty was repealed and 200+ clinical commissioning groups (CCGs) were given under s.3 of the 2006 NHS Act a duty to arrange provision of medical, and other key services and facilities, such as nursing and ambulance services, and hospital and other accommodation. The duty to arrange provision of these services and facilities will pass to 42 ICBs,1 but excluding medical services. The reasons for these exclusions are not explained. If the exclusion is enacted, there will be no duty on ICBs to arrange secondary medical services with NHS Trusts or NHS foundation trusts (or private providers). An ICB could only then arrange such services by exercising their power, but not obligation, to do so under section 3A of the 2006 Act. The duty to arrange ophthalmic services will also be removed from section 3.
- The exclusion of medical services from section 3 is particularly concerning in the light of new payment rules (see section 7 below) allowing categories of services not to be paid for. The possibility that has always existed for patients to challenge in court the non-provision of NHS services will be further reduced.

*Source: Prof Allyson M Pollock and Peter Roderick*

# 2. ICBs will only have a “core responsibility” for a “group of people” in accordance with enrolment rules made by NHS England, evoking the US definition of a health maintenance organisation which provides “basic and supplemental health services to its members”


- Clause 14 – People for whom integrated care boards have responsibility, and new section 14Z31
- In 2012, the duty on each CCG was to arrange provision of key services “for persons for whom it has responsibility”. This term was defined in the primary legislation as persons provided with primary medical services by a CCG member and others who usually reside in the CCG’s area and are not provided with such services by a CCG member. Under the Bill NHS England (NHSE) will now make enrolment rules for determining “the group of people for whom each [ICB] has core responsibility” (emphases added). This evokes the US definition of a health maintenance organisation which provides “basic and supplemental health services to its members”
- Those rules must ensure that everyone who is provided with NHS primary medical services, and everyone who is usually resident in England and is not provided with NHS primary medical services, is allocated to at least one group, subject to any exceptions made by regulations. There is no requirement of residence in the ICB area. The ICB must then arrange provision of key services for the group of people allocated to the ICB by NHSE’s rules, and such other people (not persons) as may be prescribed (clause 15, inserting a new section 3 into the 2006 Act).
- Why the concept of “core” responsibility has been introduced is not explained, and its meaning is unclear.
- There is no provision (as there is for CCGs) aimed at ensuring that accident and emergency services, and ambulance services, must be arranged for all persons present in an ICB area.
- Bizarrely, subsection (4) of new section 14Z31 proposes to give the Secretary of State a power to replace section 14Z31 with a new section which would provide that “the group of people for whom an [ICB] has core responsibility are to the people who usually reside in its area”, subject to prescribed exceptions. Why is this exceptional power to amend primary legislation needed? Why is residence in the ICB area not the starting basis for ICB responsibility?

*Source: Prof Allyson M Pollock and Peter Roderick*

# 3. It will be possible for ICBs to award and extend contracts for health care services of unlimited value without advertising, including to private companies


- Clauses 68 – Procurement regulations, and 69 – Procurement and patient choice: consequential amendments etc.
- Procurement – as opposed to direct provision – is necessary because the purchaser/provider split – the need for a 'commissioner' and a 'provider' – is not being abolished. Putting one (major) commissioner and representatives of providers in a single body does not abolish the split.
- The Bill will repeal section 75 of the Health and Social Care Act 2012, and revoke the NHS (Procurement, Patient Choice and Competition) (No. 2) Regulations 2013, which required virtually compulsory advertising of contracts for health care services.
- Clause 68 provides for new regulations on procurement of health care services and of goods and services procured with health care services. NHSE will be able to publish guidance about compliance with the regulations.
- Repeal of section 75 is welcome. Yet transparently competing for contracts is the check against corruption and cronyism within a market model. NHSE consulted on its 'NHS Provider Selection Regime' in February 2021. It proposes a light touch regime that distinguishes between (a) continuing with existing providers, (b) selecting the most suitable provider when a service is new or changing substantially, but deeming a competitive procurement inappropriate, and (c) selecting a provider by running a competition. We assume that the NHSE guidance, facilitated and required by the new regulations, will be largely based on these proposals.
- There is every possibility that under the new regulations private companies providing services will be able to extend their contracts or even be awarded new contracts without competition.

*Source: Prof Allyson M Pollock and Peter Roderick*

# 4. Private health companies will be able to be members of ICBs, their committees and sub-committees, which will plan NHS services and decide how to spend NHS money


- Clause 13 – Establishment of integrated care boards, and Schedule 2
- Each ICB will be established by order made by NHSE for an area within England, which must not coincide or overlap with the area of any other ICB. Together, the whole of England must be covered. The order must set out the ICB's constitution or refer to a published document where it is set out.
- The constitution must specify the name of the ICB and the area for which it is established. There is no requirement for them to be named as "NHS Integrated Care Boards", and no provision (as there is in the current NHS Act for CCGs) for the ICB name to comply with prescribed requirements. One of those requirement for CCGs is that its name must begin with "NHS" in capital letters.
- An ICB will consist of a chair appointed by NHSE and approved by the Secretary of State; a chief executive appointed by the chair with NHSE's approval; one member jointly nominated by (i) NHS trusts and foundation trusts, (ii) providers of primary medical services, and (iii) by the local authorities in the ICB area; and anybody else, including private companies, in accordance with the ICB's constitution and any regulations. Unlike for CCGs, an ICB constitution will not have to specify its members.
- NHSE has stated that "All members of the [ICB] will have shared corporate accountability for delivery of the functions and duties of the ICS". If representatives of private companies are members of ICBs, sharing this accountability will conflict with the legal duties of company directors, in particular the duty to "act in the way he considers, in good faith, would be most likely to promote the success of the company for the benefit of its members as a whole."
- The constitution must specify arrangements for exercising the ICB's functions, and this may include committees and sub-committees. These committees may consist entirely of, or include, persons who are not members or employees of the ICB – such as private companies.
- According to the Explanatory Notes, an ICB "will have the ability to exercise its functions through place-based committees (while remaining accountable for them) and it will also be directly accountable for NHS spend and performance within the system." (paragraph 38).

*Source: Prof Allyson M Pollock and Peter Roderick*

# 5. NHS England will have new powers to impose limits on expenditure by NHS trusts and NHS foundation trusts


- Clauses 21-24 – Integrated care system: financial controls; NHS Act 2006, new s.223C, 223GB
- These clauses combine to expand NHSE's control of expenditure to NHS trusts and NHS foundation trusts. NHSE will be allowed to impose financial requirements on ICBs as regards their management or use of financial or other resources, including limits on expenditure or resource use.

*Source: Prof Allyson M Pollock and Peter Roderick*

# 6. Integrated care partnerships will be set up as joint committees of local authorities and ICBs to draw up integrated care strategies, with no restrictions on membership and without clear transparency obligations


- Clause 20: Integrated care partnerships and strategies, and the Local Government and Public Involvement in Health Act 2007, ss.116, 116A and 116B
- The current system for needs assessment and associated strategies is set out in ss.116, 116A and 116B of the Local Government and Public Involvement in Health Act 2007. Section 116 introduced a requirement on local authorities and Primary Care Trusts (PCTs) to undertake a joint strategic needs assessment of the health and social care needs for the authority's area (JSNA). According to the Explanatory Notes, "This will determine what will be needed in terms of the discharge of health and social care functions in relation to the area of the local authority." CCGs replaced PCTs as local authority partners in 2013, and under the Bill, ICBs will replace CCGs in preparing JSNAs with local authorities.
- An "integrated care partnership" (ICP) must be set up as a joint committee by each ICB and each responsible local authority whose area coincides with or falls partly within the ICB's area (new section 116ZA). The ICP committee will have one member appointed by the ICB, one by each LA, and others appointed by the ICP. There are no requirements as to whom the ICP can appoint as members. These could and probably would include private companies, as most adult social services are provided by private companies. In the words of the White Paper which preceded the Bill, "local areas can appoint members and delegate functions to it as they think appropriate" (p.75). It will not have a constitution and will decide its own procedure.
- An ICP must prepare an "integrated care strategy" setting out how the needs assessed by the JSNA "in relation to the areas of the responsible local authorities so far as those needs relate to the [ICP's] area" are to be met by the exercise of functions of the ICB, NHS England, or the local authority(ies).
- The integrated care strategy then goes to the ICB(s) and the local authorities, and it is their job to prepare "a joint local health and wellbeing strategy" setting out how the needs assessed by the JSNA in relation to the responsible local authority's area are to be met by the exercise of functions of the responsible local authority, the ICB(s) or NHS England (i.e., the same bodies, as for the integrated care strategy but ordered differently in the Bill).
- ICBs, local authorities and NHSE must have regard to the JSNA, the integrated care strategy and the joint local health and wellbeing strategy "so far as relevant". Needs assessments for services, including monitoring of demographic changes and service developments, were in the past undertaken by public health departments in order to inform service planning, workforce, and estate planning. These provisions are no substitute for such needs assessments, particularly as public health remains divorced from health services, and when public health specialists will have at best a limited understanding of, and no direct involvement in, the health services or the workforce that are required.
- Unlike for ICBs, the Bill does not provide for ICPs to be a public authority subject to the Public Bodies (Admission to Meetings) Act 1960; and the joint committee does not appear to be a committee of a local authority to which the provisions of Part VA of the Local Government Act 1972 on access to meetings and documents of committees and subcommittees apply.

*Source: Prof Allyson M Pollock and Peter Roderick*

# 7. Payments will be determined by NHS England after consultation with providers, including private providers, and can distinguish between different types of providers, different groups of patients and different types of services


- The national tariff is to be abolished and new rules will be drawn up by NHSE termed the 'NHS Payment Scheme'.
- The rules will specify prices and/or formulae, and may "make different provision for different services or provision for some services but not others", and "make different provision for the same service by reference to different circumstances or areas, different descriptions of provider, or other factors relevant to the provision of the service or the arrangements for its provision". They may also "confer a discretion on the commissioner".
- In order to achieve a "fair level of pay for providers", NHSE must have regard to "differences in the costs incurred in providing…services to persons of different descriptions" and also to "differences between providers with respect to the range of those services that they provide".
- Before publishing the rules, NHSE must either carry out an assessment of the likely impact of the proposed scheme, or publish a statement setting out its reasons for concluding that such assessment is not needed. NHSE must also first consult with the ICBs and providers, including private providers.
- If a 'prescribed percentage' of ICBs, and/or, separately, of providers, object, NHSE must then consult with representatives of the ICBs or of the providers.
- NHSE will have wide discretion in deciding on the rules, including the ability to determine what services will and will not be paid for, and on who will be eligible.
- The way is clear for services *not* to be provided and not paid for, backed by dropping the legal duty to arrange hospital services (see section 1 above), and for lobbying by representatives of private healthcare providers. Patients having to pay for services that are no longer paid for or provided by the NHS is now likely.

*Source: Prof Allyson M Pollock and Peter Roderick*

# 8. Local authority representation on ICBs will be limited to one member covering (usually) several local authorities, whilst the more local 'place-based' ICB committees will not have power to determine their budgets


- Local authority influence on ICB decisions will be limited, as there will only be one LA representative on ICBs (see section 4 above), but the vast majority of ICBs cover more than one LA area, and usually many more.
- Local authorities may sit on the more local place-based committees of the ICB, but 'places' are neither defined nor even mentioned in the Bill. Their budgets will be controlled by the ICBs.
- Even LA involvement in the ICPs will not feed directly through to NHS provision, as ICBs will not be bound by the JSNA nor by the integrated care strategies, only required to have regard to them "so far as relevant".

*Source: Prof Allyson M Pollock and Peter Roderick*

# 9. Local authority powers to refer reconfigurations will be affected because the Secretary of State is to be given new intervention powers, but exactly how is unclear

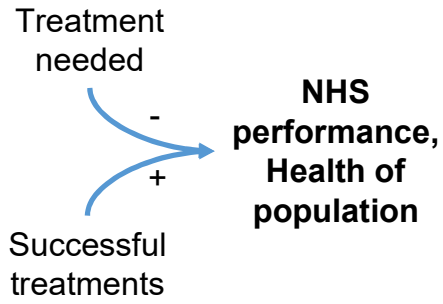

- Clause 38 & Schedule 6; NHS Act 2006, new s.68A & Schedule 10A
- An ICB or NHSE will have to notify the Secretary of State (SoS) if it proposes a change in the arrangements made by it for the provision of NHS services, where that change impacts on the manner in which a service is delivered to individuals (at the point when the service is received by users), or on the range of health services available to individuals (a "reconfiguration of NHS services").
- The SoS may then call-in the proposal for his or her decision. In addition, an ICB, NHSE, NHS trust or NHS foundation trust must notify the SoS if it is are "aware of circumstances that it thinks are likely to result in a need for the reconfiguration of NHS services".
- According to the Explanatory Notes, "Most service changes are delivered and implemented locally – planned reconfigurations are developed at local or regional levels by commissioners. The current system for reconfigurations works well for the majority of changes, and this will be left in place for many day-to-day transactions. The aim of this policy is to address the minority of cases which are complex, a significant cause for public concern, or where Ministers can see a critical benefit to taking a particular course of action." (paragraphs 93-94).
- It is not clear, however, how this new power would affect the ability of local authorities to refer reconfigurations to the SoS under Part 4 of the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013.

*Source: Prof Allyson M Pollock and Peter Roderick*

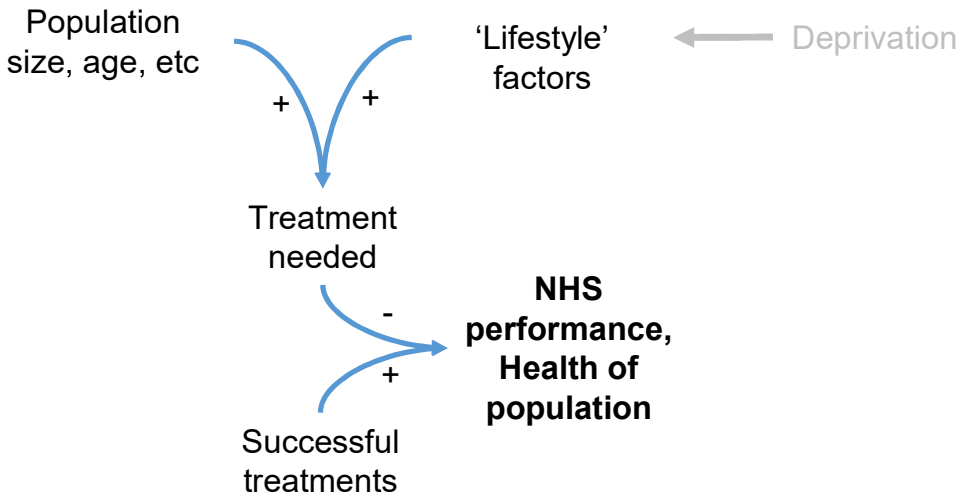
# 4. Key Dynamics of the Healthcare System


- System dynamics maps the cause and effect relationships in a system
- A 'positive' relationship x $\xrightarrow{+}$ y means that an increase in x produces an increase in y and a decrease in x produces a decrease in y
- A 'negative' relationship x $\xrightarrow{-}$ y means that a decrease in x produces an increase in y and an increase in x produces a decrease in y
- 'Positive feedback' (+) means a self-reinforcing loop (not always good news)
- 'Negative feedback' (-) means a self-balancing loop (not always bad news)

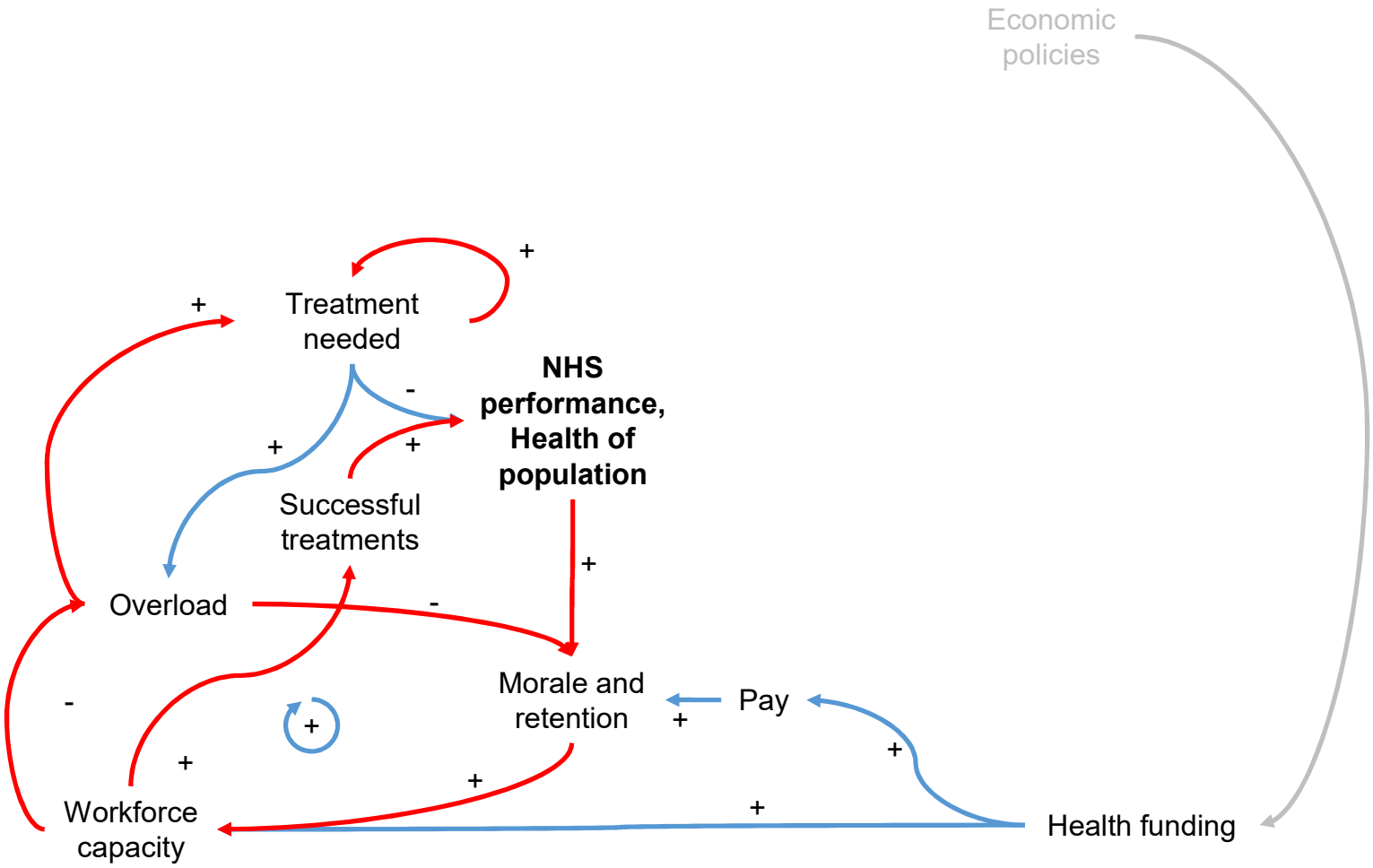
# The Key Issue is whether the NHS can meet the needs of the population



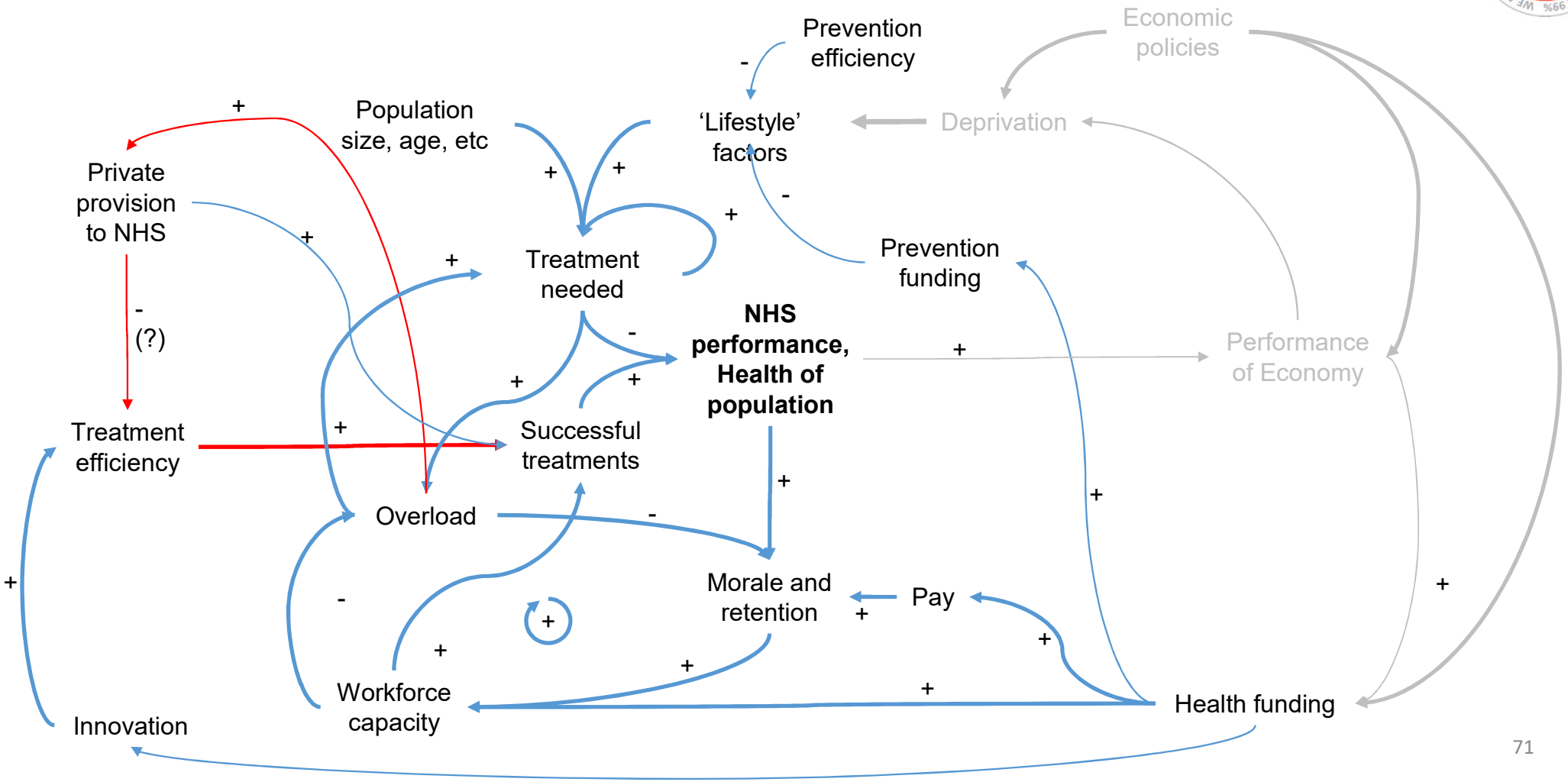
# Health is not just down to healthcare



# If the system is underfunded, it will become over-loaded and start to fail – this is a vicious circle



# Overload can also cause buying-in of expensive top-up capacity



# Some important dynamics are ‘outside the system’