Submission on the Health and Care Bill from Mark Thomas on behalf of the 99% Organisation

Mark Thomas
Founder of the 99% Organisation
Visiting Professor at IE business School

Executive Summary

Without significant amendment, the Health and Care Bill poses grave risks to the efficiency, effectiveness and accessibility of the NHS as a high quality, universally accessible health service, free at the point of use:

- the Bill creates enormous powers for ministers and Integrated Care Boards without corresponding duties and adequate safeguards;
- from the perspective of patients and taxpayers, The US healthcare system is a very poor performer. Nevertheless, although it is the least efficient, effective and accessible in the developed world, the US system appears to be the model towards which this Bill is moving the NHS. To our concern, we note that there is an enormous commercial incentive to do so;
- several members of the current Cabinet have made it clear that they do not wish to see the NHS continue in anything like its current form and have made proposals that would move the NHS towards the US system. Commercial interests are legally bound favour such a move. There are thus powerful motivations to erode three of the fundamental principles of the NHS: 1) that it is governed on behalf of UK patients and taxpayers; 2) that it provides comprehensive, accessible coverage; and 3) that it is free at the point of use;
- the Bill should be amended to protect the efficiency, effectiveness and accessibility of the NHS for the UK population.

Introduction

Most of my career has been spent in business: I was Group Development Director for UniChem plc (now Walgreens Boots Alliance) and for many years I led the Strategy practice at PA Consulting Group. I am the author of *The Complete CEO*, *The Zombie Economy* and *99%* (one of the FT's best books of 2019). I founded the 99% Organisation and am a Visiting Professor at IE business School in Spain.

This submission is a distillation of the paper produced by the 99% Organisation NHS Project team, which included former NHS consultants, management consultants, social workers and

patients with extensive experience of the NHS. The full paper is available here: https://99-percent.org/wp-content/uploads/2021/09/NHS-Fact-pack-v1.6.pdf.

I am happy to provide further detail in oral evidence to the Committee.

The main submission

1. This submission amplifies and provides evidence for the points mentioned in the executive summary.

Power without responsibility or scrutiny

2. The Bill concentrates power over the NHS into two sets of hands: those of ministers and the Integrated Care Boards (ICBs).

3. To ministers, by deleting[1] sections 75 to 78 of and Schedule 9 to the Health and Social Care Act 2012 (regulations etc relating to procurement, patient choice and competition),[2] the Bill gives enhanced powers to circumvent normal procurement rules (e.g. advertising and competitive tendering) and to award contracts at will. During COVID we have seen use of emergency procurement procedures in ways which are, at best, a sub-optimal use of public money – for example with personal protective equipment (PPE) and with Test and Trace. In the case of PPE, well over £1 Billion of public money[3] was spent with inexperienced suppliers and a significant proportion of what was delivered was not usable in practice. In the case of Test and Trace, which is costing up to £37 Billion of public money[4], the National Audit Office (NAO) has published two highly critical reports about its lack of effectiveness. Both of these procurement exercises are currently the subject of judicial review. *Without amendment, the Bill would enable ministers to procure in this way routinely and without scrutiny.*

4. The Bill also gives ministers the power to amend or abolish existing bodies, create new NHS trusts and to intervene in reconfigurations of NHS[5]. Without amendment, the Bill would enable them to restructure the NHS at will without consulting Parliament.

5. Finally, unless the Bill is amended, there will no longer be an enforceable statutory duty on any body to arrange provision of secondary (i.e., hospital) medical services. The Bill says[6] only: *"An integrated care board must arrange for the provision of the following [including secondary care]* ***to such extent as it considers necessary*** *to meet the reasonable requirements of the people for whom it has responsibility."*

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[1] See section 71 of (Department of Health and Social Care, 2021, p. 64)
[2] (Department of Health and Social Care, 2012, p. 99)
[3] (Thomas M. E., Money for Nothing?, 2020)
[4] (Thomas M. E., What's in a Name?, 2021)
[5] (Department of Health and Social Care, 2021, p. 197)
[6] See clause 16 of (Department of Health and Social Care, 2021)

Challenging an ICB for non-provision would require proving that it had not provided what it, itself, considered necessary – a practical impossibility.

6. Such a concentration of power without responsibility or scrutiny would be inappropriate for any government whether well disposed towards the NHS or not.

Risks of moving towards the US system

7. The US healthcare system appears to be the model towards which the NHS is being steered[7]. And this is curious because the US system is not a high performer either in comparison with the NHS or with other systems around the world.

8. As patients and as taxpayers, there are three dimensions on which we would like to see the NHS perform well:

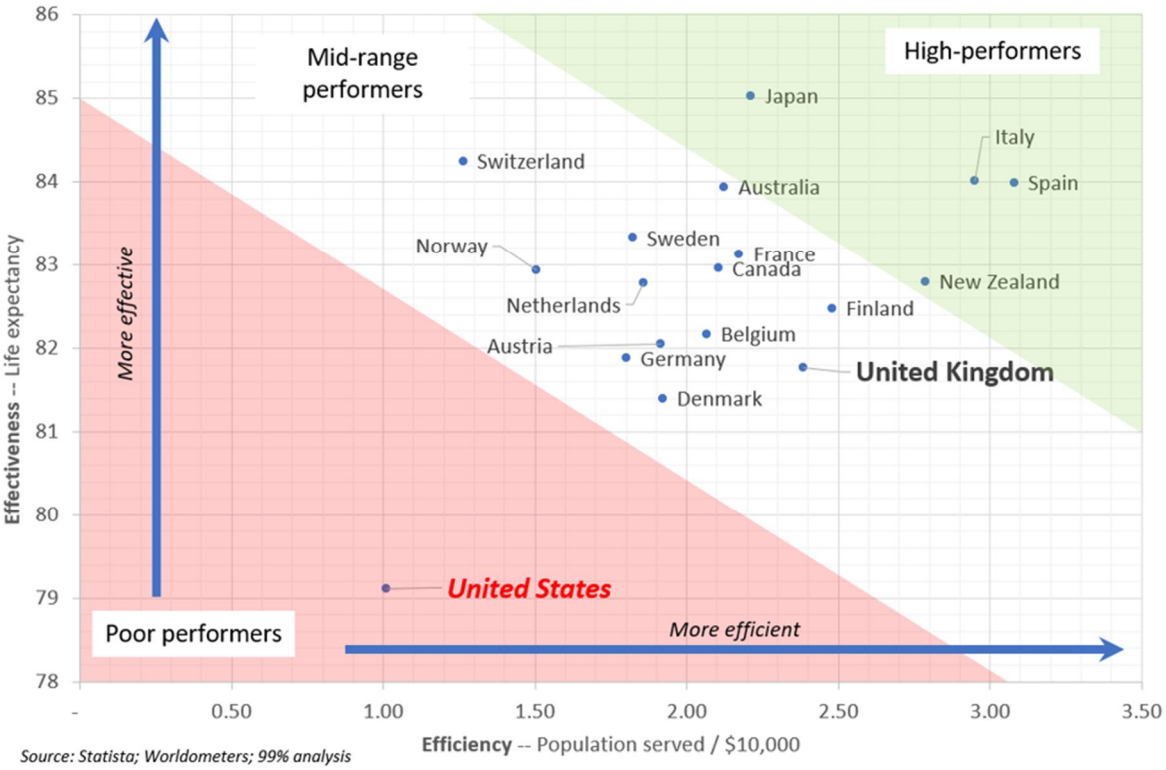
- **efficiency** – as taxpayers, we would like the NHS to provide a high-quality healthcare service to the UK population as cheaply as possible;
- **effectiveness** – as patients, we would like the NHS to provide good healthcare outcomes; and
- **accessibility** – as patients, we would like the NHS to be accessible geographically, temporally (i.e. without long waiting lists) and, of course, financially.

9. For efficiency, we can measure the number of people served per $10,000 spent. For effectiveness, there is no perfect measure, but life expectancy is a reasonable, if crude, proxy.

10. As the chart below shows, in terms of efficiency and effectiveness, the UK system is a good mid-range performer; the US system is the stand-out poor performer.

[7] (Harrington, Beetham , & Matthews, 2021)

Figure 1: Comparison of Healthcare Systems



11. In addition to these considerations there is also accessibility. The US system is prohibitively expensive for those without insurance, and, even for those with insurance, it can often be ruinous. Two thirds of American personal bankruptcies are as a result of medical Bills[8].

12. Given this, it is initially surprising that the US system might be a favoured destination. But there is a fourth dimension, which is not a concern to UK taxpayers or patients but is vitally important to other stakeholders: profit. The US system is particularly good as a profit generator. Our estimates suggest that the profit opportunity available to healthcare corporations if the UK adopted the US system is of the order of $28 Billion[9] *per annum*.

13. *The risk to the UK, therefore, is that because of the size of the prize, the interests of healthcare corporations will trump those of UK taxpayers and patients at enormous cost to their lives and livelihoods*.

[8] (Himmelstein, Lawless, Thorne, Foohey, & Woolhandler, 2018)
[9] (The 99% Organisation, 2021)

Inclination to change the nature of the NHS

14. Given the concentration of power in the hands of ministers and ICBs, we are concerned about their motivations when it comes to steering and governing the NHS.

15. John Major commented in 2016[10]:

> *"The concept that [the Cabinet] 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."*

16. The Health Secretary, Sajid Javid, has celebrated[11] his adherence to the ideas of Ayn Rand who vehemently opposed the very idea of publicly funded healthcare. At the Conservative Party conference, he made clear his preference[12] for who should fund UK citizens' healthcare: *"We shouldn't always go first to the state – what kind of society would that be? Health and Social Care: it begins at home. It should be family first, then the community, then the state."* And there is a long history of papers by Cabinet members and others promoting the privatisation of the NHS[13] and the shift to an insurance-based scheme[14] – dating far back as 1982[15].

17. On the corporate side, as drafted, the Bill will allow corporate members to sit on the ICBs (and indeed this has already started to happen[16]) and therefore to play an important role in the governance of the NHS. Directors of corporations have a fiduciary duty to the members[17] of their company – i.e. to their shareholders. Where there is a conflict of interest between taxpayers, patients and company shareholders, the corporate members are legally bound to favour their shareholders. And as noted above there is an enormous commercial incentive to steer the NHS towards the US system.

18. The evidence that this Bill, as it stands, will introduce conflicting motivations within NHS governance highlights the need for amendment to add checks and balances to the Bill.

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[10] (Mason, 2016)
[11] (Hoskin, 2015)
[12] (Javid, 2021)
[13] (Gove, et al., 2015)
[14] (Redwood, 1988)
[15] (Armstrong, 1982)
[16] (BSW Partnership Board , 2021)
[17] See section 172 (Department for Business, Energy and Industrial Strategy, 2006, p. 72)

Amendments needed to the Bill

19. For the reasons stated above, without amendment, the Bill poses a grave risk to the NHS itself and to UK taxpayers and patients.

20. Others[18] have proposed more comprehensive lists of amendments; the table below summarises what we believe to be the most important amendments needed.

What the Bill *does*	What it *should* do: Amendments Needed
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. 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. Introduce an enforceable **statutory duty on the ICBs** to ensure provision of secondary medical services 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.

[18] E.g. (Pollock & Roderick, 2021) and (Tonkin, 2021)

21. The government's response to the NHS petition[19] denies that there is either any inclination to change the nature of the NHS nor any risk of UK healthcare being privatised. Neither assertion stands up to scrutiny – indeed there are at least four distinct ways[20] in which UK healthcare can be shifted into the private sector, only one of which is not already happening.

[19] (Thomas M. E., Government Response to NHS Petition, 2021)
[20] (Thomas M. E., Four Ways to Privatise the NHS, 2021)

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