

Submission to Health Committee enquiry: public expenditure on health and social care

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I would ask that the Committee's inquiry and analysis of privatisation and resource allocation be extended to an examination of the ways in which market mechanisms, incentives, and market costs combine with reductions in NHS expenditure to reduce access to NHS funded care and the volume of available NHS services and implications for equity and equality.

1. The current financial state of the health and social care systems, including particular pressures in the system (such as the financial position of NHS Trusts and Foundation Trusts)

Despite market forces and budget cuts challenging the financial viability of hospitals in England, and thousands of people losing their jobs,¹ the health system as a whole has been in surplus for some time

- the NHS has reported surpluses for the last six years – totalling £4.2 billion in 2011-2013, returning surpluses to the Treasury;²
- cash held by the FT sector in September 2013 was £3.8 billion but may be less now;
- the vast majority of FTs,³ and the majority of NHS trusts,⁴ were not in deficit

However, because of the operation of the internal, and now external, market over 25 years, a systematic view of NHS finances has been rendered irrelevant - or at least has become obscured and distorted - by the atomised application of accounting and public expenditure rules, including capital charges, PFI charges, and the move to private rather than public sector accounting standards.

This has combined with uncertainty over commissioner decisions and new incentives for trusts to give rise to so-called "deficits" and to trusts working as though they are in failure when the system as a whole is in surplus. Good examples of this are the South Lewisham Trust, and the Wakefield, Calderdale, Hereford, and Barts hospital trusts, where affordability due to high PFI charges within the trust or in neighbouring trusts combined with efficiency savings and CCG actions are accelerating financial failure.

¹ For example, the National Audit Office reported 10,094 full-time equivalent NHS staff made redundant as a result of implementing the Health and Social Care Act 2012: Comptroller and Auditor General, Managing the transition to the reformed health system, Session 2013-14, HC 537, National Audit Office, July 2013.

² "Strategic health authorities, PCTs, NHS trusts and foundation trusts had a combined surplus of £2.1 billion in 2012-13.": Comptroller and Auditor General, 2012-13 update on indicators of financial sustainability in the NHS, Session 2013-14, HC 590, July 2013. "SHAs, PCTs, NHS trusts and NHS foundation trusts reported a combined overall surplus of £2.1 billion in 2011-12.": Comptroller and Auditor General, Securing the future financial sustainability of the NHS, Session 2012-13, HC 191, National Audit Office, July 2012.

³ NHS foundation trusts: review of six months to 30 September 2013. Published on 9th December 2013.

⁴ The NHS TDA reported in the summer that 30 (acute) NHS Trusts were predicting a deficit at the end of the year: The NHS TDA Summer Report: How is your trust performing? 27 September, 2013.

The government's rejection in June 2013 of your committee's recommendation to review the operation of "unnecessarily inflexible" accounting policies and rules for revenue and capital expenditure, especially at year-end,⁵ hasn't helped.

Decades of efficiency savings have been imposed on the NHS but since 2010/11. The efficiency factor has reduced national tariff prices by (usually) four per cent each year.⁶ The efficiency factor is detrimental to trust finance, staffing levels, and thereby clinical quality. At the end of January 2014, 22 out of 99 NHS acute trusts were predicting that they would end the year in deficit, with an overall net deficit of £247 million. Thirty nine FTs reported a deficit, compared with 21 in the same period a year before. The combined value of the deficits for FTs was £180 million.⁷ The financial position has deteriorated rapidly since this time; at the end of June 2014, 86 FTs reported a deficit totalling £227 million. In the acute sector over 80% of the trusts were in deficit, which represents over 90% of the total gross deficit.⁸

The marginal rate rule causes acute trusts additional financial difficulty⁹. This is the rule under which hospitals are only paid 30 per cent of the tariff price for emergency admissions above their level of emergency admissions in 2008/09. Hospitals do not have control over emergency attendances and admissions, which have continued to increase against a backdrop of reducing numbers of NHS beds. It has been estimated that £848 million has been withheld from acute trusts under the marginal rate rule between 2011/12 and 2013/14.¹⁰ This is another distortion of funding where the tariff does not reflect costs.

2. The extent to which patient care and support services are provided (a) by NHS bodies (b) others and how has this changed over time

Many organisations have been researching this issue. For example, the NHS Support Federation has been monitoring contract advertisements in the Official Journal of the European Union for information on the volume and scope of tendering for and awards of NHS contracts.¹¹ Spin Watch¹², Corporate Watch¹³, LHE¹⁴, and KONP¹⁵ have also been monitoring local newspapers and other local sources. The royal colleges have also submitted extensive evidence, for example on quality of ISTCs

⁵ Government Response to the House of Commons Health Select Committee Report into Public Expenditure on Health and Care Services (Eleventh Report of Session 2012–13). Cm 8624. June 2013. Cm 8624.)

⁶ National Audit Office. Delivering efficiency savings in the NHS. September 2011

⁷ Monitor. Performance of the NHS foundation trust sector - Nine months ended 31 December 2013. 2014

⁸ Monitor Board Meeting notes. Available at:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/356357/BM1492_NHSFT_quarterly_performance.pdf

⁹ Health Committee: Written evidence from the British Medical Association (ES 26). July 2013. Available at:

<http://www.publications.parliament.uk/pa/cm201314/cmselect/cmhealth/171/171vw20.htm>

¹⁰ <http://www.hsj.co.uk/news/acute-care/howe-marginal-rate-for-emergency-care-hasnt-worked-very-well/5060263.article>

¹¹ NHS For Sale. Available at: <http://www.nhsforsale.info/privatisation-list/contract-alert/contract-alert-report-april-april.html>

¹² <http://www.spinwatch.org/>

¹³ <http://www.corporatewatch.org/>

¹⁴ <http://www.healthemergency.org.uk/>

¹⁵ <http://www.keepournhspublic.com/>

and pathology services to the Health Select Committee.¹⁶ These sources provide significant, albeit indirect, evidence for the privatisation and deterioration in quality and efficiency of NHS services.

Forming a clear overview of this matter, however, is hindered by poor data collection and availability.

The government does not hold centrally the number of contracts awarded by value, length, services, and area, the identity and number of bidders for each tender, or bid outcomes. Nor does it publish the contracts and full financial details. The bid costs, including costs of public sector staff, lawyers, management consultants, and accountancy firms engaged in contracting, are not held centrally, and nor are the costs of auditing and monitoring contracts or costs of renegotiation of contracts.

Crucially much data on the administrative and management costs of the market are withheld by NHS bodies and are not collected centrally or in a systematic way.

Private sector returns on NHS funded care are also poor and data incompleteness and quality has been a recurring problem.

The latest DH outcomes framework¹⁷ shows that there continue to be serious gaps in private sector data collection and reporting for care which is NHS funded. Lack of data makes it impossible to monitor equity and trends in treatment and access and quality of care in the private sector.¹⁸

Data on PFI contracts held by the Treasury are also incomplete and often not accurate, and data on refinancing and renegotiations, interest rates, equity returns, and cash flows, alongside associated costs including legal and management fees, changes in value for money assumptions, and residual liabilities, are not published.

We have experience of, and are aware of, repeat FOI requests for contracts made to individual trusts and CCGs and to NHS England being stalled, and of access to crucial essential financial data refused on the grounds of commercial confidentiality. Because of this, value for money and affordability, contract compliance, and whether services are being planned to meet needs cannot be audited. Some FTs are not publishing full accounts, so that income and expenditure is difficult to find, let alone audit and evaluate. Expenditure on staff (management and clinical) and by category, grade, and service are not published.

3. The nature and extent of management costs in the new NHS structure

The Health Select Committee and others have previously stated that management costs are not defined and accounted for. Data are not collected on legal costs, consultancy costs, accountancy firms, PR, media, or the contracted out management services centrally, and lack of data on management costs continues to this day. We have no good information despite the Health Select Committee 2010 enquiry findings:¹⁹

¹⁶ Health Committee. Independent Sector Treatment Centres. Fourth Report of Session 2005-06. Volumes I – III. Available at: <http://www.publications.parliament.uk/pa/cm200506/cmselect/cmhealth/934/93402.htm>

¹⁷ The Department of Health. The NHS Outcomes Framework 2013/14 - Technical Appendix. Department of Health, 13 November 2012

¹⁸ Leys, C. and Toft, B. Patient Safety in Private Hospitals: The Known and the Unknown Risks. Centre for Health and the Public Interest. August 2014. <http://chpi.org.uk/wp-content/uploads/2014/08/CHPI-PatientSafety-Aug2014.pdf>

¹⁹ <http://www.publications.parliament.uk/pa/cm200910/cmselect/cmhealth/268/268i.pdf>

Whatever the benefits of the purchaser/provider split, it has led to an increase in transaction costs, notably management and administration costs. Research commissioned by the DH but not published by it estimated these to be as high as 14% of total NHS costs. We are dismayed that the Department has not provided us with clear and consistent data on transaction costs; the suspicion must remain that the DH does not want the full story to be revealed. We were appalled that four of the most senior civil servants in the Department of Health were unable to give us accurate figures for staffing levels and costs dedicated to commissioning and billing in PCTs and provider NHS trusts. We recommend that this deficiency be addressed immediately. The Department must agree definitions of staff, such as management and administrative overheads, and stick to them so that comparisons can be made over time.

4. What changes there have been over time in the proportion of FT income provided by private patients, the uses to which this funding has been put and evidence of impact on NHS patient care?

I am currently working on a paper to examine private patient income and the four legal tests. Oversight and regulation of NHS hospitals is split between Monitor and the DH, which are responsible for FTs, while the TDA is responsible for NHS trusts.

The Health and Social Care Act 2012 fails to provide any clear definitions on private patient income or non-NHS income. Monitor acknowledges this and states that “there is no set definition of what constitutes ‘income from the provision of goods and services for the purposes of the health service in England’. We simply ask that NHS foundation trusts apply reasonable parameters”.²⁰ FTs can interpret the guidance on defining income differently and more work needs to be done on this, failure to develop and apply standard data definitions also has implications for tariff calculations.

So the ambiguity in interpreting the 49% rule is because neither the Act nor Monitor nor the DH provides a clear definition of income from NHS services and non-NHS services.

Monitor and the DH each have their own accounting manuals published in March 2014²¹ and October 2013²² respectively. According to the manuals, ‘non-NHS income’ (private patient income, non-reciprocal overseas patient income, other non-NHS income and the injury recovery scheme; and since the financial year 2013/14 also income from local authorities) is part of income from patient care activities. ‘Other operating income’ is another major subset of total income and includes income from non-patient-care services, such as education, research, donations, car parking, accommodation, or rental revenue.

The 49% rule for FTs private patient income is only one of many ways in which availability of NHS funding and NHS funded services can be reduced and funding and provision can be privatised.

²⁰ Your questions answered: Annual Plan Review 2-014/15. Monitor. May 2014

²¹ NHS Foundation Trust Annual Reporting Manual 2013/14. Monitor. March 2014. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/295182/FTARM2013-14March2014.pdf

²² Manual for Accounts 2013-14. Department of Health. October 2013. Available at: [http://www.info.doh.gov.uk/doh/finman.nsf/4db79df91d978b6c00256728004f9d6b/af01c57de5465a5480257b7c0054c281/\\$FILE/2013-14%20Manual%20consolidated%20FRAB.pdf](http://www.info.doh.gov.uk/doh/finman.nsf/4db79df91d978b6c00256728004f9d6b/af01c57de5465a5480257b7c0054c281/$FILE/2013-14%20Manual%20consolidated%20FRAB.pdf)

Since abolition in 2012 of the government's legal duty to provide, the English NHS as a comprehensive health service free at the point of need has been accompanied and followed by mechanisms which enable

- less NHS provision (continuity of service guidance Monitor, failure regime, trust deficit manufacture, PFI affordability problems)
- more private providers (s.75, regulations – ie, competition)
- more private indirect involvement (so-called 'support services', CSU companies, Care.data)
- more charging for services formerly free at point of delivery by reducing entitlement and eligibility eg, continuing care and some therapies
- more private patients: private patient income eg, 49% rule for FTs but also trusts' private income, and non-NHS provided private patient care
- more mixing of NHS funded care and privately funded treatment eg, mixed NHS and private prescribing for cancer and rheumatology and neurology treatments , OP clinics, and diagnostic services

5. What types of NHS services are being provided by private sector, voluntary and social enterprises and what is the evidence around quality, costs and outcomes for those services?

See above on data

6. What has been the cost of PFI agreements to the NHS over time?

See 2 above and 7 below and PFI submission (Appendix)

7. The effectiveness of the mechanisms by which resources are distributed geographically in the NHS

The areas that the Committee should review and ask for urgent evidence on if it wishes to examine the equity implications of changes to rules and RA which incentivise and accelerate privatisation.

- A. Changes to accounting rules and public expenditure rules to incentivise privatisation eg, off balance sheet accounting, VAT treatment, resource accounting.
- B. Reforms to financing and resource allocation to CCGs and local authorities and the effect of the tariff

Resource allocation to CCGs

Previously resources were distributed geographically to contiguous area based structures known as PCTs through area based resource allocation formulae.²³ Changes to resource allocation formulae to

²³ Westminster Hall Debates 22 June 2010. Available at:
<http://www.publications.parliament.uk/pa/cm201011/cmhansrd/cm100622/halltext/100622h0006.htm>

CCGs moved from area based populations so that each CCG's population for the formula is the registered list of each GP practice in each CCG.²⁴

The implications of proposed changes to practice boundaries for local accountability and choice and access and data monitoring and equity have not been properly researched, but will result in unstable denominators and numerators. The adjustment for age rather than mortality, morbidity, and social deprivation has also been seriously criticised as it does not reflect need for care. Poor people live shorter lives and have greater health needs.

It is no longer possible to have an effective mechanism for resource allocation when CCGs are not responsible for area-based populations. CCGs must have areas, but the scope of their responsibility is no longer based on areas. When practice boundaries are dissolved in the future the problem will be exacerbated.

As I and colleagues wrote in 2011 during the passage of the Bill²⁵

The CCGs are 'person-based' or 'group-based', largely drawn from GP registrations, but neither the area nor the population are clearly defined. CCGs are supposed to cover all of England, but there is no requirement that within the CCG all their patients live in one particular area, so a CCG area can comprise (say) a part of London, a part of Hampshire and a part of Cumbria. It is impossible to see how planning, monitoring of needs, and equity of access and service use can be safeguarded when the populations are segmented, fragmented and dispersed in this way. In effect, whereas, the entire population of a given area was covered by the NHS and PCT areas are contiguous. In future, this will not be the case: it will depend on what each CCG decides. Under current plans resource allocation formula will change from an area-based formula, to one based on GP registrations (GP lists) with all the problems that will bring. These problems which are well documented include, unstable denominators and numerators due to enrolment, disenrollment of persons and turnover of patients, complex risk adjustment methods, and incentives to risk select or cherry pick. This will adversely affect public health functions including the measurement of access to services, health service needs and equity of resource allocation and funding. Furthermore, the loss of area-based population responsibilities has serious implications for the stability and accuracy of measurement of needs and the equity of resource allocation and funding and service provision. This also affects the availability and nature of information to plan for health care needs and services and for monitoring access, service use, and health outcomes, all of which are essential to securing a comprehensive service.

NHS funded services continue to be free at point of use in the private sector. However, there is little analysis of where needs are met and how they are met, and of equity; for example, area based treatment rates are not routinely published and even if they were, CCGs no longer have responsibility for all people in an area.²⁶

The NHS tariff

The tariff is neither an equitable nor efficient mechanism for allocating resources on the basis of population need. It is a price signal. It does not reflect the true costs to trusts of providing services.

²⁴ <http://www.england.nhs.uk/wp-content/uploads/2013/08/ann-c-tech-guid.pdf>

²⁵ http://www.allysonpollock.com/wp-content/uploads/2013/04/AP_2011_Pollock_HoLHSCB_B01a_C1.pdf

²⁶ http://www.allysonpollock.com/wp-content/uploads/2013/04/AP_2011_Pollock_HoLHSCB_B07_C8-9.pdf

This is due in large part to the decoupling of the true costs of care to trusts and needs of local communities from resource allocation formulae.^{27 28 29}

The best illustration of this is the PFI, where exorbitant charges indexed to a measure of inflation, such as the RPI, are continuing to create affordability problems for FTs, and contributing to deficits, provider failure and trusts going into special measures. PFI costs are not reflected in the tariff allocation.^{30 31 32}

In other words there is an uncoupling of the true costs of care to trusts and needs of local communities from the resource allocation formulae, which has been exacerbated by the fact that CCGs no longer have area based resource allocation and nor do they have area based responsibilities except for emergency care. Monitor has not reviewed the tariff in respect of PFI. The sensible solution would be for Monitor and NHS England to centralise PFI costs and debts and renegotiate contracts centrally rather than allowing PFI to drive local affordability problems, service closures, and trust failure. It would also be sensible to abolish capital charging and resource accounting which contribute to local affordability problems and undermine resource allocation and return resource allocation to geographic formulae based on need.^{33 34}

The inadequacies of the tariff as a resource allocation mechanism combined with decades of year-on-year efficiency savings, currently 4%, along with even small movements in contract income jeopardise the financial basis of trusts and sets up trusts for provider failure. It is not the case that the present range of services will continue or are indeed continuing to be provided. As trust CEOs and staff members across the country will tell you, there is no trust in England that has not cut services and provision levels and undermined care quality by changing the skill mix, reducing staff numbers, reducing levels of care, and closing beds and services. Staff members are too frightened to speak out and there is no credible mechanism for concerns to be raised. Our own trust (Barts Health) is a good case in point, where despite trust mergers to make efficiency savings and the support of CCGs, services and staff are being stretched to breaking point, with PFI as a major, though not sole contributor.

Public health and local authorities

²⁷ Audit Commission. Introducing payment by results. July 2004. Available at: http://archive.audit-commission.gov.uk/auditcommission/sitecollectiondocuments/AuditCommissionReports/NationalStudies/PaymentByResults_report.pdf

²⁸ Annex to Reforming NHS Financial Flows. Available at: http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4018705.pdf

²⁹ Response to Reforming NHS Financial Flows. Available at: http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4018792.pdf

³⁰ Hellowell, M., & Pollock, A. M. (2007). Private finance, public deficits: a report on the cost of PFI and its impact on health services in England. Centre for International Public Health Policy, University of Edinburgh, September.

³¹ Hellowell, M and A Pollock (2007), Written Evidence to the National Assembly for Wales Finance Committee with regards to its Inquiry on Public Private Partnerships.

³² Hellowell, M and A Pollock (2009) "The Private Financing of NHS Hospitals: Politics, Policy and Practice". Journal of the Institute of Economic Affairs, 29(1), pp 13-19.

³³ Pollock, A. M., & Gaffney, D. (1998). Capital charges: a tax on the NHS. BMJ, 317(7152), 157-158.

³⁴ Shaoul, J. (1998). Charging for capital in the NHS trusts: to improve efficiency?. Management Accounting Research, 9(1), 95-112.

In 2011 in our briefing on the HSC Bill we highlighted the lack of clarity over the division of public health functions and services and would ask the Committee to revisit this briefing which is attached to the appendix as it raises issues about the flow of resources and lack of clarity over division of responsibilities for services. In our briefing we highlighted how

CCGs will have responsibility for commissioning health care for their registered populations (who may come from any part of the country) whilst ensuring access to emergency and urgent care for their local population (however that may be defined). Public health departments within local government will have responsibility for their borough and council based populations. Public Health England is likely to have boundaries that are co-terminous with local authorities. As such, the delivery of public health programmes will be based on multiple structures, each operating with a different population-base and with CCGs having two different sets of populations to commission services for. Multiple denominators are not just a data and information problem they represent vulnerable people falling through the gaps in the system and put at risk the goal of comprehensive care.

How will the different populations be reconciled to allow the effective and efficient delivery of key PH programmes and functions such as surveillance, and population-based monitoring, evaluation and trends analysis? How will comprehensive integrated care be ensured and how will the government prevent people from falling through the gaps in coverage?

These issues also need to be considered as part of the NHS resource allocations to local authorities.

Conclusion

NHS funded services continue to be free at point of use in the private sector. However, there is little analysis of where needs are met and how they are met. Area based treatment rates are not routinely published, and nor are planning norms for staff and beds, both of which are important ways of looking at equity of provision and access in relation to resource allocation. In the context of the question, 'The extent to which patient care and support services are provided (a) by NHS bodies (b) others and how has this changed over time' it is important to examine the extent to which primary care and community, mental health, and hospital services are falling away, and are no longer being planned, provided, and funded as part of the NHS or by local authorities as public health services. The impact on equity of access and how people are now accessing these services, if at all, is not routinely monitored. For example, planning norms and numbers of treatment and numbers by category and as area based rates are not routinely published by CCG and local authority area. Trusts do not keep records of NHS patients being given private prescriptions.

The new structures that have been put in place since the HSC Act 2012 are still evolving. It is crucial to examine these and the mechanisms in the Act which enable NHS funded services to be reduced to facilitate greater use of private funding as a result of loss of NHS care. I have recently published an article in the British Medical Journal on one of these mechanisms.³⁵ Furthermore, implications of loss of control for planning and delivery of health services must be considered.

The intention behind the 2012 Act, and the only reason for removing the duty to provide the NHS, is that alternative funding will become necessary. In this context, that means alternative funding from

³⁵ Roderick, P., & Pollock, A. M. (2014). A wolf in sheep's clothing: how Monitor is using licensing powers to reduce hospital and community services in England under the guise of continuity. *BMJ*, 349, g5603.

private health insurance, charges or co-payments, all of which are highly regressive and not what people voted for. People will have to pay themselves for alternative providers, or go without care.

The uncoupling of planning and local area based needs from resource allocation mechanisms - including the defective tariff and the shift of services to local authorities - and the loss of local accountability and transparency is exactly why a Reinstatement Bill is required to abolish Monitor and restore the secretary of state's legal duty to provide the NHS, to ensure universal health care and the structures and mechanisms required to ensure equity.³⁶

³⁶ O'Dowd, A. (2014). Health experts launch campaign to reverse NHS reforms. *BMJ*, 349, g6057.

Appendix

- 1 Pollock, A. M., Macfarlane, A. J., & Godden, S. (2012). Dismantling the signposts to public health? NHS data under the Health and Social Care Act 2012. *BMJ*, 344.
- 2 NHS Foundation Trust Annual Reporting Manual 2013/14. Monitor. March 2014.
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/295182/FTARM2013-14March2014.pdf
- 3 Manual for Accounts 2013-14. Department of Health. October 2013. Available at:
[http://www.info.doh.gov.uk/doh/finman.nsf/4db79df91d978b6c00256728004f9d6b/af01c57de5465a5480257b7c0054c281/\\$FILE/2013-14%20Manual%20consolidated%20FRAB.pdf](http://www.info.doh.gov.uk/doh/finman.nsf/4db79df91d978b6c00256728004f9d6b/af01c57de5465a5480257b7c0054c281/$FILE/2013-14%20Manual%20consolidated%20FRAB.pdf)
- 4 PFI reports, Prof Pollock, available at: http://www.allysonpollock.com/wp-content/uploads/2013/09/AP_2013_Pollock_PFILewisham.pdf
- 5 Roderick, P., & Pollock, A. M. (2014). A wolf in sheep's clothing: how Monitor is using licensing powers to reduce hospital and community services in England under the guise of continuity. *BMJ*, 349, g5603.
- 6 Pollock AM, Price D Loss of population data sources when health systems are not responsible for geographically defined populations: implications of the health and social care Act 2012 in England. *Evid Based Med* doi:10.1136/eb-2013-10128
<http://ebm.bmj.com/content/early/2013/05/02/eb-2013-101287>
- 7 Pollock, A. M., Price, D., Kondilis, E., Freitag, A., & Harding-Edgar, L. (2013). Planning for closure: the role of special administrators in reducing NHS hospital services in England. *BMJ*, 347.
- 8 Health and Social Care Bill 2011, Briefing Note 7 http://www.allysonpollock.com/wp-content/uploads/2013/04/AP_2011_Pollock_HoLHSCB_B07_C8-9.pdf