

Dismantling the National Health Service in England

International Journal of Health
Services
1–10

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DOI: 10.1177/00207314221114540

journals.sagepub.com/home/joh



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Abstract

The National Health Service was established in the United Kingdom in 1948 as a universal, comprehensive service free at the point of delivery, which is publicly provided, funded, and accountable. Market incrementalism in England has eroded this system over three decades. The recently enacted Health and Care Act will erode it further. This article first explains briefly how legislation and policy initiatives in 1990, 2003, and 2012 furthered development of the market and private provision of health services, and then describes the main structural changes in the new Act and their implications. England is now moving decisively toward a marketized, two-tier, mixed-funding system with several similarities to the United States.

Keywords

health services, health policy, marketization, privatisation, National Health Service England, Health and Care Act 2022

The National Health Service (NHS) was established in the United Kingdom in 1948 as a universal, comprehensive service free at the point of delivery, which is publicly provided, funded, and accountable. This system is often referred to as the Beveridge or Bevan model, after, respectively, the former civil servant whose 1942 report heralded the welfare state and the minister who piloted the NHS legislation through Parliament. The model was largely, although never completely, adhered to for many years, but has been gradually eroded over the past three decades. This erosion has been particularly evident in England, as a result of market incrementalism. Responsibility for health was devolved in the late 1990s to Scotland and Wales, where there has been less marketization. Health had been devolved to Northern Ireland in 1920. The Health and Care Act recently passed by the UK Parliament¹ builds on these three decades of market encroachment to such an extent that England is now moving decisively toward a marketized, two-tier, mixed-funding system with several similarities to the United States. This article describes the main structural changes in the Act, having first briefly outlined the incremental development of the market model to date as this is essential for a proper understanding of the Act.

Incremental Erosion of the Founding Principles

Under the NHS Act 1946,² which applied to England and Wales, the service was broadly based on three “pillars”: secondary, primary, and community services. The government

was legally required to: (a) plan and provide secondary services for all local residents throughout the country as it considered necessary to meet all reasonable requirements; (b) make arrangements with general practitioners (GPs), dentists, pharmacies, and opticians for primary services; and (c) approve local authority proposals for certain community services. The government’s legal duties for secondary and primary services were delegated to contiguous, area-based public authorities.

Over the years, several changes to the initial 1946 Act eroded the founding principles, despite opposition. These changes began in the 1990s under the Conservative governments of Margaret Thatcher and John Major, continued in the 2000s under the Labor government of Tony Blair, and were developed yet further in 2012 under the Conservative–Liberal Democrat coalition government of David Cameron.

NHS and Community Care Act 1990³

From 1948, most health services in an area were directly administered and accountable to area-based bodies. In this way, services were integrated and planned to meet the

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needs of all local people in the area. Following implementation of the hospital plan and regional planning bodies in the 1960s and 1970s, hospital services were integrated and planned so that every area with an approximate population of 100 000–150 000 had its own district general hospital and associated community services. The power and responsibility for ensuring local people received the services they needed sat with the area bodies.

The 1990 Act changed that by creating a “purchaser–provider” split. This division separated area-based bodies from local services and required contracts between commissioners and providers. “Providers” was a new term in the lexicon of the NHS. Local hospital and community services were set up as “NHS trusts,” established as quasi-autonomous corporate bodies with new financial duties. In effect, the purchaser–provider split—or “internal market,” as it was commonly called—created a quasi-market, as services were still mainly under public ownership and control, and commercial contracting was not (then) introduced. The intention behind these changes and their effect was to develop a market bureaucracy, including pricing, and to inject market competition between providers. The Act was strongly opposed by the British Medical Association, which saw it heralding the end of national pay bargaining and national terms and conditions.

The Private Finance Initiative (PFI) was introduced in the 1990s, first under the Major government and then scaled up by the Blair government after 1997, becoming a global and cross-sectoral policy under the rubric of “public–private partnerships.” Instead of government raising the capital for investment, banks, builders, service operators, and equity investors created joint ventures to raise the financing and enter into long-term (30- to 60-year) contracts with the state to design, build, finance, and to an extent operate new hospitals and buildings. This enabled the sale and closure of public hospitals and services on an enormous scale. It paved the way for what in effect became private sale-and-lease-back arrangements for new hospitals and services. These were paid for out of government revenues, which created significant affordability issues for local services.

Promotion of “Choice” by Outsourcing

The Blair government also promoted “choice” of provider for hospital care. But, whereas the NHS has always allowed patients choice of services, choice was to be extended to the private sector. The NHS Ten-Year Plan published in July 2000 announced “a national framework for partnership between the private and voluntary sector and the NHS”.⁴ The same year, Health Minister Alan Milburn signed a “concordat” with the private sector to enable greater use of the sector’s beds.⁵ Milburn, who had also pushed through PFI, went on to work for PwC, which supports privatization of health care, and for Bridgepoint Capital, which invests in

private health companies. He also became a board member of Ribera Salud in Spain,⁶ a subsidiary of the U.S. health company Centene Corporation.⁷

Funds were also top-sliced from the Department of Health to ensure the policy was followed, and GPs would eventually be required to offer all elective surgery patients a choice of provider.⁸ The policy was actively opposed by the Royal College of Surgeons, which documented the adverse impacts for training, for patients, and for quality of care.⁹ However, contracting out to the private sector has continued to the extent that the independent sector provided about one in 20 NHS-funded elective episodes in 2020–2021,¹⁰ 46% of NHS-funded cataract procedures in 2021,¹¹ and almost one-third of knee and one-fifth of hip replacements in 2016–2017 (latest published data for England).¹²

Health and Social Care (Community Health and Standards) Act 2003¹³

This Act made significant changes to the structures and mechanisms for providing secondary and primary services.

After serious disagreements within the governing Labour party,¹⁴ NHS trusts were allowed to convert to public-benefit corporations known as “foundation trusts” (FTs). They were given new freedoms and powers that included generating and retaining surpluses, entering into joint ventures, and receiving capped private income. To oversee this transition to greater financial autonomy, the government created a market regulator, Monitor, which granted FTs authorizations to operate. The Act was taken through Parliament by Milburn and his adviser Simon Stevens, who later became CEO of NHS England (see below).

GPs had always been independent of the state, usually owning and operating their own practice premises. In 1948, the government refused to buy out GP premises on cost grounds. Although there was a slow flourishing of state-built and -owned practice premises in the 1960s, this came to a halt during the International Monetary Fund crisis in 1973, when capital investment dried up. The government loans body for acquiring and improving GP surgeries was privatized in 1989, after which capital for investment in premises was mainly provided by the private sector as debt. The 1990s saw a transition to sale-and-lease-back models with the private sector, often operating non-clinical services.¹⁵ Public–private partnerships along the lines of PFI were increasingly used, and GP premises would be bundled together with other public projects, such as libraries, pharmacies, and housing, to make the scale and revenue streams attractive to equity investors.

By 2003, the private sector was well-positioned to penetrate primary clinical services, which this Act enabled by permitting the introduction of what became known as Alternative Provider Medical Services (APMS) contracts. In the words of a health industry lawyer, these were “the

private sector's gateway to providing primary health care to NHS patients".¹⁶

UnitedHealth, a U.S. health company, was one of the first companies to be awarded an APMS contract,¹⁷ but it soon turned to more lucrative sources of NHS revenue, such as data analytics and "managed services solutions" under the name of Optum. In early 2021, Centene Corporation became probably the largest primary care provider in England, with more than 500 000 patients when its UK subsidiary Operose completed a takeover of dozens of APMS contracts in London.¹⁸ Weeks after the takeover, Centene's UK CEO and president, Samantha Jones, was appointed the Prime Minister's health adviser.¹⁹

*Health and Social Care Act 2012*²⁰

Despite widespread and sustained opposition, the Conservative–Liberal Democrat coalition government succeeded in enacting this legislation. It was guided through Parliament by Health Minister Andrew Lansley, who later became Lord Lansley and was hired by private health care consultants Bain & Co.²¹

The Act abolished the government's duty to provide secondary and other NHS services to meet all reasonable requirements throughout England.²² It also abolished contiguous, area-based bodies responsible for everyone in the area. Instead, it created 200+ "clinical commissioning groups" (CCGs), which were given a duty to arrange—that is, to contract with providers—to meet the reasonable requirements (not *all* reasonable requirements) of the "persons for whom it has responsibility." Those persons were defined as patients on the lists of GPs who were members of the group and anyone else added by secondary legislation. The shift from contiguous, area-based, whole-population coverage to membership-based responsibility required a change to the basis of resource allocation, from census estimates of an area population to practice lists. This in turn led to greater instability in the funding due to the movement of people following aggressive marketing and competition for patients by some GP companies. This has been witnessed in the Babylon GP at Hand case,²³ where patients changing their GP had the destabilizing effect of moving the budget as they moved to different GP practices in different CCGs.

Section 75 of the Act, and the regulations made under it,²⁴ introduced virtually compulsory commercial tendering of contracts. In the first year after the Act's implementation, one-third of NHS contracts were awarded to the private sector.²⁵

The Act also carved "public health" out of the NHS, dividing responsibilities between the Secretary of State, implemented through Public Health England, and local authorities. Protection duties were conferred on the former, and local authorities were made responsible for prevention. The expert prescient warning given to Members of Parliament (MPs) in 2011 as the Act was going through

Parliament—that "[w]hen the next pandemic strikes, for example, expect public health systems to be in disarray and unable to deliver what the public expects"²⁶—was ignored.

The 2012 Act also allowed FTs, which currently account for about two-thirds of all trusts, to obtain 49% of their income from private patients and other non-NHS sources.²⁷ This has led to several FTs, especially in London, actively advertising their private-patient provision and turning whole floors or parts of the hospital into private-patient wards or wings. The effect has been to further shrink the availability of public health care and beds and to divert NHS staff and resources to private patients. Additionally, as the government places more NHS contracts with the private sector, NHS-trained staff, doctors, and nurses will move across to work there on a fee-for-service basis or as employees of private companies.

FTs have used their new freedoms to enter into joint ventures with private companies. For example, four FTs already have joint ventures with HCA Healthcare UK (Hospital Corporation of America), which describes itself as "the largest private health care provider in the world, and the largest provider of privately funded health care in the UK".²⁸ These include its "state-of-the-art cancer centre" at Guy's Hospital²⁹ and building a £100m private hospital with University Hospitals Birmingham FT,³⁰ in April 2021, the Royal Marsden FT opened a private "dedicated and comprehensive cancer diagnostic and treatment centre" in Cavendish Square.³¹ Hundreds of medical consultants, mostly employed by FTs or NHS trusts, have equity shares in HCA and other private health companies.³² At least one FT joint venture advertises private health plans for individuals and families.³³

Since 2012

The 2012 Act also established a massive new quango, the NHS Commissioning Board, known as NHS England, mainly to oversee the NHS and its budget and to commission primary and specialist services. Simon Stevens, who had been a senior executive at UnitedHealth for about 10 years from 2004, after advising the Blair government from 1997 to 2004, returned to the United Kingdom to be appointed CEO of NHS England in 2013.³⁴ Through a series of policy announcements, he began to "work around" the Act and put in place, without new legislation, "integrated care," telling MPs in 2017 that "...in the case of some of these integrated accountable systems, we would essentially like to have population budgets without contracting between the different bits, handoffs, the frictional costs and all the rest of it. We will nevertheless, within the letter of the law, act according to the spirit of what I have just described and push as hard as we can to get there without Parliament itself having to legislate. If at some point down the line you then choose to do so, that will no doubt be a welcome recognition of where the health service will have moved to in the meantime".³⁵

Table 1. The Components of Integrated Care Systems.

A. Statutory components (mentioned in the Health and Care Act 2022) Integrated Care Board	<p><i>Status</i> A body corporate, with a constitution</p> <p><i>Main function</i> To commission most NHS services</p> <p><i>Membership</i> A chair - appointed by NHSE with the approval of the Secretary of State A chief executive - appointed by the chair with NHSE's approval At least one member nominated jointly by the NHS trusts and NHS foundation trusts that provide services in the ICB's area, approved by the chair At least one member nominated jointly by those providing primary medical services in the area, approved by the chair At least one member nominated jointly by the local authorities in the area, approved by the chair Anyone else approved by the chair</p>
Integrated Care Partnership	<p><i>Status</i> A joint statutory committee, with no constitution</p> <p><i>Main function</i> To prepare an integrated care strategy setting out how needs identified in the joint strategic needs assessment will be met, to which the ICB must have regard</p> <p><i>Membership</i> An ICB and local authorities in the ICB's area No additional minimum membership requirements</p>
B. Non-statutory components (not mentioned in the Health and Care Act 2022) Provider collaboratives	<p><i>NHSE's definition</i> "Provider collaboratives are partnership arrangements involving at least two trusts working at scale across multiple places, with a shared purpose and effective decision-making arrangements, to:</p> <ul style="list-style-type: none"> • reduce unwarranted variation and inequality in health outcomes, access to services and experience • improve resilience by, for example, providing mutual aid • ensure that specialization and consolidation occur where this will provide better outcomes and value."^a <p><i>Action required by NHSE</i></p> <ul style="list-style-type: none"> • "All trusts providing acute and mental health services are expected to be part of one or more provider collaboratives by April 2022. • Community trusts, ambulance trusts, and non-NHS providers should be part of provider collaboratives where this would benefit patients and makes sense for the providers and systems involved. • ICS leaders, trusts and system partners, with support from NHS England and NHS Improvement regions, are expected to work to identify shared goals, appropriate membership and governance, and ensure activities are well aligned with ICS priorities."^a
Place-based partnerships	<p><i>Number</i> : 47 currently^b, ultimately unknown.</p> <p><i>NHSE's definition</i> "collaborative arrangements formed by the organizations responsible for arranging and delivering health and care services in a locality or community [which] will remain as the foundations of integrated care systems as they are put on a statutory footing."^c</p> <p><i>Action required by NHSE</i> "As part of the establishment of new ICS arrangements from April 2021 ICS leaders should confirm their proposed place-based partnership arrangements for 2022/23, including their boundaries, leadership and membership."^c</p> <p><i>Number</i> Unknown</p>

(continued)

Table 1. (continued)

Primary care networks	<p><i>NHSE's definition</i></p> <p>"GP practices...working together with community, mental health, social care, pharmacy, hospital and voluntary services in their local areas in groups of practices known as primary care networks (PCNs)."^d</p> <p><i>Action required by NHSE</i></p> <p>Already established and operating under network agreements, the content of which "is not within the remit of the CCG to challenge"^e</p> <p><i>Number</i></p> <p>1250</p>
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Sources: ^a Source: NHS England. Working together at scale: guidance on provider collaboratives. August 2021. <https://www.england.nhs.uk/wp-content/uploads/2021/06/B0754-working-together-at-scale-guidance-on-provider-collaboratives.pdf>.

^bLive NHS-Led Provider Collaboratives across the country. <https://www.england.nhs.uk/mental-health/nhs-led-provider-collaboratives/live-provider-collaboratives/>.

^cThriving places - Guidance on the development of place-based partnerships as part of statutory integrated care systems. Version 1, page 3. 2 September 2021. <https://www.england.nhs.uk/wp-content/uploads/2021/06/B0660-ics-implementation-guidance-on-thriving-places.pdf>.

^dNHS England. Primary care networks. <https://www.england.nhs.uk/primary-care/primary-care-networks/>.

^eBritish Medical Association. The primary care network handbook 2021-22. <https://www.bma.org.uk/media/4222/bma-pcn-handbook-2021.pdf>.

The number of CCGs was halved, further eroding the planning of services for local people and thereby local accountability. Forty-two Integrated Care Systems (ICSs) were set up administratively,³⁶ despite the National Audit Office's finding in 2017 that "[t]he Departments have not yet established a robust evidence base to show that integration leads to better outcomes for patients".³⁷

Parliament has now chosen to legislate. Stevens has left NHS England and was appointed to the House of Lords just as the Health and Care Bill 2021/22 was entering Parliament.

The Health and Care Act 2022

The Health and Care Bill was introduced into the House of Commons in July 2021³⁸ and received royal assent on April 28, 2022. Most of the Act came into effect on July 1, 2022. The Act creatively develops further the market paradigm and reduces local accountability under the warm rubric of "integration and innovation".³⁹ It completes the detachment of funding, planning, and provision from local residents and local areas, thereby breaking decisively with the Beveridge/Bevan model.

No Longer Universal and Comprehensive

The Act abolishes CCGs and replaces them with 42 Integrated Care Boards (ICBs). Like CCGs, these are membership-based. But unlike CCGs, where Parliament decided who they were responsible for, the allocation of patients to an ICB is in accordance with as yet unpublished rules to be made by NHS England without parliamentary process. Everyone living—or receiving primary services—in England must be allocated to at least one ICB. The government has stated that "[i]t is expected that the basis of NHS England's general rule for ICB responsibility will continue

to be in relation to GP registration to ensure operational continuity".⁴⁰ This "expectation," however, is not the legal position. It is not known whether patients will be able to choose ICBs, or whether ICBs will be able to challenge allocations and thereby in effect to select patients.

If people are able to choose an ICB, this opens up the possibility of ICBs competing for patients and promoting membership-based health plans, especially for younger patients and those with lower medical risk (as has already happened with the Babylon GP at Hand case).¹⁴

An ICB will have "core responsibility" for the group of people allocated to it, and the government may also require ICBs via secondary legislation to have responsibility for additional patients. The meaning of this new concept of core responsibility has not been explained and was not discussed at all by MPs during the committee stage of the Bill in the Commons. It distinguishes between people and implies the notions of core, or basic, services and supplementary services—the latter being services that would fall outside the NHS and be subject to charges.

One inevitable consequence of the shift in 2012 from area- to membership-based responsibility would have been that a CCG only had to commission emergency services for those on its GPs' lists. This was prevented by a specific provision to ensure that a CCG arranged emergency services "for every person present in its area".⁴¹ The new Act repeals that provision, giving ICBs and providers flexibility to decide where and to whom accident and emergency (A&E) services will be provided. It has already been reported that a patient has been turned away from an A&E department because of undisclosed "protocols".⁴² By not requiring ICBs to commission emergency services for everyone in their area, Parliament is taking away the "right" of everyone to receive emergency services wherever they need them, regardless of which ICB they belong to.

Handing Over Power and Decision-Making

The ICBs, however, are a veneer. The real power and decision-making will lie with the groups of providers with whom the ICBs enter into contracts. These groups of providers—described as provider collaboratives, place-based partnerships, and primary care networks (see Table 1)—are not mentioned in the Act but were put in place administratively in anticipation of its enactment.

Provider collaboratives in mental health are currently the most developed, with an increasing proportion of beds already being provided by the private sector. This is a result of almost three-quarters (73%) of mental health beds having been closed in the NHS from 1987–2019, with patients having to travel hundreds of miles away from home and family to obtain a mental illness bed due to lack of capacity.⁴³

According to NHS England, the provider collaboratives will play “an active and strong leadership role” in the ICSs and be “a principal engine of transformation”.⁴⁴ They will include private companies, including U.S. health insurers and providers, such as UnitedHealth (Optum) and Centene (Operose). Some of these will also be members of the place-based partnerships and/or primary care networks. Moreover, they will also sit on the ICBs and/or their committees. This is a major departure from long-standing principles that require holders of public office to act solely in terms of the public interest.⁴⁵ NHS England’s expectation that ICBs will delegate their functions to providers will further bolster their power. Lord Lansley said quite rightly during the Bill’s passage through the House of Lords that power in the NHS will lie with these collaboratives with no provision for their transparency, openness, or accountability.⁴⁶ This was also confirmed by the *Health Service Journal*: “In the minds of most acute trust chiefs, it is provider collaboratives and groups, and not integrated care boards, that will wield the greatest influence (although the former may act through their representation on the latter). Many believe ICSs (*sic*) will become tiny organizations effectively operating as a population data provider for collaboratives and “place-based partnerships,” or disappear altogether”.⁴⁷

Commissioning contracts will be long-term, and under them NHSE expects “providers to be responsible for designing services and interventions to meet agreed system objectives”.⁴⁸ Furthermore, the Act allows ICBs to give providers “discretions” in their contracts to allow them to “determine the means by which services will be delivered”.²⁹

In the future, providers will be able to decide how and where services are to be provided.

Less Local Public Accountability and More Corporate Penetration

Detachment of health services from local communities has increased as the number of trusts and FTs has reduced

through mergers and “consolidation” over many years.⁴⁹ It is now impossible to identify and enumerate hospitals and services in a local area, with trusts and FTs operating over several areas under contracts with several different commissioners. The new ICS structures further this trend.

For example, there are 333 local authorities (councils) in England and 533 areas represented by MPs (parliamentary constituencies), giving an average of almost eight councils and more than 12 MPs per ICS. As severance of the local connection with health bodies is completed, local people, a single local authority, or an MP will have very little influence on the decisions of ICBs, or of the non-statutory groups who will be making decisions free of statutory obligations. This is already happening: Local people and local authorities have little say over the location of services or service closures following the merger of trusts and FTs.

In addition, in the future, a local authority’s right to challenge service closures and changes is to be “amended” in ways that have not been set out, with new powers vested centrally in the Secretary of State.

At the same time, the Act does not pass on to an ICB the obligations a CCG has to include in its constitution: (a) the arrangements it has made to involve the public in the planning of commissioning, in developing proposals, and in decisions on impactful changes; (b) the principles it will follow in implementing those arrangements; and (c) the names of its board members. And while ICB meetings will usually be open to the public, only the press, on request, will be entitled to receive copies of agendas, reports, and other documents.

Less local public accountability and transparency go hand in hand with greater corporate penetration and market deregulation.

The Act permits private companies to be present at every level of the health system, which is presumably why, unlike CCGs, the name of an ICB need not include the letters “NHS.”

Furthermore, NHSE has “accredited” 200+ private companies—such as Atos, Capita, Centene, Deloitte, Ernst & Young, McKinsey, PwC, Serco, and UnitedHealth—to the Health System Support Framework, which is described as “a quick and easy route” for population health management and digital and other support services.⁵⁰ These companies will provide technical support to ICBs and providers.

Market-driven systems inevitably lead to mergers and acquisitions and to horizontal and vertical integration of primary care, acute care, and community services. For example, as well as its leading position in primary care, since July 2021 the U.S. managed care firm Centene owns Circle Health, which in 2019 had taken over BMI, the United Kingdom’s biggest private hospital provider—yet is now reporting to be strategically reviewing its international investments.⁵¹ NHS trusts and FTs have taken over community care and several GP practices, such as in Birmingham and Wolverhampton, and entered into joint ventures.⁵² These corporate maneuvers increase

the monopoly power of providers and overall health expenditure.

The Act also abolishes the pricing system used for NHS treatments (the national tariff), replacing it with a new payment scheme, and large providers will be well-positioned to determine prices as well as staff terms and conditions, as currently happens for residential long-term care. Furthermore, “gain/loss agreements”,⁵³ which allow providers to retain surpluses from expected revenues, will provide additional incentives to reduce staffing, quality, and level of services. The Act is silent on shareholder and equity returns.

The Act also abolishes current procurement rules under Section 75 of the 2012 Act, which will be replaced by a new “provider selection regime.” Section 75 was widely opposed, not least by NHS managers and the British Medical Association, as it required virtually compulsory tendering of clinical services. Its abolition might therefore be thought welcome. However, in the context of the other reforms, this change actually opens the way for cronyism and removes even the limited legal protections that a market system offers.

United States Similarities

Although significant differences between the United States and England will remain even after the Act’s passage, at the same time, there are three striking similarities.

The ICBs resemble U.S. health maintenance organizations (HMOs) and other insurers in that they will cover only their members—that is, those allocated to them—and not everyone in a specific geographical area.

Another similarity is the funding of services. In England, public money will be given to ICBs, which will be passed on to public and private providers who also receive private money. In the United States, contrary to popular perception, government also funds most health care.⁵⁴ Alongside private funding, insurance companies, such as HMOs, in the United States benefit from much of this government funding to pay some or all of the premiums for “health plans” that the companies sell to individuals. Health plans are already available in England, including through FT joint ventures.²²

Third, HMOs and insurance plans in the United States cover only the limited range of services (from a limited group of providers) agreed to in their contracts.^{55–58} Provider collaboratives and networks are U.S. concepts. The insurers contract with a limited number of providers to buy services for their plan members. These contracts create their “provider networks” and collaboratives. Crucially, health plans will only pay for care provided by doctors and hospitals within the private insurers’ provider network, with little or no coverage for care received from other providers.^{44–46} It is extremely concerning that the Act does not prevent this from happening in England, not least because its provisions to promote “choice” are limited and unclear,

are dependent on yet to be published secondary legislation, and are not framed in a manner designed to prevent it from happening.

Little Integration of Social Care

A fundamental distinction was made under the Attlee government after World War II. While health services were to be nationally provided free at the point of delivery, delegated to and administered by area-based public bodies serving local populations, provision to the same populations of what are now termed social care services was made the responsibility of local authorities and means-tested. This distinction has existed ever since 1948 and required collaboration between the NHS and local authorities.

However, for the most part, long-term care, including geriatric, mental health, and learning disability services, was seen as an NHS responsibility for the infirm (cradle-to-grave care), with residual provision for the frail being through local authorities.

A major change in the demarcation occurred in 1990, when long-term care was transferred from the NHS to local authorities and eligibility for NHS “continuing” care was subject to time limits and criteria. This, combined with lack of state funding for capital investment and financial incentives for the private sector, resulted in means-testing long-term care and increasing privatization, as both NHS long-stay hospitals and local authority residential homes were sold off. While much of the NHS accommodation housed in Victorian asylums and infectious disease and TB sanitoriums was unsuitable, the government used the long overdue need to modernize services as a cover for privatizing provision and shifting the costs of care to individuals and their families until they had spent down their resources.

NHS England has been seeking to integrate health and social care, but this cannot succeed without legislation to change the fundamental distinction. The 2012 shift to membership-based NHS commissioners who no longer serviced the same populations as local authorities compounded the difficulty.

Although NHS England’s pre-Act administrative changes in conjunction with some provisions of the Health and Care Act go some way to integrating primary and secondary health services, the Act ducks the challenge of integrating health and social care. The nearest it comes to it are in the creation of joint committees of ICBs and local authorities, known as Integrated Care Partnerships (ICPs).

The sole function of ICPs is to prepare an “integrated care strategy” that must set out how needs identified in the joint strategic needs assessment will be met. These assessments are prepared by local authorities and, previously, CCGs to assess the health and social care needs of the local authority’s population. The Act, however, only requires an ICB to have regard to the integrated care strategy when carrying out its commissioning and other functions.

Implications for the Public

The combination of the Act's introduction of "core responsibility," contractual "discretions" for providers, reduced local public accountability, increased private-sector involvement, and market deregulation make further development of a two-tier and mixed-funding system inevitable. This is already happening. For example, the NHS-partnered patient access website⁵⁹ for GP appointments, repeat prescriptions, and "discovering local health services" is reportedly offering mostly private health care with lists of tests and treatments to be paid for.⁶⁰

The COVID-19 pandemic has exposed the effect of years of inadequate NHS funding, of bed and staff shortages, of a broken social care system, and of the disastrous impact of carving public health out of the NHS in 2012. These factors are barely addressed in the Act, yet they combine to soften up the public to expect fewer NHS-funded services and to be pushed into paying for them. This has also been made more likely by the government's policy during the pandemic, which has directed billions of pounds of public money to private hospitals,^{61–64} despite the head of NHS England questioning whether the most recent contracts were "good value for money".⁶⁵ For the first time, the private sector has been performing more elective knee and hip operations than the NHS.⁶⁶ The likely results of these developments—as in the United States—is greatly increased overall health expenditure and inequality in access to and outcomes from health services.

Conclusion

The Health and Care Act 2022 cements the major realignment of the relations between the state and the public that has been a long time in the making. Parliament has stood back and handed over most decision-making and power to unaccountable entities who will decide what services will be provided. This outsourcing of control over large sums of public money will also increase the opportunities for corruption. Health services in England will come to resemble those in the United States, where the state has also opted out of health care organization and direct provision to become an outlier among the majority of advanced democracies, distinguishable by high costs, inequality, and injustice.

With successive governments, think tanks, and the mainstream media repeatedly denying that the NHS is being privatized—and hiding behind "service integration" and the pandemic—these consequences are already becoming apparent. Public satisfaction with the NHS is at its lowest since 1997.⁶⁷ Nevertheless, at the same time, the public still overwhelmingly supports its founding principles. This provides a promising basis for continuing the vital and sustained campaigns to rebuild the NHS in England.


Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author(s) received no financial support for the research, authorship, and/or publication of this article.

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