From: Kamran Abbasi [redacted]
Sent: 24 February 2022 16:34:10
To: Peter Roderick [redacted]
Cc: [redacted]; Allyson Pollock [redacted]; [redacted]
Subject: Re: The BMJ - Manuscript Decision BMJ-2022-070145

Dear Peter and Allyson,

Thank you for your response. I'm afraid our decision on your paper is final. We've been through many iterations and we're still left with a paper unsuitable for publication in The BMJ. There is no further avenue to explore.

I appreciate the time it took to respond to the reviewers and how strongly you feel about your article.

We're very supportive of critique of the bill, which is why we have continued the dialogue about your article. But the upshot is that the paper is still not one that we are willing to publish and I'm afraid that we have no confidence that you will be able to revise it to make it publishable. The issue with this paper is the same as with others from you both, it is less about the point you are trying to make but more about how you make it. That's why I suggested you seek a further co-author to help shape the article better for The BMJ. That remains my advice to you when you submit papers to us in future.

In addition, whether you like it or not, three reviewers whose opinions we do respect have raised strong and consistent reservations about the substance of your argument. It is entirely wrong to say that we are "closing down reasoned discussion" of the bill. We want reasoned discussion to challenge the proposals, but you haven't provided it in our opinion.

Luckily for you, and for us, there are many other medical journals and publications, and I'm sure you will find a home elsewhere since you are so convinced of the merits of your work.

We will not be able to consider any further revisions of this article.

I wish you every luck with another journal.

Best wishes.

Yours sincerely,

Kamran

Kamran Abbasi FRCP Edin Lon
Editor in chief, The BMJ
BMJ
[redacted]

On Tue, 22 Feb 2022 at 14:39, Peter Roderick [redacted] wrote:

Dear [redacted],

Thank you for your email below.
You will not be surprised to know that we are unhappy with your decision to reject the paper.

We were surprised that the reviewers are current (or perhaps previous) senior executives of three organisations that need and have the ear of government. (We say 'or perhaps previous' because Reviewer 2 does not state an institution.) You will have known that their organisations have published briefings which accept the government's position that the Bill is intended to increase integration and collaboration, are more concerned with the Secretary of State's apparent power grab than the loss of universal and comprehensive health care, and have stated publicly that they do not believe the Bill will result in more privatisation of delivery or funding. This is also the line adopted by the right-wing Institute of Economic Affairs, and by the former CEO of NHS England Simon Stevens, who ridiculed Allyson when questioned by the Health Select Committee for drawing attention to parallels with elements of US health care.

More importantly though, we were shocked and appalled that you made your decision without giving us a prior opportunity to respond to the reviewers' comments.

We attach our response to the three reviewers. We are glad that two inaccuracies have been noted - one to a reference, and one to the extent that mental health services are privately provided currently. The BMJ website states that reviewers "must provide a fair, honest, and unbiased assessment of the strengths and weaknesses of the manuscript". Only Reviewer 3 has a claim to come close to that requirement. None of the reviewers acknowledge that an integrated care board is membership-based and only has to commission services for its members, does not have to commission emergency services for everybody living in its area, is permitted to include "discretions" in its contracts with providers, and is not prevented from appointing company representatives to sit on its board or committees. Reviewers 1 and 2 seek to dismiss what we say in a lengthy way without providing evidence, and Reviewer 2 indulges in a derogatory *ad hominem* attack on more than two decades of previously published and peer reviewed work in the BMJ.

Our analysis of this Bill may not be shared, for whatever reasons, by many in the health policy world, by government or indeed by BMJ editors. That does not, however, make it invalid or incorrect, but rather raises in our minds the question of why the BMJ is peremptorily silencing a minority analysis which challenges the apparent consensus. In heeding these reviews the BMJ is closing down reasoned discussion of the Bill, and failing to inform readers and the wider public about its most harmful aspects and omissions.

Yours sincerely,

Peter and Allyson

From: BMJ <onbehalfof@manuscriptcentral.com>
Sent: 15 February 2022 20:20
To: Peter Roderick [redacted]
Cc: Allyson Pollock [redacted]; [redacted]
Subject: The BMJ - Manuscript Decision BMJ-2022-070145

15-Feb-2022
BMJ-2022-070145
The Heath and Care Bill: how Parliament is washing its hands of the NHS in England

Dear Mr. Roderick,

Thank you for sending us this paper and giving us the chance to re-consider your work.

We sent it out for external peer review and discussed it at the Analysis manuscript committee meeting (present: xxx, xxx, xxx and myself, with written comments from xxx).

After careful consideration - including an additional read by Kamran Abbasi after the Analysis committee meeting - we have decided not to publish your paper.

Though we continue to agree that this is an important topic, the editors were informed by the peer reviewers, who are remarkably consistent in identifying inaccuracies and noting where claims in the paper are unsubstantiated.

We appreciate your understanding that this is a final rejection; we will not be able to reconsider this paper.

The reviewers' reports are available at the end of this letter.

Although The BMJ has an open peer review process, in which authors know who the peer reviewers were, we expect that you will keep the identity and comments of the peer reviewers for this paper confidential. You may, however, share the peer review comments in confidence (though not the names of the peer reviewers) with other journals to which you submit the paper. If you have any complaints about the peer review process or the conduct of the peer reviewers, please contact the editor who handled your paper. Please do not contact the peer reviewers directly.

I'm sorry for any disappointment caused and hope that the outcome of this submission does not deter you from future submissions to The BMJ.

Best wishes,
xxx

Reviewer: 1

Recommendation:

Comments:
There are some issues with the legislation and the structures being developed but I do not think that this paper really captures these. This is an important topic and the arguments in the paper are original and so I have taken some care to look at them (i.e. sorry the review is so long)

Introduction
“The reforms hand over most power and decision making to public-private joint ventures without statutory duties”. This is incorrect: most power and decision making, including budgetary responsibilities and commissioning decisions would reside with statutory Integrated Care Boards and NHS England, a statutory national body to which they are very clearly accountable.

"Break decisively with the Beveridge model" – the Beveridge model is widely defined in the literature as involving tax funding, universal coverage, and (largely) state ownership of providers. These characteristics of the UK health service will remain unaffected by the Bill.

Handing over power and decision-making
This chapter as a whole assumes a model in which ICBs will delegate powers extensively to the provider collaboratives outlined in NHS guidance last year, such that the latter become the primary source of decision making. This is not stated policy, and there is no reason to assume it will take place. Several aspects of the Bill, notably the extensive statutory and budgetary powers held by ICBs, the retention of statutory autonomy and duties by NHS trusts, and the intention to create council-NHS partnership leadership at "place" level, suggest that power will reside elsewhere.

The statement that "provider collaboratives and networks are US concepts" is difficult to justify. Different forms of collaboration between hospitals have existed for a very long time in the UK and other countries. Also the guidance on provider collaboratives allows for a diverse set of models ranging from collaboration on a few areas to a hospital group model- this is actually referred to in the chart but at odds with the argument that they are to be the main instrument of delivery of healthcare – there may be some of this, London seems to be heading that way but it is not the intention of the bill or the policy more generally.

The two phrases in quotation marks on lines 39-41 do not appear anywhere in the document that is cited. The phrase "a principal engine of transformation" is drawn from a different NHS document and refers to providers themselves (ie, NHS trusts), not to collaboratives. The published guidelines on provider collaboratives describe a broad range of models from loose collaboration e.g. to share some services through to more formal models with a single governance structure. They are in fact not likely to be the main driver of services in most places – these will be the rather poorly defined place-based partnerships and in these cases the local acute provider will be a partner, not the controller.

Page 2 L44-53 "Private companies… will sit on the ICBs and/or their committees". In previous versions of the Bill this was a decision for local CCGs, although presenting it as a universal certainty would still have been misleading. The Bill in its current form makes this considerably more unlikely, stating that "The constitution must prohibit a person from appointing someone as a member ("the candidate") if they consider that the appointment could reasonably be regarded as undermining the independence of the health service because of the candidate's involvement with the private healthcare sector or otherwise."

Page 2 L56 – providers can determine the way services are provided now. In future, as now, this generally has to be in consultation with or at the direction of those responsible for commissioning. It is not clear what point is being made here or how this will change.

Page 3 L1 "Currently most acute mental health services are provided privately"- this is not correct and the recent figures from LaingBuisson agree. Is there any source? I think the reference here is to highly specialised services such as secure units.

Page 3: "The similarities with US health care are striking". This risks being misleading. Healthcare in England differs from healthcare in the USA in many respects, such as universal coverage, GP gatekeeping, public sector commissioning, a general lack of charges at the point of use, and widespread state ownership of providers, none of which will be affected by

the Bill.

"ICBs… will cover their members… and not everybody in a specific geographical area". The Bill does not include the precise mechanism for how people will be divided between ICBs, but it is clear that the intention is for them to cover geographical areas. As the authors rightly note, ICBs in fact already exist, and are defined based on geographical areas. New Chapter A3 of the Bill states: "Each integrated care board is to be established by order made by NHS England for an area within England. (3) The area for which an integrated care board is established must not coincide or overlap with the area of any other integrated care board."

Page 3 Line 32 The analogy of closed networks or out of network coverage might apply but it does not work very well and attempts to limit the use of out of area providers are not new. In fact Section 69 of the Bill says that there will be regulations to protect choice of provider. This means that the point on L41-2 about access to out-of-network providers in the USA, while accurate, does not obviously translate to a UK context.

Page 3 Line 38 'as well as generate private income from other sources, such as private health insurance or out of pocket payments'. There is a need to be careful what is implied here, as they can't charge for anything that is provided as part of the NHS. The entity responsible would be the constituent parts of the ICS not the ICS itself.

Page 4 L10 Power grab – I am not persuaded that the change in 2012 legislation is as significant as suggested here or that the argument here works. Readers would need more help understanding why the 2012 change. See next section.

Breaking decisively with the Beveridge model
"The 2012 Health and Social Care Act got rid of the Government's duties to provide or secure provision nationally". This risks overstating the significance of this development. It is only the precise wording which changed: the Act retained a duty for the Secretary of State to exercise their functions to promote a comprehensive health service free at the point of use. This has not made a material difference to policy or practice.

"The new Bill completes the detachment of funding, planning, and provision from local residents and local areas". As the authors note, the system which predated the Bill contained a relatively limited role for local residents in funding, planning and providing care. If anything this is increased under the Bill, which adds local councils to ICBs and creates new partnerships involving councils at different levels. The authors note that certain CCG responsibilities regarding public involvement do not exist for ICBs, but fail to note the Bill's clauses "14Z44 Public involvement and consultation by integrated care boards" or "14Z52 Consultation about forward plans".

Line 45: the statement that 'the bill completes the detachment of funding, planning and provision from local residents and local areas, and moves to a system based on membership' is unlikely to be true except for a small number of individuals at boundaries or who might register with remote telephone based GP providers.

Line 50: there is no basis for assuming that ICBs will be in a position to select patients. This renders Lines 53-60 a bit of a logical stretch. GP at Hand is a small provider: where patients register out of their catchment area they are required to provide local access. This will not translate easily to become commonplace. Many of the wider ICB functions require

integration with local services. Even if they wanted to, the advantages of acquiring other populations from other ICSs seem slight and logistically challenging. Since funding is age and risk adjusted (and is further moving in that direction) the idea of risk selection behaviours being a danger is unconvincing.

"Moreover, an ICB will only have "core responsibility" for the group of people allocated to it. This new concept appears to give enormous flexibility over what services will be provided to patients." This reflects an incorrect understanding of the use of "core responsibility" in the Bill, which is used to denote people for whom ICBs generally have responsibility, rather than other groups of people who may be assigned to them for specific purposes. It does not relate to which services they must commission for those people. Clause 16 of the Bill enumerates which services must be commissioned: it gives a comprehensive and open-ended list allowing relatively little flexibility.

Page 5 L25 Reference 9 is to a story that does not actually represent what is stated in the text of the article. A careful reading makes it clear that patients were redirected (not very well) to services more appropriate for them, not in any way because they came from a different area.

"The Bill takes the market to its final conclusion…" The Bill reduces the marketisation of the English NHS, by removing existing rules that mean procurement must be conducted through an open market, and replacing these with regulations the draft form of which would allow for less use of competitive markets in planning and funding healthcare. The authors themselves recognise this shortly afterwards, stating that the Bill "removes even the limited legal protections that a market system offers".

Page 6 Line 18 'Market-driven systems inevitably lead to mergers' The article then points at Centene taking over primary care – which is not a market based system. It is also true that there are incentives (inevitable not a useful word here) for vertical integration in complex environments where coordination between parts of the system is difficult and this is true whether or not there is a market. Similarly, some of the horizontal mergers are not motivated by the market share drivers found in the USA but by the theory of change of regional directors and others in NHSE (larger groups can reconfigure services more easily)
.

Page 6 Lines 25 I think the argument about the implications of the abolition of the national tariff go further than the evidence allows. Only Foundation Trusts can vary terms and conditions and there is little appetite for this. There will still be a national schedule of costs/prices , many providers are not paid on some form of block (except for planned care) and gain/loss agreements (referencing a 6 year old paper which does not seem to have been largely enacted) are not in widespread use.

Implications for the public

This section discusses a range of developments occurring now and in the past, which do not relate to the Health and Care Bill.

Page 7 L 5 Trusts cannot charge for NHS services which the text implies

Conclusion

The statement that "the Health and Care Bill cements the major realignment of the relations between the state and the public" greatly overstates the effect of the Bill, which will retain a taxpayer-funded, mostly free, comprehensive health service overseen by a Secretary of State and with most providers publicly owned. The Bill will simply change some aspects of the administrative structure of the health service.

It is unclear what is meant by "Parliament is standing back and handing over most decision-making and power to unaccountable entities who will decide what services will be provided." If the entities are Integrated Care Boards, they are as accountable as previous health bodies to Government and Parliament. If they are provider collaboratives, which as the authors note are not mentioned in the Bill, no evidence is provided for the assertion that these will play such a significant role, and ICBs would not be permitted to allow them not to provide certain services.

"Health services in England will come to resemble those in the USA where the state has also opted out of health care organisation". As noted above, England and the USA will remain extremely different health care systems in many different ways, notably user charging and universal coverage. Contrary to the state opting out of health care organisation, the Bill describes a system where the state through NHS England and ICBs plays a very dominant role in organising healthcare, as in earlier administrative approaches in the NHS. Clause 40 of the Bill would in fact give the central state a more dominant role in directly determining the local organisation of services.

General and other

The structure of the arguments is not always easy to follow

There is a general tendency to analogies which don't translate very well, in particular those to the USA health system

There are a number of significant errors of fact that have implications for the logic of the case being made.

A number of the conclusions tend to go a long way beyond what the evidence will permit

Two citations I checked do not actually reference what is claimed in the text – I only checked these 2, perhaps the authors should be asked to QA the others and correct these two, the one about patients being refused treatment is particularly inaccurate.

xxx

Reviewer: 2

Recommendation:

Comments:
General

The paper is a simplistic reading and description of what the Bill will do. It is a particular interpretation that is selective and alarmist and mostly ignores any safeguards or measures that will largely prevent the authors' concerns from coming to pass. The paper cites examples that are irrelevant or don't demonstrate what the authors say they do. There is some speculation that (in parts) jumps into fantasy that not only is unsupported by any evidence but actually contradicts evidence that is readily available. The authors have a history of publishing (for example in the BMJ) this type of material whenever there are significant reforms to the NHS, and have not received enough critical challenge in the journals. While there are often some objective points of interest worth discussing, the work is unfortunately spoiled by heavily biased assumptions and subjective speculation which is likely to mislead readers.

Specific

Introduction

• The opening sentence states that the Health and Care Bill is 'revolutionary', but this description does not reflect the analysis in the article. Many of the issues highlighted in the article are those the authors have ascribed (at least once) to previous NHS legislation, relate to issues present long before this Bill was written, or describe where the Bill represents a continuation of the status quo.

• As one of the authors has considerable legal expertise and experience, the reader is entitled to expect the article to offer a complete and nuanced legal analysis of the Health and Care Bill. However, in a number of places within the article, descriptions of the impact of specific measures within the Bill are oversimplified and lacking in important caveats to properly support either this overall assessment or a number of the points in the text. Parts of the Bill set out broad rules and principles, with crucial detail left to secondary legislation that is yet to be scrutinised by parliament. Yet where the article could potentially raise legitimate questions about what this unseen future legislation may contain, the authors instead make a range of unsupported assumptions about what it will contain that are not supported by the actual text of the Bill.

• The article uses the term 'joint venture' in the introduction and elsewhere. The authors may intend this has shorthand for collaboration, but the term has a more specific meaning within the range of different models of collaboration that may be applicable to the provider collaboratives discussed here. It is therefore potentially misleading in much of this article, and should be reserved for instances where its use is justified.

Handing over power and decision-making

• This section of the article raises concerns about the role to be played by provider collaboratives within Integrated Care Systems, which the authors suggest will include private companies and will be 'a major departure from the Nolan principles'. However, the authors do not appear to have taken account of clause 14 of the Bill, which requires members of Integrated Care Boards (ICBs), their committees and sub-committees and employees to declare any conflicts of interest that may arise in decision making and how any conflicts should be managed. Moreover, the authors do not acknowledge that the Bill has been amended to prevent the appointment of a person as a member of an ICB if they could reasonably be regarded as undermining the independence of the NHS because of their involvement in the private healthcare sector or otherwise. The article also needs to clarify whether the provider collaboratives or the private companies themselves are expected to sit on Integrated Care Boards (ICBs) and/or their committees, as this is not clear as currently drafted.

• The authors suggest the Bill will allow ICBs to give provider collaboratives the discretion

to determine the means by which services are to be delivered. It is implicitly suggested in the article that this discretion will be used to downgrade NHSfunded services, but the example used by the authors is that people already having to travel long distances to access acute mental health services. It is unclear how citing an example of what is happening now illustrates the authors' point that quality of care will deteriorate if the Bill is passed.
• In the box comparing the measures in the Bill with the US health system, many of the comparisons are simplistic, inaccurate or fail to acknowledge important differences. o Membership: the authors suggest ICBs will be like HMOs, in that not all people within a specific geographical area may be assigned to the relevant ICB. The comparison with HMOs in this context is likely to be interpreted by some readers as meaning some of the population may not be assigned to any ICB and will therefore be excluded from access to NHS funded health care services. However, clause 15 of the Bill clearly states that 1) NHS England must publish rules for determining the group of people for whom each ICB has core responsibility and 2) those rules must ensure that everyone a) who is provided with NHS primary medical services (i.e. registered with a general practice) or b) who is usually resident in England but not provided with NHS primary medical services is assigned to at least one ICB. Clause 14 of the Bill also requires NHS England to ensure that, at all times, the areas of integrated care boards together cover the whole of England. In contrast, there are no such rules requiring the population covered by HMOs in the USA to provide collectively inclusive coverage of the whole population of that country. The comparison, as currently presented, is incomplete and fails to acknowledge these important differences.
o Funding for services: the authors state 'In England, public money will be given to ICBs, which will be passed on to public and private providers who also receive private money.' But the authors do not explain how (if at all) this is substantively different to what happens now, where public money allocated to CCGs is used to commission NHS services from a range of providers (public, private and the VCSE sector) on behalf of their assigned populations. All of those providers, including NHS trusts and foundation trusts, may receive other forms of income including private money. In this respect, the Bill is a continuation of the status quo.
o Limited services and denial of care: the authors raise concerns about HMOstyle gaps in coverage, especially for 'out of network' providers, and state that 'ICBs will be able to operate similarly' - essentially by forcing patients to use local services or self-fund elsewhere. However, the article omits to acknowledge clause 16 of the Bill sets out the categories of health care services ICBs must commission or that the Bill gives new powers to the Secretary of State to intervene in any changes to the provision of services. There are questions about how the planned move to ICBs and provider collaboratives is compatible with successive governments' commitment to patient choice. However, the article makes no reference to the wider requirements in the Bill to promote patient choice - clause 20 extends the existing legal duty to promote choice to ICBs, while the same clause puts ICBs under a new duty to consider the wider effect of their decisions for health and wellbeing. In particular, the article fails to address clause 69 of the Bill which requires NHS England and ICBs to promote and protect people's rights to choice, the steps NHS England must take to enforce those rights and (through regulations) to set parameters for when and how patients have the right to choice. In broad terms, this is essentially a continuation of the current regime and, as above, the authors need to clarify how this merits the description of a substantive change, let alone the 'revolutionary' change claimed in the article. The authors may be concerned about the range of policy changes that could fall within the scope of these regulations, but the article is not at all qualified in those terms.

• As the Nuffield Trust has concluded, the suggestion that ICBs represent a move towards the US system is 'completely wrong – ICBs will be statutory bodies controlled by NHS

England, tax funded, and covering everyone in a given area rather than competing for customers. They more closely resemble the Area Health Authorities which ran the NHS in the 1970s, or Scottish or Welsh Health Boards today.'
(https://www.nuffieldtrust.org.uk/news-item/will-the-new-health-and-care-billprivatise-the-nhs)
• The final paragraph in this section references the removal of the duty of the Secretary of State to provide services via the Health and Social Care Act 2012. The article does not (and should) acknowledge that this duty was not simply repealed, but was replaced by the same Act with a duty for the Secretary of State to promote a comprehensive health service and a series of requirements for what and how NHS England and CCGs were expected to commission health care within England. While the authors may believe the current legal framework is a poor substitute, it is not reasonable to ignore the fact that the framework exists - not least as much of their argument hinges on reading great importance into small changes in wording.

Breaking decisively with the Beveridge model
• The article expresses concerns about how people will be allocated to ICBs, whether people will be able to choose an ICB and (if so) whether this may lead to ICBs offering membership-based health plans. The authors may not have seen the DHSC has stated (via the Delegated Powers Memorandum on the Bill provided to parliament's Delegated Powers and Regulatory Reform Committee) that its policy intention is to continue the existing model of allocating patients based on GP registration – albeit with a slightly different mechanism required to do so due to the abolition of CCGs.
• This means the discussion of whether NHS England or Ministers intend to allow people to select an ICB (and, if so, whether ICBs would be legally able to offer the type of membership-based plans suggested by the authors) is fantasy, rather than speculation. The article cites no relevant evidence to justify the authors' concerns, and fails to acknowledge the directly relevant evidence that does indicate how people are expected to be assigned to ICBs. The examples cited – of the involvement of Babylon Health in primary care and foundation trusts offering private services – are of provider organisations, not commissioners, so are irrelevant. ICBs will be statutory NHS commissioning bodies, with clear responsibilities for commissioning a specified range of NHS-funded services and no remit to commission or provide privately funded services. The authors may argue that this offer will actually be made by provider collaboratives, but any such argument flounders on the fact that provider collaboratives will remain contractually accountable to ICBs, which in turn will be held to account by NHS England and the Secretary of State.
• The article discusses the impact of the Bill on commissioning responsibilities for urgent and emergency care. The authors have interpreted a minor change in the wording of legislation as having significant consequences, which is not supported by their analysis in the article. The authors cite the example a single patient's experience of seeking urgent care from the Northern Care Alliance, but to extrapolate from one story is unsupportable. In any event, the story cited explains that the patient's experience occurred due to the unfortunate interpretation of a system of streaming patients to the most appropriate service rather than (as the article implies) an unwelcome effort to narrow the service offer.

XXX

Reviewer: 3

Recommendation:

Comments:
The article makes some strong points about the importance of provider collaboratives, and to a lesser extent, place-based partnerships and primary care networks. Though important parts of the future healthcare system, they play little or no role in the current Bill. This has raised questions about transparency and about the intended functioning of the reformed system. However the paper does not note that this approach has the support of many NHS organisations (and non-NHS organisations) as it avoids setting out a one-size-fits all approach in legislation and allows for local flexibility.

It also notes the difficulties for single local authorities or MPs to engage with organisations as large as ICBs and the absence of clear local authority accountability. This is indeed a risk. The counter argument is that, ultimately, local authorities are not responsible for NHS spending and so cannot be given control but even so, remains a tension. It is correct to point out that here, as elsewhere, a lot is left to implementation and later guidance and so some of the thinking on collaboratives and place is yet to be developed.

In its conclusion, the paper also notes the constraints on spending and on workforce shortages. It could have developed these points as the real drivers of problems in the NHS.

However, the article does make some factual errors, and places where the issues it notes are of long-standing. For example:
- it is not the case that the private sector accounts for the majority of acute mental health services, at least by measures of spending or beds
- the government amended to bill to prevent private sector representation on ICBs. NHS Trusts, GPs and a local authority all have a place
- the implication that provider collaboratives are public-private joint ventures is debatable. Firstly, none of these new collaboratives (that we are aware of) has a formal JV structure, and secondly, it is not clear that many even include any for-profit organisations. ICBs retain power over the money and all NHS Trusts and Foundation Trusts (the building blocks of provider collaboratives) remain as statutory NHS bodies.
- people are `enrolled' into ICBs in only the loosest sense. These are geographically defined bodies. No area has `overlapping' ICBs as they are geographically distinct. Patients cannot `choose' to change ICB unless they happen to move into a new ICBs geographic territory. They are also statutory NHS bodies.
- equally, provider collaboratives (unlike the US) are geographically defined. All providers operating in one areas will be part of a collaborative. Given this it is hard to see how they could materially chose to prevent people accessing other providers (even if they wanted to) given all within an area should be part of the same collaborative. An `out of network' provider would therefore mean an `out of area' provider. I should add that I am not aware of any collaborative even discussing this form of restriction.
- strictly speaking the Bill does not abolish the national tariff, it amends it (admittedly significantly) into a new form
- NHS England has consulted on its provider selection regime (in 2021)
- Foundation Trusts have always been able to retain surpluses and NHS providers have provided services for private patients for many years.

The issue of `core responsibility' probably needs a legal opinion. As the authors correctly note, it has not been the subject of debate by MPs or peers, nor, to my knowledge raised by any others. For such a fundamental change in NHS to be slipped under the radar, without any discussion, would, I suspect, open it to immediate legal challenge if used in the way authors suggest.

Although the authors dismiss the `power grab' by Ministers, many others have noted (including Parliamentary committees) the number of places where powers shift to Ministers and away from Parliament. This occurs in many places and is worthy of note. If allowed to stand, for example, it greatly increases Ministers abilities to intervene directly in reconfigurations.

[redacted]

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for Kamran

Allyson Pollock [redacted]

Tue 11/01/2022 09:33

Dear Kamran,

The Health and Care Bill is in the Lords today and for the next couple of months.

Please find a radically rewritten paper on the Health and Care Bill which continues the policy of dismantling the NHS, building on Lansley's 2012 Act.

There has been no real critical analysis of the Bill in the BMJ or taking apart of what the proposed legislation would do. It seems the medical leadership too bought into the Bill hook, line and sinker- as have the policy think tanks such as Kings Fund and Nuffield Trust.

If you recall the main opposition to Lansley's Act was in the Lords- this time Simon Stevens is now there to ease the passage of the bill.

I cant stress how important it is for the BMJ to have an understanding of the Bill and act as an authoritative source for the Lords and the MPs too and public.

We have drafted a series of legal amendments (in a separate briefing for the Lords) but these are too technical for BMJ readership.

We will of course lose the fight as we did in 2012, but we can at least tell the public and our medical professionals what is being done and put on the record the road to mixed funding and a two tier system.

I am asking for a fast track rapid review -
Best wishes
Allyson