Title

The Heath and Care Bill: how Parliament is washing its hands of the NHS in England

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PR has nearly 40 years' experience as a lawyer, is co-author of the NHS Reinstatement Bill and has written extensively on the Health and Social Care Act. AMP has 30 years of experience of researching public health policy and the privatisation of the NHS and long term care. PR researched the Bill and wrote the first draft of the paper with input from AMP. Both were involved in further commenting, drafting and editing. We gratefully acknowledge the comments on drafts from several colleagues.

PR is the guarantor.

He affirms that the manuscript is an honest, accurate, and transparent account of the study being reported; that no important aspects of the study have been omitted; and that any discrepancies from the study as planned (and, if relevant, registered) have been explained.

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The Heath and Care Bill: how Parliament is washing its hands of the NHS in England

Peter Roderick and Allyson M Pollock

The authors argue that Parliament is handing over powers and decision-making to unaccountable entities who will decide which services will be free at the point of delivery, and which will be charged for.

Introduction

The Health and Care Bill 2021 is revolutionary. For the first time since the creation of the NHS the government is putting forward a set of reforms in which the state continues to fund health care in England, but largely abstains from involvement in its organisation. The reforms hand over most power and decision-making to public-private joint ventures without statutory duties, and break decisively with the Beveridge model of a universal, comprehensive and accountable public service.

In this paper we outline these major proposals and discuss their clear implications for the public.

Handing over power and decision-making

NHS England (NHSE) has already divided the NHS into 42 non-statutory Integrated Care Systems (ICSs). ICSs have five components (see Table) only two of which are mentioned in the Bill. Integrated Care Boards (ICBs) are new statutory bodies and replace 106 clinical commissioning groups (CCGs). Integrated Care Partnerships (ICPs) are joint committees of ICBs and local authorities. The three groups which are not mentioned in the Bill are provider collaboratives, place-based partnerships and primary care networks. ICBs will be given most of the NHS budget which they will pass on to these three groups through a series of contracts and subcontracts.

The provider collaboratives will play "an active and strong leadership role" in the ICSs and be "a principal engine of transformation".[1] They will include private companies, including US health insurers and providers, such as UnitedHealth (Optum), and Centene (Operose). Some of these will also be members of 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 the Nolan principles that require holders of public office to act solely in terms of the public interest.[2] NHSE's expectation that ICBs will delegate their functions to providers will further bolster their power. Lord Lansley said quite rightly during the second reading of the Bill in the House of Lords, that power in the NHS will lie with these collaboratives with no provision for their transparency, openness or accountability.[3]

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."[4] Furthermore, the Bill allows ICBs to give providers "discretions" in their contracts to allow them to "determine the means by which services will be delivered".[5]

For example, currently most acute mental health services are provided privately and many patients have to travel several hundreds of miles to obtain a bed. In future providers will be able to decide how and where services are to be provided.

The similarities with US health care are striking (see Box).

Box: US similarities

Membership
The ICBs resemble health maintenance organizations (HMOs) and other insurers in the US, in that they will cover their members – i.e., those allocated to them – and not everybody in a specific geographical area.

Funding for 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 US, contrary to popular perception, government funds most healthcare in the US.[1] Alongside private funding, insurance companies, such as HMOs, in the US benefit from much of this government funding to pay some or all of the premiums for "health plans" which the companies sell to individuals.

Limited services and denial of care
HMOs and insurance plans in the US cover only the limited range of services (from the limited group providers) agreed to in their contracts. [2-5] Provider collaboratives and networks are US 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 restrict access to services to doctors and hospitals within the private insurers' provider network, with little or no coverage for care received from other providers. [2-4]

ICBs will be able to operate similarly, passing the budget through large contracts to provider collaboratives which, using their "discretions", will be able to limit publicly available services to restricted groups of providers as well as generate private income from other sources, such as private health insurance or out of pocket payments.

A common problem in the US health system, is where insurers refuse to provide or pay for (or require the patient to pay more for) services received from "out of network" provider. [2-4]

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In this context, describing the Bill's new powers of the Secretary of State to direct NHSE as a 'power grab'[6] is to miss the wood for the trees. These powers are not systematic or linked to a ministerial duty to provide services, which was abolished in 2012. They are better thought of as a panic button to be pressed when the failures from handing over power to non-statutory joint ventures become apparent.

Breaking decisively with the Beveridge model

The NHS was set up in 1948 as a universal, comprehensive service free at the point of delivery, which is publicly provided, funded and accountable. The Bill's structural changes build on three decades of erosion. We explain below how this has been, and will be, brought about.

No longer universal and comprehensive

Delivery of a universal and comprehensive service was based on the integration of funding, planning and provision of health services to meet *all* reasonable requirements of *all* local residents. This was underpinned by legal duties on ministers to provide or secure provision throughout England, delegated to local public bodies.

The 2012 Health and Social Care Act got rid of the government's duties to provide or secure provision nationally. It gave 212 clinical commissioning groups (CCGs) a duty to commission services to meet the reasonable requirements (not, as previously, "all" reasonable requirements) of persons for whom they were responsible. Responsibility also switched from all local residents in an area to patients on the lists of the GPs who were CCG members. Public health was also carved out of the NHS. The new Bill completes the detachment of funding, planning and provision from local residents and local areas, and moves to a system based on membership or enrolment of the population into ICBs.

Under the Bill everybody receiving primary care services or who is usually resident in England must be allocated to at least one ICB under rules to be made by NHSE with no parliamentary process. 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 those with lower medical risk. This is already happening with the Babylon GP at Hand case,[7] where patients changing their GP had the destabilising effect of moving the budget to a different CCG.

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, but its meaning has not been explained and was not discussed at all by MPs during the committee stage of the Bill in the Commons. It 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. Already NHS foundation trusts (FTs) have entered into joint ventures with private insurers and private health companies and are actively promoting private health care on their websites (see below).

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 GP lists. This was prevented by a specific provision to ensure that a CCG arranged emergency services "for every person present in its area".[8] The Bill repeals that provision, giving ICBs and providers flexibility to decide where and to whom A&E services will be provided. The Northern Care Alliance, a large merged foundation trust, has already been reported to have turned a patient away from an A&E department because of undisclosed 'protocols'.[9]

Less local public accountability and more corporate penetration

There are 333 councils in England, and 533 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, a single local authority or 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.

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

At the same time, the Bill does not pass on to an ICB the obligations a CCG has to include in its constitution: (i) the arrangements it has made to involve the public in the planning of commissioning, in developing proposals and in decisions on impactful changes; (ii) the principles which it will follow in implementing those arrangements; and (iii) 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 or agendas, reports and other documents.

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

The Bill 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, digital and other support services.[10] These companies will provide technical support to ICBs, provider collaboratives, and ICPs.

The Bill takes the market to its final conclusion, completing the process begun with the introduction of the internal market and contracting in 1990, the private finance initiative, foundation trusts in 2003, Alternative Provider Medical Services contracts in 2004, and market contracting and abolition of the government's 'duty to provide' in 2012.

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, Centene is now probably the largest primary care provider in England[11] as well as partly owning private hospitals such as the BMI Park Hospital in Nottingham; acute NHS trusts and FTs have taken over community care and several GP practices, such as in Birmingham and Wolverhampton, and entered into joint ventures.[12] These corporate manoeuvres increase monopoly power of providers and overall health expenditure. The Bill abolishes the national tariff which leaves providers well-placed to determine both prices and staff terms and conditions. Furthermore, “gain/loss agreements”,[13] which allow providers to retain surpluses from expected expenditure, will provide additional incentives to reduce staffing, quality and level of services. The Bill is silent on shareholder and equity returns.

The Bill also abolishes current procurement rules under s.75 of the 2012 Act which will be replaced by a new “provider selection regime”. Section 75 has been widely opposed, not least by NHS managers and the BMA, as it requires 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. Draft regulations for the new regime have not yet been published.

Implications for the public

The combination of the Bill'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 website for GP appointments, repeat prescriptions and “discovering local health services” is reportedly offering mostly private healthcare with lists of tests and treatments to be paid for.

Providers of NHS services advertise private services, and can require patients to pay for supplementary services. Since 2012 FTs can receive 49% of their income from private patients and other non-NHS sources. For example, four FTs already have joint ventures with HCA Healthcare UK (Hospital Corporation of America), which describes itself as "the largest private healthcare provider in the world, and the largest provider of privately funded healthcare in the UK". [14] These include its "state-of-the-art cancer centre" at Guy's Hospital,[15] and building a £100m private hospital with University Hospitals Birmingham FT;[16] in April 2021 the Royal Marsden FT opened a private "dedicated and comprehensive cancer diagnostic and treatment centre" in Cavendish Square.[17]

The covid-19 pandemic has exposed the effect of years of inadequate NHS funding, of bed and staff shortages, and of a broken social care system – and of ignoring the expert prescient warning given to MPs in 2011 as the 2012 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."[18]

These factors are barely addressed in the Bill yet they combine to soften up the public to expect fewer NHS-funded services and to be pushed into paying for them. The likely result – as in the USA - is greatly increased overall health expenditure, and inequality in access to and outcomes from health services.

Conclusion

The Health and Care Bill cements the major realignment of the relations between the state and the public which has been a long time in the making. Parliament is standing back and handing over most decision-making and power to unaccountable entities who will decide what services will be provided. This out-sourcing of control over billions of pounds of public money will also increase the opportunities for corruption. Health services in England will come to resemble those in the USA where the state has also opted out of health care organisation to become an outlier among the majority of advanced democracies, distinguishable by high costs, inequality and injustice.
END

Table: The components of Integrated Care Systems

A. Statutory components	
Integrated Care Board	***Status*** A body corporate, with a constitution ***Main function*** To commission most NHS services ***Membership*** 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 Anybody else approved by the chair
Integrated Care Partnership	***Status*** A joint statutory committee, with no constitution ***Main function*** 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. ***Membership*** An ICB and local authorities in the ICB's area. No additional minimum membership requirements.
B. Non-statutory components	
Provider collaboratives	***NHSE's definition*** "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: • reduce unwarranted variation and inequality in health outcomes, access to

	services and experience • improve resilience by, for example, providing mutual aid • ensure that specialisation and consolidation occur where this will provide better outcomes and value." [1] ***Action required by NHSE*** • "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." [1] ***Number*** : 45 currently [2], ultimately unknown.
Place-based partnerships	***NHSE's definition*** "collaborative arrangements formed by the organisations 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." [3] ***Action required by NHSE*** "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." [3] ***Number*** Unknown
Primary care networks	***NHSE's definition*** "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)." [4] ***Action required by NHSE***

	Already established and operating under network agreements, the content of which 'is not within the remit of the CCG to challenge' [5] ***Number*** 1,250

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