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

Response of authors to reviewers' comments received on 15 February 2022

22 February 2022

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)

Reviewer comment (1):

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.

Response: The reviewer is obviously entitled to take that view of the effect of those statutory features. Our argument is that those statutory features of the Bill are only a part of the picture, and that it will be the non-statutory components of integrated care systems, along with other aspects of the Bill which we set out, that will determine where, when and how services will be delivered. That does not make our argument incorrect.

Our argument is supported by Lord Lansley (as cited in the paper). It is also confirmed by the report in the Health Service Journal on 2 December 2021:

"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 organisations effectively operating as a population data provider for collaboratives and "place-based partnerships", or disappear altogether."

Reviewer comment (2):

"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.

Response: This is a partial and loose characterisation of the Beveridge model. The principles of the model are that services are universal, comprehensive, free at the point of delivery, and publicly provided, funded and accountable. We show how all of these principles are negatively affected by the Bill.

Reviewer comment (3):

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.

Response: Most of this comment is making the same point as in (1) above, which we have responded to. We are not sure what is meant by 'stated policy'. Delegation of powers, and budgets, is expected in NHS England guidance documents, and there is no more reason to assume that the expectation will not eventuate (as the reviewer appears to believe), than there is to assume that it will occur. Either the latter is more likely, which we consider to be the case, or NHS England's expectations are unrealistic and irrelevant.

The reviewer does not make clear whether the reference to council-NHS partnership leadership at 'place' level is a reference to the place-based partnerships, or to the statutory council-NHS committee, Integrated Care Partnerships. Provider collaboratives will be part of the former (another non-statutory component without statutory duties or membership and governance requirements); and the statutory functions of the ICPs are limited to preparing an integrated care strategy setting out how needs identified in the joint strategic needs assessment will be met, and have no power or duty to implement the strategy.

Reviewer comment (4):

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.

Response:

Provider collaboratives and networks clearly are US concepts, and their introduction by NHS England is categorically different from the types of collaboration which have always been a part of the NHS. There may indeed be different models of collaboratives, but these are not controlled by the Bill. The delivery of healthcare will be by providers, working within their collaboratives and in line with the arrangements the collaboratives make amongst themselves and their decisions. According to NHS England "The members of a collaborative should agree how they will achieve their objectives and develop clearly defined plans and programmes of delivery…. In the future, there will be greater opportunities and options for ICBs to empower providers to lead transformation and delivery of services. The Health and Care Bill, if enacted, will enable ICBs to delegate functions to providers including, for example, devolving budgets to provider collaboratives."

Reviewer comment (5):

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.

Response: Both quotes appear in the same NHS England document. The reference is incorrect, and should be to 'Integrating care - Next steps to building strong and effective integrated care systems', November 2020 - https://www.england.nhs.uk/publication/integrating-care-next-steps-to-building-strong-and-effective-integrated-care-systems-across-england/. The sentence from which the second quote is taken, and used fairly in our view, is as follows: "Provider organisations and others, through partnerships at place and in provider collaboratives, become a principal engine of transformation and should agree the future service model and structure of provision jointly through ICS governance (involving transparency and public accountability)."

The separation of collaboratives and place-based partnerships suggested in the comment is not supported by NHS England's guidance which envisages "[s]ome responsibilities will best be delivered by provider collaboratives working across places (or across multiple ICSs) and some will sit with place-based partnerships in line with the principle of subsidiarity." See also: "some providers will be members of an at-scale provider collaborative and one or more place-based partnerships." – NHS/LGA, Thriving places - Guidance on the development of place-based partnerships as part of statutory integrated care systems, September 2021, https://www.england.nhs.uk/publication/integrated-care-systems-guidance/; and "Each NHS provider who is a member of a provider collaborative will be involved in a place-based partnership." – NHS, Working together at scale: guidance on provider collaboratives, August 2021, same link.

Reviewer comment (6):

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."

Response: Whether private companies are able to sit on ICBs and/or their committees depends on the law, not on any individual's point of view of what is likely or unlikely. The original bill allowed it without limitation, and the amendment tabled to prevent representatives of private companies sitting on ICBs was opposed by the government and withdrawn. As the Labour Party's health spokesperson stated: "If it is the Government's position that they do not expect private companies to sit on the board, do they say that because they do not believe it will happen, or because they do not want it to happen? If they do not want that to happen, they should support the amendment. If they do not support it, and if they refuse to join us in trying to legislate to stop private companies getting involved in the running of the NHS, all the people who believed that the Government were determined to increase private sector involvement in the NHS will be entitled to say, "We must be right.""

The government then came forward with the amendment cited by the reviewer, which is weasel worded, makes it a matter of interpretation, and does not extend to ICB committees to which ICBs will be allowed to delegate functions.

Reviewer comment (7):

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.

Response: This sentence is part of demonstrating that most power and decision-making will not lie with the ICBs.

Reviewer comment (8):

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.

Response: The reviewer is correct. As a result of almost three quarters (73%) of mental health beds having been closed in the NHS since 1987/88 to 2018/19 an increasing proportion of mental health beds are provided by the private sector.
https://www.strategyunitwm.nhs.uk/sites/default/files/2019-11/Exploring%20Mental%20Health%20Inpatient%20Capacity%20accross%20Sustainability%20and%20Transformation%20Partnerships%20in%20England%20-%20191030_1.pdf

Corporate ownership and out of area placements are a feature of acute mental health services. For example Cygnet health care with 2,725 beds and owned by US corporation Universal Health Services Inc with revenue in excess of $11 billion in 2019. https://www.nhsforsale.info/private-providers/9526-2/

Reviewer comment (9):

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.

Response: Of course the US health system is different, and we anticipated this standard response to any suggestion of similarity with it, which is why we specifically identified the similarities. Because there are differences does not mean there can be no similarities. And given that the US has a market model, and as that model, along with US corporations, have encroached incrementally into the NHS over thirty years, it is perfectly reasonable to identify similarities some of which are referred to in the paper.

Reviewer comment (10):

"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."

Response: This comment appears to misunderstand the Bill in this regard. ICBs will not cover – i.e., will not be required to commission services for – everybody in a specific area. They will be required to commission services of the group of people allocated to them.

Reviewer comment (11):

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.

Response: The regulations have not been published. See also our response to (9) above.

Reviewer comment (12):

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.

Response: We are certainly not intending to imply that they can charge for NHS services, hence 'from other sources'. The reviewer in the final sentence seems to agree with us.

Reviewer comment (13):

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.

Response: See (14) below.

Reviewer comment (14):

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.

Response: This is a standard response to a point that we have made consistently for the last ten years. The duties of the government were a foundation of the NHS model from 1946-2012, and they needed to be removed in order for the shift to membership-based commissioning, uncoupling of services from local residents and more provision by private providers including out of area providers to occur.

Reviewer comment (15):

"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".

Response: The role of local residents and areas has been downgraded since abolition of the Community Health Councils in 2002. Local authorities will have little power within the ICBs, which is not where most power and decision-making will occur, and the ICPs also have limited statutory functions (see (3) above).

We do not expressly mention new section 14Z44, but we have not failed to take note of it. The text on p5 lines 41-46, which the reviewer acknowledges, is based on the differences between that section and the corresponding section currently applying to CCGs (section 14Z2): "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 arrangement; and (iii)…". (The third point of difference is not related to the differences in those sections.)

Reviewer comment (16):

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.

Response: This comment seems to be making a different point. (In any event, allocation to an ICB will depend on NHS England's rules which have not yet been published and which will not be subject to parliamentary process.)

Reviewer comment (17):

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.

Response: The size of GP at Hand is irrelevant, as opposed to what the Bill makes possible. GP at Hand can be seen as a test run. The reviewer (and Reviewer 2) maintains the fiction of the system returning to an area-based administration and integration of services; this is not the case as providers are not directly managed by ICBs. This reviewer fails to acknowledge that US companies with extensive experience in risk selection are now providing commissioning support services, data analysis and clinical services to the NHS. The Resource Allocation Working Party's formulae were based on a capitation basis for the whole population in an area. This has now changed and the capitation is on the basis of GP practice lists (members). The bill makes possible delegation of capitation budgets to providers and collaboratives. Providers manage risks of capitation through risk selection and service restrictions – see the US experience.

Reviewer comment (18):

"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.

Response: We understand correctly the use of the term in the Bill. The reviewer is technically correct as to its use in the Bill, but there has been no explanation of why it is necessary to distinguish between 'core' and other patients. We are not criticising the long-standing list of services after the Bill was amended to re-insert medical and ophthalmic services which were missing from the original version. However, whilst the range of services is wide, it says nothing about the extent that services in each category must or will be commissioned, and since 2012 there is no qualified requirement to meet "all" reasonable requirements.

Reviewer comment (19):

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.

Response: The statement in our paper is correct: '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'.' Our point, which we should have made more clearly, is not that the patient was turned away because she was from a different area. Rather, just as application of 'protocols' prevented the lady in Manchester receiving emergency treatment, by not requiring ICBs to commission emergency services for everybody in their area (as CCGs must), Parliament is taking away the 'right' of everybody to receive emergency services wherever they need them regardless of which ICB they belong to.

Reviewer comment (20):

"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".

Response: This comment misunderstands the purpose of procurement rules. No provision of services without contracts, and no open procurement, is a market apotheosis.

Reviewer comment (21):

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) .

Response: Centene were able to take over so many GP practices because of APMS contracts which have been described by a health industry lawyer as "the private sector's gateway to providing primary health care to NHS patients". Corporate Mergers in health care have become a reality with the Competition and Markets Authority conducting investigations for example into mental health services provided by Cygnet which is owned by UHS - a US healthcare management company that operates, through its subsidiaries, acute care hospitals, behavioural health facilities and ambulatory centres in the US, the UK, Puerto Rico and the US Virgin Islands. UHS acquired Cygnet in 2014. https://assets.publishing.service.gov.uk/media/599fe2aaed915d3836c0553a/provisional-findings.pdf See also acquisition (merger) by HC-One Limited which operates 242 residential and nursing care homes in the UK of 122 care homes operated by Bupa Care Homes (BPC). https://assets.publishing.service.gov.uk/media/5a4e143040f0b648c7221424/fc-oval-bidco-bupa-care-homes-final-decision.pdf

Reviewer comment (22):

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.

Response:

The reviewer is giving his opinion, but this is not a critique of what is made possible. Moreover FTs already vary terms and conditions for staff depending on the amount of competition there is in shortage specialities- especially for consultant staff and senior managers. https://www.gov.uk/government/publications/dhsc-evidence-for-the-ssrb-pay-round-2021-to-2022/dhscs-written-evidence-to-the-senior-salaries-review-body-ssrb-2021-to-2022.

Reviewer comment (23):

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.

Response: This section argues that several factors of the Bill, which we specify, will further develop a two-tier and mixed-funding system. This comment does not challenge that. (Moreover, it would be odd, given three decades of incremental erosion of the foundational principles, if that development would somehow only begin with enactment of the Bill.)

Reviewer comment (24):

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

Response: Indeed they cannot, though we can't see how the reviewer reached this implication from our text.

Reviewer comment (25):

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.

Response: The last sentence of this comment trivialises the effect of the Bill and is not tenable. We have explained clearly why the move to a two-tier and mixed funding system will develop further.

Reviewer comment (26):

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.

Response: This comment has been responded to above.

Reviewer comment (27):

"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.

Response: Most of this comment has been responded to above. The effect of Clause 40 is to further reduce local accountability.

Reviewer comment (28):

General and other

The structure of the arguments is not always easy to follow

Response: It is not possible to make a meaningful response to this general comment.

Reviewer comment (29):

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

Response: This essence of this comment has been made and responded to above.

Reviewer comment (30):

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

Response: This is a general comment that does not specify the alleged errors. Where they have been specifically asserted in previous comments above we have responded to them.

Reviewer comment (31):

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

Response: We obviously disagree.

Reviewer comment (31):

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.

Response: The comments have already been made and we have responded above. The QA suggestion is a gratuitous swipe.

Reviewer: 2

Recommendation:

Comments:

Reviewer comment (1):

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.

Response: This general comment is mostly derogatory and its function is to disparage our work through an *ad hominem* attack. We do not respond to it further, except to point to the record of extensive peer review our papers have gone through.

Reviewer comment (2):

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.

Response: This is mostly a general not a specific comment. Having written previous papers on this issue in the context of incremental erosion of the NHS model over thirty years is neither a relevant

nor specific criticism – and hardly surprising. The creation of new integrated care systems, which are only partly statutory, with most power lying outside the statutory components, is revolutionary.

Reviewer comment (3):

• 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.

Response: Complete and nuanced legal analysis of the Bill belongs in a law journal, not the BMJ, and as the BMJ's website states "[i]t is not the job of the reviewer to extend the work beyond its current scope". Again, the rest of this comment is general, not specific. We agree that future unseen legislation is problematic, but this comment sheds no light on where we make unsupported assumptions about it.

Reviewer comment (4):

• 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.

Response: This comment does not explain for which models the reviewer considers the term 'joint venture' to be justified and unjustified. NHS England describes the collaboratives as "partnership arrangements", regardless of collaborative model. Partnerships are legally defined, and the collaboratives will not be partnerships in the legal sense unless their arrangements meet the legal test. 'Joint ventures' are not legally defined, and it is perfectly permissible to use the term regardless of model to apply to any arrangement between two or more participants who agree to cooperate on a specific activity or to achieve a specific objective.

Reviewer comment (5):

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.

Response: The opening sentence of this comment is confused. The departure from Nolan is in relation to ICB membership; the Bill is silent about provider collaboratives (and about 'integrated care systems' except as titles). Declarations of conflicts of interest do not prevent any category of membership, indeed they presuppose such conflicts. We have responded to the government amendment point in response to Reviewer 1 (comment (6)). Individual expectations of whether private companies and provider collaboratives will sit on ICBs and/or their committees are not relevant. The Bill permits the latter (and, though irrelevant, we expect it to happen); provider collaboratives are not (at least as yet) legal entities and so cannot be represented as such, though their members clearly will be.

Reviewer comment (6):

• 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 NHS funded 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.

Response: Explanatory Notes states that the Bill's clause permitting 'discretions' in contracts "allows persons with whom NHS England and ICBs have entered into commissioning arrangements to also determine the means by which services will be delivered" (para. 341) (there are several such clauses in the Bill). These 'discretions' are new. The fact that poor quality services are currently being provided supports, rather than detracts from, our argument. The 'discretions' will help make it even more difficult for patients to challenge poor or lack of provision.

Reviewer comment (7):

• 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.

Response: The 'many comparisons' which are alleged to be simplistic or inaccurate are not specified. As we have explained in response to Reviewer 1 (comments (4) and (9)) we are drawing out similarities, we are not comparing systems. The comment repeats what we have expressly written on page 4 of the paper that "Under the Bill everybody receiving primary care services or who is usually resident in England must be allocated to at least one ICB". It is as clear as day that ICBs will

not cover everybody living in a geographical area, as that is central to their design, as it is to CCG design - Clause 14 is not relevant to this point.

Reviewer comment (8):

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.

Response: This sentence is part of explaining a similarity - an unexpected similarity for most readers, we would expect - with the US.

Reviewer comment (9):

o Limited services and denial of care: the authors raise concerns about HMO style 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.

Response: Clause 16 includes (only) a range of services, and as we have stated above (Reviewer 1(18)) it says nothing about the extent that services in each category must or will be commissioned, and since 2012 there is no qualified requirement to meet “all” reasonable requirements. The comment acknowledges (euphemistically) that there are “questions” in relation to choice, and draws attention to three provisions which she implies address the issue.

The reliance the reviewer places on three provisions misses the point.

Clause 20 (new section 14Z37) is a broad general duty on ICBs (as on CCGs) to “act with a view to enabling patients to make choices with respect to aspects of health services provided to them”. Clause 20 (new section 14Z43) – the ‘wider effects’ duty referred to - is a duty on an ICB when making decisions to regard all likely effects of the decision in relation to the health and well-being of the people of England, the quality of services provided, and efficiency and sustainability in relation to the use of resources (the so-called ‘triple aim’).

Clause 69 requires regulations to "make provision as to the arrangements that NHS England and integrated care boards must make…for enabling persons to whom specified treatments or other specified services are to be provided to make choices with respect to specified aspects of them", and the regulations also "may other provision for the purpose of securing that…NHS England and integrated care boards protect and promote the rights of persons to make choices in relation to treatments or other services, where those rights arise (a) arise by virtue of [the previously mentioned provision above] or (b) are described in the NHS Constitution."

New section 14Z37 is a broad duty which applies once services are being provided (and only to 'aspects'), it does not apply if services are not being commissioned. New section 14Z43 is even broader, and makes no reference to choices. Clause 69 applies only to specified treatments or services (and only to specified aspects). The best that can be said about these provisions is that the government has recognised the problem of having moved to a membership-based system, and that there will be some circumstances where the effect of having done so must be alleviated. But none of the provisions is a structural answer to the point we are making.

Reviewer comment (10):

• 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)

Response: We have already responded regarding US similarities. Because another health policy think-tank thinks otherwise is neither nor there. The assertion that ICBs more closely resemble AHAs is way off the mark. Reviewers conflate 'area based bodies' with bodies with responsibility for all people in an area. We – and perhaps they - would wish it were so, but it is not the case. It was the case until 1990. In no respect do ICBs resemble AHAs in England, or Scottish and Welsh Boards. Scottish and Welsh boards still organise services around the needs of all local residents in an area, are not membership based and do not operate the purchaser-provider split.

Reviewer comment (11):

• 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.

Response: We have responded to this point in relation the Reviewer 1 (comment (14)). The duty to promote was not replaced. It has been in place since 1946. We were (and are) critical of the dropping of the additional duty to provide and secure provision (in section 1 of the NHS Act 2006), and the duty to provide key services throughout England to meet all reasonable requirements (in section 3 of that Act) because dropping these duties was necessary in order to permit further market encroachment on the NHS model and the shift to membership and away from responsibility for all people in an area.

Reviewer comment (12):

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.

Response: We are aware of this, and of the Explanatory Notes. The latter makes it clear that it is a DHSC "expectation" and a "general rule" for "operational continuity". It is not the legal position, and if it was, there would be no need to change the current legal position for CCGs which is on the basis of GP registration. ("It 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" (Explanatory Notes, para 312).

Reviewer comment (13):

• 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.

Response: The 'evidence' is what the law says, not what any government department, quango or think tank 'expect'. The characterisation of the promotion of membership-based plans as fantasy is derogatory. The point is that the capitation payment was made on the basis of GP practice lists. GP at Hand had two impacts - it decreased the (capitation payments) money available for some CCGs for commissioning, and destabilised commissioning budgets for all those people who had previously been assigned to the CCG through the practice list. It also destabilised GP practices as GP at Hand recruited mainly young healthy people, leaving some GP practices with less money and a sicker pool of patients. GPs also receive a capitation payment as well as fee for service income.

We do not state that ICBs will have a remit to commission or provide privately funded services – of course they don't. But NHS service and bed closures are still proceeding apace, and commissioners are increasingly substituting private health care providers for directly provided NHS care (e.g., elective surgery and mental health services). The private sector has now overtaken the NHS for elective surgery, for example for knees and hips, the most common surgical procedures - https://www.ft.com/content/e9ac6302-f000-4c7a-a7ad-1094c130625a

Reviewer comment (14):

• 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.

Response: The failure of the Bill to pass on to ICBs section 3(1C) of the NHS Act 2006 is not 'a minor change in wording of the legislation'. It is a deliberate omission. As we have written, one of the inevitable consequences 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, not for everybody present in the CCG's area. After 'the pause' in the parliamentary progress of that legislation, the government brought forward an amendment to ensure that a CCG arranged emergency services "for every person present in its area". That amendment became section 3(1C) of the NHS Act 2006. Clause 15 of the Health and Care Bill omits section 3(1C) and so it will not be passed on to ICBs. During the committee stage of the House of Lords, Baronesses Finlay and Jolly tabled an amendment (Amendment 51A) to rectify this omission, but it was not moved. We explain our point as regards the Northern Care Alliance in our response above to Reviewer 1 comment (19).

Reviewer: 3

Recommendation:

Comments:

Reviewer comment (1):

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.

Response: We thank the reviewer for his opening acknowledgment, which has no comparator in any of the comments of the other two reviewers. Where we differ from him on this point is that we consider 'flexibility' to be a cover.

Reviewer comment (2):

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.

Response: Yes, though local authorities do have a legitimate role on behalf of their local population, and this will be further undermined by membership-based rather than area-based responsibility.

Reviewer comment (3):

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.

Response: These are indeed real problems, and a serious political failure. The paper though is focussing on the Bill shifting the health system model.

Reviewer comment (4):

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

Response: We agree, and with Reviewer 1 (see above comment (8).

Reviewer comment (5):

- the government amended to bill to prevent private sector representation on ICBs. NHS Trusts, GPs and a local authority all have a place

Response: This is not a factual error**. T**he government's amendment does not prevent private sector representation on ICBs and/or committees. We have responded to this above. The paper notes the representation of trusts, GPs and local authorities.

Reviewer comment (6):

- 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.

Response: It may very well be the case that not all provider collaboratives will include private providers. But our point is that some already do, their membership is uncontrolled, and NHS England has stated (as we indicate in the Table) that "non-NHS providers should be part of provider collaboratives where this would benefit patients and makes sense for the providers and systems involved" (though them meaning and enforcement of those two pre-conditions are quite unclear). Joint ventures have varying degrees of formality, and informality, but there is no standard formal JV structure. And in any event the Bill does not seek to control or regulate the structure. We have responded more to this aspect above in response to Reviewer 2 comment (4).

Reviewer comment (7):

- 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.

Response: Most of this comment is not correct. Yes, ICBs have areas, and in this sense are geographically defined, but their 'core responsibility' and commissioning functions are not geographically determined. This is fundamental to the erosion of the NHS model from 1946-2012. It can be appreciated by noting the new section 14Z31(4) (Clause 15) which will give the Secretary of State the Henry VIII power to change the basis of 'core responsibility' from allocation under NHS England's rules to usual residence in the ICB area.

We do not understand why the reviewer is saying that patients cannot `choose' to change ICB unless they happen to move into a new ICBs geographic territory, because NHS England's allocation rules have not yet been made and the initial allocation of patients to an ICB is not required by the Bill to be geographically based (provided the patients usually live somewhere in England/are currently provided NHS primary medical services).

See also our responses above to Reviewer 1 at (10) and Reviewer 2 at (7).

Reviewer comment (8):

- 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.

Response: NHS England states that "provider collaboratives focus on scale and mutual aid across multiple places or systems". Out of area providers are increasingly commonplace for local residents in England. The areas covered by ICBs will not prevent this from happening. The collaboratives will decide where and how services are provided, aided by 'discretions' in the commissioning contracts.

Reviewer comment (9):

- strictly speaking the Bill does not abolish the national tariff, it amends it (admittedly significantly) into a new form

Response: To be technically precise, the Bill "replaces the national tariff with the NHS payment scheme" (Clause 68(a)).

Reviewer comment (10):

- NHS England has consulted on its provider selection regime (in 2021)

Response: Yes, we are aware of this.

Reviewer comment (11):

- Foundation Trusts have always been able to retain surpluses and NHS providers have provided services for private patients for many years.

Response: Yes, but introduction of the '49% non-NHS' rule for FTs was a step change intended to increase income from private patients and facilitated many joint ventures which we mention in the paper. Specifically it allows FTs to dedicate their services, beds, staff etc to private patients up to the

49% income limit, taking them out of NHS funded care. Moreover the joint ventures are now advertising paid for services on FT websites.

Reviewer comment (12):

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.

Response: See our response above to Reviewer 1 comment (18).

Reviewer comment (13):

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.

Response: We do not support increasing the Secretary of State's ability to intervene directly in reconfigurations as this will further dilute local accountability. Until 2002 Community Health Councils had the power on behalf of local residents to refer closures to the Secretary of State – i.e., to go above the head of the health authorities. Because of the size of ICBs and the fact that they are not directly managing services there are no formal mechanisms for MPs, local councillors and local people to oppose and challenge mergers of FTs, corporate buyouts of services, privatisation and service closures.

PR & AMP, 22/2/22

END.