Re: Your Submission THELANCET-D-21-08581

From: Peter Roderick [redacted]
Sent: 05 January 2022 21:09
To: editorial@lancet.com <editorial@lancet.com>; [redacted]
Cc: Allyson Pollock [redacted]
Subject: Fw: Your Submission THELANCET-D-21-08581

Dear [redacted] and Richard,

Allyson has forwarded me the email below.

I agree with what she has written.

Below are my quick responses to the first of the three points made by the first reviewer.

Peter

Reviewer #1: This viewpoint offers an interesting overview of some potential consequences of the 2021 Health and Care Bill, however the viewpoint could benefit from a more balanced perspective if possible. The article makes two main points and below we discuss each of them in turn, with some suggestions for revisions. We then make some further points for the authors consideration.
Point 1: US similarities

The article argues the Health and Care Bill will herald a US style HMO style system of organising services in terms of membership rather than population-based coverage. This argument is based upon how ICSs will be responsible for services for set populations based upon GP list membership, in a similar manner to insurance companies. This is similar to the current arrangement whereby CCGs are also responsible for set populations based upon GP list membership. Moreover, CCGs currently also have significant discretion in the range, level and scope of services provided, leading to a postcode lottery. Therefore the viewpoint fails to build a convincing argument that the proposed changes in the Health and Care Bill will lead to this US style healthcare system any more than current arrangements, particularly as the funding mechanism for the NHS is not due to change, ie a system based on general taxation and access based on clinical need, not ability to pay, versus a system based on private health insurance, Medicaid, and Medicare (the author is correct that approx. half of healthcare spending in the US is public rather than private, but this is still a substantially different system to the UK and Western Europe, where public spending is approx. 80% of healthcare spending). Moreover, there are advantages in ICSs/ or CCGs for that matter, having responsibility for delivering services to set groups of patients, in terms of allocating resources via allocation formula based upon need, and accountability for performance/delivery/quality management.

** This response is not correct.

ICBs (not ICSs, by the way) will not be legally responsible for populations based on GP lists. CCGs are, and that is on the face of the current legislation – i.e., Parliament decided it. ICBs will have "core" responsibility (not commented on) for people allocated to them by rules made by NHS England with no parliamentary process. [This is one of many examples justifying the view of the House of Lords Delegated Powers and Regulatory Reform Committee, published on 16 December 2021, that the Bill "is a clear and disturbing illustration of how much disguised legislation a Bill can contain and offends against the democratic principles of parliamentary scrutiny."] The DHSC states (EN para 312) that "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.". That is not the legal position, and if changes to the status quo were not intended, there would be no need to change the legal position.

We do not argue that the Bill will lead to a US system (though the reviewer's addition of 'any more than current arrangements' is perplexing given the claim). We point out specific similarities, which are accurate (and were checked with US experts before submission). The fact that there are differences is both obvious and besides the point (though his or her argument here ignores the shift towards a mixed funding system). **

Point 2: The Health and Care Bill will lead to greater corporate penetration

The viewpoint argues the act will lead to greater private provision of NHS services, for two reasons, first because of market deregulation, and second, because the bill would allow (in principle), for independent providers to sit on Integrated Care Boards. In terms of market deregulation, the author is correct that a major component of the Health and Care Bill is to repeal article 75 of the Health and Social Care Act, which made competitive tendering of NHS contracts mandatory. However, this is part of a wider direction of travel that encourages greater colloboration and integration of healthcare services, rather than competition. Many people have argued that article 75 has facilitated greater private provision of NHS funded services, and repealing this legislation may infact reduce opportunities for private providers to enter NHS markets. Indeed, this lead author Therefore this viewpoint may benefit from a more balanced discussion on this key aspect of the legislation. In terms of membership of integrated care boards, guidance so far had stated that as a minimum one member from NHS trusts, one primary care member, and one local authority member should be included https://publications.parliament.uk/pa/bills/cbill/58-02/0140/en/210140en.pdf . However the composition of ICBs will be determined locally, and it is possible that independent provider representatives may have a seat on some boards. However within over 5 million people on waiting lists in England alone, and independent providers already conducted over 30% of NHS funded hip and knee replacements, it is unlikely the NHS will be able to clear backlogs of elective care without at least some support of the independent sector. If independent sector provision of some NHS funded services it here to stay in the short-to-medium term (at least until the NHS can adequately invest in capital, workforce, infrastructure), does it not make sense there is at least some mechanism for coordination and colloboration between the NHS and independent sector?

** This response side-steps the point that tendering is a safeguard against corruption and cronyism in a market system; and the question at the end can perhaps be best answered by posing another one: why does collaboration require private providers to sit on statutory boards making decisions on how to spend billions of pounds of public money which those providers have an interest in receiving?

The response ignores our third reason

("Market-driven systems inevitably lead to mergers and acquisitions, and to horizontal and vertical integration. These are already occurring and will increase monopoly power of providers and total health care expenditure, as they do in the US health system. With the national tariff abolished and provider collaboratives in a monopoly position, they will also be well-placed to determine both prices and staff terms and conditions.").

As Lord Lansley said on 7 December in the second reading of the Bill in the Lords "The slogan is "Collaboration not competition" —ironically, precisely the words that JP Morgan and Rockefeller used when creating vast monopolies….On the provider side, we have new provider collaboratives

which, in fairness, is where the power in the NHS will lie. The Bill makes no provision for them in terms of transparency, openness or accountability." **

Other Points

Point 3: The NHS will no longer be required to provide emergency services to everybody present in the area

The article makes this quite controversial claim without adequate referencing. I have tried to find a document/webpage to substantiate this and have struggled to do so. Indeed if it was a component of the Health and Care Bill I would suspect it would have received more publicity. I suggest if this is the case that the authors elaborate on this point further, with more details in which contexts individuals could be denied emergency services, with clear references.

** The shift from area- to membership-based responsibility occurred under the 2012 Act. One of the inevitable consequences of this shift would have been that a CCG only had to commission emergency services for its members, 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 gets rid of section 3(1C) and so it will not be passed on to ICBs. **

From: Allyson Pollock [redacted]
Sent: 05 January 2022 15:05
To: The Lancet Team <editorial@lancet.com>; Horton, Richard [redacted]
Subject: Re: Your Submission THELANCET-D-21-08581

Dear [redacted] and Richard
Happy New Year and thanks for your email

This is so disappointing.

There is no critical analysis of the Bill anywhere in the medical canon- just plaudits.

Its not helped by the fact that so many of our senior medical leaders and policy think tanks are now fully on board- and on boards too of private companies or acting as advisers. Simon Stevens did a very good job

The reviewers have not engaged with the legislation or the substantive arguments in our article. Indeed it is as though they haven't read it -

It really feels as though any discussion of the bill is being firmly censored and dismissed-

We did not mention the Lancet Commission because it focused mainly on funding and did not consider the major structural changes that have taken place or the removal of the duties on the sec of state for health or the impact of Lansley Act that we could see.

The colleges and BMA have failed to engage too

I have never felt so dispirited and sad- of course the government will get the Bill through but we should at least fight for the NHS. Not for ourselves, but for all those that cannot.

This is all there is currently
https://www.theguardian.com/profile/allysonpollock

I would like to appeal or for you to find a way of engaging with what we have written if it is not clear.

This is too important to just accept your decision.

I wish to appeal may we?

Best wishes
Allyson

From: em.thelancet.0.7879f2.1f1a2faf@editorialmanager.com <em.thelancet.0.7879f2.1f1a2faf@editorialmanager.com> on behalf of The Lancet Team <em@editorialmanager.com>
Sent: 05 January 2022 14:48
To: Allyson Pollock [redacted]
Subject: Your Submission THELANCET-D-21-08581

Manuscript reference number: THELANCET-D-21-08581
Title: The incremental demise of the NHS in England: how the Health and Social Care Bill consolidates the market paradigm

Dear Professor Pollock,

Thank you for submitting The incremental demise of the NHS in England: how the Health and Social Care Bill consolidates the market paradigm to *The Lancet*. As you know, I have been seeking external peer review, and have now heard back from two reviewers.

The reviewers' comments were mixed. After discussing the paper further with Richard Horton, we were unable make this submission a priority for our general readers when compared with other papers also under consideration. As a result, I regret to inform you that we have decided to decline this submission.

I am sorry to disappoint you on this occasion and hope that the reviewers' comments, appended below, will help to guide a successful submission elsewhere.

Yours sincerely,

[redacted]
The Lancet

Reviewers' Comments:

Reviewer #1: This viewpoint offers an interesting overview of some potential consequences of the 2021 Health and Care Bill, however the viewpoint could benefit from a more balanced perspective if possible. The article makes two main points and below we discuss each of them in turn, with some suggestions for revisions. We then make some further points for the authors consideration.

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infrastructure), does it not make sense there is at least some mechanism for coordination and colloboration between the NHS and independent sector?

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Point 4: There is no evidence base that integration leads to better outcomes for patients
The authors reference a 2017 NAO report, and state there is no robust evidence based that integration leads to better outcomes for patients. I think this is an oversimplification of the debate around integration. In many cases it may lead to better patient (and workforce) experience, but not necessarily better outcomes. Moreover a major issue is that we do not have adequate metrics to measure the degree or success of integration, and there is a lack of investment in research/policy evaluation for this purpose. The authors may wish to discuss some of these points?

Point 5: The authors neglect how a major aspect of the Health and Care Bill is greater ministerial control of the health and care sector
The authors may wish to discuss how the Health and Care Bill includes provisions for the Health Secretary to intervene in decisions about changes to local services and to direct NHS England. By bringing the health and care sector under greater ministerial control this may impede opportunities for the long-term planning requirements for a more sustainable health and care service.

Point 6: So what do the authors suggest as the policy solution/response to the current challenges facing the NHS?
The NHS is facing lots of challenges currently, lack of coordination/integration between primary, secondary, community, and social care, growing backlogs for elective care, huge inequities in provision, scarcity of resources. The Health and Care Bill attempts to address some of these issues, but maybe the biggest point is that will the NHS really benefit from a major disorganisation during a period of acute pressure, and will it instead be a major distraction to tackling some of these challenges. Maybe the policy response is not reorganisation, but long-term investment and planning in capital, training, health information technology, infrastructure, workforce, etc. At least some perspective on an alternative direction of the travel for the NHS tied to some of the arguments the author is making would make the viewpoint more relevant and appealing to the reader.

Reviewer #2: 1) The argumentation clear and well written-up.

2) I am concerned that the LSE - Lancet Commission on the Future - is neither referenced nor used to help ground the reader. That is a significant omission that seriously reduces the reader´s ability to contextualize what is largely a political argument.

3) The discussion is not clearly enough linked to a health systems framework - for example by function or within a specific function. Can you link your conclusions more clearly to implications for other health systems? What are the more globally-relevant lessons learned - for health systems or for politics around health system reforms?

4) The comparison to the United States, while interesting, does not make the article convincing. The US is positioned as the "bad" system so that anything similar to the US is wrong. I found the piece lacking in evidence on what makes the US system "bad". I am not suggesting it is a "good" system, but the article requires more specifics of the aspects of the system that are non-functional or lead to undesirable health, societal or economic outcomes. In other words, to argue that it is bad because the US system is bad is not the same as sharing the implications for health, equity and/or cost. Further, it would seem more appropriate to compare to several health systems - rather than only to the US - and identify the negative elements. I would also suggest identifying other health systems, or elements of other systems that are "good" and why. I realize that this is a viewpoint/essay and not a health policy research paper so it is too much to ask to do a complete comparison across multiple health systems, but more balance and more health systems "basics" are needed.