

PLEASE CIRCULATE THIS DOCUMENT AS A WHOLE OR AS INDIVIDUAL QUESTIONS TO EVERYONE YOU CAN IN THIS COUNTRY, AND ASK THE RECIPIENTS TO DO THE SAME

Frequently asked questions on the Health and Social Care Bill

Lucy Reynolds, Martin McKee, Clare Gerada, David McCoy

7 January 2012

This briefing is based on what is written in the Health and Social Care Bill rather than the promises and reassurances that have been made by ministers and officials. The two have frequently been quite different, and the media have mainly reflected the latter. It is the Bill's content that will shape the future NHS; this document seeks to increase public understanding by bridging the gap between what is in the Bill and what has commonly been portrayed in media coverage.

Q1: Hasn't the NHS got such major problems that it needs this complete restructuring?

A: No. The NHS must deal with 21st century health care challenges, such as how to offer cutting-edge treatments of proven effectiveness, and how to fund care to an aging population (though the implications of ageing for healthcare costs have been [greatly exaggerated](#)). However, the NHS delivers very well in comparisons with other health services, for instance in the series of studies conducted by the [Commonwealth Fund](#) or a recent [comparison of 17 countries](#). Public levels of satisfaction with the NHS are at an [all-time high](#). Interestingly, a steady stream of one-sided, inaccurate media stories highlighting NHS flaws works to create the opposite picture. A good example is a [recent report](#) on the high number of avoidable deaths from diabetes in the UK, which failed to note that the UK's record on this measure is [among the best in the world](#). Simplistic assertions, such as that alleging that the death rate from heart disease in the UK was twice that in France, simply do not stand up to [rigorous scrutiny](#).

There is no coherent explanation from those proposing the changes about how they would generate concrete improvements. The available evidence, most recently [cited by OECD](#), suggests that large scale organisational change may actually reverse our recent progress. This is not to say that the NHS is without problems or defects. However, the type of change that is proposed will not address the identified problems and could well make them worse.

Q2: Should we be reassured when the Government says that the NHS is not being privatised?

A: No. It is indeed being privatised, using tried and tested methods set out in a [manual for privatisers](#) written by Minister of State at the Cabinet Office, Oliver Letwin.

The government makes the contrary case based on a mistaken definition of privatisation. Their statement that "NHS care will be free at the point of use" is irrelevant to the real issue, which is the

ownership of the organisations providing services. The Bill includes mechanisms for: progressive increases in state-funded provision by private providers; one-way transfer of NHS trust hospitals (100% public sector) into semi-independent Foundation Trusts (public/private hybrids created by former Secretary of State for Health Alan Milburn); and outsourcing of much of the service commissioning task to the corporate sector. The Department of Health is also encouraging NHS hospitals to move directly into the private sector through management buyouts under a new “right to provide”: a [workshop](#) for NHS staff who want to exercise this “right” takes place on the 25th January 2012. All these measures fully adhere to the standard definitions of privatisation. The recently released NHS Operating Framework even includes explicit targets for increasing the share of care provided outside the public sector, and most of the new providers will be commercial enterprises rather than charities, as explained in a recent [Lancet article](#).

Q3: Isn't the Bill necessary because health outcomes in the UK lag far behind those in other countries, as government spokesmen have told us?

A: No. It is true that some outcomes, such as the government's key population outcome measure, avoidable mortality, have historically lagged behind other comparable countries. This reflects previous underfunding of our system relative to other European countries and especially compared to the USA. Following sustained investment since 1999, and supported by targeted initiatives such as the National Cancer Plan, these outcome measures have now [improved markedly](#). A recent [OECD report](#) showed that the rate of decline in avoidable mortality in the UK was the second fastest of all industrialised countries.

No-one at all has offered any suggestion on how or why market reform of the NHS would improve population health outcomes; in fact all available evidence points to the opposite result.

Q4: Do we not need to have this reform because money is so short?

A: No. The Coalition has been keen to tell us that their market reforms are cost-saving. In fact they will deliver less care at higher cost, and if the NHS budget cannot be increased, we shall soon find ourselves contributing to the system as individuals, as in the USA. Costs will increase because the shift into the use of competitive markets for arranging care necessitates extra bureaucracy. This is needed to accommodate individualised tracking of costs of care and compliance with competition legislation.

In addition, the service funding arrangements planned will almost certainly push up costs without improving outcomes. This is because the market model relies on consumer satisfaction to drive quality improvements, but it also assumes that consumers are as well informed as the providers, and of course with medical care this is usually far from the case. Patients can judge waiting times and staff attitude, but few can assess accuracy of diagnosis. Most cannot know whether the treatment recommended is necessary or if it is mainly undertaken to earn money for the provider, but the new “Any Qualified Provider” (AQP) system pays hospitals for what they do and allows them to keep any profits they make, incentivising overtreatment by for-profit hospitals. This may sound as if it should be a rare problem, but in the US system, which is the most similar to the one we are moving to, [The](#)

[Economist](#) estimates that 10%-12% of all 2009 health care expenditure went on unnecessary treatment.

Q5: Will the new health system create new profit opportunities as Lords Health Spokesman Earl Howe promised would-be investors last September?

A: Yes. The Bill appears to be designed to enable the private sector to profit from the publicly-funded health system, as well as to generate an increase in use of privately funded medical care through several mechanisms. The government is setting explicit targets for increasing the proportion of non-public sector organisations which will be paid from the NHS budget so as to ensure new commercial opportunities for such investors.

As well as arranging for private providers to compete with what are currently NHS hospitals, the government has set qualifications for the technical commissioning tasks which NHS staff cannot meet but which management consultancies, accountancy firms and insurance companies can. Thus many Clinical Commissioning Groups will have to outsource the commissioning work to these firms.

Q6: What will be the impact on the NHS budget of paying for these extra costs needed to run markets in health care?

A: Since it seems unlikely that the NHS budget will expand (indeed the Coalition has demanded higher productivity for the same budget over the next few years), all this extra spending on unnecessary administration and profits can only come at the expense of the amount and quality of care funded. So in fact not only will this reform fail to save taxpayers' money, it will divert scarce resources into unproductive expenditure. This will inevitably reduce the provision of care below the level that the 2009 NHS was providing, with increasing loss of NHS access as the market system is rolled out. It will be the most vulnerable groups in society who will bear the worst effects of this, including the chronically ill, the elderly and young children.

Q7: I had the impression that the reform was all about putting GPs in charge, which sounds like a good idea. Isn't that the case?

A: No. Through their involvement in Clinical Commissioning Groups (CCGs), GPs will be acquiring new financial and legal responsibilities for balancing budgets and deciding whose care can be paid for and whose cannot, but they may well see a reduction in their professional autonomy rather than an increase. Specialist services will be provided for most patients through the Any Qualified Provider (AQP) process (identical to the [Any Willing Provider](#) process used for commercial procurement in the EU and the USA). GPs initially believed that they would be able to help their patients navigate the system and arrange optimal care. However it turns out that because any provision through AQP must be administered under competition laws, it is the role of the [patient alone](#) to choose a provider. Because the GP is part of the system, it would distort competition between providers if GPs advised patients on which to choose – so they won't be allowed to. Thus GPs will gain only workload and risk, and patients will be deprived of the GP's know-how on which providers might be the most suitable.

Q8: Isn't it mainly social enterprises that will become new NHS providers?

A: No. This idea relies on another misrepresentation, one publicly protested by the [Social Enterprise Coalition](#) because the definition used is broad enough to cover every company.

To promote the idea that social enterprises will play a role, much publicity has been given to the award of a contract to Circle Health Limited to run the failing Hinchingsbrooke Hospital. In fact, although the day-to-day work of the operational company Circle Health Ltd is overseen by those of its staff who are members of the Circle Partnership, the majority of the shares in Circle Health Limited are owned not by this staff partnership but by private equity investors through investment company [Circle Holdings PLC](#). At least three of these major investors have recently [contributed sizeable sums](#) to the Conservative Party. Turning to the management team, all but one of the directors of Circle Health Ltd are reportedly financial services specialists without previous health care experience, while the CEO is a former banker. So actually the company running Hinchingsbrooke Hospital is controlled at shareholder, board and management levels by financial services interests rather than by its clinical management team, and it is not a social enterprise as generally understood. Nevertheless the government represents this company's contract to run Hinchingsbrooke as proof of a bright future for social enterprises in running the NHS!

Experience so far shows that real social enterprises are rarely able to win large contracts to provide health care, although independent observers considered some well qualified to do so. They lack the in-house contracting expertise to be found in the major corporations entering this market, so their bid documentation may not be the best, and if it is not complete and correct they will be excluded from the running. Social enterprises have insufficient financial reserves to survive more than a handful of unsuccessful bids, as credible bids are costly to prepare. Some tenders also require sizeable financial guarantees, and that can be a huge obstacle. For instance the social enterprise "poster child" Central Surrey Health (CSH) recently put in a strong bid against commercial competitors, but lost out to Richard Branson's company Assura Medical because CSH could only come up with a £3 million bond, [rather than the £10 million required](#).

Q9: Will the NHS still provide care for everyone free at the point of delivery?

A: Yes and no. Again, it's a matter of definitions. The Secretary of State for Health will no [longer be accountable](#) to Parliament to secure and provide a comprehensive health service. The position can be understood from careful consideration of the much-heard phrase "[NHS care will continue to be free at the point of use](#)". Indeed the care that continues to be NHS-funded will continue to be free as far as we know, but an increasing proportion of care will no longer be available on the NHS, and such care may then not be free of charge. A group of [general practitioners in Yorkshire](#) has already pre-empted the enactment of the Bill by deciding, unilaterally, that certain minor surgical procedures will no longer be covered by the NHS, then offering to provide the treatment privately through a company they own.

Not only is the NHS budgets flat-lined, but much of it will be spent on unproductive expenditure to create and run the architecture for a full-scale healthcare market. The sums for a comprehensive free-of-charge NHS don't add up if the market reform is carried out, and the roll out of transferable

personal health budgets later this year heralds the start of a transition to a contributory system for some types of care.

NHS Chief Executive Sir David Nicholson, in a [BBC radio interview](#), confirmed this position when he said that “if you’ve got a long term condition you might want to think in future about different GPs and whether they’re providing a full range of services for particular people with long term conditions”. The clear implication is that some or all Clinical Commissioning Groups (CCGs) will not be providing comprehensive care on the NHS.

In addition, the government is making [concerted attempts](#) to remove the geographical limits on GP practices. These are essential to ensuring universal coverage, and also to gathering information systematically so we can monitor the need for and the effectiveness of care. CCGs, unlike Primary Care Trusts, will not be responsible for everyone living in a geographical area, only [“persons for whom it has a responsibility”](#), which remains undefined. Although CCGs are required to have a [“sufficient geographic focus”](#), this also is not defined. The whole ethos of the Bill is to spin the NHS off from the public sector into a competitive market, and under this arrangement it is the workings of the market itself that will dictate what services will be provided and where.

Q10: Will more affluent people be able to rely on private health insurance to pay for any medical treatment they need?

A: No. Medical insurers require customers to declare pre-existing medical conditions before offering cover, and if it is certain that a condition will require treatment, then that treatment won’t be covered: after all, it’s only possible to insure a risk, not a certainty. So anyone who has a chronic health condition may find themselves paying the full costs of their treatment to the extent that it exceeds the personal budget they receive from the NHS. The likelihood in these straitened times and the current political environment is that now that the principle of comprehensive care is being eroded, NHS coverage for chronic conditions may shrink substantially over the next few years as personal budgets are rolled out following the pilot which is to complete during 2012.

Q11: Won’t this reform enable the NHS to benefit from higher private sector efficiency?

A: No. There is no evidence that the private sector is more efficient than the NHS, and in any case the impact of efficiency gains differs between public and private sectors because their aims differ. Publicly provided health services exist only to provide health care. In contrast, under company law, profit-making corporations have as their overriding goal the generation of profit, and this is the case whether they are in the healthcare industry or any other. While the individuals that work for private healthcare providers may be personally committed to the care of their patients, they are legally required to prioritise shareholder earnings over benefits to patients. They must provide good care as far as this allows them to maximise profits, rather than for the sake of delivering good care.

The current cosmetic surgery controversy highlights the fact that that some private medical service providers put their financial interests before the welfare of their patients, and it appears that many

of the patients involved will have to sue the companies concerned to get their substandard implants removed, unless they pay the cost of the removal operation. The Secretary of State of Health has told these private clinics that he expects them to do the right thing, but some do not [appear](#) to be choosing to adhere to this advice. The NHS market reform will leave many NHS patients exposed to the impact of the conflict of interest between the financial interests of medical service companies and the professional medical ethics of their staff, an issue highlighted by the situation of the surgeon who reportedly protested about using the cheap implants from PIP but [was ordered to proceed](#).

Because most patients lack the technical understanding to judge medical quality, strict regulation is needed to ensure that only care of high medical quality can lead to high profits, but the coalition government explicitly favours “light touch” regulation. Such minimal regulation is exemplified by the [under-resourced and overstretched](#) Care Quality Commission, which has allowed profit-making care home providers to self-certify that they complied with regulations. This explains how the owners of the Winterbourne View residential home were able to get away with employing a skeleton staff of untrained minimum wage workers despite charging up to £3,500 per week per resident from local authorities and residents’ families. Such cost-saving efficiency permitted the home’s private equity owners to generate 37% profit in 2007 (Private Eye no.1290 10 June-23 June 2011). The “light-touch” regulator failed to notice any problem until a particularly [persistent whistleblower](#) covertly filmed and televised the physical and psychological abuse of learning-disabled residents. Analogous problems were subsequently uncovered at three other [homes under the same ownership](#). In the absence of stringent regulation, there is no mechanism which links profitability to the provision of competent medical services, so there is no reason to suppose that private sector efforts to increase efficiency would result in medically excellent services.

In other words, efficiency gains in public services have the effect of increasing the value for money of the services they provide in exchange for the public funds they receive. In contrast, efforts to increase efficiency in the private sector are aimed at maximising profit made for the money invested, i.e. maximising the gap between what they receive for their health care efforts and what they spend on them. Where the money to pay for services comes from a public healthcare budget, this means that the most “efficient” companies may be achieving not the highest but the lowest value for money for the taxpayer.

Q12: Isn’t competition good for encouraging innovation and enterprise? Or for raising quality?

A: No. While the theory is fine for markets in consumer goods, half a century ago mainstream economic theory incontrovertibly established that competition does not work in this way in health care because of [inherent market failures](#). In a complex care system requiring co-ordination between providers, the use of regulated competitive markets will create legal restrictions on information-sharing between providers and collaborative problem solving, both of which are important drivers of innovation and enterprise in health services.

There is recent research which claims to show that competition between NHS hospitals raises service quality, but this research [has been contradicted](#) by subsequent analysis. Even if NHS hospitals were in fact in competition in the situations studied, which they were not, the studies fail to compensate adequately for confounding factors; they also assume causation instead of proving it.

It is well known that price-based competition between profit-making providers causes a “race to the bottom” on quality: as contract prices are shaved to the bone in order to have more chance of winning bids, [standards of service delivery fall](#). It [has been said](#) that competition in the market-based NHS will be on quality rather than price, achieved by means of fixed tariffs, but in fact most services do not have tariffs allocated, and with Clinical Commissioning Groups paying for services from a fixed and less than generous budget, the truth is that cheaper bids are going to be more likely to win because that will preserve scarce funding to treat other patients.

Q13: The provisions of the Bill are already being implemented and some politicians have said it is too late to abandon it. Is the best thing just to keep going now?

A: No. The only things that are being implemented are those that do not require new law. Indeed, it has been argued that this confirms the point that, for the government to achieve its publicly stated goals, it does not need any new legislation at all.

The provisions in the Bill go very far beyond anything that has taken place so far, as reflected by NHS Chief Executive Sir David Nicholson’s famous statement that the changes are [“so great you can see them from space”](#). Much of the current discussion on how to implement the Bill addresses relatively minor incremental changes, although to those directly involved they are disruptive and damaging. But passage of the Bill will result in a complete reordering of the system, which will move the whole of the NHS into a regulated competitive market.

In any case, would any rational person recommend that if you are going in the wrong direction but have come a long way already, then it’s best for you to keep going?

Q14: If the NHS is so good why must we now fight to keep it?

A: The foundation of the NHS was a great act of social solidarity in the aftermath of the Second World War, a period when the UK had huge debts. The [intention](#) was that people should be freed from the fear of the financial consequences of illness and that good health care should be available to all regardless of wealth. In the face of the challenges of extended old age, increased range and cost of treatments, rising patient expectations and the global financial crisis, the NHS still manages to be one of the most cost-effective and equitable health services in the world. And the [public love it](#). But to the corporate sector, a successful public service merely represents an unexploited profit opportunity.

So the politicians for ideological reasons, and the private sector for financial reasons, have had the NHS – traditionally publicly funded, publicly delivered and publicly accountable – in their sights for some time. They have [acted together](#), beneath the radar, to drive through this Bill in order to turn the NHS from an integrated public service into a branding attached to a market of competing, mainly private, providers. Those who are interested in how this happened should consult the 2011 book [“The Plot against the NHS”](#). Since the 1980s, successive governments have pursued a policy towards the NHS that the electorate hasn’t voted for and doesn’t want, a profoundly anti-democratic state of affairs.