

Unite Health and Social Care Bill Briefing



Commons Second Reading

Monday, January 31, 2011

The thinking behind the Bill: The NHS White Paper, July 2010

In July, just 42 working days after promising the end to “top-down NHS re-organisations”, the coalition published the White Paper, Equity and excellence: liberating the NHS, which proposed sweeping structural changes. An NHS analysis concluded: “There is no doubt the White Paper signals the biggest re-organisation of the NHS in its history”.

Strategic Health Authorities (SHA) and Primary Care Trusts (PCTs) that currently oversee health at a regional and local level will be abolished, with local GPs forced to form consortia that will take on commissioning services. They will have to buy services from “any willing provider”, including private companies, and patients will be able to get treatment from profit-making providers at the NHS tariff. The White Paper explicitly refers to the patient as “consumer”.

The consortia will be accountable to the NHS Commissioning Board, a centralised quango with the power to assign GPs to a consortium and allocate resources to them. It will also commission other “family” health services directly. The board will be accountable to the Department of Health for managing within an annual limit but there will be significant independence from ministerial oversight in law. The board will also take over some functions of the National Institute for Health and Clinical Excellence (NICE).

The public health functions of PCTs will be taken over by a new Public Health Service and Local Health and Wellbeing Boards.

Meanwhile, all NHS Trusts will become (or be taken over by) Foundation Trusts. They will be de-regulated and the White Paper says that they will be given “the opportunity” to become employee-led social enterprises. The White Paper states that Foundation Trusts will not be privatised, but does not say how this will be prevented within the context of competition law. The Bill provides no detail on either of these aims.

The White Paper opened consultation on extending the current freedoms that Foundation Trusts have, including abolishing the limit on private income, enabling mergers and ability to change their own governance. These are reflected in the Bill.

The White Paper says that they will all be able to determine their own pay scales, a move that seems designed to smash the power of trade unions to protect their staff or oppose the break-up of the NHS.

Changes to the system of regulation are similarly modelled around a market system. Monitor (currently the regulator for Foundation Trusts) will become an “economic regulator” for both health and social care. Its remit will be to promote competition, using the Office of Fair Trading (OFT) powers to apply competition law to both privately and publicly funded health and social care services; regulate pricing with flexibility between an ‘efficient’ or ‘maximum’ price; authorise “special funding arrangements for essential services that would otherwise be unviable” (with agreement of the Commissioning Board and subject to rules on state aid); intervene directly in the event of failure; undertake market studies and refer structural problems to the Competition Commission.

A body called HealthWatch will be created to act as the voice for the “consumer”.

NHS WHITE PAPER: ANALYSIS

In summary, the White Paper continues with the divide between commissioners and providers that has been used in previous policies for an “internal market” within the NHS, where the primary sector “commissions” secondary treatment.

However, it is fundamentally different from such initiatives as carried out under the Labour government. Nor is it simply a reversion to the more radical market-based policies of the last Conservative government, despite the echoes of GP fund-holding.

These largely aimed to create an internal market, in which NHS units perform the functions of buyer and seller in an attempt to generate the perceived efficiencies of a market within the closed economy of a single public service, albeit with a tendency towards deliberate fragmentation in the name of diversity and decentralisation. The coalition’s policy is quite different – not so much an internal as external market.

It seems to draw some inspiration from the more radical neo-liberal ideas of the state as a

commissioner, not provider, of services, in which the public sector’s role was simply to hand over taxpayers’ cash to the cheapest private company that could provide the service. This model was applied to areas like local government and the national rail network, but the NHS was a step too far – until now.

The White Paper heralds several major steps towards this end goal. Firstly, by ensuring that the consortia commission “any willing provider” and allowing patients to insist upon doing so as individual consumers, they open the door to private providers to compete directly with the NHS in a healthcare market.

Secondly, by abolishing NHS Trusts, encouraging the resulting Foundation Trusts to behave as profit-making companies, and ultimately allowing them to become “social enterprises”, it heralds the slow-motion privatisation of the NHS provision itself.

As NHS Trusts became Foundation Trusts, which then became increasingly profit-oriented, then became independent “social enterprises”, the NHS would eventually become somewhere between a franchise chain and an accreditation scheme. Ultimately, if EU competition law were applied, then private corporations might seek to compete with the social enterprises to take over directly.

In fact, the coalition’s plans go a step even beyond simply creating a market in healthcare provision, by effectively privatising the commissioning side as well.

In one sense, this will be the direct result of the White Paper, because GP practices are already effectively small private business, and many GPs undertake private practice alongside NHS services. Removing the NHS Primary Care Trusts and passing their functions on to the GP consortia is therefore a form of privatisation in itself – not least as a number of the consortia have incorporated as limited companies. It should also be noted that over 200 GP surgeries are also owned and run by the private sector, often in the guise of large corporations like Assura and Virgin, under the existing Alternative Providers of Medical Services programme.

Perhaps more significant, however, is the role that the private sector will play in the operation of commissioning itself. This is a specific set of management skills that most GPs will not be able to undertake themselves, but corporations in both the health sector and more generally, for example in the management consultancy and accountancy sectors, will be able to offer services that compete with the former PCT staff or whatever in-house capacity the consortia may be able to develop.

The only part of the NHS which seems to remain secure as a completely public sector organisation in the normal sense is the NHS Commissioning Board, which seems set to become a powerful bureaucracy accountable only for limiting spending.

In international health policy terms, the government's long term aim is to replace "socialised healthcare" with something closer to a "single-payer insurance" model, where the government insures citizens for the cost of healthcare that is provided by private companies in a free market, with the only twist being that (for now) it is funded through general taxation rather than an insurance scheme in the usual sense.

This appears to be the sentiment behind the superficially reassuring promise in the opening paragraph of the White Paper, that the government "upholds the values and principles of the NHS: of a comprehensive service, available to all, free at the point of use and based on clinical need, not the ability to pay." (The coalition uses this in the narrow sense of the NHS paying for healthcare, not providing it.)

The result will be quite different in nature to the NHS as we know it, which will be caught in a pincer movement of privatisation. Both primary and secondary sectors, both the "commissioners" and "providers", will have taken the first steps towards privatisation, with the next steps clearly signposted in the White Paper as well. Ultimately, that will undermine even the government's limited concept of the values of the NHS, because healthcare delivered for private profit can only be driven by the financial needs of the provider, not the clinical needs of the individual patient – let alone those of society as a whole.

HEALTH AND SOCIAL CARE BILL – PART 1: COMMISSIONING

One of the major changes proposed by the Bill is the creation of commissioning consortia, which is outlined in Clauses 9-10 and 21-24 and Schedule 2.

There are a number of general concerns about the practical implications of this change.

WHO COMMISSIONS?

Firstly, there is question of management capacity. Who will undertake the actual work of commissioning?

Existing GP Practices: If GPs do in fact take on commissioning themselves then this would seem to damage care as their time and energy was taken away from treating patients; and they may not have the expertise to carry out these functions or the related management and financial functions.

Former PCT staff: Many former PCT staff expect to immediately take jobs with the consortia and continue their previous role, potentially on more lucrative salaries or as consultants. They will, however, be entitled to large redundancy pay outs due to the scrapping of the PCT – the Impact Assessment to the Bill suggests that the overall redundancy cost is about £48,000 per person and totals over £1bn. Health Service Journal estimated that PCT staff would be awarded £55,000 each on average. This is a staggering waste if many of these people will walk straight out of the door of the PCT and in to the consortium. One ex-PCT head has told his MP that he will receive a £250,000 payout from the NHS – and the following week start work, at a higher salary, as head of commissioning for the consortium.

Private consultants: Many of the new consortia will instead take on consultants from the private sector, who are already aggressively marketing their management, legal, financial and other services to the pathfinder consortia. For example, one of the largest pathfinders, Great West in London, has hired UnitedHealth. These firms will ultimately cost more because they need to satisfy shareholders and will often have higher pay for

senior execs, which we will pay for as taxpayers. They may also have conflicts of interest where they are work for both commissioners and providers.

None of these options appear to be a sensible route from a public policy or taxpayer value standpoint. Even if the government is determined to push ahead with its new commissioning arrangements, it would make far more sense for the existing staff of PCTs to be transferred to the new consortia. Any redundancies would be limited to those necessary in the locality and the overall cost would be vastly reduced. Nor would private sector involvement, or more red tape for doctors, be needed.

The suspicion will arise that this process has been designed precisely to allow entry in to the market by private corporations, regardless of the cost to the public purse.

POSTCODE LOTTERY

There is a very real danger that this Bill will create a "postcode lottery" in which there are wide variations in the type and quality of care or treatments available in different geographical areas and a consequent effect on health inequalities.

The government appears to have climbed down from the previous suggestion that there would be no boundaries for consortia, with Clause 21 (1) specifying that the consortia will not "coincide or overlap" [p25, line 32] but this just means that the option to move in to the catchment area of a different consortium will only be available to those with the means to move house. It also leaves open the possibility that consortia could cover discrete but not unified areas, resembling US health maintenance organisations.

There is also a danger that certain types of provision, e.g. more complex and expensive treatment like mental health care, will not be commissioned; or that other types of provision, such as family planning, fall in the cracks between the consortia and the local authorities' public health function, with neither side wishes to devote the resources to commissioning it.

The Bill also leaves open how to ensure provision for people not registered with a GP. Coverage of people not registered with practices – such as homeless, travellers and other vulnerable groups – is a major question in relation to health inequality. But the Bill simply states that further regulations may provide for consortia to have further responsibility for those with a "prescribed connection" with their catchment area. [Clause 9 (3)]

CONFLICTS OF INTEREST

The new commissioning arrangements also seem to give huge scope for conflicts of interest. Firstly, there is a conflict between GPs' role as budget holders and commissioners of services and as clinicians, which could lead to the rationing of care. But there is also the problem that many commissioners may also be providers; and that doctors might easily acquire financial interests, such as shares.

The safeguards that the Bill provides, however, are extremely weak. The constitution of a consortium must "make provision for dealing with conflicts of interests of members or employees of the commissioning consortium". [Schedule 2, p227] The consortium can write its own policy – not only are they self-regulating but they can even write the regulations.

Nor are they even obliged to have any policy relating to anyone except members or employees. This provides for a simple loophole where private companies are undertaking the commissioning function – they can simply be contracted rather than directly employed.

REMUNERATION

A related problem is that the terms of the Bill give rise to fears that doctors may be able to pay themselves banker-style bonuses and import private sector pay in to health.

The Commissioning Board will conduct a performance assessment of the consortia every financial year, assessing not only health quality

outcomes but also financial management criteria. [Clause 22] On the basis of this assessment, the Board may pay a bonus. The Board may also make advance payments to a consortium before the end of the financial year if it is “likely to perform well during that year”. It also makes explicit that individual doctors can receive this directly as a bonus:

A commissioning consortium may distribute any payments received by it under this section among its members in such proportions as it considers appropriate.

Despite suggestions that the consortia would be regarded as NHS bodies for staff pay, the Bill states that a consortium may “pay its employees such remuneration as it sees fit” and “employ them on such other terms and conditions as it may determine”. [Schedule 2]

CORPORATE FORM AND TRANSPARENCY

Adding to these concerns, the Bill does not specify what legal form the consortia should take. Many will be Community Interest Companies, which do not distribute profits and have “asset locks” preventing their property ending up in private hands. But the Bill seems to leave open the possibility that they may be limited companies or even unincorporated associations, and a number of the initial consortia are private companies, which seems to raise the possibility that they will pay dividends to the members, i.e. GP practices.

Though there have been legal opinions [e.g. Beachcroft for HSJ] that the consortia will be public bodies, it is not made clear in the Bill that this will be the case for purposes such as the Freedom of Information Act or public sector pay and it is unclear how this would work where they are private limited companies.

Instead, there is separate provision in the Bill [Schedule 2] for regulations “requiring a commissioning consortium to publish ... prescribed information relating to the remuneration determined by it” or for the Board to “publish guidance for commissioning consortia

on the determination of remuneration”. This seems to leave pay transparency or restraint entirely in the gift of the Board and ministers. Nor would it address a consultants or contractors as opposed to employees.

The Bill also allows consortia to appoint committees made up partly or entirely of lay representatives at their discretion. Again, this is weak – the consortium may choose to be overseen by anyone it appoints – and leaves the regulation to the regulated.

HEALTH AND SOCIAL CARE BILL – PART 1: OTHER ISSUES

EU OBLIGATIONS

Clause 15 provides the Secretary of State with powers to require the Board or commissioning consortia to implement any obligations relating to EU health functions. This needs further clarification, as it unclear what types of obligation the government has in mind, especially considering that the EU’s remit on health care is fairly limited. Worryingly, however, the major EU legislation on health has been under the market and treated health care as a service industry, not a public service.

For example, there may be some concern about the eventual shape of the EU Cross-Border Health Services Directive, which at one stage envisaged a system in which richer individuals could “queue jump” by getting private treatment abroad using the NHS tariff, which they could then top up. Though many of these issues have now been overtaken by the far more drastic internal changes in this Bill, the application of EU law could make them impossible for future governments to reverse.

There is also the wider concern that this clause may be used to apply EU competition law in a way that would make the healthcare market irreversible. It is not made clear how these powers might be used, or, for example, why only the Board and consortia are covered.

SECURE PSYCHIATRIC FACILITIES

Clause 12 sets out a separate regime for the secure psychiatric facilities at Broadmoor and elsewhere. Currently NHS Trusts, which will be abolished, the NHS Commissioning Board will now commission new providers. The Secretary of State must authorise these and has powers to direct them in any way but it is left unclear how the government intends to use these.

It is unclear how this relates to the provision for existing NHS Trusts to become Foundation Trusts – will this be case with the existing secure facilities? Or might they be privatised entirely, evading the rules preventing this for other NHS services? Or, on the other hand, might they remain directly provided by the NHS, meaning that those detained in such facilities, for instance, the Yorkshire Ripper, are the last NHS patients in Britain?

DUTIES OF THE SECRETARY OF STATE

The changes in Clause 1 go to the heart of the government's view of the NHS, changing the government's duty from that (in the NHS Act 2006) to "provide or secure the provision of services" to "act with a view to securing the provision of services" when dealing with the Board, consortia and local authorities. Clauses 2-4 then set out duties to improve quality, reduce inequalities and promote autonomy but (unlike, for example, in the later sections on the duties of the regulator) there is no guidance on how contradictions in these might be resolved.

HEALTH AND SOCIAL CARE BILL – PART 3: ECONOMIC REGULATION

Part 3 of the Bill goes to the heart of the government's approach to health, setting out the framework for economic regulation and in particular the role of the regulator, Monitor.

DUTIES

Monitor's primary duty is set out in a way that views patients as consumers: "to protect and promote the interests of people who use health care services ... by promoting competition" and "through regulation where necessary". [Clause 51]

Where "any of its general duties conflict with each other, it must secure that the conflict is resolved in the manner it considers best" – a rather sweeping provision that seems to give Monitor a very wide scope. [Clause 55]

The role of Monitor as a wide-ranging enforcer of competition is concerning, not least as the organisation's bureaucracy has already enthusiastically advocated a mix of deeper cuts and more privatisation.

It seems to view itself as much a promoter of foundation trusts as a regulator of them in the public interest, for example being found by judicial review to have failed in its duty to enforce the cap on private patient income and accused of ignoring local authority concerns about FT service changes.

The role of regulating Foundation Trusts (FTs) might conflict with the wider economic role, and the fact that all Trusts will be Foundation Trusts only makes that problem worse. For example, Monitor might need to decide whether or not to rule that a FT which bids for too much work from commissioners, as they will be incentivised to do within a market system, could end up blocking the development of the wider market.

The Bill sets out a series of provisions in Clause 55 that are intended to legally direct Monitor to avoid this conflict of interest, for example instructing it to ignore its duties towards Foundation Trusts when carrying out other duties.

Where Monitor "secures the resolution of a conflict between its general duties" in a matter that has a "significant impact" on providers, users, or the public in England, Monitor must publish a statement – a rather weak form of accountability.

If “the Secretary of State considers that Monitor is failing”, they may “direct” Monitor to perform the functions that it is failing in, and in the absence of it doing so, the Secretary of State may take over its functions or transfer them – but it is unclear what kind of contingency the government has in mind.

COMPETITION LAW

Clause 60 gives Monitor powers under competition law that it can use concurrently with the Office of Fair Trading.

The application of competition law to healthcare is extremely concerning, as if the full weight of EU competition law came to apply to the NHS as if it were a service industry then the process of privatisation would not only be accelerated but might become entirely irreversible.

It should also be read in conjunction with the Impact Assessment that these powers can be invoked where a private provider complains that a commissioner is favouring the “incumbent provider” – such as the local NHS Foundation Trust.

Monitor would then be able to investigate local GPs with full enforcement powers and levy a penalty of up to 10% of turnover where there has been anti-competitive practice. In extreme cases, criminal offences can be prosecuted.

This may be unlikely, but just the prospect of it may be a useful weapon for private providers in influencing local GPs to commission their services and counteract political pressure to save local NHS hospitals.

Clause 15 in Part 1 may also open up concerns regarding EU competition law.

DESIGNATION OF SERVICES

Chapter 3 of this Part creates a new system for “designating” particular NHS services where continuity of care must be maintained even in the case of provider failure. For example, a local A&E ward may be “designated” a vital service

that cannot be threatened by the Foundation Trust becoming bankrupt. Any service that is not designated will be allowed to fail if it cannot compete.

This will raise a number of concerns for MPs, particularly as the government has made it clear that the market must over-rule objections from local representatives, and that their constituents will be consumers, not citizens, for the market to work.

Clause 69 outlines the system for designation: a commissioner (local GPs or the Board) will be able to apply to Monitor for the designation of a service e.g. local GPs may request that their local A&E, or hospital, is “designated”. The commissioner must also consult local authorities, HealthWatch – and rival providers of that service.

Monitor then makes the ultimate decision itself, based on the criteria that ceasing to provide that service would have a “significant adverse impact on the health of a person in need of the service” or cause failure to prevent an adverse impact.

This appears to be subject to “the absence of alternative arrangements for the provision of the service”, however – which may mean that Monitor will have to decide between different hospitals or other services, especially in large cities.

The Bill does not appear to envisage that being designated will be the preference for providers, however. It allows the provider of a designated service to appeal to the First-tier Tribunal against a designation if it is based on an error of fact or law, or is unreasonable. [Clause 70]

This is because designation will incur higher costs as the provider will need to pay a premium in to a risk-pooling scheme, set out in Chapter 7 of Part 3, which will mean either it charges higher prices and has a competitive disadvantage, or that it will need to absorb that cost itself.

Where the provider of a designated service fails, a “health special administration” regime is set out in Chapters 6 and 7 of Part 3. The most alarming sections are contained in Clauses 115 and 117, which allow for an NHS provider that has failed to be transferred where it cannot be

rescued. In particular, it can be transferred not only to another Foundation Trust, but to “another licence holder” – including a private company – and that it may include the transfer of property. This opens up the prospect of entire NHS hospitals ending up in private hands.

LICENSING

Chapter 4 of Part 3 sets out Monitor’s function of licensing health care providers.

Clause 81 provides that all NHS Foundation Trusts will be automatically licensed. However, these licences carry conditions that grant Monitor wide-ranging powers over the providers in pushing markets. For example, Clause 90 states that standard conditions of a licence “may include conditions ... requiring the licence holder to do, or not to do, specified things (or to do, or not do, specified things in a specified manner) in order to promote competition in the provision of health care services”.

The Impact Assessment makes slightly clearer what this might mean, suggesting that NHS hospitals would be required to share operating theatres and brain scanners with their private rivals.

PRICING

Chapter 5 of Part 3 gives Monitor powers to determine pricing throughout the NHS.

One of the most alarming features of the Bill is that this includes [Clause 103] the power to set a maximum price rather than a national tariff or formula for determining a local price. This opens the door to competition based on price rather than quality, despite this not being a stated aim of government policy. There is wide ranging evidence that price competition leads to reducing quality.

HEALTH AND SOCIAL CARE BILL – PART 4: NHS FOUNDATION TRUSTS

Part 5 of the Bill deals with the secondary care side of the NHS – Foundation Trusts, and the

remaining NHS Trusts.

Clause 164 states that these will all become Foundation Trusts by 2014, but gives the Secretary of State powers to vary the date – more clarification is needed on this.

This move in itself is alarming as many of the NHS Trusts are not prepared to become Foundation Trusts, and might not even have been authorised by Monitor had they applied. Where there are serious financial concerns, there must be doubts that these hospitals or other services can survive in a free market, at least without service reconfigurations or restructures – which in practice usually amounts to closed departments and redundancies.

Other provisions are also concerning.

LIFTING THE PRIVATE PATIENT CAP

Clause 150 removes the existing cap on Foundation Trusts providing private health care. This means that they can now expand their private health businesses in to as great a proportion of their overall service as they wish – NHS patients may find themselves a minority in their own hospitals.

That in turn will often mean that NHS patients lose out, as private patients are occupying beds, facilities and services. NHS waiting times may rise, while patients are marketed the option of paying to jump the queue. Indeed, it may create a perverse incentive to do that – cutting against even the government’s limited concept of the NHS as healthcare provided free and allocated according to need.

The government’s Impact Assessment acknowledged the “risk that private patients may be prioritised above NHS patients” but doubted this would happen, for arguable reasons, such as FTs’ inability to distribute profits. They can, however, pay bonuses. The argument that existing FTs have not maximised their private income ignores the planned market expansion, and relies on a period when demand for private health was dramatically falling along with NHS

waiting times. That may now be reversed. Furthermore, the government envisage non-European Economic Area (EEA) foreign patients being a major growth area, so domestic demand may be irrelevant. This could affect community cohesion given the likelihood of press stories about health tourists blocking NHS patients, potentially with an effective taxpayer subsidy in the form of overheads.

Combined with forced opening of NHS facilities to private companies, this will mean creeping privatisation even within what remains of the NHS. It may further open up hospitals to EU competition law, especially if a majority of income is private. There is also a legal opinion from Beachcroft suggesting that they would be open to a "state aid" case because of the effective cross-subsidy of private patients.

REMOVING THE ASSET LOCK

Clause 148 contains a provision deleting the Section 45 of Labour's 2006 NHS Act. That Section contains an "asset lock" on Foundation Hospitals, requiring the regulator's approval before designated property, which is set out in their original authorisation to become a Foundation Trust, is disposed of.

Existing NHS Trust property is designated in this way where the regulator considered that it was necessary for the Foundation Trust's purpose of providing NHS health care. Otherwise there might be a danger that a FT sells property to deal with short-term financial problems or for other purposes not directly related to health needs.

This protection will now be removed, providing another potential route by which public assets will end up in private hands.

BORROWING

Similarly the removal of the prudential borrowing code, also in Clause 148, is designed to de-regulate Foundation Trusts with regard to activities that would be appropriate for a private provider, in this case borrowing rather than asset sales.

The Department of Health is planning to create a borrowing facility to replace access to public dividend capital, and as public borrowing is always cheaper, there are good reasons that this should generally be preferred to FTs borrowing in financial markets using public assets as collateral. Again, there needs to be strong protection against NHS assets ending up in owned by private companies rather than public services. The Bill seems to weaken the existing oversight instead.

SOCIAL ENTERPRISE

Government plans to allow NHS Foundation Trusts to become employee-led social enterprises are not reflected in the Bill.

It is unclear whether they have quietly performed a u-turn on this, or they believe that that can do it through existing powers.

If the latter, this is concerning because the legislation governing Foundation Trusts was always intended that they would be governed by a mix of patients, public and staff rather than just one of those groups.

If the government intends that individual services within a hospital will be contracted out to social enterprises, rather than the entire FT being run and governed as such, then this simply opens up the danger that the social enterprise itself will be considered a competitor in the marketplace and the service it provides subject to competitive tendering in future.

Ultimately, that is another potential path to even the remaining NHS Foundation Trusts gradually becoming privatised.

HEALTH AND SOCIAL CARE BILL – PART 5: PUBLIC INVOLVEMENT AND LOCAL GOVERNMENT

Chapter 1 of Part 5 deals with the creation of "Healthwatch" and Chapter 2 sets out the involvement of local authorities.

HEALTHWATCH

Healthwatch will represent users of health services and the public (or, as the White Paper put it, the “consumer”) by providing advice on their views to the Secretary of State, NHS Commissioning Board, Monitor and local authorities. This power is by definition entirely advisory and there is not much detail on what recourse the body might have should it feel that its views have been ignored.

Local Healthwatch will perform these functions on a local authority level, and the Clause 170 makes provision for these local organisations to provide the independent advocacy service for individual patients that local authorities must provide, though the Bill does not oblige them to do so via Healthwatch. This may lead to concern that in the context of swingeing cuts to local authorities, councils may choose the cheapest option.

The local organisations are also based on local authority areas, which may not coincide with the commissioning consortia, let alone hospital catchments. A large consortium covering several Healthwatch organisations may have much more clout than any of them.

LOCAL GOVERNMENT

Clause 178 only requires the new Health and Well-being Boards to have “at least one” councillor, whereas there are a number of senior officers. There are also single representatives from consortia (and all the relevant consortia may be represented by one designated person) and local Healthwatch. The rest of the Board is entirely up to the local authority to decide. There is a strong case for both a more democratic voice, with an elected majority, and a requirement for representation of staff through recognised trade unions.

Their role and powers will be strictly limited – for example, Clause 179 lists a number of duties on integrated working, all of which are framed by the word “encourage”. Powers are largely left to the Secretary of State to determine through regulations under Clause 175, which may include

a requirement for NHS bodies or providers to consult the local authority and powers for the local authority to then refer matters to the government, regulator or the Board.

Neither local authorities nor Healthwatch will have powers that would allow them to over-ride competition or prevent privatisation.

HEALTH AND SOCIAL CARE BILL – PART 8: NICE

Part 8 of the Bill establishes the National Institute for Health and Care Excellence (NICE) as a body corporate (it is currently a Special Health Authority) and makes various provisions for it.

This is, however, effectively a downgrading of the existing role of NICE, which was established to end the “postcode lottery” of different PCTs commissioning different treatments. The pharmaceuticals industry had long lobbied for such a change as NICE’s role in technology appraisal had restricted their ability to sell expensive drugs to the NHS.

Though Clause 221 provides power for the Secretary of State to issue regulations requiring consortia to make funding available within three months for treatments that NICE recommends, and Clause 225 allows the NHS Commissioning Board to direct NICE to issue commissioning guidance, the overall effect is to reduce NICE to a body that issues advice rather than clear directions.

Clause 224 also gives the Secretary of State power to make arrangements for NICE to provide services to “other persons”. The Explanatory Notes suggest that this might include “pharmaceutical companies”. [EN para 1149] This raises concern that NICE might end up with conflicts of interest if it is advising drug manufacturers privately while separately making recommendations on their products in the public interest.

It is concerning that the legislation downgrades NICE while the government is still consulting on

replacements. For example, the Department of Health consultation “A new value based system for the pricing of branded medicines” sets out proposals for the pricing of drugs in which NICE will have an appraisal and advisory role. However, the consultation (and related ministerial statements in the press) suggests that major decisions affecting the pricing of individual drugs might be made with the direct involvement of ministers. Given the conflicts of interest that arise with the connections of Conservative ministers to the pharmaceuticals and private health industries, this is a significant and controversial issue. This area should be further scrutinised during the passage of the Bill.

HEALTH AND SOCIAL CARE BILL – PART 10: ABOLITION OF ARMS LENGTH BODIES

Part 10 of the Bill deals with the abolition of various arms length bodies following the Department’s review. This may be an opportunity to discuss some of the bodies (mainly not dealt with here) where the government is considering privatisation, especially where they may do so without separate primary legislation.

Clause 262 abolishes the NHS Institute, and the Explanatory Notes suggest that powers in Part 1 will allow it to be partially absorbed by the Commissioning Board. This needs clarification, however, not least regarding the government’s previous statement that “alternative commercial delivery models” might be explored, which seemed to imply privatisation.

HEALTH AND SOCIAL CARE BILL – PART 11: MISCELLANEOUS

Clauses 274 and 275 in Part 11 deal with transfers of property, liability or staff due to changes made in the Bill, with further details in Schedule 21 (on property) and Schedule 22 (staff).

Clause 274 gives the Secretary of State wide-ranging powers to make transfer schemes, or direct the NHS Commissioning Board or a qualifying company (this means a company partly

or wholly owned by the government for NHS purposes) to do so, including detailed instructions as to how to do so.

Staff transfers may make provision that is “the same or similar” to the TUPE regulations.

Perhaps the most alarming provision in these sections of the Bill is contained in Schedule 21, which lists in detail the different transfer schemes that may be effected under Clauses 274-275.

Specifically, these include the transfers of Primary Care Trust or Strategic Health Authority property to “Any other person who provides services as part of the health service in England and consents to the transfer”.

This means that private companies that are providing services to the NHS would be allowed to take over NHS property.

These provisions are not repeated in Schedule 22, so could not be used to transfer staff.

Property and staff of other bodies that are abolished in the Bill are subject to far more prescriptive transfer schemes that generally specify the government or other NHS bodies.

Further clarification is needed on the circumstances in which ministers would hand over NHS assets to private providers and why they need powers to do; restrictions on public property ending up in private hands are also needed in these sections of the Bill.

There may also be some concern on transfers to the commissioning consortia where these are private, potentially profit-making, companies.

Both of these concerns relate to the general drift of the Bill, but these Clauses may provide a specific route to addressing them.

