

## Health and Social Care Bill

### Questions which must be asked about this Bill by the Public Bill Committee

Unite believes that the speed with which this bill is progressing through Parliament – from rough proposals in July 2010 to probable law by summer 2011 – is intended to stop MPs thoroughly examining how these far-reaching proposals will change the ownership and operation of our most significant public institution.

We urge MPs on the Public Bill Committee to use this opportunity to ask the following vitally important questions:

#### **Will the Bill regulate the use of private provision or accelerate their control over the NHS?**

Is taxpayers' property being handed over to big business? Unite believes there is a genuine risk of this and that the Bill should be amended to put locks on NHS assets.

**What will happen to NHS assets under this Bill?** The Bill deletes retention of the existing regulation of Foundation Trust disposals of designated assets, so who will regulate their disposal?

In the event of a Foundation Trust or hospital going “bust”, for example, will the assets remain in public hands use following an insolvency.

The failure regime must be improved. The Bill seems to allow even those services “designated” as essential to end up in private hands as a result of the special health administration regime, whereas those not designated could simply go bust.

Can the Bill be amended to ensure that public assets do not fall into private hands?

Can the Bill be amended to ensure that the public can have a say on what is a designated service to protect health services?

When Foundation Hospitals were first introduced, the then minister Hazel Blears was explicit that these assets must always remain in community hands; is the Coalition government reneging on this promise?

How can FTs be prevented from borrowing excessively using NHS assets as collateral? **Why are the regulator's powers concerning compulsory access to NHS facilities so vague? Is this to ease the entry of private sector providers into the new free market?**

Unite's concerns about the regulator's power to enforce access to facilities have been confirmed by the government's explicit proposals for this in the Impact Assessments. This access is entirely on the basis of economic reasons with a view to opening up the market.

Monitor's powers and duties need to be clarified and, if need be, changed. This enforced access is a specific example of the insidious privatisation of the NHS that will occur unseen.

Is it the government's intention, for instance, to force NHS hospitals to share operating theatres and so forth with private providers, regardless of whether this causes NHS patients discomfort or prolonged suffering?

How can the Bill be altered to ensure that access to NHS facilities is purely on clinical grounds so that clinical factors trump economic?

Will the consequence of a large-scale access enforcement regime be that an NHS provider would need fewer staff or even that they might be transferred along with the facility?

### **Private Patient Income cap**

Unite opposes the lifting of the private patient income cap. We urge MPs to consider an amendment tightening up the use of any proceeds and restricting any extension of private provision at the expense of NHS patients. The BMA has specifically proposed an amendment along these lines.

Will MPs act to place a duty on FTs so that, in expanding private patient provision they cannot reduce the services available to NHS patients, only create new capacity.

### **Corporate subsidies**

One of the more alarming discoveries in the Impact Assessments was the proposal to create a “fair playing field” by subsidising private providers at the expense of the NHS. The government believes that the NHS distorts the playing field and so the Bill must correct it.

This is contrary to the spirit of claims by ministers that they do not intend to do so, and outright contradict those made by Liberal Democrat internal briefings and letters to constituents which claim that the Bill would actively prevent such a practice.

Unless MPs alter the Bill, the NHS – and therefore UK taxpayers – will be paying 14 percent of the costs of private providers, not to enhance patient care but solely to ensure that they can create a free market in health.

Will MPs insert provision that will stop corporate subsidies being decided by Monitor?

Will MPs also act to stop private sector from attacking NHS employees' pension rights or other such measures which private providers will claim give the NHS a cost advantage?

### **Definition of NHS**

What and whom is our NHS for? The Bill has thrown this sixty year certainty into question.

What are the legal duties of the Secretary of State for Health – and what will they be if this Bill is passed without amendment?

And will there be regulation of the NHS branding? How will it be used by private providers to ensure public trust is not undermined?

### **Care vs competition**

#### **No price competition**

The provision for maximum tariff pricing has caused alarm across the political and industrial spectrum. The medical organisations and professional bodies are opposed, as are many experts and even those who are generally supportive of the government's approach, e.g. The LSE's Professor Julian Le Grand.

Will competition be on the basis of price or quality of care? Although government states that it will be on care quality, safeguards are needed to ensure this.

The Bill should be amended so that it is Monitor's duty when setting prices to ensure that competition is always on quality, not price.

### **The role of Monitor**

An over-powerful Monitor would undermine the entire concept of GP-led commissioning.

The primacy of economic regulation as Monitor's first duty, alongside the powerful position of the regulator within the overall healthcare system, is a particularly dangerous combination in relation to its general approach as well as in specific functions like pricing.

How can the Bill be amended to strengthen its duties towards health outcomes rather than competition.

The powers of Monitor, for example, could be restricted to ensure that they are used in a way that is compatible with delivering healthcare and that there is recourse against heavy handed approaches. This would act against the more extreme scenarios like GP surgeries being raided for evidence of anti-competitive behaviour.

The BMA has proposed an amendment with particular concern for how GPs may come under pressure to conform to competition law and could even face investigation and legal action – the “remedies” that the Impact Assessments referred to.

### **Allowing ethical commissioning**

Another part of this package will be to consist of guarantees that commissioning will not be done purely on the basis of cost, or even just cost and quality, but can also take account of wider factors such as sustainability or even ethics.

Similarly, consortia may wish to take account of other factors, e.g. they may wish to prefer their local hospital because limiting the use of transport also means limiting the number of traffic accidents and the amount of pollution.

More obviously, they will want the ability to resist loss leaders or providers who might offer better treatment for the simplest cases but refuse to take on the more complex cases, and thus risk ending up with no willing provider for them.

### **How will commissioning work for patients?**

What is the reach of the 'Any Willing Provider'? Will consortia be permitted to commission particular providers rather than simply decide what types of treatment they will offer at all?

There is a view that they will be compelled to offer all patients a choice of any nationally licensed provider who offers the relevant treatment and has applied to the consortium, though the Department of Health seem to be denying this. It is therefore a point of some confusion.

'Any Willing Provider' does not have a legislative base so is not dealt with specifically in the Bill. This is a point that the government could technically leave open and only reveal after the Bill has passed.

## **Improving Transparency and Accountability**

### **Stopping super-salaries**

The Bill should be amended to deal with high pay at the top including

- mechanisms for pay transparency
- chief execs should be within pay salary scales and part of collective bargaining

- applying the rules on salaries greater than the Prime Minister's

The following bodies would need to be covered by salary regulation:

- GP consortia - though we would need to look at including contractors
- NHS Commissioning Board
- Monitor
- Care Quality Commission
- Foundation Trusts
- Other providers – so capturing the would-be private providers

There are already some provisions in place, for example allowing ministers to set regulations governing pay of consortia members and employees and a requirement for ministerial approval of pay policies for the Board and Monitor.

However, we need clarification on what regulation the government intend to bring in, if they intend to do so at all.

Furthermore, it is important that we attempt to extend this to private companies undertaking the commissioning on behalf of consortia, and to ensure that commercial confidentiality is not a valid exemption as it would be under the Freedom of Information Act.

More importantly, it will be important to extend whatever provisions already apply to all providers of NHS services rather than just the NHS Foundation Trusts or other existing NHS bodies.

### **Preventing conflicts of interest**

The new market risks conflicts of interest between commissioners and providers, and the proposed safeguards against this in the Bill are very weak, allowing consortia to write their own rules.

Will MPs support amendments to create a register of interests, or compel consortia to do so?

The creation of a register of interests for prescribing doctors was a key recommendation of the 2005 Health Select Committee inquiry into The Influence of the Pharmaceutical Industry, and was at one point a policy of the Scottish government, but does not seem to have ever been implemented.

It was telling that the ABPI's justification (in 2005) for the current system was that self-regulation had been proved to work by the House of Commons. The lessons of that scandal have now been learned, but the government may be sowing the seeds for another by extending the market in health.

And will ministers give Health and Wellbeing Boards some power over consortia in their local authority areas? Hundreds of GP surgeries will be run by private sector providers who might then find themselves able to influence commissioning in markets

where their parent companies are seeking to sell. Such conflicts of interest need to be guarded against.

Arrangements on interests should reach beyond just members and employees of consortia and in to contractors who undertake commissioning functions themselves. This goes to the heart of the functioning of a market with private interests being able to shape the public service. This is about protecting the honest doctor rather than suggesting that there is widespread bad practice or corruption.

### **Will this Bill allow vast parts of the new health market to sit outside Freedom of Information provisions and the equality act?**

Will MPs ensure that any health care provider is covered by the FOI and the equality act. The Bill defines the consortia as public bodies for purposes of the Freedom of Information Act by replacing that Act's reference to PCTs with the consortia. Similarly, it maintains the Freedom of Information Act's provisions covering primary care providers and NHS Foundation Trusts.

There is a serious concern about commercial confidentiality, which provides a wide-ranging exemption under Section 43 of the Fol Act.

Such exemptions sit uncomfortably with the government's rhetoric about information and accountability.

This Bill might also be an opportunity to extend greater transparency and accountability to Foundation Trusts where that is desirable. Obviously the key point will be to ensure that transparency is improved for all providers, i.e. particularly focusing on the private sector, and this will bring us back to the point about what the NHS actually is under the Bill.

### **Will the lack of accountability put the new regime out of Parliament's reach?**

What powers will Parliament retain to direct the National Health Service in the wake of this Bill?

There remains the concern that the series of arms-length relationships and non-public providers that will make up the new-look health service will place it out of the reach of Parliamentary scrutiny. The Bill makes some weak provisions for Select Committees to request information from the NHS bodies but the indirect relationships between them and the Secretary of State, who is accountable to Parliament, leaves open what the scope of ordinary Parliamentary Questions and other Parliamentary processes will be in relation to their work.

Even more concerning will be the scope of Parliamentary scrutiny over providers and consortia who are even further removed from the Secretary of State.

Amendments on Fol and other transparency rules should go hand in hand with provisions to guarantee that all the NHS bodies, including all providers, will be accountable to Parliament, especially as this is likely to be something that attracts wider political support in Parliament itself.

### **How transparent and accountable are the Health and Wellbeing Boards?**

One way of strengthening transparency and accountability might be to increase the powers of the local boards, which are not entirely clear and fairly weak where they are. This uses one of the government's own proposed innovations.

There are a number of areas in which the Boards' powers could be expanded; as an example, the Boards could be given powers to require information, without protection of commercial confidentiality, from consortia, their contractors, and all providers of NHS care in their area. Thus this could also be used as a way of bringing firms contracted to undertake commissioning functions in to the range of public accountability, which would sit with the concept of the Boards overseeing the consortia in a strategic way.

### **Democratising the Boards**

Currently the Boards have a minimum of just one elected councillor, and where that is the case there will be more officers of the local authority than members of it. There is a case for ensuring that at least half of the Board are elected councillors, for example, and obviously for staff representation.

The weakness of the government's current plans for democratic oversight in health can be neatly contrasted with the proposals for elected police commissioners.

### **Strengthening powers of HealthWatch**

A similar approach to the Health and Wellbeing Boards might be applied to HealthWatch, which is currently toothless. In particular, ensuring that the body had powers over private providers means that it could be used to expose them for bad practice and/or deter them from the market in a similar way to other provisions for further transparency and oversight.

### **Will private providers erode pay to boost profits? Will standards fall? How will training of NHS professionals be supported by a fractured system of many providers?**

#### **Banning the two-tier workforce**

All providers should be part of the Agenda for Change national collective bargaining. Where private providers are making profits not through efficiency but simply through poorer working conditions, this is unlikely to lead to higher quality care.

The government's recent abolition of the code of practice that prevented a two-tier workforce by enforcing the "no less favourable" rule for contracted out services raises the prospect that private providers will meet the national tariff while still making a profit margin simply by driving down the wages and conditions of their staff. This would in itself lead to poorer standards of care.

Decent pay and conditions leads to better standards of care. And separate, local bargaining means more bureaucracy and higher management costs as every FT would need its own HR department.

#### **National oversight of training and education**

The Bill does not seem to specify where responsibility and funding training and education will lie. Presumably this will be a matter for the NHS Commissioning Board but that does not seem to be spelt out.

The assumption might be that this would be a matter for regulations or the Secretary of State's directions to the Board or the annual mandate.

It needs to be made clear that training and education and future workforce development is maintained at a national level, undertaken with a strategic and long-term view rather than left to local bodies or market forces.

## **Other issues which need close examination**

### **Why is there a deadline for Foundation status of 2014? This is not for clinical reasons.**

The Bill sets a deadline for all NHS Trusts to become Foundation Trusts by April 2014.

This is damaging on a number of levels, for example risking the financial stability or even viability of some existing NHS providers, and potentially meaning an early end to national bargaining for workers.

It also shows that the government is working to a political timetable rather than one that is designed around the needs of health or the health service.

The Bill also includes power to vary the date, but the government has not clarified on what basis they would choose to use it except in the vaguest terms.

### **No to EU law?**

Clause 15, extends EU health competence over the NHS. This Clause ushers in the extension of European competition law to the NHS and as such is one of the most dangerous elements of the Bill.

Its inclusion may reflect Andrew Lansley's pro-European leanings.