Concerns about the Health and Care Bill 2021

Health Policy Progress Group

INTRODUCTION:

The Health and Care Bill now in parliament is the culmination of a decades-long series of legislative steps which have repurposed the NHS away from its original Beveridge-model, tax-funded universal comprehensive care delivered by employees of the state.

It creates the legal platform for the final transformation of the NHS by exposure to market forces within a legal framework that advantages large private sector actors.

The result is designed to destroy GP provision and NHS hospital care as we have known it, and will result in less effective, patchier, costlier care in future.

CONTEXT:

The most strategically important legal changes buried in this legislation must be placed in historical context to be fully understood. In the 1980s, a privatisation blueprint was co-authored by Oliver Letwin and John Redwood — 'Britain's Biggest Enterprise': https://www.cps.org.uk/files/reports/original/111027171245-BritainsBiggestEnterprise1988.pdf, which has been implemented by the various Acts of Parliament affecting the NHS since then.

The Health and Care Bill 2021 shows clear progression from the 2012 Health and Social Care Act, and no changes of direction away from the completion of the Letwin & Redwood NHS privatisation plan, which has over the last three decades deliberately brought the NHS to this point. It may have been helpful that Mrs Letwin reportedly became director of legal

services at the Department of Health during this time: https://www.lawgazette.co.uk/analysis/the-gong-show-2013/68852.article

This is not a Bill that could be amended to make it good, or even to make it barely acceptable: it is a privatisation bill. It needs to be discarded and we should instead seek legal changes which would move us toward restoration of Bevan's NHS.

Further, it is important not to be confused by the current calls for more public money to pay for the NHS. The NHS has only become so expensive latterly because it is funding not only an unnecessary market administration, and Private Finance Initiative profiteers, but also an ever-increasing range of profit-driven health industry corporations.

KEY CONCERNS:

1. This Bill paves the way for private hospitals accessed through the GP services outsourced to the insurance industry to take over provision of care, in the form of "Integrated Care Schemes".

   The Bill further hollows out the structure and authority of the NHS at the national/central level, to leave care provided as much as possible by private hospitals, accessed through referrals from insurance-industry-run integrated care schemes http://www.energyroyd.org.uk/archives/14951 .

   In the end state of these changes, there will be no more NHS GPs, no more NHS hospitals, and the role of the state will be merely to pay for these private entities to profiteer at the expense of the citizenry.

   The new system will resemble a state-organised Kaiser Permanente style insurance-based medical care system, which was explained to one US President as a means to disguise for-profit activities as non-profit, and one which will reward GPs and/or their employers for denying needed care to patients. During the 1971 conversation between President Richard Nixon and John D. Ehrlichman that led to the HMO act of 1973:

Ehrlichman: "Edgar Kaiser is running his Permanente deal for profit. And the reason that he can … the reason he can do it … I had Edgar Kaiser come in … talk to me about this and I went into it in some depth. All the incentives are toward less medical care, because … the less care they give them, the more money they make."

[Source: University of Virginia Check – February 17, 1971, 5:26 pm – 5:53 pm, Oval Office Conversation 450-23. Look for: tape rmn_e450c.]

https://www.investmentwatchblog.com/nixon-and-ehrlichman-discuss-kaiser-permanente-in-1971/ .

It will be funded through higher National Insurance deductions from wages, and maybe direct "co-payments for care, which are legalised by the Bill. Care will be supplied less and less by public sector hospitals and more and more by private sector healthcare industry players such as Hospital Corporation of America.

https://www.mirror.co.uk/news/uk-news/nhs-hospital-corporation-america-donates-2246513

https://www.independent.co.uk/life-style/health-and-families/health-news/world-s-largest-private-healthcare-company-hca-plans-expansion-nhs-8659439.html and Virgin

https://www.nhsforsale.info/wp-content/uploads/2019/05/short-contract-report-2_3_2018-1.pdf .

Virgin's medical operation has already used the "patient choice" concept of competition law as a way to access income from the NHS budget https://www.ccpanel.org.uk/cases/index.html .

2. The Bill's Schedule 6 removes the universal care guarantee that has long been at the heart of the NHS and the Bill enables the introduction of charging for NHS services.

   Sections 86-92 hollow out the remaining minimal state functions in controlling the NHS.

The powers of the Secretary of State can be delegated to other entities, which can later be quietly abolished, or merely kept so underfunded that they will do nothing.

Section 89 legalises charging for NHS services provided by Health Education England, the Health & Social Care Information Centre, the Health Research Authority, the Human Fertilisation & Embryology Authority, the Human Tissue Authority, and NHS England. This legalisation heralds defunding by the state of these organisations, with the Secretary of State delegating the decisions to charge fees in order to enable “plausible deniability” at government level.

Large and inappropriate flexibility is added to arrangements for charging for NHS services, which will enable quiet defunding and disposal of NHS assets at local level.

3. It completes the transformation of NHS England from a provider of services to a purchaser.

   There is a cessation of commitment of provision of healthcare concealed in the first section’s name change: the NHS Commissioning Board, responsible for purchasing and not providing, will assume the name NHS England which previously referred to an organisation with responsibility for the whole system, both purchasing internally and externally, and ensuring provision of care.

   "NHS England" is reduced to a purchaser and competition-regulating entity which may use private sector secondees (sections 5 & 11) or even outsource parts of its work to private companies.

   This heralds the completion of the promise made to potential investors in a privatised NHS made in 2010 by Mark Britnell (NHS Commissioning Director, then KPMG partner):

   > "***In future, the NHS will be a state insurance provider not a state deliverer. In future ‘any willing provider’ from the private sector will be able to sell goods & services to the system.***"

4. It paves the way for a monopoly takeover by private health corporations.

   Section 69 removes the Health and Social Care Bill's section 75, which forces competition on price and quality criteria, and blocks private sector monopoly control of NHS services. This much-vaunted repeal of section 75 will leave, not a public sector NHS as its proponents have hoped, but a part-competitive environment hostile to prioritisation of patient outcomes. It will favour maximisation of private profits and establishment of private sector monopolies and oligopolies within the NHS. This article briefly explains the issue as part of a recap of the NHS privatisation a couple of years ago: https://www.lrb.co.uk/the-paper/v41/n21/john-furse/the-nhs-dismantled

   Section 67 strengthens patient choice, which looks attractive but it is a Trojan Horse for application of competition law favouring entry of for-profit providers for higher-profit services. These will drain income out of NHS hospitals so they will no longer be able to cover their overheads, and thus speed their insolvency and disposal by The Special Administrator, whose functions are transferred to NHS England by section 59.

   Section 75's removal and the 2021 Health and Care bill's refocus on patient choice are the bait and switch to sell the completion of Letwin's plan as its reversal.

5. It allows private corporations to take control of health budgets.

   Private companies furthering their own commercial interests are allowed to be involved in the management of the Integrated Care Boards which will take over management of what were our GP services. NHS hospitals will be in direct competition with private hospitals which will compete for those services on which the NHS hospitals could have made a surplus to cover essential but loss-making services.

   This will add to the financial destabilisation already delivered by usurious Private Finance Initiative fees, and take them into the "Special Administrator" insolvency regime (see section 58 and Schedule 8 of the Bill). The Special Administrator's role is to break them up and dispose of the remnants into the private sector.

6. It prevents doctors and NHS managers from putting patient care first

   Patient welfare is now just one of three desiderata in treatment choices. It is the second aim of the new ”triple aim duty” added by sections 4, 43 and 57, requiring decisions to reflect public health, individual patient interests, economic priorities. This new “triple aim duty” deprioritises individual patient welfare as the absolute goal of medical treatment, in favour of abstract ideas about public health and economic efficiency, to bind all NHS hospitals.

   Lack of prioritisation of “first do no harm” to patients will create an ethical minefield for doctors. It sets a dangerous precedent for patient welfare.