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Policy Paper

Duty to care:
In defence of universal health care

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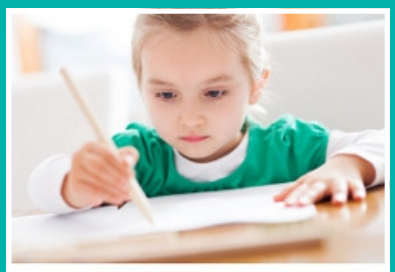

December 2012 marked the 70th anniversary of the Beveridge Report, significant not only for its content but also for its context. In the midst of World War II, with a budget deficit and national debt that makes today's look negligible, the Report laid the basis for the radical reforms introduced by the Labour Government in 1945.

If war-time Britain could summon up the energy and hope to build a better world in 1945, this generation certainly can too. Seventy years ago the Beveridge Report announced the pursuit of a new settlement, one that would dramatically change the structure of Britain for the better. With this in mind, this series of work looks at what Beveridge's analysis of society can teach us about the Giant Evils of today and how we use this to chart an alternative course for a welfare state - or *Social State* - fit for a new settlement in 2015.

This paper was commissioned as part of the series to address the Giant Evil of 'disease' and to propose new policy priorities for health after the next election.

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Executive summary

The Beveridge Report of 1942 noted the threat to society from the Giant Evil of 'disease' and announced the intention to provide a nationwide health service which would cover medical treatment for all requirements. In 1946 the aim was embodied in law and in 1948 the NHS came into being. The NHS has been an international model ever since because it provided what no other country in the world has achieved at the same cost: universal health care in the form of equal access to comprehensive care, irrespective of personal income. The Health and Social Care Bill 2011 passed into law without an electoral mandate because no major political party or parliamentary institution in England was willing or able to defend the NHS and the principles it encapsulated. It was a constitutional outrage.

The NHS model

In this paper, we first show how the original welfare state model of the NHS enshrined government responsibility for universal health care in the duty on the Secretary of State to secure or provide comprehensive health services. The architects of the NHS recognised that equity in health care could only be achieved by sharing the risks and costs of care across the whole of society from rich to poor and from healthy to sick. It was for this reason they embedded solidarity and collective provision into the structures and mechanisms underpinning the system of funding and for delivery of care. Behind these arrangements was the Secretary of State's core duty to provide or secure a comprehensive health service, a duty repealed by the first clause of the Health and Social Care Act. The duty originated in 1946 legislation that made the government responsible for provision to the whole population of all medical, dental and nursing care.

Abolishing the duty and with it universal healthcare

Secondly, we describe how the duty was abolished under the Health and Social Care Act and look at what this means for health care in England. While the duty to provide comprehensive health care to the whole population was in place, the government was limited in the extent to which it could open health services to the market and introduce user charges. Abolition of the duty makes it easier to

transform the English NHS from a nationally-mandated public service into a number of fragmented and competing services based on commercial contracting and providers with limited accountability. The consequences for equity of provision, funding and access are substantial. Quite simply, markets do not and cannot deliver equitable, comprehensive health care; that is not what they are for.

A political response

Finally, we argue that reinstatement of the duty and the system it encapsulates must be the cornerstone of health policy in a Social State. England is not alone in its assault on universal health care. Across Europe countries are cutting health service budgets in order to deal with public and private debts created by the banking crisis. These policies are being forced on Greece, Spain, Italy and Portugal by the loan conditions imposed by the IMF, the European Union and the European Central Bank. In all countries, as in England, households are being forced to take on more of the financial risks of illness. Proponents of the argument that tax-financed or 'free' health care is a privilege we can no longer afford are unable to explain why universal health care was instituted when the world's economy was very much smaller than it is today. If the UK could create an NHS when the country was literally bankrupt, why in England (but not in Scotland or Wales) can the government not sustain the NHS today? The answer of course is political not financial. By removing the mandate on government to provide a health service, the Health and Social Care Act 2012 is the crowning achievement of those who would destroy the systems that underpin universality. Our response must be political too.

Introduction

At 2.36 in the afternoon of Tuesday 27 March 2012, immediately after prayers from the Lord Bishop of Ripon and Leeds, the Health and Social Care Bill 2011, repealing the legal foundations of the NHS in England, was given royal assent and became law. It was a dry and formal end to a tumultuous parliamentary passage, for the Bill had not reached the statute book without a struggle. Campaigning groups, NHS staff and professional organisations had fought for nearly 2 years against what must count as one of the most regressive pieces of UK legislation of the last 60 years. Promoted using the rhetoric of 'patient choice', in reality the Bill challenged tax-funded health care and public provision by introducing structures borrowed from an American insurance industry notorious for its high cost and unfairness.

Rarely can a reform have traded under colours as false as this. That the Bill became law in the end is testimony not to our robust democratic processes, but to the autocratic power of government. The Coalition came to office in May 2010 on a manifesto promising no further top-down reform of the NHS, and then promptly did the opposite. The Labour Party's own market reform record, many elements of which, like privatisation of clinical care, the Coalition was now implementing with new vigour, stifled its opposition.

The Bill passed into law without an electoral mandate because no major political party or parliamentary institution in England was willing or able to defend the NHS. It was a constitutional outrage. Its passing marked the end of a National Health Service in England that for more than sixty years served as one of the most successful models in the world, widely praised and copied.

The Beveridge Report of 1942 announced the intention to provide a nationwide health service for all citizens that would cover medical treatment for all requirements, a notion which finally came to fruition in 1948 when the National Health Service was created. The NHS became an international model because it provided what no other country in the world has achieved at the same cost: universal health care in the form of equal access to comprehensive care, irrespective of personal income.

For most of its existence the NHS was based on the principle that the poor, the chronically sick and the frail elderly would receive the best available care only if the rich received the same service. Since the 1970s, and throughout the 1990s, we have witnessed a dismantling of publicly-funded long term care services, including nursing care for the elderly and those with mental illness, and the huge inequalities in access and provision that have accompanied it. The same applies to NHS dentistry. The Health and Social Care Act is a prelude to the adoption of these stratagems for hospital and primary care because it repeals the law ensuring that everyone, wherever they live, rich or poor, receives equal treatment for equal need.

In this paper, we first show how the original welfare state model of the NHS enshrined government responsibility for universal health care in the duty on the Secretary of State to secure or provide comprehensive health services. Secondly, we describe how the duty was abolished under the Health and Social Care Act and look at what this means for health care in the UK. Finally, we argue that reinstatement of that duty, and the ideals it encapsulates, must be the cornerstone of health policy in a Social State and for any future plans to undo the catastrophic policy adopted by the Coalition government.

The NHS model

"Medical treatment covering all requirements will be provided for all citizens by a national health service" William Beveridge, 1942[1].

Ushered in on 5 July 1948 the UK NHS was established to provide to the entire population of the UK, health care free at the point of delivery. Its aim was to treat all alike on the basis of need and not on the basis of ability to pay. Charity, market-based provision and National Insurance schemes had failed to deliver the universal health care that the nation required. In the 1930s, only 43% of the population were covered by the National Insurance scheme, and these were mainly men and only for the services of general practitioners. More than 21 million people, mainly women and children, were not covered by the scheme, and the sick carried the burden of paying for their care. It was not until the Second World War that the population had a taste of universal health care when the government created the emergency bed services and emergency medical service which brought all hospitals under government control.

The UK NHS was created by national consensus in order to ensure that every citizen was guaranteed health care. For the first time the population as a whole would have 'freedom from fear' and above all freedom from the costs of ill health. The NHS was only one of the pillars of the new welfare state. As Beveridge scathingly noted "want is a needless scandal due to not taking the trouble to prevent it - it is well within the economic resources of the country to prevent it". During the war years he had been asked by the government to work on a plan for eradicating what he termed the five giants: ignorance, idleness, want, disease, and squalor. His report, The Plan for Social Security and Allied Social Services[2], was published in 1944 and sold out within 24 hours. It bequeathed to a nation, worn out from war, a huge programme of reform, which would bring public services to the forefront of redistribution, equity, and a more just society. The NHS would become an international model.

The architects of the NHS recognised that equity in health care could only be achieved by sharing the risks and costs of care across the whole of society from rich to poor and from healthy to sick. It is well established that poverty and ill health are closely associated. The poor have higher rates of sickness and illness than the wealthy. Risk sharing means that those with the highest needs must not be

penalised for being both sick and poor. So solidarity and collective provision were built into the structures for funding and delivering care.

Whilst a commitment to central taxation was seen as the most progressive and efficient way of pooling the costs of health care, it was also recognised that services must be integrated so patients could not be denied care or passed from one service to another to save money or avoid high cost individuals. The higher costs of delivering services to rural communities must be shared with urban communities because the cost of ensuring access to services is greater in more remote areas. Expensive treatments or rare conditions such as bone marrow transplant and blood transfusion services require service integration and risk sharing so that the less expensive parts of the service or investigations subsidise the more expensive. When a patient was admitted for a routine operation and required ventilation and intensive care, the cost of this treatment was spread across the whole system.

Integration was enshrined in a system of public administration that ruled out the division of services into separate profit opportunities that would prevent spreading costs across the system. Furthermore, until 2012, administration was based on geographical areas organised in upper and lower level tiers. These were known variously as regional and strategic health authorities, area health authorities, district health authorities and, ultimately, primary care trusts. These organisations covered all citizens (temporary or permanent) resident within their borders. Resources were channelled to them on the basis of measurements of the whole population's health care needs. No-one was to be excluded. Crucially each organisation had responsibility for ensuring provision in accordance with need, so all hospitals and services were accountable to the authority responsible for their area and under its direct management. Only in this way could provision for the needs of the population be planned. And until 1990 this is what integration meant: control by a single area-based authority over all budgets, services, planning and needs assessment. However, the model would be seriously disrupted in 1990 by the injection, at Margaret Thatcher's insistence, of competition among hospitals.

The Secretary of State's duty to provide

Underpinning these arrangements was the Secretary of State's core duty to provide or secure a comprehensive health service, a duty repealed by the first clause of the

Health and Social Care Act. Repeal was the fulcrum of the free market agenda because the duty compelled the minister to allocate resources according to need instead of leaving allocation to a combination of market forces, actuarial measures and unaccountable organisations.

The duty originated in 1946 legislation that made the government responsible for provision to the whole population of all medical, dental and nursing care. Sections 1 and 3 of the National Health Service Act 1946 required the Minister of Health to promote free of charge:

> **"the establishment in England and Wales of a comprehensive health service for the prevention, diagnosis and treatment of illness",** and to do so by providing **"to such extent as he considers necessary to meet all reasonable requirements […] (a) hospital accommodation; (b) medical, nursing and other services required at or for the purposes of hospitals; (c) the services of specialists, whether at a hospital, a health centre […] or a clinic or, if necessary on medical grounds, at the home of the patient…"**[3]

These essential legal principles were to remain unchanged for more than sixty years and, following the introduction of equivalent legislation in Scotland, they ensured equitable and comprehensive health care throughout the United Kingdom. They were essential because a minister may only be held to account legally for services that he or she is responsible for by law. Their repeal was a hugely controversial moment in the history of the NHS in England. No previous reform, and there were many, had been designed actually to abolish this national principle although many inroads had been made into the structures necessary to deliver it.

The determination of the government to push the legal change through in the face of a barrage of criticism served only to underline the strategic nature of the measure: that the proposed market system, was inconsistent with the NHS founding duty. Quite simply, markets do not and cannot deliver equitable, comprehensive health care; that is not what they are for. Given a duty to provide comprehensive health care to the whole population, the government was required to design an administrative system that would allow it to discharge that responsibility. Such a system would be inclusive, covering everyone. On the other hand, if the duty were to be the promotion of a market, the structures that would follow would be those consistent with the strategies of corporations, namely the freedom to select services

and patients on commercial grounds. If markets were to be introduced, the universal provision duty had to go.

Legal functions are therefore the key to health system structures, which is why the government stuck fast to its repeal of the duty to provide throughout the long parliamentary debates. The classification of health systems according to their method of financing has tended to obscure this fundamental fact. Traditionally, health systems have been distinguished according to how they raise money. Since 1948, most funding for health care in the UK has been raised through general taxes. Individuals and businesses are not mandated to contribute to the costs of health care except as part of their general duty to pay taxes. Instead, the government has been mandated to provide universal health care free at the point of delivery.

Financing methods reflect government duties and responsibilities and the structures that governments put in place to discharge them. Tax-financed systems are associated with directly managed health care facilities rather than commercial contracting methods of control. Most NHS-type systems around the world are based on a mandate similar to the UK's and on administrative structures designed to allocate health care resources according to need.

The distinctive NHS method has served for many years as an international model because it has proved to be the most efficient and surest route to universal access yet discovered.

Why the administrative system is important for universality

Distinctive administrative functions flow from the minister's duty to provide and the assumption by the government of responsibility for the costs of comprehensive health care to the whole population. Their focus is on needs assessment and resource allocation across geographic populations in order that no-one can slip through the net or go without care. The NHS is a prime example of how to nurture a geographic approach so as to ensure inclusiveness. The system has encouraged extensive data collection and analysis of population health, health inequalities and access to health care by social class and ethnicity.

The approach is entirely different in market systems. Here financial risks are allocated across different parts of the system through market contracting, and there

is no duty to provide services on a comprehensive basis or to collect data on a geographic basis. Instead, administrative functions in market systems focus on fragmenting the population, the services and the risk pool in order to facilitate cherry picking or cream skimming by insurers and providers, members or enrollees. Providers compete for the profitable patients and services. It was this system that the Health and Social Care Act was intended to usher in by launching an attack on NHS 'red tape'.

The attack on 'red tape'

From 1948 to 2012 the NHS was the vehicle whereby the government was made responsible by parliament for providing equitable health care but a succession of statutory changes increasingly undermined the government's capacity to carry out this function efficiently, especially so far as hospitals were concerned. Market-orientated reforms began in 1990 with the introduction of a purchaser-provider split and the new approach of 'commissioning' (known as the internal market). Commissioning meant that hospitals were detached from their areas and needs based planning. Instead, they were expected to stand alone and compete with one another for NHS funds. By 2000, under the banner of 'money follows patients' the government had begun paying hospitals on the basis of the work they could attract from other hospitals – the more work they got, the more money they received. Those that could not compete would go to the wall. In 2003 a new type of public hospital called a Foundation Trust was created. Foundation Trusts were put beyond ministerial control so as to give market forces more influence over hospital policy. Opportunities for contracting out clinical care gradually increased so that by 2008 the Department of Health experimented with a policy of full competition on the provider side. Meanwhile, commercial contracting had grown substantially in primary care and the general practice sector.

However, whereas most of the changes prior to 2012 involved reducing government control over the various components of the health system and creating measures to give the private sector market opportunities, the new Act attacked the fundamental control mechanism, namely the area-based system of public administration. That system had served for more than sixty years to keep expenditure under control whilst seeking to ensure resources were efficiently allocated and distributed

according to need and the duty to provide comprehensive cover on behalf of the whole population.

Within weeks of the UK's 2010 general election, the new Coalition government laid out plans to "liberate" the English NHS. The "natural condition of organisations", it proclaimed, "ought to be freedom rather than being shackled"[4]. A factsheet was published to hammer home the message:

> **"We're moving away from top-down organisation and control. We're removing targets that tie up NHS staff in red tape and we're getting politicians out of decision-making. We're removing whole tiers of management that sit above doctors and nurses and instead giving them the power to decide what's best for their patients. We're giving patients more choice and control over their care, rather than managers telling them what they get. Our changes are about simplifying and modernising the NHS; not top-down change." [5]**

The inclusion of patient choice in the message had become the standard way of promoting market over government control.

But the administrative tiers and resource allocation mechanisms could not be abolished and replaced with a market system if the Secretary of State's duty to provide were retained. So long as the duty was there the government would have to ensure the continuation of a broadly similar funding and administrative system because this was the only way in which it could meet its responsibility to provide for everyone's health care needs. If the duty were abolished, as the Act decreed, the government could strip out the administrative tiers through which universality had been secured, namely strategic health authorities and primary care trusts. In abolishing the duty, the Act therefore took market reform further than previous governments.

The new administrative structures that have replaced primary care trusts, Clinical Commissioning Groups (CCGs), are not area-based and do not have responsibility for all the health care needs of all residents. Instead, like insurance companies, the groups are based on the principle of membership: each groups is responsible for some of the health care needs of the people who are patients of its constituent general practices. CCGs have some freedom to enroll and disenroll members and

unlike primary care trusts, there are no obligations on CCGS to ensure provision to residents within an area except for a very limited range of services.

The strategy behind the Health and Social Care Act

The administrative change was achieved by absolving government from responsibility for the full financial risk of health care (by repealing the duty to provide) and by passing financial risk on to a range of funders, some of which are outside central government. Risks were passed to clinical commissioning groups, local authorities, public and private providers, the public and, ultimately, patients. An administrative system dedicated purely to the assumption of risk by government was no longer required in law because the government had ceased to bear full financial responsibility for meeting the principle of providing equal care for equal need. Accordingly, primary care trusts were superfluous to the new market bureaucracy which would rely on risk selection mechanisms.

The whole reform package was sold as a means of doing essentially the same as before but using competition or patient choice, rather than administrative controls, to do it more efficiently. Following economic theory, the government argued that in an ideal world external or market pressure was necessary to prevent providers pursuing their own interests, hospitals admitting more patients than necessary and doctors prescribing or referring patients to hospital without proper regard for costs.

How the duty was repealed

Until 2012, the first and foremost duty placed on government by NHS founding legislation was the duty to provide comprehensive health services throughout England and Wales. In 1946, the Act which created the NHS read:

> **"(1) It shall be the duty of the Minister of Health […] to promote the establishment in England and Wales of a comprehensive health service […] and for that purpose to provide or secure the effective provision of services in accordance with the following provisions of this Act".**

By 2006, the wording, though slightly weakened and modified, remained broadly the same:

> **"(1) The Secretary of State must continue the promotion in England of a comprehensive health service […] (2) The Secretary of State must for that purpose provide or secure the provision of services in accordance with this Act".**

In each case, the phrase "in accordance with this act" was a reference to, among other things, the specific services that were deemed part of a comprehensive health service.

The government's approach to the legislative process that would change this long-standing duty and their policy rationale was less than candid. In fact, it was a flagrant misrepresentation. For a start, the enormity of the change was only apparent to those capable of understanding draft legislation. In contrast to the simplicity of the 1946 legislation and the leaflet that went to every household, the language in the 2011 Bill obscured its main purpose. When first introduced to the House of Commons, the Health and Social Care Bill 2011 began:

> **"(1) Section 1 of the National Health Service Act 2006 (Secretary of State's duty to promote health service) is amended as follows. (2) For subsection (2) substitute - "(2) For that purpose, the Secretary of State—**
>
> **(a) has the public health functions conferred by this Act, and**
>
> **(b) in exercising functions in relation to a body mentioned in subsection (2A), must act with a view to securing the provision of services for the purposes of the health service in accordance with this Act.."[6]**

The key phrase here is “For subsection [2] substitute”. Subsection [2] of the NHS Act 2006 was the governmental duty to “provide or secure” that had been relied on since the NHS was created as the legal basis for a comprehensive health service. Scarcely can a fundamental change of duty have been so little advertised; but then this was not a measure that the government wanted to trumpet. The Coalition Government denials that a change of substance was taking place made the task of interpretation harder still. It was determined not to change this clause: when the Bill reached the House of Lords, its champion there, Earl Howe, would tell another peer that the Bill was “vital” but “in practice […] will change little”[7].

Barrister Peter Roderick exposed the true significance of the legal language. During the final six month passage of the Bill through the House of Lords, Peter and colleagues at Queen Mary, University of London published 15 detailed legal and public health briefings and several academic articles. These laid bare the government’s intentions. The government attacked its authors and rejected the analysis but was unable to say why it was wrong.

The government could not silence the growing number of critics such as Dr Clare Gerada, the chair of the powerful Royal College of Genera Practitioners (RCGP) which represented the majority of the GPs, the very same doctors who, according to the government, would be at the helm of CCGs and responsible for the allocation of NHS funds. The RCGP warned of the perils that lay ahead.

Nor could the government quell the growing public and political storm. Various alterations were made to the wording as the Bill wound its way through committees of the House of Commons and House of Lords as the government sought to placate and appease its critics. But the amendments were mainly cosmetic and offered no real concessions. Abolition of the duty to provide turned out to be a government red line, a measure it simply refused to give up. By 3rd February 2012, 239 amendments had been tabled to the Bill to be moved on report. Of these, 165 (mainly government) amendments were tabled on 1st February 2012. By the time the Lords voted through the Bill, Clause 1 of the Bill provided that, for the purpose of promoting a comprehensive health service, the Secretary of State “must exercise the functions conferred by this Act so as to secure that services are provided in accordance with this Act”. But this was not the same as the original wording and it did not restore the duty to provide. The Bill did not lay down a duty on the Secretary

of State to secure provision of health services but only a duty to exercise other functions to secure provision. So if the other functions conferred by the Act did not impose a duty on the Secretary of State to provide or secure provision, then he or she would have no duty to provide or to secure provision. Since another clause in the Bill removed the Secretary of State's duty to provide key listed services under the 2006 Act, the legal duty to provide services would disappear.

The legal link between the minister and health care provision was therefore broken and replaced by a series of limited, discretionary powers. As ministers cannot be responsible to Parliament for the exercise of functions that are not theirs, in future, MPs wanting to make recommendations to governments to improve services to patients would only have a miscellany of distant levers to pull. At best there was to be a line of accountability between Parliament and the new public body (the NHS Commissioning Board) set up by the Bill (and to which many of the former duties of the Secretary of State were to be transferred). But as a House of Lords Committee wrote in its report on the Bill:

> **"there is a constitutionally significant difference between ministerial responsibility to Parliament and the accountability of a public body (such as the NHS Commissioning Board) to a minister. In constitutional terms the latter can never be a substitute for the former because, in the latter case, Parliament is not involved. As the Minister correctly stated in his opening speech in the second reading debate, 'We in Parliament can only turn to the Secretary of State'. Parliament cannot call or hold the Chair of the Commissioning Board, for example, to constitutional account. A select committee can of course call him as a witness, but giving evidence as a witness to a committee and being liable to be held to account by Parliament are not the same thing." [8]**

Parliament would not therefore be able in future to hold the Secretary of State to account for failures in the provision of health services in the way it can now because there would be no legal duty to provide or to secure provision of those services. Instead, MPs, Lords and Select Committees would have to rely on a watered down duty to 'promote' a comprehensive health service, an emergency power of intervention and several discretionary powers. Without a stand-alone duty to secure provision, select committees wanting to make recommendations to governments to improve services to patients, would have fewer and less effective levers to pull.

The effect was to transform the English NHS from a nationally-mandated public service required of the government under primary legislation, into a service based on commercial contracting, underpinned by ministerial and local discretion and secondary legislation, and exacerbated by non-accountability to Parliament of commissioners and providers. Abolition of the duty of the Secretary of State to provide or secure provision of health services was the seminal change that brought this transformation about.

The government would not give way and restore the fundamental duty to secure and provide because its repeal was strategic, a direct consequence of the policy to abandon a system of health care delivered by public bodies under statutory duties. The Bill introduced a more discretionary and more market-based system in which the minister is at one remove from services to patients. It was an “abdication Bill”, as Lord Owen pointed out; it meant the loss of Ministerial control and responsibility for a national health service. The Minister could not be called to account by the people for the provision of comprehensive health care. This simple fact was lost in a debate that confused the primary duty of government with political micromanagement. That was always a misrepresentation (nobody was arguing that politicians should control the use of bed pans) but it served to distract attention from the knock-on effects of deregulation.

What does this mean for healthcare?

The abolition of the legal and statutory basis of the NHS[9]

Repeal of the Secretary of State's duty to secure or provide health services and its replacement by the weaker duty to "act with a view to securing" comprehensive services facilitated abolition of the Health Secretary's general powers of direction over NHS bodies and providers. Instead of controlling the health service, the minister's role will in future be focused on public health functions, which become the responsibility of local authorities. Significant consequences would follow.

New commissioning groups may determine who gets publicly financed care

For example, the Act repealed the Health Secretary to "provide [certain health services] throughout England, to such extent as he considers necessary to meet all reasonable requirements". Instead, new commissioning groups made up of general practices will "arrange for" the services necessary "to meet all reasonable requirements" and determine which services are "appropriate as parts of the health service". A commissioning group does not have a duty to provide a comprehensive range of services but only "such services or facilities as it considers appropriate". Nor must it arrange comprehensive services for all persons living in its area.

Commissioning groups will be responsible to NHS England (a new body set up by the Act) but the board will not have a power of general direction over the health services for which consortiums contract, or over patients' entitlements. Providers of health services will be subject to an independent regulator known as Monitor. But like commissioning groups, Monitor will not have a duty to ensure comprehensive provision for all residents or to ensure equity and universal access. Its general duty is only "to protect and promote the interests of people who use health care services".

Commissioning groups' duty to arrange for health service provision applies to their enrolled population, that is, the patients on the lists of the general practices that make up the group, not all residents living within a defined geographical area. Full implementation of the patient choice agenda, the banner under which reform was promoted, will mean that general practices, and therefore commissioning groups, will be able to accept patients regardless of where they live. Practices and

commissioning groups will be able to compete (and advertise) for patients from across the whole country just as private healthcare corporations and health insurers do now. They will of course also be able to reject costly patients.

Local authorities will become providers of last resort

Because the Secretary of State will no longer be able to ensure comprehensive, universal cover to all residents in geographically defined areas, the legislators have drafted a safety net whereby local authorities can be required to undertake NHS functions. Under the Act, the Health Secretary can require councils to provide "services or facilities for the prevention, diagnosis or treatment of illness". Local authorities alone have a duty to provide for geographical populations. Healthcare services that commissioning groups and market providers deem will threaten their financial viability can therefore be transferred out of the NHS in much the same way as long term care and continuing care responsibilities were transferred out in 1996. Patients who cannot get access to general practices or services of commissioning groups may have to default to local authorities, which would become the provider of last resort, and the core functions of the Health Secretary will shift to the chargeable local authority sector[10].

Loss of equity of access

The Secretary of State does not have a duty to promote equity of access apart from a vague duty to "have regard to the need to reduce inequalities between the people of England with respect to the benefits that they can obtain from the health service". The NHS Commissioning Board will not have a general power of direction over consortiums or be under a duty to ensure equal access for equal need to health services. A vague equity duty also applies to commissioning groups in the form of a requirement to "have regard to the need to reduce inequalities between patients". Equality of access is not a required outcome of commissioning groups' duty to secure "continuous improvement" from the provision of services; nor is it part of annual "commissioning plans" that groups will be required to prepare. These will cover only continuous improvement and the financial duty to break even.

Duty to provide services free of charge

There are new mechanisms to introduce charges and privately funded healthcare. The Secretary of State's duty to provide free services that are "part of the health

service in England", except where charges are expressly allowed, is undermined because the power under the Health and Medicines Act 1988 to impose charges is transferred from the Secretary of State to commissioning groups. Commissioning groups will determine which services are part of the health service and which are chargeable, and they have been given a general power to charge.

The cap on Foundation Trusts' generation of income from private care is raised, allowing them to earn almost half their income from non-NHS patients, thereby blurring boundaries between what is NHS-funded care and what is private. No longer a case of the duke and the dustman sharing the same NHS ward on the same terms; now Trusts will be in a race to generate income from private paying patients and the principle of equity will be disrupted further.

Abolition of direct control over NHS provision

The new commissioning groups will become budget holders and determine which primary services they contract, from whom, and at what cost. Patients may therefore be exposed to a plurality of primary care contractors for different services. All general practices will be required to join a commissioning group. Various bodies can apply to become a commissioning group, including Foundation Trusts and for-profit organisations that run general practices.

Increasingly, general practice and commissioning functions will be operated and managed by for-profit companies, 23 of which (including Virgin, Care UK, and Chilvers McCrae) already run 227 general practices. Professional autonomy will be eroded if, for example, referral management centres run by corporate providers are used to ensure referral and prescribing practices conform to corporate budgets and the needs of shareholders. These centres are currently rejecting one in eight general practitioner referrals and seem to operate along the lines of *prior authorisation arrangements* in the United States, whereby doctors are required to obtain approval from a higher authority before making a referral for treatment or investigation. Some of the centres, such as UnitedHealth UK's recently established *referral facilitation service* in Hounslow, London, are run by subsidiaries of US multinationals.

Abolition of NHS trusts

From 1 April 2014, all NHS hospital and community trusts are required to become Foundation Trusts. Foundation Trusts may enter into joint ventures with and

distribute surpluses to for-profit companies and raise commercial loans without restriction. For example, in May 2013, Cambridge University Hospitals entered a partnership with John Laing Investments and Ramsay Health Care UK to build a £120 million private hospital complex on Trust property. The NHS Commissioning Board and general practice consortiums will also have powers to form and invest in commercial companies.

Provider regulation will be overseen by Monitor with a duty to promote competition. Controversially, regulation by Monitor and the Quality Care Commission will be chiefly through commercial licensing and contracting and limited by a duty of "maximising the autonomy of individual commissioners and providers and minimising the obligations placed upon them". Regulators are required not to impose "unnecessary burdens" and regulation can be dispensed with, as more providers enter the marketplace. The "necessity" of public regulation can be challenged by corporations in the courts. Proposals by the European Commission to introduce such tests to health services created Europe-wide controversy in 2004, and had to be withdrawn because they were deemed to conflict with public health policies such as controls over market access. However, conflict between competition policy and the Health Secretary's duty to promote a comprehensive service will be resolved not by Parliament but by Monitor, "in the manner it considers best".

Chapter 2 of the Act introduces new competition duties that will allow remaining public controls over health services to be challenged by multinational companies and investors anywhere in the world. Trade rules outlaw public policies that prevent, restrict, or distort competition in trade within the UK or the European Union, such as setting prices, public subsidies for teaching and research, and controls designed to ensure fair distribution of resources. Rules on free movement of capital could undermine powers that the government proposes to reserve for protection of service continuity. One company, Circle, the first to take over a Foundation Trust, is already using competition rules to challenge a Primary Care Trust's decision to restrict the volume and range of services under the commercial contracts for NHS elective surgery. The government's own Cooperation and Competition Panel has warned that EU competition law could rule illegal non-competitive arrangements such as integrated care initiatives, cancer networks, data-sharing initiatives between hospitals or professional bodies, and specialised commissioning of stroke services.

The impact of deregulation

What deregulation means for free health services

In the absence of ministerial responsibility it becomes possible to blur the boundaries between free health care and chargeable social care. Many NHS services are being transferred to local authorities, which can charge for care. During the passage of the Health and Social Care Bill last year these services included[11]:

- immunisation, cancer and cardiovascular screening
- mental health care
- dental public health
- public health
- sexual health services
- management of drug and alcohol addiction
- emergency planning and health protection service
- child health services

The Act also abolishes rules that make certain health services mandatory. Under the Act, the following services are no longer required, by law, to be provided free of charge[12]:

- Services and facilities for pregnant women, women who are breast-feeding
- Services for both younger and older children
- Services for the prevention of illness
- Care of persons suffering from illness and their after-care
- Ambulance services
- Services for people with mental illness
- Dental public health services
- Sexual health services

Under this system, players in the health care market can choose the services they wish to provide and the patients for whom they provide. The principle is not, as the Coalition repeatedly claimed, increased patient choice but increased choice of patient.

What deregulation means for commercial control of health services

Deregulation opens up new possibilities for the private sector. Free of the responsibilities under which public bodies have to act, commercial firms can take on a larger health care role and assume greater control over resource use in the NHS. This is not an accident. The government is determined that commercial corporations, not doctors and other health professionals, shall control health spending. Accordingly, more and more NHS services are being put out to tender to for-profit companies and taxpayer funds are being given to commercial corporations whilst publicly run health facilities are closed down.

As the 2012 Act is being implemented, corporations will have more say in determining our entitlement to free health services. In future, no single organisation will be responsible for ensuring the health care of a whole area and it will no longer be clear who should be held accountable when things go wrong.

Our relationship with our doctor will change when for-profit companies run more services. As a patient we will no longer necessarily come first: how can we feel confident that our doctor is putting us first when he or she is an employee of a for-profit company and working to its financial targets. How will we know that we can trust our doctor when their clinical decisions about your tests and treatment are subject to approval by commercial concerns? These tensions are an everyday reality in the USA and market based health care.

Privatisation and marketisation have increased in advance of the Act. Some services, including those for the most vulnerable people in society, were last year contracted out to for-profit companies such as Virgin and Serco, which have little or no experience in delivering care. These include services for children with mental health problems and physical disabilities in Devon[13], and community nursing and health visitor services in Surrey[14] and Suffolk[15].

Many NHS hospitals are owned and operated under the expensive Private Finance Initiative, creating serious financial problems for them and putting neighbouring hospitals, accident and emergency departments and services at risk. For-profit companies and investors now control GP practices and other local health services.

According to the Financial Times, Virgin already earns around £200 million a year by running more than 100 NHS services nationwide, including GP surgeries[16]. A private company registered in the Virgin Islands now manages the local hospital in Huntingdon, Hinchingbrooke NHS Trust.

What deregulation means for patients

NHS staffing levels are emerging as a key concern of the Francis Inquiry[17] into substandard care at Mid Staffordshire hospital, where finances were put before patient care and staff numbers cut to save money. Inappropriate and low levels of staffing have previously come to light in the corporate nursing home and residential care sector through scandals like Winterbourne. Now Francis shows us that the same policies beset the acute hospital sector where in the pursuit of financial economies "no thought seems to have been given in any part of the system […] to the potential impact on patient safety and quality."

According to Francis, the solution is better training and regulation of staffing levels. The Department of Health responded by announcing an "independent study" of training and support for "healthcare and care assistants"[18]. But it has not said yet how it will respond to Francis's recommendations for "evidence-based tools for establishing the staffing needs of each service", and proper risk assessment "when changes to the numbers or skills of staff are under consideration".

Concerns that inquiry findings might be "diametrically opposed to the direction of travel set out by the government" were last year attributed to David Nicholson, when NHS Chief Executive[19]. The government plainly has a dilemma. The market brought in by the Health and Social Care Act extends the principle that care providers should be free to determine staffing levels, terms and conditions. Staffing norms (as opposed to minimum standards) contradict this market model.

In the USA, just as Francis has suggested was the case in Mid Staffordshire, studies of staffing levels in hospitals have found associations with mortality, infections, failure to rescue, and other outcomes[20]. Using this evidence, California established minimum staffing standards for hospitals in 2004 and improved hospital staffing levels[21]. In a study of patient safety, satisfaction, and quality of hospital care in 12 countries in Europe and the United States, improved work environments and

reduced ratios of patients to nurses were associated with increased care quality and patient satisfaction[22]. In European and US hospitals, after adjusting for hospital and nurse characteristics, nurses with better work environments were half as likely to report poor or fair care quality and give their hospitals poor or failing grades on patient safety. But in the USA, where the health care industry is politically powerful, investors have resisted government norms and standards. As Corporate Watch[23] and Spinwatch[24] have revealed in the UK and US many politicians have stakes in health care corporations and have major conflicts of interest. So patients suffer.

How the government is manufacturing NHS deficits to foster privatisation

On an almost daily basis, the media, with government assistance, pumps out bad news stories about the NHS. When the public was being prepared for the Health and Social Care Bill, the Prime Minister, the Secretary of State and his ministers, all criticized the poor performance of the NHS compared with other health systems. Their claims were debunked but the attacks have persisted not just on the system as a whole but on professional groups within it.

It is clear that the government is manufacturing a crisis and that by constant criticisms and reductions in service levels and quality they are shaking public confidence in the NHS. In this it is being assisted by its new appointees. Malcolm Grant, the Chair of NHS England (formerly the NHS Commissioning Board), who does not use the NHS, said in April 2013:

> **"It's not my responsibility to introduce new charging systems but it's something which a future government will wish to reflect [on], unless the economy has picked up sufficiently, because we can anticipate demand for NHS services rising by about 4 to 5 per cent per annum."**

There is no justification for that statement. Pro-market politicians and the Treasury have called for charges since 1948. Bevan resigned over the principle and put a marker down. Compare Grant's careless talk with the sentiments expressed by The Royal Commission on the NHS in 1979 which found against charging:

> **"We can say clearly the NHS is not suffering from a mortal disease susceptible only to heroic surgery. Already the NHS has achieved a great deal and embodies aspirations and ideals of great value. The advances to be made – and which undoubtedly will be made – will be brought about by constant application and vigilance."** [25]

We are being encouraged to accept the principle that we will, in future, have to pay privately for services that were once free. But claims that we can no longer afford the NHS are untrue.

The NHS is not over budget. Last year the NHS budget was underspent and £2 billion was returned to the Treasury[27]. Headline stories about hospital and other health service deficits only mean that resources are unfairly distributed not that the NHS is unaffordable overall.

The policy of attributing deficits to individual hospitals, though taken for-granted today, is a dangerous one, as Treasury mandarin, Sir Richard Clarke, pointed out in 1964:

> **"In the dispersed services such as education and hospitals … units of administration are small, and their performance must be uneven. It is difficult to form a judgement about how efficient those relatively small independent units are, and how much scope there may be for saving, and by what management techniques and services this potential saving can be realised – without of course endangering the quality of local responsibility and flexibility to local circumstances which is fundamental to these services." [26]**

Government claims that it is protecting the NHS budget are also untrue. According to the official watchdog, the Statistics Authority:

> **"expenditure on the NHS in real terms was lower in 2011-12 than it was in 2009-10." [28]**

The NHS is being run as if it is in a financial crisis but this crisis is of the government's making. Current plans for cutting NHS budgets, hospital beds and sacking thousands of vital NHS staff are based on documents drawn up by management consultancy firms including the US company, McKinsey & Co[29]. The policy will lead to closure and hollowing out of public services and the creation of opportunities for an expanded market for private provision and the introduction of user charges.

The policy is fuelling cuts, closures and mergers on a scale that is unparalleled as shown in Table 1. There is no evidence to support change on this scale or the unfair distribution of funds[30].

Table 1: Cuts, closures and mergers[31].

Cuts and closures	**Mergers** (reducing services, increasing waiting times and travel distances)
• In North West London the government plans to cut 25% of beds, and throughout London at least 7 accident and emergency departments will close, with further departments under threat. Up to 5600 jobs in North West London will be lost by 2015. Barnet and Chase Farm Hospitals NHS Trust is cutting 208 posts. • In Merseyside, 4000 NHS jobs will go by 2014. • In South Yorkshire, Rotherham Hospital is set to lose 750 staff by 2015. • In West Suffolk, Serco is planning to cut 137 Community Healthcare jobs. • In Devon and Exeter, the Royal Devon and Exeter NHS Foundation Trust plans to cut 1115 full-time equivalent posts between 2011 and 2014. • In Greater Manchester, there are plans to downgrade Trafford General Hospital's A&E to urgent care and cuts to intensive care, acute surgery and children's services. Maternity services have already closed. Salford Royal NHS Foundation Trust plans to cut 750 full-time posts by 2013. Bolton NHS trust is making 500 redundancies. • In Warwickshire, the George Eliot Hospital NHS Trust plans to cut the equivalent of 257 full-time staff between 2010 and 2014. • In Cornwall, Royal Hospital Truro proposed to cut 400 jobs in 2011. • In Portsmouth, Queen Alexandra Hospital cut 700 jobs and shut 3 wards in 2011. • Across England, twenty four out of thirty NHS Direct call centres will close. • 6000 nursing posts have been cut since the Coalition came to power in 2010.	• Merger with North Tees was followed by closure of A&E in Hartlepool in August 2011. • Merger of South London Trust is followed by recommendation of closure of Lewisham hospital A&E. • Merger of Queen Mary's Sidcup NHS Trust (QMS), Queen Elizabeth Hospital NHS Trust (QEH) and Bromley Hospitals NHS Trust (BHT) to create a single hospital on several sites in 2009 was followed by closure of Queen Mary's A&E and labour unit in 2010. • Merger of Norfolk and Waveney and Suffolk mental health trusts was followed by cuts in beds for acute mental illness and community mental health teams. • Barnet and Chase Farm Hospitals NHS trust currently plans a merger which is likely to result in closure of A&E, maternity and paediatric services. • Merger resulted in closure of Trafford General Maternity Unit in 2010 and A&E is threatened. • Merger with Blackburn Hyndburn and Ribble Valley (BHRV) NHS Trust in 2003 was followed by closure of Burnley A&E in 2008 and the paediatric inpatient ward in 2010. • Merger resulted in closure of Rochdale Infirmary, Greater Manchester A&E in 2011.

Reinstating the duty to provide health services

Lord Owen's Bill to reinstate the Secretary of State's duty to provide health services

The Health and Social Care Act 2012 must be changed because it removes the democratic and legal basis of the NHS at a time when services are being cut and reconfigured on an unprecedented scale. The government has no mandate for this Act. We did not vote for the abolition of our NHS. Neither was it a part of the Coalition Agreement. Unlike England, citizens of Scotland, Wales, and Northern Ireland will continue to have an NHS.

In February 2013, Lord Owen, himself a former health minister who played a formidable role during the passage of the Bill alongside Shadow Labour Health Whip Glenys Thornton, Ilora Finlay, Philip Hunt and many others, took up the challenge and tabled a Private Members Bill in the House of Lords that would reinstate the Secretary of State's duty to provide comprehensive health services:

> **"Some will say why go to all this trouble if a Labour government wins more votes than the Conservatives it will not be necessary. The answer to that question is that some of the changes which we are proposing in this short Bill amends both Labour and Conservative legislation, both the 2006 and the 2012 Acts of Parliament. It is also not enough to have a new government and a new Secretary of State for Health. The Health and Social Care Act of 2012 is drafted so that decision making is not controlled by the Secretary of State who only has severely limited powers of intervention. A Cabinet, let alone a Secretary of State does not change the law of the land merely by being elected – they have to legislate and there are many pressures on them for urgent legislation.**
>
> **A short Bill that has been discussed over a few years, championed in elections and won the support of the vast majority of people who work in the NHS, should be able to win the competition for legislative time. A government that seeks to act in advance of the legislation could well be repulsed, subjected to judicial review and challenged in the courts of law.**
>
> **This 2012 Act was especially drafted to take away the powers of the Secretary of State and vest huge power in the largest ever quasi-autonomous, non-governmental organisation or Quango, the NHS Commissioning Board. The commercial entities**

that will start from April 2013 in ever increasing numbers to marketise the NHS will not be ready purely because of a General Election, to acquiesce in the stopping of contractual negotiations. They will want to push ahead and get in under the wire. It is also very necessary to make crystal clear that it is very unlikely that such commercial organisations could guarantee on tendering for an ever increasing flow of NHS contracts after the next General Election."[32]

The National Health Service (Amended Duties and Powers) Bill restores the legal and democratic basis of the NHS and the rights of citizens' to ultimately hold the Secretary of State to account. It will re-establish the Secretary of State's duty to provide the NHS in England and gives him or her Ministerial powers of direction and planning in order that the duty can be properly discharged.

Specifically, the Bill will[33]:

- reinstate the Secretary of State's duty to provide health services that was formerly contained within Sections 1 and 3 of the NHS Act 2006;
- subject all NHS bodies and bodies providing services for the NHS to ministerial direction;
- repeal the duty of autonomy and restore sufficient ministerial control over provision consistent with the Secretary of State's overarching duty to provide health services to the whole of England; and
- give Monitor an objective, so that its purpose is to help deliver the NHS.

Conclusion

England is not alone in its assault on universal health care. Many European countries are cutting health service budgets in order to get help in dealing with the banking crisis. In 2012, Portugal raised user charges for health care by €150 million. In 2013, charges will be raised by another €50 million. Between 2011-12, Greece increased user fees and cut the country's health budget by €1.4 billion. The Czech Republic cut their budget by 30%. At the end of last year Spain used the extraordinary device of a royal decree to repeal overnight its universal health care law and major reductions in health spending have been agreed in Ireland, Ukraine, Latvia, Romania, Hungary and Iceland, the Czech Republic, France, Netherlands and Austria. In all these cases, as in England, households are being forced to take on more of the financial risks of illness, rehabilitation and nursing care.

Meanwhile, in the low and middle-income countries of the world, international aid is increasingly aligned with policies that rely on households continuing to pay for health care. These policies set aside the World Health Organisation's long-standing commitment to elimination of co-payments: an era of safety nets in which tax financed care is limited to the impoverished has replaced the era of universal access. The results can only be diminished services for the poor and not-so-poor in a climate of growing injustice.

Proponents of the argument that tax-financed or 'free' health care is a privilege we can no longer afford are unable to explain why universal health care was instituted when the world's economy was very much smaller than it is today. If the UK could create an NHS when the country was literally bankrupt, why in England (but not in Scotland or Wales) can the government not sustain the NHS today?

The answer of course is political not financial. These changes are the culmination of a transition from public to private responsibility and control as market dogma spread by large global corporations and financial institutions has penetrated only to abolish an institution that has defined us in our own eyes and internationally. By repealing the government's mandate to provide a health service, the Health and Social Care Act 2012 marks another backward step in this long recessional from universality.

Bevan said of the NHS it "will last as long as there are folk left with the faith to fight

for it". Many millions of people fought over a century to establish it, millions of us are still fighting for it today; on the streets, in our hospitals, in our campaign groups, in our trade unions, in the corridors of the BMA and the RCN, in the Royal Colleges, in local government and in our parliament. This wanton destruction of the legacy of two world wars and more than a century of activism and commitment to universal public health care is a public health catastrophe. It is an act of tyranny. The NHS in England must be re-established. Our response must be political too.

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