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STATEMENT BY THE RT HON LORD OWEN ON THE EVE OF THE REPORT STAGE OF THE HEALTH AND SOCIAL CARE BILL

Still Fatally Flawed – the Proposed NHS for England

The great majority of the bodies that speak for the health professions are now calling into question the fundamentals of the Health and Social Care Bill. Ever since I published *Fatally Flawed* on my website[1] on 30 March 2011, I have been waiting and hoping that most of the Royal Colleges would realize that the Health and Social Care Bill was quite unlike any other legislation on the NHS put forward for debate since 1946. The very size of the Bill and its complexity makes it unamendable.

As we come to Report Stage in the House of Lords it is crystal clear that despite the best efforts of all those concerned and despite the many amendments that will be passed, the fundamental structure will remain intact. The Chairman of the National Commissioning Board envisaged in the Bill, himself a distinguished academic and barrister, has described the Bill as "completely unintelligible"[2]; one of the reasons that the complex inter-reaction of this legislation has taken time to come through to the health professions. Today the risks of going ahead with the Bill are now being professionally assessed by more and more of the Royal Colleges as being greater than the risks of stopping this Bill even in its last stages.

Of course there are exceptions and the Royal College of Surgeons has written to me clearly content for the Bill to continue. Yet that is not the view of all surgeons. The President of the Royal College of Ophthalmologists wrote to me only a week ago saying, "

> "The Bill does have some positives at face value. It puts doctors and patients at the core of the NHS and benefits will accrue from this. There is some concern that this may not be translated into actual practice.

[1] www.lorddavidowen.co.uk

[2] Martin McKee, Does Anyone Understand the government's plan for the NHS? BMJ 2012: 344:e399doi: 10.1136/bmj.e399 (published 17 January 2012)

There are other major concerns which need to be addressed if the reform bill is to make things better and not worse. Commissioning, as it is being inferred, will introduce unfair competition in which major teaching hospitals are likely to be disadvantaged. Willing providers are likely to bid for the 'lucrative procedures' leaving hospitals to deal with the complex procedures, which in turn are inadequately funded as per current tariffs. This particularly applies to ophthalmology where cataract surgery is being diverted to independent providers who do not provide training. In some centres there aren't enough cataracts left to fulfil the training needs. The number of cataract operations performed by consultant ophthalmologists too is dropping leading to deskilling. Equally importantly, the income generated from the volume of cataract surgery is used to subsidise more complex procedures whilst still retaining a positive financial balance. Loss of this volume of cataract surgery will have significant negative knock on effects on other complex procedures disadvantaging patients."

He went on to say:

"Another potential serious consequence is the risk that emphasis will shift from providing holistic care to patients to 'organ based care'. Different services will be commissioned from possibly the cheapest providers. This will mean that patients have to travel to one centre for one type of treatment and to another centre for another treatment affecting a different organ. In ophthalmology several patients have more than one condition affecting the eye for example diabetes and cataract and glaucoma, glaucoma and cataract, macular degeneration and cataract or glaucoma. If different conditions are commissioned from different providers the patients will have to move around. This will require very efficient communication between centres to avoid duplication of medication and other intervention. We feel that such insights can only be provided by the doctors who are at the coal face delivering health care. If policy decisions are made without such insight we will be putting patients at risk.

Currently there are two major thrusts from the government in relation to the NHS. One is to make a saving of 20 billion pounds and the other is the Health and Social Care Reform Bill. Unfortunately the two are being linked and PCTs and Trusts are using the reform initiative to push through changes that are purely driven by cost saving objectives. This has muddied the waters and brought disrepute to the proposed reforms. In ophthalmology this is reflected in arbitrary thresholds of visual acuity being set for cataract surgery. Thresholds for the first and second eye are different with a greater loss of vision being required before surgery can be considered for the second eye. The thresholds that are set have no scientific basis whatsoever and are purely determined by the number of cataract procedures that can be deferred to meet the savings targets. Moreover, the thresholds are variable across the country creating a post code lottery. The variable thresholds being set by different PCTs/Commissioners is further proof that these are based on financial rather than clinical needs. This is depriving many deserving patients from necessary surgery. Certain

> procedures such as lid warts and benign growths are being banned altogether without any alternative options being offered to patients.
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> If this is what the future of the NHS will look like then the Bill has serious problems. If this reflects the gap between the spirit of the Bill and its implementation then greater clarity is required in the form of explicit instructions to commissioning groups."

Of course, in terms of whipping Conservative and Liberal Democrat MPs and Peers, the Bill can be placed on the Statute Book. The House of Lords can only revise legislation and mainly negotiates amendments with the Government. The only person who can stop this legislation is the Prime Minister.

Yet if the Prime Minister went to the Cabinet, as he should, and asked for it to be withdrawn, the NHS would heave a collective sigh of relief and next day start to implement, under existing legislation, those aspects on which there is widespread agreement. Stephen Dorrell MP, himself a former Secretary of State for Health, pointed out that this could be done when this legislative monstrosity first started to emerge. A year has elapsed since the Bill was presented. We have already had an unprecedented Government induced legislative 'pause'. This ensured an intensive debate and has served the useful purpose of delineating an agreed pattern of reform for the future under existing legislation.

Why should David Cameron listen and decide to shelve the legislation? In the summer when he ordered the 'pause' he was aware of public disquiet, reflected in opinion polls. He was entitled to hope that the Future Forum committee that he appointed would help to alleviate concerns. But the Future Forum was not a representative grouping and increasingly as the medical profession looked behind the White Paper and started to understand the dertails, concern mounted. Never before have the doctors, nurses, midwives, physiotherapists as the professional bodies concerned with professional standards, come together in such numbers to oppose legislation going ahead.

David Cameron is the first Prime Minister to face such a professional outcry. It is no good him pretending that this protest is linked to issues of pay and pensions because the BMA and the RCN want the Bill dropped. Both organizations have a dual function, trade union and professional ethics and standards. What is uniting the health professions is a risk assessment of the dangers of the Bill made in the context of evidence-based medicine.

David Cameron should remember the words he spoke about the NHS during the election. Most of those who work in the health service were aware of his own late son's illness and felt that when he spoke about the NHS not having any more top down reorganizations, he carried the conviction of someone who had real experience of what the NHS represented in British life. When he talked of his 'Big Society', many envisaged the ethos of the NHS would be part of that. During the 2010 General Election the NHS was not, as in previous General Elections, anywhere near as big an issue between the parties. Voters believed not only that there would be no more top down reorganisations but the Conservatives had absorbed the strengths and realities of the NHS. There was nothing from the Liberal Democrats either to identify them with these reforms. It is also noteworthy that the most recent assessment by the OECD[3] in praising the achievements of the NHS drew attention to the fact that this was despite the adverse consequences of numerous reorganizations. Why are we having the mother and father of all past NHS reorganisations?

Supporters of the Conservative/Liberal Democrat coalition groan when people point out they have no mandate for this legislation but that is the fact. They fought an election with no voter envisaging anything remotely like this Health and Social Care Bill. Furthermore, they have broken the conventions of legislation that while a Government after Second Reading in the House of Commons can implement some limited aspects of the legislation in advance of the Bill receiving Royal Assent, the democratic approval process must not be prejudiced. The conventions never envisaged the collapsing of so many existing structures and the attempt at wholesale implementation prior to

[3] Health at a Glance 2011. OECD Indicators 10.1787/health_glance-2011-en http://www.oecd-ilibrary.org/social-issues-migration-health/health-at-a-glance-2011_health_glance-2011-en

Royal Assent. Yet some in and around the coalition now invoke, as an argument for not going ahead with the legislation, the prospect of chaos if the legislation is stopped. Not only do they exaggerate the likely effect of not going ahead but even to use such an argument is a constitutional outrage.

It is now incumbent on the Prime Minister to hear directly from representatives of those Royal Colleges that believe the Bill should not proceed and address their objections. It was after all the Prime Minister who stated that "put simply, competition is one way we can make things better for patients. This isn't ideological theory. A study published by the London School of Economics[4] found hospitals in areas with more choice had lower death rates." The Prime Minister needs to hear from the professions why this paper has been challenged repeatedly, not just on its conclusions but on its methodology, most recently in an article in the Lancet "No evidence that patient choice in the NHS saves lives".[5]

The Prime Minister also needs to hear the professional view asking for publication of the Department of Health's Transition and Strategic Risk Registers concerning the Bill. The date of the Freedom of Information Tribunal hearing has been brought forward to the 5 and 6 March. At the very least the Government should concede that if the Tribunal uphold the Information Commissioner's view that the Register should be published, they will not go through further appeal proceedings and allow the Register to be published before the Third Reading of the Bill in the House of Lords. It appears that the contents of one of the risk register is now leaking and there are claims that the chief warning in the report is that it looks as if:

> *"Lansley's reforms will spark a surge in health care costs and that the NHS will become unaffordable as private profiteers siphon off money for their own benefit. The report specifically warns that GPs have no experience or skills to manage costs effectively. The profit element*

[4] Cooper Z, Gibbons S, Jones S, McGuire A. Does hospital competition save lives? Evidence from the English NHS patient choice reforms (Working paper No 16/2010). London: LSE Health/The London School of Economics and Political Science, 2010. http://eprints.lse.ac.uk/28584/1/WP16.pdf (accessed Sept 29, 2011).
Cooper Z, Gibbons S, Jones S, McGuire A. Does hospital competition save lives? Evidence from the NHS patient choice reforms. *Econ J* 2011; **121**:228-60

[5] Pollock AM, Macfarlane A et al. No evidence that patient choice in the NHS saves lives,The Lancet, Volume 378, Issue 9809, Pages 2057 - 2060, 17 December 2011

contained in Lansley's reforms is the chief reason for the report citing these worries. This is the reason Lansley refuses to publish the report, because he has claimed that his bill will make costs in the NHS more affordable. This flaw in the bill if exposed would undermine his entire argument and it is the reason the report will not be published until the bill becomes law."[6]

The Prime Minister should also be ready to listen to the concern of the profession on the latest evidence from Holland. The Dutch competition authority (the NMa) has had the effect of fragmenting service provision and impeding the provision of high quality care[7]. We have learnt recently of a €7.7million fine levied on the Dutch GP association for a "bad case of anti-competitive behaviour" which was the National Association's efforts to ensure that all areas of the country were adequately provided with GP services[8].

It is an extraordinary development that a Bill that was heralded by the Government as primarily being about enabling and freeing GPs has ended up with the Royal College of General Practitioners calling for the Bill to be withdrawn. The Dutch Patients and Consumers Federation is now calling for the involvement of competition in healthcare to be urgently reviewed. Since the enforcement of competition in the Netherlands and in the UK will both come under the same EU regulations, the Government cannot go on saying they are not sure of what the EU competition law will do. Monitor will have to work in the same way as the NMa in the Netherlands. Also once again we have the Government refusing to publish relevant facts. In this case the legal opinion that was given to the last Labour Government in 2006 on the implications of EU competition law on health when Labour has said they are more than willing that it should be published. The most recent guidance of the Office of Fair Trading (Public Bodies and Competition Law) issued in December 2011 states that for both UK and EU competition law "non-compliance with competition law can have serious consequences".

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[6] http://eoin-clarke.blogspot.com/2012/02/andrew-lansley-covers-up-nhs-report.html

[7] Sheldon T, *Is Competition Law Bad for Patients*, BMJ 2011; 343:d4495 and 2012;344:e439

[8] Sheldon T. Dutch GP association is fined €7.7m for anticompetitive behaviour. *BMJ* 2012;344:e439 http://www.bmj.com/content/344/bmj.e439?view=long&pmid=22250223

Professional concerns about the impact of the EU law on the NHS are serious. They are entitled to know whether the Prime Minister stands behind the speech made to the NHS Confederation in 2005 by Andrew Lansley when David Cameron was not the leader about the party's plans for the NHS. Lansley said, "Much of what I have described is like the EU's developing framework for services of a general economic interest. I recognize this and I welcome it. The vital aspect of our relationship with Europe should be to encourage the EU to be concerned with promoting competitive markets."

The Prime Minister should also be ready to explore with the professions the questions about the role of Monitor in the light of the recommendation of the Future Forum that competition in the NHS should be limited to competition on quality not on price. It appears that under the Bill the "Most Economically Advantageous Tender" (MEAT) arrangement is likely to be permitted to be used by the National Commissioning Board and the Clinical Commissioning Groups.[9] But as so often with the Bill this detail on competitive tendering will emerge later through Regulations that we have yet to see and will be the case also on competitive tendering. Regulations are unlikely to be published even in draft before the Bill is planned to receive Royal Assent. The devil will be in the detail. Talk of a level playing field for tendering is misleading. Charities and not-for-profit organizations will not have the same financial and technical resources as private companies.

Earl Howe wrote to Peers on 22 December about the Regulations "requiring commissioners to justify their decisions in terms of benefits to patients and value for taxpayers money. The Regulations would reflect the existing Principles and Rules for Competition and Cooperation in the NHS". But in fairness to the last Labour Government competition was not for universal application. There was no insistence that any willing provider had the right to tender for virtually every health provision contract in England.

The MEAT procedure involves combining both quality and price, with contracts chosen at the lowest price for some acceptable pre-declared level

[9] ACEVO Procurement and Commissioning P3 http://www.acevo.org.uk/document.doc?id=51

of quality. This is how most competition contracts, in effect, work. First the contractor has to deliver a service at an adequate standard and then the decision is influenced by price. In health the risk is that this becomes all too often a race to the bottom on quality of provision.

The Government is attaching far too much importance to a few studies whose conclusions and methodology have been professionally challenged. Only recently Earl Howe partially quoted Professor Smith in a 2009 Health Report to the OECD having commented that, “competition can take many different forms, and sharpening competitive forces is likely in general to be an important tool for most health systems”.” Yet Professor Smith suggests that for completeness and balance this quote ought to include his previous sentence too; “true market competition introduces a set of raw incentives that carries serious potential for adverse outcomes for many aspects of healthcare.”

Many in the health professions want to proceed with care and caution over the introduction of competition policies in healthcare. They are ready to see further experiments in competition but they want an objective evaluation and an evolutionary approach that was becoming the hallmark of the internal market in the NHS. The Prime Minister, however, needs to explain to the health professions directly why and on what evidence he is endorsing the abandonment of the internal market present since 1988 and instead introducing a full blown external market. In the process ensuring a rationed healthcare system popularly accepted as democratic and as fair will be replaced by rationing through QUANGOs and competitive tendering seen as unfair.

It is not just the health professions but a growing body of informed opinion who are not prepared to accept that healthcare can be likened to just another utility. The Bill envisages Monitor’s role modeled on the laws that have already been set up for utility regulators. It is the commercialization and marketisation of the NHS that runs through this Bill which calls into question the very existence of an NHS in England in 5-10 years time. It does not help that growing perception when the Government has appointed two non-executive directors to join the Chair/CEO of Monitor who are all former

McKinsey senior managers and have specialized in privatization; the Chair/CEO has the very same background, suggesting that skills in privatisation are considered essential qualifications for a senior role in Monitor. Nor that in 2010 private equity investors in New York received a personal invitation to enter NHS provision from a former NHS Director of Commissioning through a presentation on profit opportunities arising in the UK healthcare sector, which stated "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 sells goods and services to the system. The NHS will be shown no mercy and the best time to take advantage of this will be in the next couple of years. GPs will have to aggregate purchasing power and there will be a bid opportunity for those companies that can facilitate this process."[10]

The Prime Minister would be well advised to have the Chancellor of the Exchequer accompany him in any discussions with the health professions. Treasury officials are beginning to speak openly, though admittedly in private, about their growing concerns over delivery of the £20bn efficiency savings by 2015. Those in the Treasury who have served in or know well the Department of Health are fully aware that an organization in turmoil undergoing massive reorganization does not usually provide efficiency savings. There is an even more important aspect – an organisation in which its most dedicated supporters feel alienated is even less likely to accept pay restraint and pension reform, other key government priorities.

Of course, halting the Health and Social Care Bill will be a political rebuff, a 'U' turn over which the Labour Party would be bound to crow for a while. But the Prime Minister showed over the Government's forestry proposals that that sort of criticism lasts for a few days and is soon forgotten. The prize for foregoing the Health and Social Care Bill is potentially immense. A relieved workforce, a uniting of the health professions, an accompanying readiness to adopt a reform programme within existing legislation at a faster pace than ever before. These are major advantages worth far more than temporary

[10] Apax Partners conference, Opportunities Post Global Healthcare Reforms, October 2010 http://www.powerbase.info/images/f/fe/Apax_Healthcare_conference_2010.pdf

political embarrassment. An NHS that is all working together can and will adopt a positive reform programme. There is no appetite within the health professions for the status quo. What they all want is coherent evidence-based reform.

I am very grateful to Dr Lucy Reynolds, Health Services Researcher, for bringing to my attention many new facts and information.