FUTURE OF THE NHS Allyson M Pollock, Peter Roderick

Why we need a bill to reinstate the NHS in England

US healthcare "solutions" are the death knell for the NHS

The 2012 Health and Social Care Act marked the end of England's NHS. But you wouldn't know it from the election debates, as cries for more funding compete with differing claims over privatisation. Politicians seem to be deliberately avoiding the elephant in the room. This isn't surprising. At the last election the Tories remained silent about their plans to break up the NHS, knowing that most people would reject them. The coalition agreement reneged on its promise to protect the NHS. Labour is still in denial about the Blairite embrace of the market, which provided the platform for the 2012 act to take the commercial thinking to its logical conclusion.[1]

What do we have now? NHS trusts struggling with deficits triggered by PFI and reductions in NHS funding.[2] A health secretary with no legal duty to provide services. Clinical commissioning groups (CCGs) with no duty to provide, only to contract and tender in the marketplace—but not for everybody in their area, only for "persons for whom they are responsible" (except for emergency care). Compulsory tendering diverting billions of NHS funds to private providers. NHS trusts prospectively abolished so that all hospitals will become foundation trusts, structurally designed to be 51% NHS and 49% non-NHS, underpinned by Monitor's licence conditions that require the compulsory list of services to be provided only until April 2016. After this, new reduced lists of services will be drawn up.[3] And as if that's not enough, foundation trusts must draw up "patient eligibility criteria." Since when were NHS hospitals legally required to choose in advance whom they would and would not treat? Since section 103 of the 2012 act.

CCGs are reducing the services for which they will contract. Hospitals such as Queen Elizabeth Hospital in Birmingham have restrictions on referrals from outside provider catchment areas.[4] GPs no longer provide home visits to some patients.[5] Across the country NHS services are being closed. These reductions pave the way for mixed funding arrangements and a shift to private insurance and charges to patients.

Simon Stevens, now head of NHS England after his stint in the US at United Health, knows full well what is in store for us all. In the US, neither health maintenance organisations nor the accountable care organisations—created in the wake of the 2010 Affordable Care Act—are backed by a government duty to provide (like CCGs). They have a duty only to their members (like CCGs). Like CCGs they are not accountable to local people; and their public resource allocation is capitation, not geographic, and doesn't cover everyone.

With ministerial legal accountability for services gone, Jeremy Hunt said in June 2014, "We need CCGs to become accountable care organisations."[6] The US public's distrust and dislike of health maintenance organisations (rebranded as accountable care organisations) is well documented, resulting from the denial of care to millions of people going hand in hand with overtreatment, care inequalities, restrictive networks of providers, and cherry picking of healthy patients.[7 8]

The US organisations are characterised by loss of clinical autonomy, huge administration costs, exorbitant salaries to chief executive officers, and fraud.[9] Since 1948 no one in the UK has been made bankrupt because of healthcare bills; in the US a fifth of adults struggle to pay healthcare bills, which account for two thirds of all personal bankruptcies.[10]

Under universal healthcare systems, governments ensure that the risks and costs of care do not fall on patients. In marketised systems, contracts require risks to be identified and allocated by contractors and providers. Commercial providers need to be able to decide which risks they will take (and won't) and how they will price and select those risks. In healthcare high risk groups are typically older, poor, chronically ill, disabled, or mentally ill. And membership based bodies don't cover everyone, by definition.

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NHS England's embrace of the market is moving apace. Foundation trusts and general practices can merge and enter into joint ventures with health insurers, PFI consortiums, and corporate providers. The "vanguard sites" and new models proposed in NHS England's *Five Year Forward View* resemble the US models: primary and acute care services, multispecialty community providers, and large federated GP networks offering out of hospital care.[11 12] The devolved Manchester plan—15 NHS providers, 12 CCGs, and 10 local authorities co-commissioning and providing care—crystallises the health maintenance organisation form.[13]

Rescue bill

US "solutions" are the death knell for the NHS. The NHS must be reinstated and 25 years of pernicious marketisation reversed. Hence the need for the NHS Bill tabled in parliament in March.[14] The Greens, the Scottish National Party, and the National Health Action Party have pledged support. Labour's plan to remove compulsory contracting, to cap private sector profits, and to limit foundation trusts' income from private patients are palliative but will not halt the terminal decline of the NHS. The NHS Bill (www.nhsbill2015.org) would abolish the internal market and contracting, centralise PFI debts, and restore the health secretary's duty to provide health services throughout England—as in Scotland and Wales.

The question for all election candidates: will they be true to the founding vision of the NHS and support the inclusion of the NHS Bill in the Queen's Speech on 19 May?

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FUTURE OF THE NHS Lucy Reynolds, Martin McKee

Is the NHS safe from international trade agreements?

Lessons have come from Slovakia

International trade agreements generally attract little public scrutiny in the United Kingdom, but while some are uncontroversial, others are not.[1] One, the Transatlantic Trade and Investment Partnership (TTIP),[2] currently being negotiated between the European Union and United States, even features in the 2015 UK general election manifestos, with all three main parties supporting it, albeit with certain reservations, and upcoming parties such as the Green Party and National Health Action Party opposing it.[3] There are concerns that TTIP, which will cover over 40% of the world's economy, would enable global corporations to over-ride a future UK government seeking to reverse aspects of NHS privatisation,[4] potentially leading to the replacement of the NHS with a US style market based system.[5]

The UK government could opt to remove many aspects of healthcare from the scope of TTIP, just as the French government has excluded its cultural sector. Yet the coalition government has declined to do so, arguing that this is unnecessary. David Cameron described fears that the TTIP might damage the NHS as "bogus nonsense" and an "empty threat."[6] Vince Cable, the Liberal Democrat business secretary, said confidently that there would be no requirement for a future government to open up more NHS services to competition or private provision.[7] Both refer to the EU commissioner for trade, who has sought to "correct some of the misconceptions circulating,"[8] asserting that nothing in TTIP would require a national government to privatise health services or prevent it from bringing previously privatised services back into the public sector. Similar reassurances have been given by other EU officials and cited extensively by UK ministers.

But are they right? Are those expressing concern, including a wide range of non-governmental organisations such as the UK Faculty of Public Health,[9] misinformed or scaremongering? A tribunal report just released under freedom of information procedures indicates that there really is a problem.

Bypassing the courts

An awareness of how trade agreements work helps in understanding the problem. Because courts often fail to support companies,[10] as with the failure by Japan Tobacco International to overturn Australia's ban on branded packaging,[11] large corporations and certain governments initiated an alternative, the Investor-State Dispute Settlement (ISDS) system.[12] This allows corporations whose profits are threatened, such as by controls that could reduce the number of cigarettes they sell, to overturn public health decisions by elected governments. ISDS bypasses the courts: rulings are given instead by commercial arbitrators with no requirement to accommodate public policy objectives. ISDS is a core element of the TTIP.

Why this is important is apparent from an ISDS Tribunal case arising from the 2008 decision by the Slovakian government to require health insurers to be not for profit, a principle previously ruled as lawful under European law by the European Court of Justice.[13] An Austrian bank that owned shares in one of the previous for-profit companies—thus once removed from any agreement between the government and the insurers—claimed compensation for loss of the money that it might have made if profit making from national health insurance had continued. It invoked an Austria-Slovakia investment agreement negotiated in 1990 by the Czechoslovak government and inherited by Slovakia.[14] This treaty allows commercial entities to claim compensation from public funds through ISDS style "investor protection" rules against "expropriation" (otherwise known as renationalisation).

Lucy Reynolds

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> Even indirect investors in public services may be able to penalise governments financially if they seek to roll back the market in healthcare

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Given the European Commission's stated confidence that the TTIP could not be used to circumvent national governments and courts, it was unsurprising that it argued before the 2010 Slovak trade tribunal set up to hear the case that the tribunal had no right to do so and that such matters should be settled by the courts, with the European Court of Justice as final authority. The trade tribunal rejected this view, ruling that that court had no monopoly in determining interpretation of European law. Although the Slovakian government ultimately prevailed, because of technical flaws in the case against it, this tribunal report clarifies several important points.

Firstly, opinions of European Commission officials or government ministers, Slovak or British, about what an international trade agreement permits or prevents cannot be considered definitive.

Secondly, even indirect investors in public services may be able to penalise governments financially if they seek to roll back the market in healthcare. They will do this not in the courts, which apply the law in the public gaze and can accommodate public policy concerns, but in secret arbitration tribunals. Thirdly, had Slovakian freedom of information law not permitted the release of the details of this case we would never have known about them.

We still don't know what is being discussed in the negotiations on the TTIP. But now we may well draw less comfort from official reassurances.

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NO HOLDS BARRED Margaret McCartney

Rigging the NHS for votes

ELECTION 2015

With just days to go the NHS may be vital to the election, but the politicians' promises, if only they are elected, are astonishing—in their naivety and their lack of an evidence base.

Labour is pledging a "world class" health system, with a "guarantee" of "a GP appointment within 48 hours, and on the same day to those who need it." It will offer training for GPs "in spotting early signs" of cancer and says that, by 2020, "patients will wait no longer than one week for vital cancer tests."[1]

The Liberal Democrats say that they will "commission a fundamental review of the NHS and social care finances" and will give "patients easier access to GPs and more choice, with more practices open at evenings and weekends and offering phone and Skype appointments."[2] The party also says that, since the "new" general practice contract of 2004, "getting an appointment with a GP outside of the working day is . . . often extremely difficult."

Meanwhile, the Conservative Party wants to "ensure you can see a GP and receive the hospital care you need, 7 days a week by 2020, with a guarantee that everyone over 75 will get a same day appointment if they need one." If people who are obese or who have a drug or alcohol addiction "refuse a recommended treatment," the party says, "we will review whether their benefits should be reduced."[3]

The NHS is a community endeavour that runs on "fair use." It has limited staff, and pledging more access in one place must mean reducing it somewhere else. Pushing for 48 hour access can disrupt continuity of care; this is valued by patients and doctors,[4] protects against non-evidence based medicine,[5] and relieves concerns about safety.[6]

It may not be popular, but the truth is that not everyone needs to see a doctor within 48 hours. Some things can safely wait a week. And GPs already have to see patients who are in urgent need on the same day.

There are huge uncertainties about using Skype. And it's ageist to assume that 75 year olds have more right to see a GP than disabled, multimorbid 40 year olds do. Talking about fair use may not make for easy votes, but it does make for a sustainable NHS.

The worst of the manifesto propositions, however, is the Conservatives' plan to cut already meagre benefits for sick people who "refuse" treatment. So much for "no decision about me, without me"—and how stigmatising it is to point the finger of blame at these highly vulnerable groups.

Not everyone needs to see a doctor within 48 hours

We cannot have more reorganisations at a whim; everything the NHS does should be underpinned by evidence. The NHS is too precious to be rigged for votes.

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IF I RULED THE NHS Alan Maynard

Put all GPs on a salaried contract

ELECTION 2015

I would buy stocks and plenty of rotten eggs. I would install one set of stocks outside Richmond House in London and another outside Quarry House in Leeds. Evidence free practitioners of NHS "re-disorganisations" and other faith based policies—Jeremy Hunt, Andrew Lansley, Andy Burnham, and Alan Milburn—would be punished, as an example. Iain Chalmers, Ben Goldacre, and other "evidence apostles" would be supplied with the eggs. Such public shaming could be avoided if interventions were appropriately piloted and accompanied by well designed evaluations of their cost effectiveness.

I would put all GPs on to a salaried contract, completing what Aneurin Bevan would have preferred and which was prevented by the BMA's usual restrictive practices. I would accompany this contract with a national system of activity and outcome data in primary care. It is scandalous that while there are relatively useful data for the secondary care system, such as hospital episode statistics, similar comprehensive data on primary care are absent. This absence enables service providers to assert descending chaos and funders to believe that all is well. You cannot manage without measurement, and it is time to improve accountability and demonstrable value for money in primary care.

The complex and Byzantine subsidies provided to the drug industry cost taxpayers billions

All clinical commissioning groups would have to have integrated primary, secondary, and social care data systems by the end of 2015. Such data are essential, given the often evidence free fanatics who advocate "integrated care" as the "solution" to the NHS's woes. Before proceeding to integrate services, NHS managers would have to protect taxpayers by ensuring that investments in primary and social care were substitutes for, not complements to, hospital activity—that is, increased numbers of GPs might increase referrals to hospital. Faith based behaviour would be managed in the stocks.

Instead of treating mental health services as the Cinderella of the NHS, I would ensure new investment through economy in spending on drugs across the NHS. The complex and Byzantine subsidies provided to the drug industry through policy instruments such as the Pharmaceutical Price Regulation Scheme and the Cancer Drug Fund cost taxpayers billions. Variation in prescribing choices indicate substantial scope for reducing waste. It is time for accountability and economy in drug spending in hospital and community healthcare.

Cries of "crisis" in the NHS would be countered by requiring all NHS facilities to publicise the cost of primary care and the NHS, demonstrating the remarkable good value that citizens get. For instance, the average cost of universal primary care provision was recently reported to be £136 per patient.[1] The average cost of primary and secondary care is just under £2000 per person in England.[2] Protection of this modest spending, ensuring that people don't have to pay out of their own pockets in times of ill health and enshrining the principle of collective responsibility for each other's healthcare, remains essential.

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