

Health and Social Care Bill Unpicking the spin

A Briefing Paper for Journalists

by Dr John Lister, Senior Lecturer in
Health Journalism, Coventry University

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Five key misleading claims about the Bill

As pressure mounts on ministers to withdraw the government's controversial Health and Social Care Bill, David Cameron and Andrew Lansley still rest their case on five key misleading statements in addition to the suppression of a vital document exposing the risks of implementing their proposals.

It's now clear that the tribunal hearing the government's appeal against two rulings by the Information Commissioner – that they must release the risk register on the bill that was drawn up by Department of Health officials at the beginning of last year – will not take place until after the key votes are taken in the House of Lords.

But the public have also been misled by repeated government claims that the bill would

- save money,
- give local control over services,
- put doctors in charge,
- empower patients,
- and improve outcomes.

If any of these were true, there would be little opposition: nobody is really against these objectives. But they are NOT the focus of the Bill. Worse, NOT ONE of these assertions holds water. Each bland assurance conceals policies that head in precisely the opposite direction.

An expensive gamble

Far from saving money, Andrew Lansley's Bill is set to cost £3 billion or more to implement, and it will increase the level of bureaucracy, with at least five tiers of management beneath the lumbering machine of a new, unaccountable National Commissioning Board and a proliferation of new quangos.

The new structure will be even less locally accountable and even less well regulated than the current system.

There is no clarity on which bodies will be responsible for many of the 120-plus statutory duties – many of them upholding financial transparency or protecting patients' rights and vulnerable sections of the population – currently carried out by Primary Care Trusts (PCTs), which are to be abolished.

New estimates suggest £1 billion could be saved immediately by stopping the implementation of the bill.

Less local than ever

It's also clear that the new Clinical Commissioning Groups which Andrew Lansley wants to replace Primary Care Trusts and take over the commissioning of local health services will be as big or bigger in many cases than the PCTs they replace.

There is talk of CCGs merging to cover populations of 1 million or more – giving far less local control or accountability to local communities than the system they are replacing. And CCGs will be subject to controls by a new "National Commissioning Board". Tokenistic Health and Wellbeing Boards will be a stitch-up between CCGs and local council bosses, and new local "Health Watch" organisations will be toothless, pointless bodies with minimal impact.

The £20 billion cash squeeze which accompanies Lansley's Bill will ensure that many local communities that value their local hospitals and health services will find that despite their views they are scheduled for closure, with decisions rubberstamped by GPs on the new Commissioning Groups.

GPs reduced to rubber stamps

Neither GPs, nor the token clinicians who will be drafted in from other areas to "local" Commissioning Groups, will be really in charge of the work of commissioning.

As clinicians focused on their own list of patients and their very local needs, GPs are not trained to plan services for larger populations, and generally lack the time, energy and facilities to take on complex managerial tasks previously undertaken by PCTs on their behalf.



Government documents have already made clear that the plan is for commissioning services to be contracted out to private management consultancies. These faceless bureaucrats will formulate budgets and plans which would then be rubber-stamped by GPs on CCG committees, who will be a convenient scapegoat to take the blame for unpopular decisions.

Consultancy firms expect to pick up as much as £1.3 billion each year from this work "supporting" CCGs.

GPs second-guessed

GPs will not only NOT be in control of the commissioning, they will increasingly be second-guessed and overruled in their clinical decisions, especially as the cash squeeze tightens on the NHS. We already know that the choices of patients and the clinical decisions of many GPs are now being routinely overturned by bureaucrats working in remote "referral management centres", many of these privately run, who vet referrals for hospital and other treatments, and have been sending back one in eight referrals suggesting that the GP send the patient somewhere cheaper.

GPs as spectators

Nor will GPs be in charge of deciding which companies and non-profit providers are allowed to compete for the delivery of NHS funded services in their locality. This power will be held nationally by the regulator Monitor, itself an unaccountable quango, led by a former senior partner in US-based city consultancy McKinsey. Monitor, with another quango, the Care Quality Commission, will draw up the list of which providers it deems "qualified" to deliver services to patients, irrespective of the views of patients, GPs, and other health professionals.

But in the aftermath of the breast implant scandal and the debate over the qualifications of commercial cosmetic surgeons, it is shocking that companies only need to meet minimal financial requirements to qualify: under EU law, no clinical criteria will be involved in assessing those on the list for approval to deliver clinical care paid for by taxpayers: the word "qualified" is totally misleading.

Lansley's Bill sets out to create a competitive market in health care, governed by competition law and by the so-called 'Cooperation and Competition Panel', rather than

by any requirement to allocate services according to local health needs. The result is certain to cause even greater inequalities in access to health services and in the quality of health services between one area and the next: the postcode lottery will get much worse.

GPs to be gagged by competition law

Not only will GPs have no voice in selecting which companies should be allowed to offer services to their patients, they will be banned by competition rules from influencing patient choice.

Companies that feel they have been discriminated against will be able to complain to the Competition Commission. EU competition law will also apply to these areas where the private sector is being brought

in for the first time to deliver NHS services.

GPs as scapegoats for unpopular decisions

The cash squeeze means that Commissioning Groups will effectively become rationing bodies with little scope to improve services for patients. Already it is clear that the minority of GPs who have involved themselves in the setting up of CCGs are in the main from the more prosperous and well resourced GP practices, mostly in the wealthier suburban areas with the fewest health problems and least pressure on services.

This is bad news for the allocation of resources to meet the health needs of deprived inner-city populations, where

hard-pressed GPs in under-resourced practices struggle to keep services afloat.

GPs in opposition to the Bill

All these obvious limitations on the powers of GPs are among the reasons why GPs have consistently been at the forefront of the opposition to Andrew Lansley's Bill: throughout the Parliamentary process of the bill every poll has shown a majority of GPs has been opposed to it, culminating in a recent RCGP poll in which 98% of GPs called for the bill to be withdrawn.

Other Royal Colleges are gradually catching up with the GPs in understanding the real implications of the bill and the way it will impede them from exercising their clinical judgement, developing their clinical skills, and serving their patients.

I'LL JUST CONSULT MY ACCOUNTANT ABOUT YOUR TREATMENT...



"I'm not Dr Jekyll - I'm Mr Hyde the accountant"



"We're Acme Consultancy Services - your Commissioning Support Organisation"

Making a mockery of patient power

But all the limitations on GPs are also limitations on their patients, making a mockery of claims that patients will be "put in the driving seat" and that patient choice will drive the development of local services.

No patients have been consulted about the establishment or the subsequent mergers of clinical commissioning groups: this has been done unilaterally by a minority of GPs, following their own personal agendas, and often without reference even to their local GP colleagues.

And patients will have no more voice than they have ever had on the closure of popular local services when CCGs, steered by management consultants, push through cutbacks in the teeth of public opposition.

In reality the driving force in the new market style NHS will be the private sector, as commissioners, both as referral management agencies, and as providers that are free to pick and choose which services they see as profitable to offer, while the public sector is reduced to a rump of those services which the private sector finds unattractive to deliver.

Lansley's baseless claims on outcomes

Claims that the Bill will somehow magically improve health outcomes and the quality of services are also equally spurious. Despite frantic efforts by tame academics and others to find some support for the claim that competition improves healthcare services, the facts show otherwise.

The universally recognised catastrophic failure of privatised hospital cleaning services resulting from competitive tendering in the 1980s is a concrete example of the many ways in which competition, especially on price, undermines the quality of health care.

The reality is that health outcomes and the effectiveness of treatment had been rapidly improving in the NHS, as waiting times were reducing – until Andrew Lansley took over, and threw the system into increasing chaos, compounded by relentless pressure for £20 billion worth of cuts.

Now waiting times are increasing, skilled staff are losing jobs, elderly care and mental health are facing drastic problems through fresh cutbacks in resources, and there is no prospect of relief while the government holds course and the cuts continue.



"Apparently your health insurance only covers placebos."



"IMPLEMENTING THESE CHANGES WON'T BE EASY. WE'RE PRETTY SET IN DOING THINGS THE WRONG WAY."



Dodging all the real problems

Lansley's Bill fails to address any of the real problems of the NHS: the chronic lack of resources for mental health services, the shambolic state of long-term care of the elderly, the huge and rising costs of another 20 or more years of the Private Finance Initiative, and the erosion of the NHS by cash strapped commissioners drawing up lists of so-called "low priority" treatments and operations which will no longer be available free on the NHS, but for which patients in many areas will face a choice of going private – or going without.

The Bill threatens to soak up more resources and management time, add new levels of fragmentation, organisational chaos and confusion, but offers none of the promised compensating advantages.

Hundreds of marginal amendments, grudgingly included to head off even stronger opposition, have not changed the essential content and direction of the Bill, or its project to bring in a competitive market in health care.

It puts the private sector in charge, while disempowering GPs, hospital staff, patients, local communities and elected politicians, who will have little chance to call commissioners or providers to account for a service consuming £100 billion plus of taxpayers' money each year.

To proceed would make matters worse. Lansley's Bill cannot be put right through amendment. More damage can only be avoided by dropping or defeating the Bill.

■ **FURTHER Details and comment:** John Lister
07774 264112 email john.lister@virgin.net

■ **Useful websites:** www.healthemergency.org.uk,
www.keepournhpublic.com