



David Cameron: a personal guarantee of chaos

David Cameron's speech outlining five "personal guarantees" and trailing some proposed changes to the Health and Social Bill has been welcomed by some as a "significant change" and a "step in the right direction".

However, a detailed analysis shows that not only was there nothing in the speech to seriously address the concerns that have been raised about this Bill, but that the proposed "compromise" options could make it even worse rather than better.

Monitor

David Cameron promised that Monitor's duties would change:

Now, as our legislation currently stands, Monitor, the health regulator, has a duty to promote competition.

This could be misinterpreted and we don't want any doubt in anyone's mind.

Monitor's main duty is to protect and promote the interests of people who use health care services and it will use competition as a means to that end. Not simply to promote it or prevent it, but to secure the services patients need.

It will be tasked with creating a genuine level playing field, so the best providers flourish and patients get a real choice.

And when I say that, I mean it.

I mean a genuine level playing field.

..

Monitor will now have a new duty to support the integration of services – whether that's between primary and secondary care, mental and physical care, or health and social care.

However, these changes are neither as significant nor as welcome as they might first appear.

Firstly, Cameron's statement on the main duty of Monitor appears to simply repeat the existing wording of the Bill, which describes the "main duty" of Monitor as "to protect and promote the interests of people who use health care services ... by promoting competition where appropriate". This is not a pledge to amend the Bill, but a defence of its original drafting.

Secondly, the government have already issued plans to create a "genuine level playing field" and the powers for Monitor to do so are contained within the Bill. This is not, however, designed as a defence of the NHS against cherry picking or undercutting by private competitors – quite the opposite.



Instead, the proposal outlines a series of what the government believes to be unfair disadvantages suffered by private providers compared to the NHS – including access to the public dividend capital (which the government admits is the most financially efficient source of investment for public infrastructure), the NHS pension scheme and even the fact that private providers must pay corporation tax.

The government has proposed to address this “problem” by developing the NHS tariff in a way that would allow different prices to be paid to different providers – so that private providers, for example, are paid back their corporation tax through a “bonus” on the tariff.

The suggestion that there would be a blanket subsidy for private providers did lead the government to bring forward an amendment at Committee Stage of the Bill stating that the categorisation of provider types could not be on the basis of their ownership.

This does not, however, address the basic issue – ministers confirmed that the pricing methodology would still take account of the factors originally outlined. So an individual private provider could still claim a “bonus” on the tariff for their tax, even though there would not be a simple flat rate extra for all private providers.

The government’s policy documents make clear that they consider the current playing field is weighted in favour of the NHS, so when Cameron pledges “a genuine level playing field” he is actually proposing a subsidy for the private sector.

Nor is the duty to promote integration as helpful as it seems – Cameron appears to mean integration across sectors at a macro level rather than ensuring that care for patients by specific providers is integrated. In short, he means integration *instead of* co-operation rather than *through* co-operation. He is supporting Lansley’s argument (one that misunderstands the complexity of healthcare services compared to running a mobile phone network) that the private sector integrates vertically even as it competes horizontally so that integration and competition can therefore co-exist. Individual providers will continue to be fragmented by outsourcing and compete for patients rather than co-operate for their care. But the need for integration is not just across sectors or levels of care, it is also between different providers – something that is hard to achieve when they are competing.

The government rejected amendments to give Monitor duties and powers to promote and enforce collaboration and integration during Committee Stage – ministers do not seem to have changed their mind on the evidence of Cameron’s remarks.

Nor does Cameron address Monitor’s powers. This is important because many of Monitor’s powers are linked to specific duties – and their duty to promote competition comes with an armoury of weapons that can be deployed for that purpose. For example, they may insist that NHS hospitals share facilities such as operating theatres or scanners with private competitors who do not have their own equipment. They do not



even have to consider the clinical impact of such a demand. And it may only made “in order to promote competition in the provision of health care services” – not for any other purpose.

In fact, Monitor’s powers include the draconian ability to impose any requirement on a license holder that it deems necessary to “promote competition” – but only to promote competition.

Finally, a change in the overall duties of Monitor may make little difference in practice. Cultural attitudes, senior staff appointments, etc will inevitably determine their approach more than the precise phrasing of their duties in legislation, particularly as Monitor will presumably retain eight secondary duties and twelve matters it must “have regard to” in carrying them out, along with provision that where they conflict, it may resolve the contradiction in whatever “manner it considers best”.

Furthermore, the regulator’s board is appointed by the Secretary of State and in so far as it is accountable to anyone, that will be who they answer to. Given that Andrew Lansley authored this Bill and the policy behind it in the first place, some minor tinkering with the duties of Monitor, while its powers remain intact, should reassure no one.

2013 Deadline

Cameron implied (and it has since been heavily briefed) that the 2013 deadline for consortia to be operating would be dropped and the Board given greater oversight:

We will make sure local commissioning only goes ahead when groups of GPs are good and ready, and we will give them the help they need to get there.

And the NHS Commissioning Board will oversee commissioning on behalf of the Secretary of State.

This proposal makes the problem worse, not better. It threatens to recreate the worst elements of GP fund-holding in the 1990s, and create a whole new problem of postcode lotteries as the country is covered in a patchwork of different commissioning systems.

This will also inevitably lead to greater cost and confusion as different systems will then be needed to manage the different arrangements over the country.

Furthermore, this may leave commissioning in the hands of “enthusiasts” who are clearly unrepresentative of the wider profession and may even have private interests or political leanings that will lead them to push competition and privatisation in their own area.

The proposal raises more questions than it answers. What will happen if some GPs in an area wish to retain the PCT while others wish to go ahead with their own



consortium? What happens where a consortium goes ahead covering a fraction of a PCT area?

Clinical commissioning

Cameron suggested that consultants and nurses would be put on consortia boards and other professionals brought together in to “clinical senates”:

Hospital doctors and nurses will be involved in clinical commissioning.

We will also introduce clinical senates where groups of doctors and healthcare professionals come together to take an overview of the integration of care across a wide area.

This appears to suggest that one consultant and one nurse be on each consortium board, and that a new body called a “clinical senate” be created.

This fudge just illustrates the problems inherent in trying to amend the flawed proposal for GP-led commissioning rather than considering how to create clinically led commissioning from a blank page. A bad policy has simply been made even more illogical by trying to graft on elements of an entirely different framework.

Consultants and nurses have a huge variety of different specialist areas and it will be near impossible for just one of each profession to add a significant range of expertise to a consortium board. Doctors and nurses only make up around half of the NHS clinical workforce, so a huge range of allied health professions remain excluded.

This also just seems to add to the problem of conflicts of interest where “purchasers” are also providers, which Cameron said nothing to address. Though there is much benefit in ensuring that NHS commissioners are closely linked to NHS providers it is hard to do this within the overall system created by the Bill – it appears to be a recipe for private competitors to mount legal challenges if they are not commissioned, assuming that the consultant and nurse are even from NHS providers, which is not specified.

It is hard to assess how the clinical senates will work or fit in to the structures of the NHS – either now or as proposed in the Bill – given the absence of any concrete detail. Will they act as an “upper chamber” to the consortia boards? At cluster level? Work with the CB regional offices? How do they relate to existing clinical networks? Will they be staffed? We do not know.

At worst, however, this seems to add another layer of management on top of the new bodies that the Bill is already creating. Again, there is no explanation of how this can be squared with managing conflicts of interests within a split purchaser-provider system.



Greater clinical involvement in commissioning could have been achieved without these problems were that the objective at the outset – but by attempting to shoehorn it in to this Bill, it threatens to just add yet more confusion, chaos and cost.

Waiting times

Cameron promised to retain the 18-week waiting limit in the NHS Constitution:

So we're keeping the 18 week limit.

That's in the NHS contract and constitution. And it's staying.

This is a strange pledge, as there was no suggestion that it was going to be removed. The problem is that the government is not planning to enforce it, and NHS bodies legally need only “have regard to” it. Many commissioners will therefore attempt to produce the demanded “efficiency savings” by simply making patients wait longer, while Foundation Trusts will likely add to the problem as they reduce their NHS capacity to exploit PPI.

What he didn't say

Press briefings ahead of Cameron's speech also suggested that he would promise that the Bill would not mean privatisation and that it would retain the NHS as a national service, preventing postcode lotteries.

However, Cameron did not actually use the word privatisation in his speech at all, simply pledging:

...we will not be selling off the NHS, we will not be moving towards an insurance scheme, we will not introduce an American-style private system.

However, no one has suggested that the form of privatisation promoted by the Bill will be a block sale of NHS units, though there is certainly the prospect of NHS assets ending up in private hands. Nor has anyone suggested that the Bill is designed to cause an overnight switch to a US or continental style insurance system. But the government's concept of the NHS is nonetheless very much a system for paying for healthcare, rather than providing it. And many of its functions will be privatised as a result – something that Cameron does not actually contest, let alone promise to prevent.

Nor did his remarks on national standards indicate any change in approach. Instead, he attacks “one-size-fits all monolithic state provision” and argues that “when GPs are in control of their budgets, they can decide the best possible care for their patients and design health strategies that suit their local area.” His promise that the NHS Commissioning Board will issue “clear national quality standards” is simply a restatement of what is in the Bill.



None of these points address the real problem: that GP consortia may determine what NHS services are available in their area, and the Secretary of State no longer has the duty to provide comprehensive healthcare. Again, Cameron's "guarantee" is simply a defence of the existing Bill, not a promise that it will change.

Nor did he address any of the vast range of other objections to the Bill, not least those set out in the Liberal Democrats' conference policy motion.