NHS Bill FAQs

Campaign for the NHS Reinstatement Bill

On Friday 11 March, the National Health Service Bill 2015-16 will have its second reading in Parliament, tabled by Green MP, Caroline Lucas. It currently has the support of 76 MPs including Lucas, Jeremy Corbyn and John McDonnell.

- We need your support to get more MPs to be present.
- We ask you to add your name to the list of MPs supporting the Bill.
- Please support the Day of Action on 11 March.

Q1: Is the NHS Bill another big reorganisation that the NHS cannot afford?

A1: Some argue that we cannot face another NHS reorganisations. *In reality, the NHS cannot afford another 4 years of the current destructive disorganisation reaping havoc on the NHS right now.* The Health & Social Care Act 2012 (HSCA) was implemented by the Coa dangerously *destabilised state*. Clinical staff are extremely anxious at the vastly escalating time and resources of senior clinicians and managers being taken away from frontline services and given to competitive and defensive tendering for services, including core services*. Bits of specialist services are being privatised threatening the remaining NHS core services.* For example, the loss of elective orthopaedic surgery to a trust, undermines offer emergency trauma services delivered by the same team of orthopaedic consultants, nurses, therapists and related services . In Nottingham, the removal of non-urgent dermatology into private hands has led to the demise and loss of acute dermatology services for adults and children.

The NHS Bill secures the future of the NHS in England by putting it back fully into public ownership, management and accountability. It gives the Secretary of State for Health the duty to provide the National Health Service. It stabilises the NHS and protects it from further fragmentation. Labour now has a clear choice for health policy in England: either to continue on the market road to a fragmented, insurance-based model of health care or to re-establish the universal integrated public service model of Scotland and Wales.
The argument of 'no more top down reorganisation' is no longer credible and is a diversion from a debate about the real issues.

Q2: Will the ending of the purchaser-provider split inhibit service redesign?

A2: The purchaser-provider split was only introduced to facilitate the market, PFI and privatisation. It uncoupled service providers from area health authorities and, in so doing, from local populations and their needs assessments. Providers must compete for patients and service income (from across local areas). This also has an impact on resource allocation making it difficult to ensure that funding flows to services on the basis of needs of an area.

The pricing mechanism bears no relationship to the resource allocation formulae given to areas. This affects and disrupts service planning and removes providers from local control and accountability, especially when marketised. The market has created new costs including the costs of contracting and marketing (which have more than doubled from 6% to

14% and are likely to move towards 30% with full market contracting). It has also inhibited service planning (due in part to the removal of public health and population-based information). Providers must now respond primarily to tariffs and plan how they can generate income for security and survival*. Clinical need no longer has primacy.*

For more than 40 years there was no internal or external market, the NHS was able to ensure that services were planned and delivered on the basis of needs of local residents at low cost. Even now, clinicians are at the forefront of service development and innovation, only held back by underfinancing, diversion of energy to market processes such as tenders, and competition militating against cooperation.
See also http://www.nhsbill2015.org/wp-content/uploads/2015/04/Rebuttals-to-NHS-Bill-criticisms.pdf

Q3: Are the Health & Social Care Act changes that important, the NHS is still free?

A3: The principle of healthcare to all, free at the point of use, has been shattered by the legal changes of the HSCA. It has ended the right to healthcare for all who need it (universal access). *CCGs are person-based not area-based in their responsibilities.* And there is no longer the right to a full range of health services (comprehensive healthcare). *This has allowed numerous examples where CCGs are restricting or removing health services.* What the public in England is entitled to under the NHS is already changing *back to the postcode lottery*. Real examples include restriction of hearing aid provision or cataract operation to one side only; vasectomy being removed from NHS services; or elective surgery for joint replacement being restricted.

Q4: Aren't you exaggerating the amount of private contracts?

A4: Since April 2013 the enforced tendering and private contracts has escalated. Private companies are winning a high proportion of these contracts. In the last five years there has been a 50% increase in the amount spent by PCTs/CCGs and Trusts on non-NHS providers, increasing the total spend from £6.6bn to £10bn *per year*. Although the Conservatives claimed that private contracts had only changed by a small proportion by the election of May 2015, the lead-in time for the 2013 implementation means that the risk is escalating rapidly now.

Q5: Isn't the NHS too big and in need of change? It needs to be broken up and devolved.

A5: The vanguard projects of Hunt and Stevens *('Five Year Forward View')* and now not only breaking up the NHS, but they threaten important aspects of governance. National standards of services offered by the NHS provide a democratic overview and ensure health equalities are maintained. National standards of clinical care will be lost. Loss of national terms and conditions of staff threatens the quality of training and the right to train and work across the NHS with similar standards for experience and skill training; and national parity of pay and pensions is also threatened if national terms and conditions are lost, leading to further inequality as big trusts in more attractive areas are able to attract staff more easily than others.

Q6: What will happen to all the employees in CCGs and trusts that the NHS Bill abolishes?

A6: Firstly, the Bill includes a clause ensuring incremental change back to a national NHS. Secondly, the essential change is that CCG staff and commissioners *will be working for the public NHS* and not for a separate organisation whose major task is to put services out to competitive tender. They will be working with the local communities, local authorities and health providers to work out the needs of the local population and to plan services within the NHS through cooperation and not competition.

The Bill transfers staff to the NHS and will not permit large redundancy payments unlike what happened after the Health and Social Care Act. There, many PCT employees were paid hundreds of thousands of pounds individually, only for them to continue working for the CCGs. Some jobs created purely for the market will go. But expertise and experience

support services. Costs will be saved and some available to repair the damage since 2010.

Q7: Isn't the cost of marketisation exaggerated?

A7: A whole army of staff is now employed by trusts to manage contracts, to monitor them, to tender to keep their own services or to tender to compete for new services for survival. Another army is employed to find enforced savings to meet CCG and NHS England imposed annual and 5-year plans, when everyone knows that the NHS is underfunded. Currently the NHS, after 10 years of *annual* 2-4 -6% annual reductions in required funding, has no room for manoeuvre a deficit of £3bn is projected at end of financial year 2015/16. Average trust deficit is £15m. We need an adequately funded NHS, where the money goes on services and management of services, rather than on contract monitoring, tendering, marketing, external consultancy payments and cost improvement programmes. A conservative estimate is that an end to market mechanisms and privatisation will save the NHS £4.5bn annually.

Q8: The NHS is a bottomless pit that we cannot afford. Is a universal health system unaffordable given the enormous gains in life expectancy?

A8: Not only is there no evidence to support these claims, there is evidence to the contrary. The assertion that the rising cost of an aging population makes the NHS unaffordable is a myth. (See http://www.nhsbill2015.org/wp-content/uploads/2015/03/Myth-of-Ageing-fact-sheet.pdf).

The NHS was a world leader for cost-effectiveness in the June 2014 *Commonwealth Fund* report. The NHS came out top of all developed health services and first in 8 out of 11 criteria This analysis was based on annual data 2010/12 *before the impact of the HSCA in England from April 2013.* By 2010, the percentage of GDP spent on health in the NHS had reached the European average. Since then it has slid back down the rankings and our performance is suffering too, as a result of financial strangulation of the NHS. Cancer targets, A&E performance and waiting lists are worsening due to underfunding. 4000 nurse training places were slashed since 2010 leading to shortage of nurses and excessive payments to agencies for agency staff propping up an understaffed NHS. A reinstated NHS will give high quality care and be cost-

Q9: Market-driven competition and choice is to be preferred because it increases quality.

A9: Since 1948, the UK has had a universal public health system free at the point of delivery and health care funded through central taxation. The UK NHS became the model health systems across the world: it offered the lowest cost, most efficient and fairest system, and guaranteeing health care to all its citizens without fear of charges or denial of care. In 2012, after two decades of market incrementalism, the universal public model was abolished in England – *NB: Scotland and Wales still retain it* in favour of the market driven model of the US and other countries.

The US is one of the richest countries in the world, it has the most expensive health care and in spite of that it denies more than one in five of its population access to health care. Overtreatment, denial of care and catastrophic costs go hand in hand in its many different health systems. Those countries that have adopted the US model of mixed funding have more marketisation, the greatest inequalities in access and lack of coverage, and highest personal costs. *A universal public health care system is the hallmark of a civilized society. It is morally desirable, politically necessary and financially affordable for governments to legislate for its citizens to that end.*

The question of how much any country should spend is inextricably linked to the chosen model, the degree of marketisation and number of inequitable health systems a government is prepared to tolerate in its country. To this end an NHS Commission into how the NHS should be funded would be a travesty. The question is: *Do we want an NHS?'* And if so: *'Will politicians allocate sufficient funds for that purpose?'* A European average level of funding for the NHS has been shown to deliver an above average quality health service prior to the Health & Social Care Act.

Conclusion

We must win back the NHS; must stabilise and secure its future; and reorganise it back to health from condition critical. *Only a change in the law can save it.* The NHS Bill reinstates an NHS that is publicly managed, publicly provided and publicly accountable. It reasserts the principle of healthcare that is free at the point of use for all who need it.

We are calling on all MPs to support the Second Reading of the **NHS Bill 2015-16** on 11 March so that it can progress and have a serious chance of more thorough scrutiny and debate.

More information is available:

Campaign for the NHS Reinstatement Bill	www.nhsbill2015.org
NHS Support Federation	www.nhscampaign.org/
OurNHS	www.opendemocracy.net/ournhs
Keep Our NHS Public	www.keepournhspublic.com

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