Dear Colleague,

The health bill currently in the House of Lords is now undoubtedly a better bill because of the Liberal Democrats. A number of people deserve credit for improving this bill. Firstly, and most important, are our party members who made it clear at our conference in Sheffield in March last year that we would not accept a bill that puts profits before patients. We secured a “pause” in the legislation, which led to a number of substantial changes to the bill.

None of the changes in the Bill could be described as “substantial”. Some were meaningless, such as the renaming of “Any Willing Provider” as “Any Qualified Provider”, without any change in the procedures concerned. This is because the AWP process set out in EU law must be followed in its entirety and so the promised extra qualifications have not been and cannot be added.

for instance that competition could only be on quality and not on price.

Under EU procurement law one of two procedures must be used whenever public sector procurement is carried out through competitive tendering. One is purely on cost, and the other (the “Most Economically Advantageous Tender”) combines cost and quality. So any statement that procurement in the NHS will be only on quality is wrong.

Furthermore, procurement on the basis of ‘quality’ from a market of providers who are incentivised to maximise their income is extremely difficult because of information asymmetries and other forms of market failure that are common in health care markets.

Since the "pause", there have been further changes, which owe a great deal to the hard work of our health minister, Paul Burstow, and our parliamentary health committee led by co-chairs John Pugh and John Alderdice. Second, our Liberal Democrat peers in the House of Lords, led superbly by Judith Jolly, have done an outstanding job scrutinising the bill line by line. With the help of the House of Lords constitution committee, several eminent Conservative peers, Labour's Lords team led by Baroness Thornton and Lord Hunt, and a determined group of crossbenchers, many members of the medical professions, an all-party consensus has now ensured that the Secretary of State will remain responsible and accountable for a comprehensive health service financed by taxpayers, accessible to all and free at the point of need.

- All the parties may indeed have reached such a consensus, but if so, all are misinformed: this is not the case in law. The duty of the Secretary of State has, as preferred by the private healthcare lobby, been much reduced.

- The Bill as it now stands still reduces the duty of the Secretary of State in relation to providing free and comprehensive healthcare; Clause 1 has been
rewritten several times, but while every version effectively cuts the accountability of the Secretary of State no explanation of the insistence on change has ever been given. Why does the government neither agree to retain the 2006 wording for the Secretary of State’s responsibility nor cease to claim that the change is at once too unimportant to explain and too essential to concede on?

- This removal of accountability fits with the new arrangement that the market will set the amount and type of health care services made available, and the fact that any intervention in such a market by the Secretary of State could be penalised as an abuse of a dominant market position. Retaining responsibility by removing Clause 1 could see large fines levied against the government under competition law.

- Preventing the application of competition law is not achievable by declaring that it will not apply. It also cannot be achieved by trying to remove the sector competition regulator Monitor, which is like trying to prevent crime by abolishing the police. Competition law must be applied whenever competitive tendering or AQP are used; the triggers in the Bill for the application of these processes are section 73 plus use of the term "patient choice", as in competition law this is a synonym for competition.

- Clinical Commissioning Groups are not accountable to the Secretary of State, and they have no duty to secure comprehensive health services, nor mechanisms to enable them to do so. Providers may offer whatever services they please, and the economic regulator similarly has no duty to ensure a comprehensive health service,

- The Secretary of State will not be responsible for a comprehensive health service, and it is not to be expected that the competitive markets that will shape provision will generate a comprehensive service that optimally addresses the medical needs of the population. Indeed such an outcome would be surprising, since the market allocates service provision by profit opportunity, with more providers entering profitable fields, while activities where profits are not forthcoming will be abandoned by potential providers. In particular people with multiple chronic medical conditions tend to be challenging and expensive to treat, and it will be they who are least well served by the new arrangements.

- Together these arrangements bring to an end comprehensive health care in England and an end to the principle of health care available on the basis of need alone, a core principle of the NHS since 1948.

- Almost all the medical associations have declared outright opposition as the implications of the bill have become clearer. Even the surgeons assert that the Bill, if passed, will damage the NHS and widen healthcare inequalities, with detrimental effects on education, training and patient care in England. This is despite the fact that surgeons have by far the most to gain from the changes: they dominate existing private medical practice, and senior surgeons have been integral to the NHS privatisation plans right back to Professor Ian McColl in 1987 and Lord Ara Darzi during New Labour’s tenure.

*This should guarantee the future of the NHS, one of Britain's greatest social achievements. In addition, led by Phil Willis and others, arrangements have been put in place to make the UK a world leader in medical research,*

- These research arrangements exclude any mechanism to recoup for the NHS any of the costs of collecting and sharing the data with the pharmaceutical industry,
once it manages to commercialise any fruits of this research. This amounts to a subsidy from a cash-starved NHS to big business.

to raise the status and protect the independence of the Public Health service,

- While the government has laid claim to having strengthened the Public Health service, a more thorough analysis of the new arrangements reveals that Public Health has in fact been weakened, compromised and made unsafe. The independent voice of PH specialists has been weakened. Many public health functions and services are being transferred to local government but without adequate legal safeguards to ensure that they are adequately funded or even continued at all. The fragmentation of services and the damage to the country's health information system - caused by competition and privatisation – will undermine critical public health programmes such as infectious disease control, as well as the ability to respond to public health emergencies effectively and rapidly.

- Some parts of the public health remit have already been privatised. Examples include much of the health promotion budget, which has been tendered out to public relations companies, and the “health care in public health” tasks which are being outsourced as part of the commissioning tasks reserved for the private sector “Commissioning Support Organisations”, most of whose work was formerly carried out by public sector staff.

and to ensure that all profits from the treatment of private patients in Foundation Trust hospitals must benefit the NHS.

- Foundation Trust hospitals have not-for-profit status, so to do anything else would be illegal.

The Bill has now undergone more than 200 hours of scrutiny and had more than 1,000 amendments made to it, amendments that have put patients and the people who know them best at the very heart of the legislation. This is not the bill that we debated as a party last March. Crucially, some elements of Labour’s 2006 Health Act, which opened up the possibility of a US-style market in the NHS, have been radically changed, such as the gold-plated contracts for the private sector, which allowed a Labour government to pay private providers a total of £250m for operations that weren’t even performed. We can also take pride in the fact that it was the Liberal Democrats who changed this bill to ensure that no government will once again be able to favour the private sector over the public sector like the last Labour government.

- This is certainly a welcome change but did not require a Bill. However, it is simply untrue that the perverse favouritism of the current and last government for private providers will be ceasing. The most recent version of the Department of Health documentation shows that 14% more will be paid to private sector providers than for public sector providers carrying out the same tasks, as explained below.
The bill also now has in place safeguards to stop private providers "cherry picking" profitable, easy cases from the NHS, and we have made sure that private providers can only offer their services where patients say they want them.

- Cherry picking has **not** been eliminated. Providers are required to set out transparently the eligibility criteria determining which patients they are prepared to treat. This however does not **prevent** cherry picking, it merely documents it.

- Despite any reassurances they may give, the Government will not eliminate cherry picking by providers because the process we call by that name is one of the fundamental mechanisms of the market model. Providers shift their efforts to the activities most profitable to them and abandon other service provision. This, in the market model, is supposed to result in optimisation, as consumers pay more for scarcer services, and fail to pay for services they do not value.

- In the real world of health care, service provision should respond to medical need not to profit maximisation, and the outcome of profit-driven healthcare is far from optimal medically. We know from countries which arrange their healthcare in this way that it results in untreated disease, unnecessary suffering and mortality, exploitation of patients who are provided unneeded and sometimes harmful interventions, and in some cases the spread of infection.

We are also clear that no one should be allowed to spend public money without telling us how they are going to use it. That is why we have insisted that decisions about patient services and taxpayers' money must be made in an open, transparent and accountable way.

- In that case the Bill should be amended to include obligations for private sector providers to disclose full information about their patient intakes and outcomes. At the moment they have no obligation to supply or even collect this information. Where the public sector holds this information it uses the “commercial sensitivity” provisions in the Freedom of Information Act to block exactly the kind of information that patients require for a properly informed choice of provider.

We now have a bill that delivers on the issues that Liberal Democrats have campaigned on for years. For the first time, there will be real democratic accountability in the NHS through new Health and Wellbeing Boards that will give councils a real role in shaping local health services. Public health will finally be returned to its rightful place in local government. Integration between health and social care will become the norm rather than the exception.

- Health and Wellbeing boards have a minimal elected element, and no right to do more than write letters of complaint.

- Provisions for local HealthWatch in the Bill were never strong and have recently been significantly weakened. Not only is HealthWatch England being set up without any effective way to influence events, but it is being set up as a subunit of the scandal-hit Care Quality Commission. Many HealthWatch complaints about care provision would implicate the CQC for failing to address the problem, thereby creating a conflict of interest for the CQC.
However, given how precious the NHS is, we want to rule out beyond doubt any threat of a US-style market in the NHS. That is why we want to see changes made to this bill that have been put forward by our Liberal Democrat team in the House of Lords to make sure that the NHS can never be treated like the gas, electricity, or water industry. First, we propose removing the reviews by the Competition Commission from the bill to make sure that the NHS is never treated like a private industry.

- This change is positive but is not in itself of much benefit. It will not stop the NHS being “treated like a private industry”. This will happen because the Government intends to pass the Bill, and that will subject the whole NHS to the EU requirement to enforce competition law.

- Unfortunately current Liberal Democrat attempts to tinker with regulators and make declarations about applicability of bodies of law to the NHS are meaningless and ineffective.

Second, we want to keep the independent regulator of foundation trusts, Monitor, to make sure hospitals always serve NHS patients first and foremost.

- Monitor, the economic regulator, will try to fulfil this task through enforcing competition law in the NHS. The Government is required to ensure this is done wherever AQP or competitive tendering are used in commissioning. If there is no sector-specific regulator like Monitor then this duty defaults to the Office of Fair Trading.

- Significantly, it is never patients which take advantage of these “rights” in either England or the Netherlands, where national health care provision was turned over to competitive markets last year. Indeed the Patients Associations in both countries are protesting about the effect of these “patient rights” on healthcare delivery. The “patient rights” to provider choice are frequently used, however, against the public sector by corporate providers: see for example the current case in which Assura has brought a competition complaint to the health authorities in Yorkshire.

Third, we will introduce measures to protect the NHS from any threat of takeover from US-style healthcare providers by insulating the NHS from the full force of competition law.

- Competition law applies whenever AQP or competitive tendering are used. According to the published guidance from the Department of Health, their use will be compulsory in securing all NHS services (except for contract renewals).

- If it is the Liberal Democrats intention to protect NHS hospitals from takeover, then the only way to achieve it is to call for the immediate abandonment of the Bill, as the outcome of passing it will create exactly this vulnerability. It should be noted that there has been intensive lobbying of Ministers by US healthcare corporations, and it is plain from the detailed content of the Bill that their requests have been encoded into the reform. It is to be expected that such corporations will be among the biggest winners from the Bill. Elderly people, the chronically ill, and the families of disabled children are expected to be the biggest losers.
Incidentally although we are switching to US-style care (with all the problems showcased in Sicko) it is not just US-based companies which will be taking over our healthcare provision: a German company has been awarded a contract to run 20 hospitals, a South African company which has been implicated in organ trafficking is slated for new NHS contracts, and every single contract tendered out will have to be advertised throughout the EU.

The opportunities for these transnational corporations to provide NHS-funded services will mainly come from the shutting of Foundation Trust hospitals which cannot consistently make surpluses. The Bill creates new arrangements for these financially-triggered shut-downs; there is no provision for communities to prevent the loss of valued, busy hospitals in this way.

We will also insist that anyone involved with a commissioning group is required to declare their own financial interests, so that the integrity of clinical commissioning groups is maintained.

Declaring such interests is essential but inadequate. GP leaders have repeatedly requested the government to block conflicts of interest that could damage the relationship between doctors and patients, but these calls have been ignored, because the new US-style system relies on a tension between conflicts of interest at primary care level (GPs) and opposing conflicts at secondary care level (hospitals) to control the soaring cost inflation that otherwise results from paying providers for all the services they can sell. None of this serves any function except to facilitate market entry for the healthcare corporations which have been lobbying the government for profit opportunities.

“Quality premiums” will be awarded to GPs who cooperate fully with the rationing of care that will be a feature of the new system. In other words, GPs who are willing to deny care that would benefit their patients will make more money by so doing. GPs are right to fear that public knowledge of this information will engender mistrust between doctor and patient.

There are also no blocks on other inappropriate transactions to allow GPs to profit by either making or refusing referrals to patients. Some of the “entrepreneurial” GPs that Andrew Lansley has set up as leaders in his reform have already profited from opportunities of this kind.

The Liberal Democrat leadership accepts that conflicts of interest will occur. A register is to exist but there will be no sanctions. This is an inadequate response; as well as the aforementioned, multiple conflicts of interest are embedded in the system including the following:

- The National Commissioning Board has twin roles, running what is left of the public sector NHS while at the same time overseeing the privatisation through outsourcing GP commissioning to a group of preferred providers including McKinsey, KPMG, McKesson and several insurance companies.
- The interim Chief Executive of Monitor and its two new non-Executive directors all have senior experience in privatisation of public services.
- The Chair of the Competition and Competition Panel, which will handle competition issues within the NHS, receives a £800,000 a year salary from
McKesson Inc, which is already a major outsourcing service provider to the NHS and which stands to gain more business. He is also linked to two other major investors poised to benefit from passage of the NHS Bill.

- Two of the four economic studies being cited by the Government to support their assertion that the organisation of NHS service provision through competitive markets will not damage quality of care were written by anti-trust members of the advisory panel to the Cooperation and Competition panel.

Finally, we will put in place additional safeguards to the private income cap to make sure that foundation trusts cannot focus on private profits before patients. These changes are needed, not just because of this bill, but also to plug the holes left by Labour’s 2006 Health Act that allowed private providers to make profits at the NHS’s and taxpayers’ expense. It was that act that started the process of the marketisation of the NHS by allowing private providers to be paid on average 11% more than the NHS.

- Despite the claim of a “level playing field” for the mixed public-private competitive market, in fact it will be operated at a 14% advantage in favour of the private sector. This calculation is reported in the Combined Impact Assessments of the reform, last issued at the end of 2011, and was carried out by KPMG, which is among the private organisations expected to gain most from the passage of the Bill. It awards compensation to the private sector for their exposure to corporation tax and VAT-exempt supply status and for more generous public sector pensions. It also penalises the public sector for the “advantage” of access to “cheap” funding through PFI. None of the cost advantages to the private sector are included in this calculation.

- Items that should outweigh the tax adjustments suggested by KPMG include the sizeable costs of training medical students. It would also seem reasonable to include the substantial extra costs to the NHS of the “blue light specials”, the ambulances which leave from the back doors of private hospitals which have no critical care facilities. They take patients in life-threatening condition by medical errors to nearby NHS hospitals so that staff there can save them.

These changes will ensure that competition and diversity in the NHS will always be done in the interests of patients and not profits.

- This will only be the case from the perspective of the competition authorities, who consider act on the basis that the only important patient right is that of choice of provider, a right of limited utility to patients but used in practice by corporate providers trying to break into new markets. The competition authorities accordingly never require any proof that competition is beneficial, but require that patient benefit be proved for any increase in cooperation.

- Both patients and the taxpayer are expected to lose very heavily from the forcing of “competition and diversity” into the NHS.

- The Department of Health has set an explicit target (PHF09 in the 2012/3 Operating Framework) to increase the proportion of non-public sector provision purchased with NHS funding. This creates a systematic bias in commissioning that
may often conflict with patients’ wishes: surveys all show that patients prioritise access to a good local service.

Next month we will return to where this process all began a year ago when we meet at our party’s spring conference. Once these final changes have been agreed, we believe conference can be reassured that it has finished the job it started last March and the bill should be allowed to proceed. We believe these changes will appeal to those in the House of Lords and the House of Commons who share our commitment to the NHS, and believe it can now embark on the reforms that matter: putting patients at the centre, working with local communities, and responding to the financial challenges of an ageing population.

That will demand a united effort not only from the NHS but from all of us who cherish it.

Then the essential work will begin to ensure that the necessary changes are introduced as smoothly as possible in full collaboration with everyone who works in the NHS. The real test will be to demonstrate tangible benefits to patients. After all, in the end, it is the interests of patients which should count most of all.

Best wishes Nick Clegg  Baroness Shirley Williams

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i Rose D. NHS fairness tsar urged to quit by doctors over ‘conflict of interest’ following £799,000 payment for U.S. private health giant. 4 march 2012