Public Matters Briefing Paper

NHS BILL 2021

Examining forthcoming proposals for 'Integrated Care'

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PREFACE

This briefing is designed to provide to elected representatives at all levels a broader view of the changes that have taken place in the NHS in England under Simon Stevens' leadership since 2014 than is usual both in the media and in policy circles. These changes, already put in place, will be confirmed in legislation expected in the Queen's Speech on May 11th.

Simon Stevens, CEO of the NHS in England, has announced his intention to step down in July. This is not unexpected. Stevens has always indicated that he had one clear objective: to see through his 2014 Five Year Forward View to completion in the creation of 'Integrated Care Organisations'. What is not necessarily clear to the public and to politicians at central and local government level, who are involved in these changes, is the extent of the influence of US Medicare providers and insurance corporations on his process of change. This is despite the fact that the other contenders for the post when Stevens was appointed and those who are being considered to replace him are from the international corporate sector, as he was.

Local Authority adult social care services, which in theory provide a major component of 'Integrated Care', have been moved out of council provision over time. In 1979 64% of residential and nursing home beds were still provided by local authorities or the NHS; by 2012 local authority share was 6%; in the case of domiciliary care 95% was directly provided by local authorities as late as 1993; by 2012 it was just 11%. A similar incremental change has been reflected in private and voluntary sector provision in the NHS in England since 1990. It is not yet so extensive, but covers all aspects from property ownership and management to support and clinical services.

Public Matters has a long standing concern that there has been little in the policy domain to question or challenge the reshaping of the NHS under Stevens' leadership and, indeed, over most of the last 30 years. In the case of Stevens this appears to come from an unwillingness to challenge his contention that he speaks 'for the NHS itself'. High profile think tanks such as the King's Fund and the Nuffield Trust have been involved over time in lobbying for the NHS to learn how to reshape itself from US Medicare providers, in particular Kaiser Permanente, the Veteran's Association and the Spanish Valencia system, itself owned by the Centene Corporation and based on the US model. Their briefings and reports therefore reinforce the view that NHS England is pursuing.

We acknowledge that there has always been a close cultural and political relationship between the USA and the UK. Indeed for many years it was characterised as the 'special relationship'. However, even the most glancing knowledge of American healthcare, characterised by journalist, Walter Cronkite, as 'Not health, not care, and not a system' shows it to have few characteristics in common with the NHS. Indeed the character of the NHS is uniquely British. It is an 'exceptionalism' which Simon Stevens has said must come to an end, as arguably it has with 'Integrated Care'.

This briefing asks whether this is genuinely the intention of our legislators and whether it would have public support were it better known and gives recommendations for a more measured approach.



GLOBAL CONTEXT

The NHS has, since its inception, been an outlier in global health terms. Most other countries which provide universal health care do so with a mix of private and public provision and a mix of state and personal out-of-pocket funding (insurance based & co-payments). The NHS began with national ownership, nationally negotiated staff terms and conditions and full publicly funded cover for all. This system also made it an outlier in terms of cost – it was cheap.

The other outlier is the US which is unique in the OECD countries because it does not provide universal coverage. Nor does it have one system of provision. It has a mix of private and public hospitals and a mix of state and personal out-of-pocket funding. But some people will bear the entire cost of their own and their families' healthcare, some will have access to the state funded or part-funded schemes, Medicare, Medicaid and the Veteran's Association and some have no cover at all.

Approximately 151 million Americans receive their healthcare coverage through an employer-sponsored health benefit plan. From 2006 to 2018, the total cost of healthcare per employee (reflecting both employer and employee costs) rose 75% while the median annual salary of a full-time American worker grew by only 25%. 126 million Americans are covered by the state-funded or part-funded Medicare, Medicaid and the Veteran's Association. Around 44 million adults in the US have no health insurance, while 38 million do not have adequate health coverage.

The US has, in aggregate of its state, insurance and co-payments, the most expensive health care system in the world, yet doesn't cover everyone. Its outcomes are poor, particularly in relation to its cost.

https://www.commonwealthfund.org/publications/issue-briefs/2020/jan/us-health-care-global-perspective-2019

CURRENT DEVELOPMENTS

The recent takeover of 49 GP surgeries in London by US insurance giant Centene has comes as a surprise and shock to many who, even without knowing much detail, are aware that US healthcare is the polar-opposite of the NHS. Before these new acquisitions Operose Health, Centene's UK subsidiary, was already running GP practices in Nottingham, Milton Keynes, Luton, Birmingham, etc. totalling 21 surgeries and practices.

Centene is now the largest GP provider in England.

The Centene Corporation is the 42nd-biggest firm in the US, according to the Fortune 500 list. It has grown by becoming a big supplier in the marketplace of the US's public healthcare systems, Medicare and Medicaid and, more recently the Affordable Care Act provisions, which are intended to keep private health insurance costs more affordable.

Medicare and Medicaid are publicly funded but privately managed and the insurance companies who handle it have a long and chequered history including defrauding the state and federal governments. In March this year the state of Ohio sued Centene for what its Attorney General called

"an elaborate scheme to maximise company profits at the expense of the Ohio Department of Medicaid and the state of Ohio. Corporate greed has led Centene and its wholly owned subsidiaries to fleece taxpayers out of millions."

https://www.ohioattomeygeneral.gov/Media/News-Releases/March-2021/Ohio-Sues-Multiple-Centene-Entities-for-Breach-of

Since the 1980s there has been a tension between providers of healthcare and the insurers in the US, because the insurance companies want to pay as little as possible and the providers want to maximise the treatments they get paid for. A system has been developed for keeping down healthcare costs for insurers and public programmes by trying to ration services, promote cheaper treatments and use incentives to keep people out of hospital. This has had various names since the 1980s, Health Maintenance Organisations, managed care, Accountable Care, hospital-at-home, place based care and **Integrated Care Systems.** Colloquially, many Americans call this system 'denial of care'.

https://www.verywellhealth.com/health-insurer-vs-doctor-care-2615095



Centene has renamed part of its UK subsidiary operations as Operose Health. It has made acquisitions other than the 70 GP practices across the country (with a combined patient list of 500,000). In 2020 the Competition and Mergers Authority investigated the merger of British private health companies Circle and BMI, both of which provide services to the NHS, and in which Centene has a share. The CMA considered its share large enough that it may have resulted in Centene being able to exercise material influence over the merged entity.

https://assets.publishing.service.gov.uk/media/5ec3e28cd3bf7f5d411ada9c/SLC_full_text_decision.pdf

Centene is also a growing player in NHS Integrated Care Systems.

Samantha Jones was appointed as NHS England's New Care Models Programme Director in January 2015 leading the implementation of new models of care as outlined in the NHS Five Year Forward View.

In December 2018 Jones was appointed CEO of Centene UK. Interviewed about her new role she said

"what I do know is that the capabilities and work in integrated population health systems in Ribera Salud in Spain and from the US, which are supported and backed by Centene are those which we could capture and use in the UK"



Samantha Jones has now moved into a new role as a senior civil servant advising the Prime Minister on Health Integration.

Integrated Care Systems are how the NHS has been reshaped since 2014 by NHS England's CEO, Simon Stevens, through various stages of 'transformation' including his 5 Year Forward View, Sustainability and Transformation Plans and the NHS Long Term Plan.

https://www.kingsfund.org.uk/sites/default/files/Integrated-care-summary-Sep11.pdf

The direct influence of Health Maintenance Organisations were used as a specific reference in parliament in relation to the 1990 Act's internal market (now a full market since 2012).





But since 2014, Stevens has used all the other US terms before finally settling on **Integrated Care**. This culminated in him saying that parliament **could catch up** with what he had been doing by passing legislation, which would,

"be a welcome recognition of where the health service will have moved to in the meantime."

It seems surprising that there has been *almost no reaction to the shocking admission that*Stevens has seen through a major top-down reconfiguration of the NHS in England without parliamentary approval. Especially since it includes changing organisational structure at the top level and closing services on the ground.

Speaking to the Heath and Social Care Select Committee (March 2021) Stevens managed to explain that the proposed legislation is at the same time

- too late (because the transformation is already too far advanced to be reversed) and
- too soon (because transformation effectiveness cannot be shown until it is further advanced).

Graham Winyard, <u>CBE</u>, ex-medical director and deputy chief medical officer of the NHS in England seems to have found it so and said so in his evidence to the Health and Social Care select committee inquiry in 2018;

"In spite of this being such 'big stuff' (...) they have adopted an incremental approach that completely subverts established expectations of the open and explicit public consultation that would be expected";

"(Accountable Care Organisations) represent another major structural change in the NHS and previous changes have always been the subject of consultation and legislation";

"In a period when the perceived paramount importance of Parliamentary sovereignty is driving fundamental changes to the United Kingdom it cannot be right that the NHS is to be transformed by using legislation designed to take it in one direction to move it in a diametrically opposite one."

"Nor should a sovereign Parliament allow the Executive to behave in this way and 'push as hard as we can to get there without Parliament itself having to legislate. If at some point down the line you then choose to do so, that will no doubt be a welcome recognition of where the health service will have moved to in the meantime.' [Simon Stevens to the Public Accounts Committee Q118]

"I very much hope that the Health Committee's hearings will be the beginning of a process in which Parliament will take back control of major decisions on the NHS and how it should be reshaped, and in so doing reassert the central importance in its operation of public bodies with proper governance."

http://data.parliament.uk/writtenevidence/committeeevidence.svc/evidencedocument/health-and-social-care-committee/integrated-care-organisations-partnerships-and-systems/written/77274.pdf

But not only did parliament 'allow the Executive to behave this way'; it requested Stevens draw up the new legislative proposals to match what he had already put into operation.

'Accountable Care' was the term used immediately prior to 'Integrated Care' but was eventually discarded by Stevens who said that he thought it was 'confusing' for campaigners who mistook it for the US model. This article by Stewart Player in Open Democracy lays out how, in fact, Accountable Care has been used as a method of preventing a proper public service model from developing in the US and dismantling the one we have here in England.

https://www.opendemocracy.net/en/ournhs/accountable-care-american-import-thats-last-thing-englands-nhs-needs/

We are conscious that people prefer 'stories' about the NHS: patient care; heroic staff; US takeovers. But for legislators it's important to understand that all these things fall within the legal framework which either allows for, or disbars, certain activities.

Neither Centene, nor the other giant US insurance companies presently active in the NHS, could have bought into the NHS as providers, or have been engaged to shape Integrated Care Systems, if the NHS hadn't already been broken up in ways which allow it to happen.



The Path to Integrated Care

and the White Paper

Almost as soon as the metaphorical ink had dried on the Health & Social Care Act (2012) a cross-party consensus began to develop that it had been 'a mistake'.

Mark Porter, chairman of the British Medical Association's governing council, said:

"Rather than listening to the concerns of patients, the public and frontline staff who vigorously opposed the top-down reorganisation, politicians shamefully chose to stick their head in the sand and plough on regardless."

https://www.independent.co.uk/news/uk/politics/government-s-reorganisation-nhs-was-its-biggest-mistake-say-senior-tories-9790247.html

These admissions came in the same month Simon Stevens produced his '5 Year Forward View' (5YFV), October 2014. Stevens claimed his blueprint for the long-term future of the NHS would bring collaboration in the place of competition and create savings whilst improving care across the board. It was hailed as the 'antidote' to 2012's 'mistake'.

The move to 'accountable' or 'integrated' care had really been prefigured by different stages of legislation over the previous 30 years since the 1990 Act, but started in earnest with the appointment of Simon Stevens to the post of CEO of NHS England. Stevens was part of Alan Milburn's New Labour health team but spent the intervening 10 years in top positions at US insurance giant United Healthcare.

Others in the running were Kaiser Permanente's CEO Bernard Tyson and Mark Britnell, director at KPMG (an indicator of the significance of the corporate sector to these reconfigurations).

There was a manifesto commitment to legislation by the Conservative Party in 2019 and the Bill is expected in this year's Queen's Speech, following the publication of the White Paper in February.

https://www.independent.co.uk/news/uk/politics/simon-stevens-really-right-person-run-nhs-8902251.html

Boris Johnson has claimed, 'This (legislation) has been shirked by governments for about 30 years'." But it would be more accurate to say that, although steps had been taken to move in the 'accountable/integrated' care direction, they had not been carried through – largely because of opposition to the increasing corporate involvement which has accompanied each step. This has even involved corporate involvement in the writing of legislation itself.

Open Democracy FoI requests elicited that the taskforce for the forthcoming Bill includes Adrian Masters – who, alongside his former McKinsey colleagues, had a huge role in writing the 2012 Act.

Why did the government say revealing NHS plans is not in the public interest? | openDemocracy

At the heart of the 5YFV (which contains the basics that have been carried through every subsequent version and name change) is the idea that the NHS in England will never again be funded to a level that maintains its services in the way they are run now.

It puts together a series of proposals for change in which **cuts are made by a fundamental reshaping of how services are provided.** Expensive specialist and emergency care is relocated to centralised hubs, property is to be sold, new 'skills mixes' are being brought in, including more volunteers and more care is to be delivered in the community via partnerships with local authorities. It claims this approach will lead to fewer emergency admissions with an improvement to overall health and less dependency on NHS services.

https://www.nursingtimes.net/roles/hospital-nurses/skill-mix-changes-and-new-roles-in-emergency-and-urgent-care-08-01-2018/

The scope of this aspiration is far reaching. It not only assumes the NHS can cope with a growing population without corresponding growth in services, but that it will do so with a reduction in the number of facilities. As Caroline Molloy, editor of Open Democracy said at the time, 'I get fed up with politicians telling me that I will have better care if they close my local hospital'.

The Royal College of Emergency Medicine reported in a submission to the Health & Social Care Committee:

"The Department of Health and the NHS have repeatedly tried to achieve reductions in Emergency Department demand over more than a decade without success. Why these measures might succeed where others have failed remains unclear."

The plans are based on reductions in NHS hospital bed capacity.

"Discussing demand reductions in these terms invites the idea that patients in the UK are in some way excessive users of the services of Emergency Departments. In fact, the international evidence indicates that this is not the case."

http://data.parliament.uk/writtenevidence/committeeevidence.svc/evidencedocument/health-and-social-care-committee/integrated-care-organisations-partnerships-and-systems/written/76851.pdf

At the end of 2015 Stevens produced a follow up to the 5YFV, the **Sustainability and Transformation Plans (STPs).** These plans were the start of a process that he expected to end up in **Accountable Care Organisations** (until he found there was a PR need to change the name).

The country was carved up into 44 'footprints' which have since, through mergers, become 42. STPs were five-year plans covering all aspects of NHS spending in England. The footprints cover an average population size of 1.2 million people.

Allocations of funding for local authorities and public services are normally within geographical, constituency or cultural boundaries. STPs have little or no regard for these, but are based on the financial needs of the new centralised hubs.

Most STP leaders come from clinical commissioning groups (CCGs) and NHS trusts or foundation trusts. Only a small number come from local government and that was reflected in the widespread disregard for local authority input to the plans.

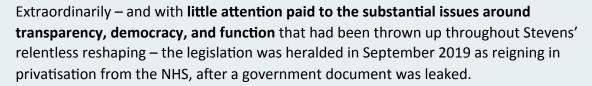
https://www.england.nhs.uk/wp-content/uploads/2016/02/stp-footprints-march-2016.pdf

https://local.gov.uk/sites/default/files/documents/2017-06-28%20STP%20survey%20-%20Full%20findings%20report%20FINAL.pdf

The Long-Term Plan for the NHS, which preceded Stevens' draft legislative proposals, called for each of the 42 STP 'footprints' to be 'Integrated Care Systems' by April 2021.

These are now in place.

THE WHITE PAPER



NHS privatisation to be reined in under secret plan to reform care | NHS | The Guardian

But, commenting on the potential for future legislation in 2019, David Lock QC said:

"The big picture is that you have a market system. If you do not want a market system and you want to run a public service, you need a different form of legal structure."

Key to understanding the White Paper proposals and the forthcoming Bill is the fact that the legal structure for the market most explicitly remains.

Far from reversing the 2012 Act, or providing any evidence that this form of proposed 'Integration' leads either to cost savings or to better outcomes for patients, the proposals consolidate the market paradigm which the government has favoured during the Covid-19 pandemic.

They have awarded contracts worth £10.5 billion without any competition to the end of July 2020. This has been rationalised on the basis of the need to act swiftly in the face of a national emergency. But, in normal times, transparently competing for contracts is the check against corruption and cronyism within a market model.

In the White Paper proposals, a statutory ICS body will receive a 'single pot budget' which will merge the budgets for general practice with acute and other services. Its board will include representatives of NHS trusts, local authorities and general practice and 'others determined locally.'

Throughout the White Paper the term 'others' is used to refer to what can only mean private sector providers but is never explicitly labelled as such.

A 2018 paper from the NHS Strategy Unit explained how the single pot budget functions in Integrated Care. The report, commissioned by NHS Midlands and Lancashire Commissioning Support Unit, states that:

'Risk and reward sharing is a key feature of the policy agenda for Accountable Care Organisations in the US and Integrated Care Systems in England.

It offers commissioners the opportunity to co-opt and incentivise providers to moderate growth in healthcare demand by sharing in the savings or cost over-runs. Risk and reward sharing can be seen as step in the journey towards the full transfer of financial risk to providers.'

https://www.strategyunitwm.nhs.uk/publications/risk-and-reward-sharing-nhs-integrated-care-systems

In a public service NHS the 'risk pool' is the whole country and the payment is assumed by the government on behalf of the whole country. The government can decide to be tight or generous with funding allocations, but at the end of the day the risk and cost remains at the national level. Even the much talked about 'deficits' that approximately half the NHS hospital trusts have are evened out at the Departmental level. The Department of Health and Social Care's books always balance to zero at the year end.

Not so with Integrated Care where, as the Strategy Unit explains, the objective is to pass the risk on to the provider group.

The Chancellor of the Exchequer has already announced that the ICSs will not be able to run deficits on their 'single pot budgets'. As part of the new five-year funding deal announced for the NHS in 2018, which covers the formation of the Integrated Care Systems, NHS England said that no trusts should be in deficit by 2023/24. In some areas of the country we already have GPs being paid incentives not to refer patients to hospital.

 $\underline{https://www.england.nhs.uk/wp-content/uploads/2018/12/nhs-operational-planning-and-contracting-guidance.pdf}$

In the pursuit of profit in their share of risk-and-reward will private providers be looking for more 'denial of care'?

But this still leaves a lot unexplained. Funding regimes are not made explicit in the White Paper. How is financial 'integration' to be achieved when health services are free according to need and social services are means-tested and involve both local authority and personal contributions?

Potentially even more problematic is when funding is for different populations – GP lists don't overlay with local authority boundaries. The Strategy Unit is specific that although money may be saved in the collaborative arrangements by removing expensive tendering, the **costs will increase with the elaborate contracts needed in profit-and-loss sharing.**

Public corporations don't have 'profits', private ones do.

And the Shelford Group (the elite rich NHS Foundation Trusts) have already made their position clear about shared risk over 'control totals' (precursors to the single pots):

"If system control totals have a place in the current legislative framework, they should aggregate not replace organisations' separate control totals. If they replace or take primacy over organisational control totals, it will lead to high performers bailing out weaker ones, as used to happen in the past. It is essential that high performers are not demotivated and demoralised by having to bail out under-performers. That would be a recipe for loss of financial discipline in those organisations that are managing their finances effectively, and it would do nothing to improve financial management in struggling organisations."

There is nothing to suggest that general (GP) practices owned by US corporations would be excluded from membership of an ICS. Given that the GP sector will continue to have a leading role in the commissioning of services their ownership could leave the way open for US and other private interests to have significant influence in commissioning.

And the proposals are clear that the regulatory framework currently regulating competition in the NHS in England will be removed in favour of a "bespoke health services provider selection regime that will give commissioners greater flexibility in how they arrange services".

What that might look like is already available on the NHS England 'Health Systems Support Framework' whose accredited suppliers of support services include 3 of the giants of US health insurance.

Centene

Optum (the UK subsidiary of United Health) and **Cerner**.

https://www.england.nhs.uk/hssf/supplier-lists/#lot-4-informatics-analytics-digital-tools-to-support-system-planning-assurance-and-evaluation

The growth of 'NHS private care' is not reined in either, with Foundation Trusts still able to receive 49% of their income from outside the NHS, including private patients. Those trusts which have developed their private patient capacity often say that it brings in additional income to cross-subsidise their NHS work. But there is a very unequal distribution of opportunity to engage in private work at scale, so the reality is some trusts developing that capacity substantially and others not at all.

The claim of cross-subsidy may also be being called into question. Public Matters' work on private patient income shows the Royal Marsden as top of the league as a provider of private healthcare. Their 2019 Annual Report discusses the need for their private patient business to use its profits to invest in developing its private patient offer to maintain its market position. They further discuss whether they will continue to take NHS patients from outside their immediate area, unless those patients need specialist care that can't be provided elsewhere.

NHS privatisation exposed: Scale of treatment for paying patients at NHS hospitals revealed | The Independent | The Independent

The scene is set for facilitating the introduction of membership providers, which are copied, as explained earlier, from the US 'health maintenance' and 'accountable care' models.

What is clear from the proposals are the new powers of central government.

It will be able to intervene directly in reconfiguration processes, allowing it to smooth the implementation of provider-driven service change.

It would also give ministers power to transfer functions between arms-length bodies such as Foundation Trusts and to abolish them afterwards without further primary legislation.

This would be an astonishing power to by-pass Parliament.



RECOMMENDATIONS

The two Houses of Parliament should urgently table debates on the critical issues of transparency and accountability around the changes to the NHS since the 2012 Act. The powers assumed by the executive of NHS England appear to have usurped the prerogatives of parliament.

Questions should be asked, which have not hitherto been asked, about whether Medicare-style 'Integrated Care' is an appropriate model for the NHS if it is to retain its unique character as a public service which aspires to provide high quality, accessible, equitable, cradle-to-grave care for everyone.

The White Paper's proposals to create new statutory bodies to empower the 42 ICS' to form collaborative organisations with private sector providers, including US insurance corporations, should not go forward into the Bill in May's Queen's Speech. There is nothing in existing legislation to prevent the current statutory bodies from collaborating to improve and coordinate their services. Indeed they have been doing it for decades. Merging budgets and executive functions to include the private sector will further damage the service, not improve it.

A Green Paper on Social Care is urgently required to address the severe problems in services.

A 2018 survey of MPs showed that over half felt they did not sufficiently understand what was happening in health and the NHS and found much of what was written to be 'bamboozling'.

The cross party consensus that what is happening is the 'right' thing' is contradicted by the energy many will put into joining their local campaigns to save their local hospitals from closure or downgrade.

Clear and comprehensible information on the new legislation must be a priority or once again Mark Porter of the BMA will be justified in saying:

Rather than listening to the concerns of patients, the public and frontline staff who vigorously opposed the top-down reorganisation, politicians shamefully chose to stick their head in the sand and plough on regardless."

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