The British Medical Association (BMA) is the voice of doctors and medical students in the UK. We are an apolitical professional association and independent trade union, representing doctors and medical students from all branches of medicine across the UK and supporting them to deliver the highest standards of patient care. We have a membership of over 153,000, which continues to grow every year.

The BMA’s position
The National Health Service (Amended Duties and Powers) Bill primarily seeks to make changes to existing legislation, most notably the Health and Social Care Act 2012 and the National Health Service Act 2006, with an impact on the following areas:

- Duties of the Secretary of State
- Financial powers of NHS Foundation Trusts and NHS Trusts
- Competition and procurement in the health service
- The NHS and national or international agreements

We believe that the Bill is a step in the right direction to address concerns about the current lack of ministerial accountability and responsibility for the NHS in England, as well as ongoing concerns about the over-emphasis on market forces and use of competition in the NHS in recent years. The BMA strongly believes, for example, that integration must be given clear prominence over competition, not least because a rise in the number of health providers increases the risk of fragmentation. We also argue that the NHS should always be the preferred provider of patient care; but where alternative providers are already delivering services to patients, commissioners must ensure that these services are integrated with GP practices and hospitals.

However, this Bill gives potentially wide powers to the Secretary of State in a number of areas. We are clear that care must be taken to ensure that the legislation does not risk introducing even more political interference in the day-to-day running of the NHS. The operational autonomy granted to the NHS in the Health and Social Care Act 2012 was, in many respects, a move which the BMA welcomed. Furthermore, it is unclear how the Bill relates to a number of important bodies and structures created by the Health and Social Care Act, such as health and wellbeing boards.

Finally, healthcare professionals would oppose further re-organisation of the health service – we would be extremely concerned if the legislation were a precursor for further top-down structural change.
Key points

- The Health and Social Care Act 2012 came into force fully on 1 April 2013, introducing a number of new structures and arrangements for the NHS in England. It is a complex and far-reaching piece of legislation, reflecting the wide-ranging nature of the Government’s programme of reform for the NHS in England. There are ongoing concerns that it has introduced serious operational challenges.

- The National Health Service (Amended Duties and Powers) Bill is a step in the right direction to help address concerns about lack of ministerial accountability and responsibility for the NHS, as well as ongoing concerns about the over-emphasis on market forces and use of competition in the NHS in recent years.

- The Bill’s focus on reinstating and enhancing the Secretary of State’s duties to promote and to provide are helpful measures to secure confidence in the Secretary of State’s ultimate responsibility and accountability for the NHS. However, care must be taken to ensure that the legislation does not risk bringing in inappropriate political interference in the day-to-day running of the NHS.

- The Secretary of State’s powers in relation to procurement and contracts are too widely drafted. These are not sufficient safeguards if a Secretary of State wants to continue to promote competition. However, if statutory checks and balances were introduced, these provisions could provide a welcome limitation on the use of competition and promote integrated services.

- The Bill gives wide discretion to the Secretary of State over determining the level of income that Foundation Trusts and NHS Trusts can generate from private patients. However, appropriate safeguards are included.

- The Bill removes Monitor’s responsibilities in terms of competition and, therefore, its prioritisation as a policy goal. The Bill instead puts decision-making powers back in the hands of the Secretary of State. While this is better than the present situation, the safeguards rest purely upon a sympathetic Secretary of State. Although we agree with the Bill’s policy intention to limit competition, further amendments are required to fully realise this intention.

- It is positive that the Bill contains provisions to limit procurement or competition obligations being imposed on the NHS should the Transatlantic Trade and Investment Partnership be ratified.

- Healthcare professionals would oppose further, major re-organisation of the health service – we would be concerned if the legislation were a precursor for further, top-down structural change.

Background
The Health and Social Care Act 2012 came into force fully on 1 April 2013, introducing a number of new structures and arrangements for the NHS in England. It is a complex and far-reaching piece of legislation, reflecting the wide-ranging nature of the Government’s programme of reform for the NHS in England.

Despite the Government’s assurances to the contrary, the Act was the catalyst for massive, disruptive, top-down reform of the NHS. These changes have been set against a background of an increasingly tough financial climate for the NHS at a time when the health service is seeking to achieve unprecedented levels of
savings. The legislation has been a major distraction, costly to implement, and has taken vital funding away from frontline services.

The BMA is committed to the founding principles of a National Health Service delivered in a cooperative and coordinated environment, where patients are guaranteed the most clinically-appropriate and cost-effective care. With these key principles in mind, we have actively engaged with the Government and others to influence the direction of policy travel presented in July 2010.

During passage of the legislation, we repeatedly stated that some potentially positive elements of the reforms – giving clinicians greater responsibility for commissioning and shaping local health services, increasing public and patient involvement, and putting a greater focus on improving public health – were threatened by other aspects, particularly those that sought to increase and enforce competition. We also expressed concern about the significant gaps in the legislation which needed to be addressed to ensure proper accountability, to prevent unacceptable variation and to ensure appropriate national oversight.

Since passage of the Act, we have raised concerns about the impact it is having on the ground. Doctors feel that far from improving the delivery of integrated, patient-focused care, the Act has created serious operational challenges, undermining the ability of commissioners and providers to exercise clinical judgement fully and operate in the best interests of their patient populations.

Doctors continue to be worried that the Act focuses too much on competition and that there is a lack of coherent, strategic, national leadership and a clear line of ministerial accountability.

Duties of the Secretary of State

Duties to promote and to provide

At present, the Secretary of State’s duty is ‘to promote a comprehensive health service’ and ‘to secure that services are provided in accordance with this Act’. The pre-2012 duty (NHS Act 2006) was ‘to promote a comprehensive health service’ and ‘to provide or secure the provision of services in accordance with this Act’.

During the parliamentary debates on the Health and Social Care Act 2012, serious concerns were voiced that there was insufficient explicit assurance about the Secretary of State’s continuing responsibility for the NHS.

Since the legislation has been in force, a constant source of concern has been that leadership and accountability over the NHS is unclear.

The Bill seeks to adjust the Secretary of State’s duties as ‘to promote a comprehensive health service based on social solidarity’. It also seeks to reinstate the Secretary of State’s duty ‘as to provision of certain services’.

These changes would allow delegation of functions and responsibilities to NHS England and Clinical Commissioning Groups (CCGs), but would clarify that the Secretary of State retains ultimate responsibility for the provision of a comprehensive health service, whilst also allowing the NHS England and CCGs day-to-day operational independence. The addition of ‘based on social solidarity’ to the Secretary of State’s duty to promote a comprehensive health service is a positive step. This helps clarify Government’s lasting responsibility towards the NHS were there to be structural changes in the future.

The Bill’s focus on reinstating and enhancing the Secretary of State’s duties to promote and to provide are helpful measures to secure confidence in the Secretary of State’s ultimate responsibility and accountability for the NHS. However, this must be balanced with the need for bodies within the NHS to have sufficient operational independence.

Procurement and contracts

The Bill’s provisions relating to procurement are loosely drafted and give the Secretary of State potentially wide power to decide the rules. However, the Bill does state that the Secretary of State shall ‘promote the health service as an efficient service based on mutual cooperation and social solidarity...’ which sets the tone for any subsequent rules about procurement, presumably preventing competition from becoming the central lever.

The provisions in the Bill also give the Secretary of State free rein to decide what ‘anti-competitive or any other behaviour...against the interests of people who use health services’ looks like. While the BMA supports the
fact that this would override the role of the Competition and Markets Authority (CMA)\(^4\) in the NHS, the Bill is worded too loosely to provide sufficient assurance for the future.

The Bill makes provisions about the status of contracts in the NHS. It states that ‘any person who is aggrieved at the award of designation [NHS contract] to a provider…may refer the matter to the Secretary of State for determination…’ This reads as a provision that removes the role of the CMA and Monitor to investigate such complaints, but this is loosely drafted, and again, gives discretion to the Secretary of State. This and the other clauses relating to procurement do, however, set out to create a more favourable environment for commissioners and providers to work together in the design and delivery of more integrated care and services, around the needs of patients.

**The Secretary of State’s powers in relation to procurement and contracts are too widely drafted. These are not sufficient safeguards if a Secretary of State wants to continue to promote competition. However, if statutory checks and balances were introduced, these provisions could provide a welcome limitation on the use of competition and promote integrated services.**

**Private patient income**
At present under the Health and Social Care Act 2012, Foundation Trusts can generate up to 49 per cent of their income from treating private patients. During passage of the legislation, we argued that significantly raising the amount of income Foundation Trusts can earn from other sources has the potential to act as an incentive for them to undertake more non-NHS activity at the expense of NHS patients’ ability to access services. We were concerned that this could lead to a two-tier health service, as Foundation Trusts invest more resources in non-NHS facilities.

The Bill seeks to allow the Secretary of State to determine the level of income that can be generated from private patients, and to allow an individual Foundation Trust to exceed it on a case-by-case basis, if agreed by the Secretary of State. Once again, these are broadly defined powers in the legislation. The Bill, however, does insert two safeguards that the BMA called for during the debates on the Act. Firstly, we argued that a Foundation Trust treating private patients should not have an adverse impact on providing services to NHS patients. Secondly, we stated that NHS patients should benefit from the Foundation Trust treating private patients (i.e. private patient income should be re-invested into improving NHS services).

The Bill also allows parallel freedoms for NHS Trusts with respect to raising income from treating private patients. At present, NHS Trusts can agree with the NHS Trust Development Authority the amount of non-NHS income that they are able to receive, but there is no corresponding legislation.

Even though the Bill inserts safeguards to govern how NHS Foundation Trusts and NHS Trusts use these freedoms, it is reasonable to ask why they have been extended to NHS Trusts. Were the Secretary of State to set the cap at a high percentage, this would send the message that trusts are being encouraged to behave more like commercial entities than NHS bodies.

**The Bill gives wide discretion to the Secretary of State over determining the level of income that Foundation Trusts and NHS Trusts can generate from private patients. However, there are useful safeguards inserted to ensure that there is no adverse impact on NHS patients and that NHS patients should benefit from the Foundation Trust/NHS Trust treating private patients.**

**Competition and procurement in the health service**
During the passage of the legislation, the BMA was opposed to the expansion of Monitor’s role, especially if it forced commissioners to promote competition between providers. The BMA believes that the Health and Social Care Act 2012 places too much emphasis on commercialisation and competition, which threatens to undermine the ethos of the NHS and make both integrated care and collaboration between primary and secondary care harder to achieve. Currently, the Act treats the need to integrate services and ensure there is competition between services and providers as equally important. The BMA strongly believes that integration must be given prominence over competition. The equal status between integration and competition in the Act
has led to confusion among commissioners who may feel that their default should be to put all services out to competitive tendering.

The Bill takes out Monitor’s reference to competition in the Health and Social Care Act 2012 e.g. sections 62(2), 62(3) and 62(10) in the Act. The Bill also takes out applicability of the Competition Act 1998 and attempts to exempt the NHS from having to follow EU competition law.

However, the removal of 62(10) may have worrying implications as this could have an impact on the current protection on the proportion of services provided by the private and public sectors. At the moment, Monitor must not intentionally carry out its functions in order to change this, a move the BMA welcomed. The Bill removes this protection.

The Bill also transfers Monitor’s functions regarding approving hospital mergers and acquisitions to the Secretary of State. This is another mechanism that limits Monitor’s powers, but in reality would lead to greater scope for the politicisation of health service decisions.

The Bill removes Monitor’s responsibilities in terms of competition and, therefore, its prioritisation as a policy goal. The Bill instead puts decision-making powers back in the hands of the Secretary of State. While this is better than the present situation, the safeguards rest purely upon a sympathetic Secretary of State. Although we agree with the Bill’s policy intention to limit competition, further amendments are required to fully realise that intention.

The NHS and national and international agreements
The provisions in the Bill seek to address concerns about the impact of the Transatlantic Trade and Investment Partnership (TTIP) on the NHS.5

The BMA shares concerns that TTIP could tip the balance of power further towards private corporations and away from the public sector. Whilst receiving commitments that ‘the further liberalisation of the procurement of health services is not a focus of these negotiations’, the BMA has concerns that TTIP threatens the NHS’s ability to provide high quality healthcare to all, regardless of wealth, by:

- Facilitating the further commercialisation of the NHS via the inclusion of health services within the agreement’s scope
- Permitting proposed investor protection (IP) and investor to state dispute settlement (ISDS) mechanisms to be used to attack public services. For example, providing companies with the legal means – backed by the threat of compensatory payments - to prevent the reversal of the outsourcing of NHS resources to the private sector

We do not believe that the proposed text of the treaty6 provides sufficient safeguards for the protection of healthcare services and remain concerned at the failure to include legal provisions to prevent corporations from challenging public policy decisions, for example preventing US corporate interests from contesting any future UK Government legislation which sought to repeal the Health and Social Care Act 2012.

The European Commission launched a public consultation7 on the proposed IP/ISDS mechanisms in March 2014 and has suspended negotiations on this part of the TTIP until the responses have been analysed - due in November 2014. We are hopeful that our concerns will be taken on board during this process but, as the Treaty stands, we have serious concerns about how TTIP will facilitate the further commercialisation of the NHS.

It is positive that the Bill contains provisions to limit procurement or competition obligations being imposed on the NHS should the Transatlantic Trade and Investment Partnership be ratified.

November 2014
Notes and references

1 The Health and Social Care Act 2012 establishes health and wellbeing boards as a forum where key leaders from the health and care system work together to improve the health and wellbeing of their local population.

2 A BMA survey published in May this year found that only one in twenty doctors (5 per cent) believe the Health and Social Care Act 2012 has improved the quality of services for patients. While half of doctors (51 per cent) surveyed reported a change in how they plan and deliver care following the introduction of the Act, almost a third of this group (28 per cent) believe it was having a negative impact on patient care, and almost three quarters (73.6 per cent) believed the Act - which increases the role of private providers in the NHS through the roll-out of competitive tendering for services - had led to a fragmentation of care. More information available at: http://bma.org.uk/working-for-change/hsca

3 House of Lords Select Committee on the Constitution, 18th Report of Session 2010-12, Health and Social Care Bill, 30 September 2011

4 The CMA now has jurisdiction to review mergers between FTs and NHS trusts, leaving Monitor responsible for providing advice to the NHS Trust Development Authority on mergers between NHS trusts.

5 The Transatlantic Trade and Investment Partnership (TTIP) is a trade agreement that is presently being negotiated between the European Union and the United States. More information available at: http://ec.europa.eu/trade/policy/in-focus/ttip/about-ttip/

6 As at July 2014.