Landscape:

1. <u>What is the NHS?</u>

2. <u>State of NHS finances:</u>

   What is the extent and effect of austerity in today's NHS?

3. <u>Outsourcing:</u>

   The role and extent of private providers in the NHS today

1. <u>What is the NHS?</u>

1.1 A comprehensive health service designed to secure improvement in the physical and mental health of the people in England.

1.2 From the point of view of the consumer (the patient) – it is simply free healthcare (w. the exception of prescription, dental, and ophthalmic charges). In practice this consists in:
- Hospital accommodation
- Other accommodation for any specific purpose named in the Act
- Medical, dental, ophthalmic, nursing and ambulance services
- Facilities for pregnant women or women caring for young children
- Such other facilities as are required to prevent illness and care for those who have experienced it
- Such other services as are required for the diagnosis and treatment of illness

1.3 Essentially, this has been the case since 1948, when the NHS was founded.

1.4 But where are these services supposed to come from? Who is responsible for them? The simple, if slightly circular answer, for many years, was simply 'the NHS'. But what is (or was) that?

1.5 When initially conceived it consisted of regional Hospital Boards which ran the hospitals in their jurisdiction, a network of GPs providing primary care services as independent contractors, and then a further network of 'outpatient' care providers such as midwives, public health workers, ambulance services and the like – run by local authorities.

1.6 The first big change to that structure came in 1990. Economic observers had suggested that healthcare provision could be improved by introducing an 'internal marketplace' within the NHS, where healthcare providers could use their budget to 'purchase in' various services from elsewhere within the NHS. The new legislation produced a purchase-provider split: Health Authorities no longer ran hospitals, but instead 'purchased' care either from their own, or from other authorities' hospitals. Hospitals themselves (and mental health providers, and ambulance services) became NHS trusts, operating under contract with local purchasers. Many GPs became 'fund holders', and were provided with a budget for each patient from which they could purchase medical services from hospitals. Although this introduced an element of competition, it still meant that NHS resources remained within the NHS.

1.7 The next big change – probably the most extensive structural reorganisation in the history of the NHS – came with the introduction of the Health and Social Care Act 2012 (which amended the National Health Services Act 2006).

1.8 That brought an important change of principle, and a host of organisational changes: the change in principle was this – since the inception of the NHS the government (through the Secretary of State for Health) had been under a duty to *provide* the services that make up the NHS: that obligation has changed, and the duty now is to *commission* services for a local population, rather than to *deliver* those services itself. The practical effect is that the marketplace from which the NHS can commission its services is no longer internal: *private* healthcare providers are now competing to provide NHS clinical services.

1.9 More and more services which were previously being provided *by* the NHS itself, are now being provided *for* the NHS *by* profit-making organisations. With that in mind, what are the key structures of the new NHS?

1.9.1 Secretary of State for Health and Department of Health – responsible for strategic leadership and funding for both health and social care in England

1.9.2 National Health Service Commissioning Board (aka, 'NHS England') – an independent body whose main role is to set the priorities and objectives for the NHS. Also commissions primary care services.

1.9.3 Clinical Commissioning Groups (CCGs) – the replacement for Primary Care Trusts; number over 200; responsible for commissioning most secondary care services (often via one of a number of Commissioning Support Units (CSUs); obliged when doing so to take into account both NICE guidance and CQC data

- NICE (National Institute for Health and Care Excellence). Responsible for developing national guidance, standards and information on providing high-quality health and social care. Issues guidance which indicate quality standards. The guidance is generally not 'binding', but it often informs the standard of care required of clinical professionals, and it can sometimes be hard for clinicians who have departed from NICE guidance to argue that they have also acted competently. NICE also issues technology appraisal guidance: this guidance *is* mandatory, and in most cases the relevant tech must be made available for treating patients within 3 months.

2. State of NHS finances: What is the extent and effect of austerity in today's NHS?

2.1 A highly political question.

2.2 The answers I will be providing come – for the most part – from Peter Dolton, a Professor of Economics who published a paper for the National Institute of Economic and Social Research in May 2017: funded by the Nuffield Foundation.

2.3 The first conclusion to share is one that might surprise many people in the room: '*the evidence that there is suggests that patient satisfaction with the NHS is higher than it has*

ever been'. Worth remembering that we tend only to see the cases where people are unhappy with their treatment, and that that can easily skew views as to what the general population thinks of the NHS.

2.4 Another ray of light is that '*more money is being spent on the NHS in real terms [and as a fraction of national income] than ever in its history… an average of £2,160 per person per year*'.

2.5 That is about it though for good news: while spending is going up, it is not going up as fast as demand… We have an ageing population, and an increasing range of increasingly expensive treatments which are available to them (in principle at least), so while we may be spending more than ever before on the NHS, that still does not seem to be leading to a step improvement in available services.

2.6 In one very simple measure of services: the number of hospital beds available per day dropped from over 300,000 in the late 1980s to under 150,000 in 2013/14.

2.7 Meanwhile, the number of elective admissions to hospital are climbing fast. From 2003 to 2016 there was a 65% rise in A&E attendances, and a 60% increase in hospital referrals. So expenditure is climbing, but at nowhere near the same rate as demand.

2.8 What about the NHS's 'books' though – what is the position like looking at the accounts:

- NHS trusts in England are in combined deficit of over £750 million
- There are various predictions as to the likely total funding shortfall for the NHS in a few years' time, but according to Professor Dolton most credible estimates predict a shortfall of £20-£30 billion by 2020
  (*20 to 30 thousand million* - at £10,000 a day it would take well over 5,000 years to save up that much money)
- A survey of 6,000 members of the public suggested that over 70% do *not* think that income tax should be increased to pay for more NHS funding.

2.9 The reality then is that this is a time of unprecedented, and growing, demand on an NHS with finite resources. The potential solutions are simple, but seem to be either unpalatable or unrealistic:

- Increase taxes
- Allocate a greater proportion of public spending to health
- Consent to being charged for specific services
- Make substantial improvements in efficiency within the health service.

3. Outsourcing

3.1 If austerity, the availability of a full private market for healthcare services, and the drive for increased efficiency are the backdrop to the modern NHS, how much NHS work is shifting into the private sector?

- By 2015 the NHS was contracting out over **£20 billion**-worth of healthcare services per annum
- Almost ¼ of NHS England's total budget is spent on contracts within the private sector

— A paper in March 2015 estimated that there were already around 53,000 contracts between the NHS and the private sector, and that *the annual cost of arranging and administering those contracts was around **£1.5 billion*** (CHPI – Centre for Health and the Public Interest)

3.2 What is the *significance* of that level of private sector involvement?

3.2.1 First, we need to bear in mind the objectives of private healthcare providers. The sole intended function of *NHS* service providers is to promote the health of the population. Private healthcare providers on the other hand have what are at best 'additional' objectives: the directors of private companies are *obliged* to prioritise the interests of their shareholders, and are usually personally financially incentivised to make a profit for their company. While NHS service providers have to do the best they can with the money they are receiving, private healthcare providers have to reach agreed service levels *and* to make a profit for the company.

3.2.2 Second, those service levels, and indeed the relationship between the body commissioning the services and the company providing them, can be highly problematic. A 2015 paper from the Centre for Health and the Public Interest makes the following key points about the difficulties inherent in the NHS contracting out large volumes of work:

3.2.2.1 Healthcare is more complicated to 'purchase' than anything else: it '*is a complex good, meaning that it is very difficult to specify exactly what service is needed within a contract, making contracts for healthcare particularly difficult to monitor and enforce*'.

3.2.2.2 There is an asymmetry of information at the negotiation of contracts stage, where private healthcare providers often have far more information than commissioners both about the work that they do and the cost of doing it; information which they may consider to be commercially sensitive, and which they may be unwilling to share.

3.2.2.3 There is often a significant imbalance in the skill level and experience of the staff involved in negotiating the contracts. This has been a historic problem when government departments negotiate with big business: the government's Chief Procurement Officer told the Public Accounts Committee in 2014 that '*the suppliers sell deals, run deals, and are earning big salaries. They have done it [negotiated big contracts] multiple times. Sometimes they are up against officials who have none of those characteristics*'. This is the world that the NHS is stepping into in terms of outsourcing private care to big businesses.

3.2.2.4 It is often difficult for the party commissioning the care to assess how well the company providing it is doing. There is, once again, information asymmetry – '*[which] makes it almost impossible for a commissioner of services to know whether a provider is delivering according to the terms of the contract, or is cutting corners or reducing quality in order to gain extra revenue*'. In effect, the contractor always knows more than the commissioner about how well the contractor is performing.

3.2.2.5 Finally, the threat of contract enforcement is often not credible: those commissioning the care and services are often reluctant to enforce contracts,

or impose financial penalties, both for fear of exacerbating existing problems, and, presumably, because of an absence of realistic alternative care provision.

3.3 The reality appears to be that the NHS is poorly equipped to determine whether the private providers to whom healthcare services are being outsourced will provide safe, high quality care, and good value for money.

3.4 Other areas where private companies have been brought in to provide services to vulnerable members of the population hardly inspire confidence: analogy with private prison providers (*eg,* G4S).

3.5 There are also a number of high profile examples where private healthcare provision has failed in a fairly spectacular way:

- Castlebeck Care (Winterbourne View Hospital)
- Serco (Cornwall's out-of-hours GP service)
- Vanguard (Musgrove Park Hospital's overspill cataract surgery cases)

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March 2018