

OBSERVATIONS

HEALTH AND SOCIAL CARE BILL

In defence of the NHS: why writing to the House of Lords was necessary

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Last week more than 400 public health doctors, specialists, and academics from across the country wrote an open letter to the House of Lords stating that the Health and Social Care Bill will do “irreparable harm to the NHS, to individual patients, and to society as a whole,” that it will “erode the NHS’s ethical and cooperative foundations,” and that it will “not deliver efficiency, quality, fairness, or choice.”¹

The prime minister claimed that the letter actually supported aspects of the bill, while the secretary of state for health was dismissive, maintaining that people signed it without reading it and that it was “politically motivated” and unsupported by “a shred of evidence.”

These claims were wrong. There was no qualified support for the bill. Nor did signatories write in a political capacity: they wrote in their professional capacity and with the public interest in mind. Nor are public health professionals alone in having concerns: the public, the BMA, and many of the royal colleges continue to express deep and continuing concerns.

Public health professionals are responsible for assessing the healthcare needs of the entire population. This entails looking across the entire health system to ensure that its different components come together efficiently, effectively, and fairly. They are expected to speak out as advocates for the population and especially for those people with poorer health outcomes. But more importantly, our concerns are based on a wealth of evidence, much published in peer reviewed journals.²⁻⁵

There are many problems with the bill. For one, it abolishes direct accountability of the secretary of state for health to secure comprehensive care for the whole population and the mechanisms and structures for securing that duty.⁶ The health secretary has also stated that equitable resource allocation will no longer be his direct responsibility and that national resource allocation formulas will change from area based populations to GP registrations, a move that portends a shift towards a model of competing insurance pools or funds, for which the evidence from other countries is adverse.^{7 8}

The bill will usher in a new era of commercialisation but still does not make clear the public duties of the economic regulator, Monitor. And while the proposed duties of clinical commissioning groups remain weak, they will be given the freedom to compete for or select their registered populations, as well as “flexibilities” in defining which services to provide. Allowing clinical commissioning groups to also enter into joint ventures with private companies will create inequalities in entitlement to care and introduce commercial conflicts of interest.⁹

New commercial actors will be driven to compete and maximise income, overshadowing the need to cooperate and collaborate in ways that place the patient and population at the heart of the health system. The absence of clear responsibilities for geographically defined populations will make it difficult, if not impossible, to link clinical NHS commissioning with social care services or with plans and interventions to act on the social determinants of health.

While we value clinical engagement in population based planning and commissioning, the more important problem is that the bill hands over greater control over public budgets to the dictates of the market. We believe that most healthcare professions reject this proposed transformation and are aware of the clinical, professional, and ethical shortcomings of market based health systems such as those that exist in the United States.¹⁰

The health secretary has called for a debate that is based on evidence. We agree. But this requires transparency about the evidence base and the intentions that have shaped the bill. So far, the proposed structures do not conform to the goal of a universal and equitable health service, free at the point of delivery, and accessed on the basis of need and not ability to pay.

Competing interests: All authors were signatories to the letter that is the subject of the article. As public health physicians they have an interest in the continuing survival of the NHS.

- 1 Kmietowicz Z. Public health doctors call for House of Lords to reject health bill. *BMJ* 2011;343:d6391.
- 2 Liu Y, Hsiao W, Eggleston K. Equity in health care: the Chinese experience. *Soc Sci Med* 1999;49:1349-56.
- 3 Stocker K, Waitzkin H, Iriart C. The exportation of managed care to Latin America. *N Engl J Med* 1999;340:1131-6.
- 4 Himmelstein D, Woolhandler S. Quality of care at investor-owned vs not-for-profit HMOs. *JAMA* 1999;282:159-63.
- 5 Schoen C, Doty M, Robertson R, Collins S. Affordable Care Act reforms could reduce the number of uninsured US adults by 70 percent. *Health Aff (Millwood)* 2011;30:1762-71.
- 6 Pollock AM, Price D. The Health and Social Care Bill: how the secretary of state for health proposes to abolish the NHS in England. *BMJ* 2011;342:1695-7.
- 7 Van de Ven WP, Beck K, Buchner F, Chernichovsky D, Gardiol L, Holly A, et al. Risk adjustment and risk selection on the sickness fund insurance market in five European countries. *Health Policy* 2003;65:75-98.
- 8 Van de Ven WP. Risk adjustment and risk equalization: what needs to be done? *Health Economics, Policy and Law* 2011;6:147-56.
- 9 Reynolds L, McKee M. "Any qualified provider" in the NHS reforms: but who will qualify? *Lancet* doi:101016/S0140-6736(11)61264-6.
- 10 Himmelstein D, Woolhandler S, Hellender I. Bleeding the patient: the consequences of corporate health care. Common Courage Press, 2001

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