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Education and debate

NHS and the Health and Social Care Bill: end of Bevan's vision?

Allyson M Pollock, David Price, Alison Talbot-Smith, John Mohan

Although the Labour government has repeatedly pledged its commitment to the NHS, its latest reforms pave the way for multiple providers of health care

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The Health and Social Care (Community Health and Standards) Bill 2003 is the most controversial piece of legislation to come out of the government's 10 year strategy for the NHS in England.¹ The bill, which abolishes government control of NHS trusts by turning them into competing independent corporations called foundation trusts, is a major policy reversal. It could lead to considerable local variation in services and endangers one of the NHS's founding principles—to provide equal care for equal need.

What are foundation trusts?

The new bill allows both NHS and non-NHS bodies, including private companies, to apply to become foundation trusts. Although their principal purpose is to provide goods and services to the NHS, they will be able to carry out any type of business. With guaranteed independence from direct government control, their sole statutory general duty will be to operate "effectively, efficiently, and economically." They will not have shareholders but will be expected to make and retain surpluses for new investment or for servicing loans raised on the financial markets.² The scale of such borrowing will depend on their ability to make surpluses.³ The government has given them several new powers to generate surpluses (box 1). These powers, taken together with changes to the methods of allocating resources,⁴ threaten to destabilise the provision of health services and systematically widen inequalities of access to care.

In the face of growing opposition to the bill from the BMA, trade unions, and the public, the government claims that regulatory safeguards in the bill will protect the core principles of universality and access on the basis of need (see bmj.com). However, as we show below, careful scrutiny shows that the safeguards are weak or non-existent.

Responsibility of independent regulator

The bill establishes an independent regulator who will authorise foundation trust status (box 2). The authorisation will set out the foundation trust's main objectives and the health services it must provide. The regulator will report to parliament and takes over the secretary

of state's powers to create or dissolve NHS services. However, it is not clear that the regulator's responsibility to uphold the principles of the NHS is the same as that of the secretary of state.

The National Health Service Act 1977 requires the secretary of state to promote a comprehensive, free, health service to improve the health of the people and to provide facilities "as he considers necessary to meet all reasonable needs"—that is, equitably.⁶ Section 3 of the new bill appears to safeguard this role by requiring the regulator to act consistently with the secretary of state's duties. The Department of Health, however, says that "The Independent Regulator will operate a discrete statutory framework and will not replicate the Secretary of State's existing powers of direction or have a role in performance management."² He is required



Is Blair betraying Bevan's vision of universality and equity?

FIONA HANSON/PA



Government's safeguards to maintain universality and equity are listed on bmj.com

Box 1: Powers of foundation trusts to generate income

- Trade in NHS and non-NHS services
- Buy and sell land and assets and retain the proceeds
- Create commercial arms or join existing commercial ventures
- Subcontract clinical services to commercial companies
- Borrow money from private lenders within a prudential borrowing regimen
- Ask the secretary of state to lower their annual costs by exercising discretion when valuing the assets that are transferred to them
- Benefit from subsidies, loans, and grants from the secretary of state, including their NHS capital allocations for the next three years⁵
- Retain surpluses under the new national tariff system
- Control boundary between the NHS and charged-for health and social care
- Flexibility to direct or transfer staff into the private sector

only to “take account of the interests of the wider NHS.”⁷ These interests are not defined, and the government has resisted attempts during the bill’s committee stages to give the regulator the same duties as the secretary of state.

Does the bill promote progressive distribution of public resources?

Foundation trusts’ revenue will come from competitively awarded contracts with primary care trusts⁷ and not from funds allocated on the basis of a given local population’s need for services. Moreover, the government has introduced a new national tariff system, financial flows, which requires providers to charge centrally determined prices for individual episodes of care.

The argument is that this will make providers drive down costs and increase efficiency. However, the actual cost for a given hospital of providing an episode of care is not only a result of its relative efficiency but is also determined by historical factors such as the cost of buildings and equipment and the mix of specialties and types of care provided. Under the new bill, the secretary of state can arbitrarily reduce the value of a foundation trust’s inherited assets, enabling it to keep its costs below the regional tariff. In addition, the kind of hospital trusts likely to achieve foundation trust status soonest are also those that currently receive considerable subsidies to support teaching and research and education, thereby enabling them to keep their service costs low.

Foundation trusts with costs lower than the tariff will be able to create and retain surpluses. These surpluses will be drawn from the total public funding available to each primary care trust and hence will be at the expense of other services, including primary care and community services as well as other hospitals.

On top of this, the capital allocated to foundation trusts will not be specifically calculated on the basis of need² but will depend on their surpluses. The greater the surplus a foundation trust makes, the more capital it will be allowed to raise on the financial markets.

From 2005-6 onwards, this will affect the distribution of capital to other parts of the NHS because capital allocations to foundation trusts will then be counted against the total capital made available by the Treasury to the Department of Health. Thus higher capital spending by foundation trusts will lead to lower capital spending being permitted elsewhere in the NHS. In addition, the government has said that it intends to subsidise public-private partnerships entered into by foundation trusts by providing income guarantees to their private sector partners.⁵ But it has not included guarantees for other external loans. The incentive for foundation trusts provided by these subsidies seems bound to aggravate the inequitable distribution of capital across the NHS.⁸

Inequity arising through local generation of income

Not all the mechanisms available to foundation trusts for generating income have safeguards attached. For example, foundation trusts will be able to sell property and retain the proceeds without reference to the strategic health authorities, which currently have a say in the allocation of such proceeds. Although the bill does include a clause protecting former NHS property, protected property is defined at the discretion of the regulator, not the government, and foundation trusts can negotiate with the regulator to deregulate and sell protected property after their initial authorisation. Some foundation trusts will have more generous dowries of land and estate than others and be better placed to ask the regulator to deregulate assets.

Foundation trusts can also generate income from private patients. The government says that foundation trusts will not be allowed to generate surpluses by increasing the proportion of their income that comes from private patients. But this safeguard has been diluted in the bill. Section 15(1) originally stated: “An authorisation [of a foundation trust] must restrict” health care provision for private patients. The bill has now been amended: must has been changed to may.

Foundation trusts will be allowed to form joint ventures with private companies, including healthcare corporations such as those currently bidding to provide diagnostic and treatment centres for the NHS. Many of these companies have special expertise in the sale of private insurance as well as private health care, and the bill does not preclude NHS patients being offered and charged for additional elements of care not available under the NHS. Furthermore, the restriction on the

Box 2: Powers of the regulator

- Controls over the use and sale of public (former NHS) assets
- Decisions about what NHS health services are required for the local population and whether they will be provided by the public or private sector
- Control of the scale, nature, location, and duration of local health services delivered by foundation trusts
- Control of the scale of public and private provision
- Control of trust dissolution and merger
- Control of foundation trust’s borrowing levels
- Control over private patient income

proportion of income that can come from private patients does not apply to income generated by commercial partners, and foundation trusts may be able to secure additional borrowing on the basis of the cash flows generated by these partners.

Duty to provide NHS services free at point of use

The secretary of state says that NHS foundation trusts will be prevented by their terms of authorisation from charging NHS patients.² But the licensing of foundation trusts will be controlled by the regulator, and the bill does not say an authorisation must contain the prevention referred to by the secretary of state. Clause 6(3) states: "The authorization may be given on any terms the regulator considers appropriate."

For example, foundation trusts will operate on the increasingly complex boundary between free NHS care and chargeable personal care. Under the Community Care (Delayed Discharges etc) Act 2003, the NHS may now charge local authorities for personal care.⁹ All hospital trusts will have a financial incentive to redesignate elements of care previously provided by the NHS as personal care and to implement the new guidance that recommends placing a time limit on NHS-funded care.^{10 11} Some foundation trusts may be better placed than others to shift costs by redesignating what is provided by the NHS.

Accountability

The government says that although foundation trusts will not be subject to performance management by the strategic health authorities, they will be locally accountable and therefore responsive to healthcare needs. Foundation trusts will have members drawn from local residents, patients, and staff, and members will elect at least half the board of governors, who in turn will appoint a board of directors.

However, the bill does not require members to be representative of the local population or answerable to it. Nor does it recognise the problem of recruiting members from among people who are frail, less articulate, or have to travel large distances for specialist services. Effective power will rest with an unelected board of directors whose decisions cannot be vetoed by the governors, let alone the members.⁷ Moreover, unlike other hospital trusts, foundation trusts will not be required to have patients' forums or patient advocacy services, and such patient bodies will have reduced powers under the new local authority scrutiny system, which gives them only consultative rights at the discretion of the regulator.

Governmental regulatory checks can be applied through the new regulatory body, the Commission for Healthcare Audit and Inspection. However, the commission's recommendations are made to the regulator, who alone will determine whether a reported failing is important. Neither the grounds for this evaluation nor any remedies are laid down in the bill.

Strategic health authorities will have limited input at the foundation trust authorisation stage, and little thereafter. Although the bill requires foundation trusts to cooperate with other NHS bodies, this duty is counterbalanced by their freedoms in relation to the

Summary points

The formation of foundation trusts will reduce the role of government to funder of NHS care

The safeguards to ensure that equal care is available to everyone who needs it are insufficient

The regulator, and not local people, will be responsible for deciding which services are provided and where

Foundation trusts will find themselves driven to select patients, treatments, and services on the basis of financial risk rather than healthcare needs

recruitment and retention of staff and to subcontract clinical care to the private sector. Furthermore, they will "not be required to comply with management and operational guidance from the Department of Health" and hence will be under no obligation to cooperate in planning of services for whole regions or even the country.⁷

Treatment of staff

The government is currently engaged in national negotiations over the contracts for general practitioners, hospital consultants, and non-clinical staff. However, the bill gives foundation trusts the power to employ staff and in exercising this power to "do anything which appears to it to be necessary for the purposes of or in connection with its functions." For example, foundation trusts will be free to break up clinical service elements such as elective surgery, urology, or cardiac services and subcontract clinical work out to commercial firms. This could involve directing or transferring NHS staff to the private sector, where national agreements may not apply.

Under the general practitioners' contract, primary care trusts can already subcontract the non-core elements of general practice services to the private sector, which is not bound by national agreements for NHS staff. General practitioners may decide to become employees of the private sector, in which case core services and NHS staff would transfer to the private sector, where again national agreements need not apply.

Special waivers have also been built into the national pay for non-clinical staff. These allow foundation trusts to offer recruitment and retention inducements substantially different from other trusts.¹²

Conclusion

Equal access for equal need and universality do not appear in the list of core principles in the legislation or in the published guidance on foundation trusts.¹³ In addition the legislation contains no mechanisms to protect the principle of redistribution through resource allocation, integration of services, and planning based on needs. The bill will lead to multiple systems of care in England with the quality of NHS provision increasingly dependent on the wealth and resources of local communities.¹⁴

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Contributors and sources: AP is head of the Public Health Policy Unit. She has researched and published widely on the NHS. DP is a political scientist who has collaborated with AP for several years, specifically on the use of private finance in the public sector and health care. ATS is currently a part time PhD student and has written with AP a guide to the structure and organisation of the new NHS. JM has researched into the history and development of the NHS and has collaborated with the unit on research into equity in the delivery of primary care. The article is based on publicly available government documents.

Competing interests: JM was a specialist adviser to the House of Commons Health Select Committee into Foundation Trusts during January-April 2003 but writes in a personal capacity.

- 1 House of Commons. *Health and Social Care (Community Health and Standards) Bill*. London: Stationery Office, 2003. www.publications.parliament.uk/pa/ld200203/ldbills/094/2003094.htm (accessed 4 Sep 2003).
- 2 House of Commons Select Committee on Health. Letter from secretary of state for health. Appendix 16 to the minutes of evidence for the second report: foundation trusts (2003). www.parliament.the-stationery-office.co.uk/pa/cm200203/cmselect/cmhealth/395/395ap17.htm (accessed 10 Oct 2003).
- 3 House of Commons. *Health and Social Care (Community Health and Standards) Bill*. Explanatory note, paragraph 58. London: Stationery Office 2003. www.publications.parliament.uk/pa/ld200203/ldbills/094/en/03094x-.htm (accessed 4 Sep 2003).

- 4 Department of Health. *Reforming NHS financial flows: introducing payment by results*. London: DoH, 2002.
- 5 House of Commons. *Health and Social Care (Community Health and Standards) Bill in Standing Committee E*. www.publications.parliament.uk/pa/cm200203/cmstand/e/cmhealth.htm (accessed 23 Jun 2003).
- 6 *National Health Service Act 1977*. London: HMSO, 1977.
- 7 Department of Health. *The government's response to the health committee's report into NHS foundation trusts*. London: Stationery Office, 2003: Cm 5876.
- 8 Third reading of the Health and Social Care (Community Health and Standards) Bill. *House of Commons Official Report (Hansard)* 2003 Jul 8: col 956.
- 9 *Community Care (Delayed Discharges etc) Act*. London: Stationery Office 2003.
- 10 Department of Health. *Intermediate care. Health service circular 2001/01, Local authority circular (2001)1*. London: DoH, 2001 www.info.doh.gov.uk/doh/coin4.nsf/Circulars?ReadForm (accessed 10 Oct 2003).
- 11 The Community Care (Delayed Discharges etc) Act (Qualifying Services) (England) Regulations 2003. www.legislation.hmso.gov.uk/si/si2003/20031196.htm (accessed 14 Oct 2003).
- 12 Department of Health. *Agenda for change. Draft contract*. London: Department of Health, 2003.
- 13 House of Commons Select Committee on Health. Memorandum by the King's Fund. Appendix 6 to the minutes of evidence for the second report: foundation trusts (2003). www.parliament.the-stationery-office.co.uk/pa/cm200203/cmselect/cmhealth/395/395ap07.htm (accessed 10 Oct 2003).
- 14 Pollock AM, Price D. *In place of Bevan? Briefing on the Health and Social Care (Community Health and Standards) Bill 2003*. London: Catalyst 2003. www.ucl.ac.uk/phpu (accessed 10 Oct 2003). (Accepted 7 October 2003)

“Failed back surgery syndrome”

Lina Talbot

An inappropriate diagnostic label may exacerbate the discomfort of patients who develop persistent and disabling symptoms after back surgery

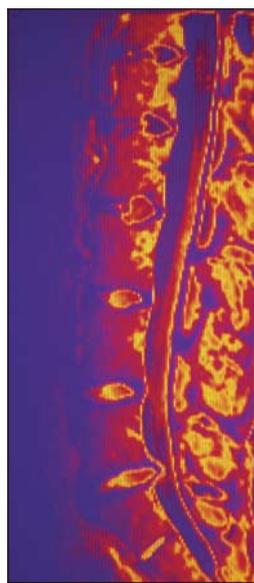
Every general practitioner has one—a patient who has had back surgery but hasn't improved. Around 2000 cases of failed back surgery syndrome are produced each year in the United Kingdom.¹⁻³ This is an uncomfortable statistic, and it is an uncomfortable condition to manage. Patients are often young and were previously active but now face chronic pain for years. They come from the surgeons but are no longer surgical candidates. They have been through the gamut of orthopaedic, neurological, and radiological opinions followed by physiotherapy, occupational therapy, and possibly clinical psychology, funnelling them inexorably towards the pain clinic. Unfortunately, they fare badly there too, with just over one in three patients achieving more than 30% pain relief.

I know about this dreary path at first hand. Nowadays, we may increasingly be questioning the advisability of surgery for prolapsed disc, but not operating can also produce long term disability. Comparison of the UK rate of spinal surgery with that in other countries shows that UK surgeons are not sharpening their scalpels to the ringing of cash tills. Yet 5–10% of patients who have back surgery return home without relief of their radicular pain.^{2,3} Worse still, after about six months, the pain may be showing an unpleasant whiff of neuropathy.

Personal view

I practised general medicine in both England and Germany. When the radicular pain returned after my

microdiscectomy, I battled for months to cope with ward work while seeking out an unoccupied bed in a quiet corner for periodic breaks. The availability of beds, in Germany at least, makes medicine seem the perfect occupation for someone with failed back surgery. I returned to the neurosurgeon, who did computed tomography,



False colour nuclear magnetic resonance image of prolapsed disc

pronounced that the prolapse had not recurred, and told me it would take more time. Despite twice weekly physiotherapy and utmost care with all physical activities, I gradually worsened and developed bladder problems.

Only after many consultations and investigations did I pick up a book and read about *Postdiskotomie-Syndrom*. I then began to understand that, although the nerve roots were not damaged directly by the surgery, they were now encased in a web of scar tissue causing pain and spasm every time this was tweaked enough by movements of the spine and legs.

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