WHO THEY ARE, WHAT THEY DO AND HOW TO GET INVOLVED

On 1st April 2013 the Health and Social Care Act 2012 came into force bringing with it many new structures and arrangements for the NHS in England. Primary Care Trusts and Strategic Health Authorities were abolished to be replaced with NHS England and Clinical Commissioning Groups who are now responsible for the vast majority of NHS services with local authorities taking on new public health commissioning responsibilities. Monitor has assumed the role of system regulator for all NHS funded services.

NHS England: NHS England is an independent body whose main role is to improve health outcomes for people in England. It is responsible for providing leadership in improving patient outcomes and driving up quality of care, overseeing the operation of clinical commissioning groups, allocating resources to CCGs and commissioning primary care and specialist services. You can find out more information at their website: http://www.england.nhs.uk/

CCGs (Clinical Commissioning Groups): All GP practices belong to a CCG which also includes other health professionals, such as nurses. They are responsible for planned hospital care, rehabilitative care, urgent and emergency care including out of hours, most community health services and mental health and learning disability services. CCGs can commission any service provider that meets NHS standards and costs. These can be NHS hospitals, private sector providers, social enterprises, or charities. In commissioning services they must take account of the services they commission with reference to the National Institute of Health and Care Excellence (NICE) guidelines and the Care Quality Commission's data about service providers. You can find out more about the Mid-Essex CCG at their website: www.midessexccg.nhs.uk. Public board meetings are held bi-monthly. Details can be found on their website under Events.

PATIENT AND PUBLIC ENGAGEMENT

Both NHS England and CCGs have a duty to involve their patients, carers and the public in decisions about the services they commission.

Health and Well Being Boards: Health and Well Being Boards aim to give communities a greater say in understanding and addressing local health and social care needs and have strategic influence over commissioning decisions across health, public health and social care. Boards bring together CCGs and councils to develop a shared understanding of the health and well being needs of the community. They are intended to strengthen democratic legitimacy by involving democratically elected representatives and patient representatives in commissioning decisions and provide a forum for challenge, discussion and the involvement of local people. Information can be found at: http://www.maldon.gov.uk/site/

Patient Participation Groups (PPGs): Patient participation is a partnership between patients, GPs and their Practice. Such groups aim to help patients take more responsibility for their health, contribute to improvement of services and quality of care as well as fostering improved communication between a Practice and the patient. If you would like to get involved in your PPG please contact the practice manager for your surgery to find out more.

Health Watch Essex: Healthwatch Essex is a new independent consumer body created to gather and represent the views of the public. It plays a role at both national and local level to make sure that the views of the public and people who use services are taken into account. Through a network of volunteers and working with existing voluntary and community groups its aim is to find out what matters to local people. Healthwatch has powers in law which means that the authorities have a legal responsibility to use their findings to shape and improve services. For further information please visit: www.healthwatchessex.org.uk. Membership is open to the public as are the strategic board meetings details of which are posted on the website.

THE HEALTH AND SOCIAL CARE ACT 2013

(The information below comes from the Keep Our NHS Public website and does not necessarily reflect the views of the organisers, doctors and other organisations present)

On 1st April 2013 the Health and Social Care Act 2012 came into force. It replaced the old structure with Clinical Commissioning Groups, removed the responsibility of the Secretary of State to secure comprehensive and universal healthcare provision and lifted the cap on private patient income from Foundation Trusts enabling them to earn up to half their income from private patients. Just before the Act went live in April 2012 a regulation known as Section 75 was inserted which requires all commissioning decisions to be open to competition from private providers.

A little bit of history

Since the 1990s the English NHS has been divided into two parts:

- Providers i.e. NHS hospitals, Ambulance or Mental Health trusts or private companies or charity/social enterprise
- Purchasers – the organisations that spend the NHS budget on buying or commissioning healthcare from the providers.

This divide called the 'purchaser/provider' split created a market for healthcare. This was, in the beginning, largely an internal market where NHS managers purchased clinical services from other parts of the NHS. Since then there has been a gradual movement towards privatisation starting with such support services such as cleaning, catering and administration and later such things as the private provision of GP out of hours services and logistics, and NHS treatments as a means to reduce hospital waiting lists. Private Finance Initiative deals also created public private partnerships for building NHS hospitals with private capital.

What is happening now?

Since the Bill's enactment privatisation has been accelerating as many clinical services are being awarded to private providers. However, unlike past privatisations like water, energy and rail, this privatisation is happening piecemeal through decisions made largely at local level by purchasers i.e. CCGs. There are a variety of mechanisms in place which include putting a contract out to tender so that private companies can bid, using the new 'Any Qualified Provider' model (a shopping list of providers from which a patient can choose), or the use of fixed sum personal budgets for patients with long term care needs allowing them to buy healthcare from either the NHS or private providers. Already over £5billion worth of contracts to run or manage clinically related services have been advertised in the nine months since April 2013.

How do private companies make money from the NHS if we don't (currently) pay?

At present they get our tax money instead. NHS hospitals and providers used to get a grant from government based on the needs of the local population. Now, however, the NHS runs a system called Payment by Results which means that providers (NHS or private) get paid per treatment procedure which then gives them an incentive to compete against each other. The payment or tariff is set low which reduces NHS providers' funds although private companies can afford to run 'loss leaders' or may just cut corners and run services on the cheap.

Does it matter if services are privatised? Could it make it more efficient?

Cherry Picking: Private providers pick off the cheaper and more profitable bits of the NHS whilst leaving the most costly aspects of healthcare such as A&E, intensive care and patients with complex needs, emergencies and training to the NHS. This has the effect of leaving them to struggle through lack of adequate funding.

Transaction Costs – the costs of administering this market are huge. Administration costs were 5% in 1979 but by 2010 research commissioned but not published by the Department of Health showed it had risen to 14%. It is likely to be substantially higher now. The marketisation of the NHS will ultimately cost more.

The failure of insurance models. The best known example of market failure in healthcare is the US where the average citizen pays twice as much in insurance and taxes as we do in the UK for a system which delivers far worse outcomes. Their system of competing providers is hugely bureaucratic and private providers extract substantial profits taking money away from patient care and there is substantial fraud. This model is also the biggest cause of personal bankruptcy in the USA (62%). The NHS as a public service model was the second most cost efficient in the developed world. (A peer-reviewed study for the Royal Society of Medicine pre-2010).)

Competition plus cuts lowers standards. In an environment of substantial cuts (or efficiencies as they are sometimes called) to the NHS budget over five years market competition tends to mean competition on price. The provider that can put in the cheapest bid for the contract to provide a service may well win it even if they score lower on quality of care although this is denied. See: (http://www.bbc.co.uk/news/uk-england-suffolk-20395749).

The idea that private providers provide better value is not borne out by the history of privatisation from rail, energy to water. Competitive tendering is likely to fragment healthcare as services are provided by different service providers and lead to lower quality and extra costs for the NHS. A survey carried out by The Kings Fund indicated a record drop in patient satisfaction in 2012 which comes after nearly a decade of improving levels of satisfaction with the health service. It said that the most likely causes for the decline were the health reforms and the funding squeeze. Some services are already being rationed or the cheapest alternatives offered for patient treatment (even though this may not in the end save money), waiting lists and hospital wait times are increasing and charges being threatened. Already health care insurance companies are using the impacts of this in their advertising to encourage patients to take out private health care insurance.

It will still be 'free at the point of need' though won't it?

'Free at the point of need' doesn't mean 'all the care you need free at the point of delivery' necessarily. The NHS may not charge but may simply withdraw the service. This is much easier since the Act scrapped the Secretary of State's legal responsibility to secure a comprehensive health service. There is already evidence that this is increasing for example in some areas people are no longer having two cataracts treated on the NHS – one good eye being judged enough. For the last few years some services have been redefined as extras or non core and people are now having to pay. As the cuts bite and waiting lists increase people are being pushed towards paying or getting insurance to go private if they want or need prompt treatment that they used to be able

to get on the NHS. Sometimes they are even encouraged to pay to jump the queue to get exactly the same treatment in an NHS hospital.

Why is privatised healthcare less accountable?

The NHS as a public organisation is accountable to the public through its elected representatives. Private companies on the other hand are accountable to their shareholders not to the public and, unlike NHS Trusts private providers, do not have to hold their board meetings in public or answer freedom of information requests by claiming commercial confidentiality. The public often doesn't even know who is providing their services underneath the NHS 'kite mark'. What is more, regulators cannot provide the same kind of accountability as public ownership a fact which is most often demonstrated in relation to the privatised utility regulators.

What is the relationship between privatisation and cuts/efficiencies?

Already NHS hospitals, clinics and Trusts are finding it more difficult to make ends meet because they are losing their 'easy' procedures to the private sector who are already cherry picking the more profitable patients. They are also having to compete against private providers who promise the CCGs (who are trying to balance their budgets) that they will provide services more cheaply. They do this by putting in loss leader bids or cutting the number of skilled staff. When CCGs run a tender themselves the cost to the NHS provider of submitting a bid can itself be up to £1/2 million or more. Some hospitals are also being crippled by expensive PFI debts. In order to get Foundation Trust status they have to show the regulator Monitor that they have balanced the books and are financially sustainable – in other words that they are operating like a business.

On top of this the impact of the £20bn cuts over 5 years is already being felt. Whilst they are not supposed to affect frontline services four thousand five hundred nurses have been made redundant over the last 2 years and the Royal College of Nursing reported recently that there is a 20,000 shortfall in nursing staff One in three NHS Trusts are in debt, there are 4000 fewer acute hospital beds, there has been a 70% increase in patients waiting up to 12 hours in A&E and whilst doctors are struggling to meet patients' needs £5.4 billion of NHS funding has been returned to the Treasury in the past three years. As a result there are increasing financial pressures on CCGs and hospitals where it is leading to the closures of wards, departments such as A&E and maternity and whole hospitals.

If you want to know more please go to the following links.

www.keepournhspublic.com
www.nationalhealthaction.org.uk