Why the amended Health Bill still creates a worrying outlook for the NHS

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The bill's goal of an open market for public, private and voluntary sector providers throughout health and social care remains unaltered. The government intends the public sector share of provision to shrink due to failures and insolvencies, creating gaps for market entrants. NHS insolvencies may open sizeable urban plots to become available for new healthcare providers, or for property development. Primary care trust and strategic health authority closures will add to this significant side-effect of the reforms.

The public sector NHS services which go bankrupt will be those that cannot cover their costs with the fees they earn - with those burdened by PFI charges likely to be among early failures. In the long term there will be no public sector providers: NHS trusts are required to become foundation trusts, and in turn these are likely to transfer into the private sector through management buy-outs.

A key objection to the bill concerns its enabling role in denationalising the NHS. This role persists despite rewording of Clause 1. The Secretary of State for Health will henceforth only have a duty to act "so as to secure" the provision of comprehensive healthcare.

The government claims that its commercial NHS market will spontaneously generate comprehensive provision: this seems highly improbable. The usual consequences of market-led provision are inadequate services for poorer and less healthy populations and over-provision in affluent areas.

Should this occur, future health secretaries will lack levers to influence the situation, following the transfer of oversight functions to the NHS Commissioning Board - which can in turn "arrange for any other person to exercise any of its functions" (Clause 20) - and the replacement of service planning by market forces.

While the DH rejects accusations of privatisation, most new market entrants will be corporate. None will be new public sector actors so, however often Messrs Cameron and Lansley recite their care-free-at-the-point-of-use mantra, this constitutes partial privatisation.

The transition will initially be inconspicuous, with all services provided under the NHS logo, and accessed via clinical commissioning groups. Future referrals must be organised through competitive commissioning funded by fee-for-service ('payment by results'). Service packages exceeding £157,000 require full commercial tendering, but smaller-scale services will use the 'any willing/qualified provider' process.

Under AQP, organisations wishing to provide NHS-funded services register with the Care Quality Commission, and patients choose among them. CCG

members could be sued for influencing patient choice - an “anti-competitive practice disadvantaging other potential providers”. Amendments to the Bill reword the regulatory obligations for commissioning, but without any change in meaning. Monitor’s functions regarding competition take precedence over its other roles (Clause 69).

The impact of other amendments is equally modest: duties to apply the NHS constitution, keep health service functions under review, promote research, set tariffs, encourage integrated working, and diversify clinical involvement in commissioning are laudable but of minimal long-term importance given the core content of the bill.

Fifteen amendments strengthen public involvement – and it is intriguing that a reform so strongly promoted as benefiting patients had devoted so little attention to their interests. Funding for HealthWatch England is being cut just as its role is expanded. Amendment 192 enabling partial closure of foundation trust board meetings will reduce patient and public accountability.

The planned rationalisation of ‘quality premiums’ (amendments 143-146) lacks detail, although the rationing which they reward is already underway. In addition to private sector demand created by unmet needs, co-payments are likely after the current Parliament (during which the government has ruled out new NHS charges) – and all these new restrictions will generate an aggressive health insurance market which is already appearing, with major UK insurers introducing modular healthcare policies to cover treatments no longer accessible through the NHS.

The outlook for the NHS remains precisely as declared by former DH commissioning director Mark Britnell last November, in a since widely-publicised speech to US private equity investors: “In future, the NHS will be a state insurance provider, not a state deliverer. In future ‘any willing provider’ from the private sector will be able to sell goods and services to the system.”

The bill post-pause does nothing to prevent this promised transition. If it passes into law without major modification, in a few years the national part of our NHS will be reduced to a logo, a budget and a few quangos.