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NORTHERN IRELAND

# LEGAL QUARTERLY

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NORTHERN IRELAND
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**Special Issue:**
The Health and Care Act 2022: new legislation – new legacy?

Guest editors: Mary Guy and Jean McHale

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# The Health and Care Act 2022: new legislation – new legacy?

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The Health and Care Act 2022 is a major piece of legislation which garnered considerable publicity in relation to its important introduction of yet another major reorganisation of the National Health Service (NHS) in England and also of aspects of the delivery of social care in the same region. However, its relatively short passage through Parliament (from July 2021 to April 2022) belies its scope and the fact that other aspects of the legislation apply either across the United Kingdom (UK) as a whole or in various parts of the UK other than, or as well as, in England. It introduces new criminal offences concerning virginity testing[1] and hymenoplasty offences which are applicable across the UK jurisdictions,[2] clearly referencing contemporary concerns.[3] The Act provides for the extension of the criminal prohibition on commercial dealing in organs and related offences in England, Wales and Scotland to enable prosecution of those offences where these arise outside the jurisdiction.[4] Furthermore, legislation concerning international healthcare arrangements, for example, in relation to reimbursement of the cost of emergency medical

1 Ss 136–147 Health and Care Act 2022.

2 Ibid ss 148–159.

3 See further G Iacobucci 'Doctors call for ban on virginity testing and hymenoplasty discussion' (2021) 347 British Medical Journal n2037 and S Ray 'The British campaign to ban virginity testing and hymenoplasty' in M Jaschok, U H Ruhina Jesmin, T Levin von Gleichen and C Momoh (eds), *The Routledge International Handbook of Harmful Cultural Practices* (Routledge 2023).

4 S 170 which inserts a new s 32A into the Human Tissue Act 2004, which applies in England and Wales, and a new s 20A into the Human Tissue (Scotland) Act 2006; and for a background discussion of the law concerning extra-territorial enforcement concerning organ transplantation see further S McGuinness and J V McHale 'Transnational crimes related to health: how should the law respond to the illicit organ tourism?' (2014) 34(4) Legal Studies 682.

treatment[5] is broadened beyond its original post-Brexit application to the European Union (EU) and Switzerland. The reforms introduced in the 2022 Act also include amendments to the Human Fertilisation and Embryology Act 1990, which regulates reproductive technology treatment and embryo research across the UK.[6] This means that those receiving fertility treatment will now be able to store their gametes and embryos for up to 55 years where consent is given to continued storage each decade whereas donors of such material will also be able to consent to storage for up to 55 years without needing reconsent after each decade.[7] The changes to practice concerning early medical abortions introduced during the Covid-19 pandemic enabling abortion via telemedicine and administration of prescribed administration at the woman's home have now been placed on a permanent statutory basis for England and Wales under provisions in the Health and Care Act 2022 amending the Abortion Act 1967.[8]

The Act also finally implements the recommendations originating from the *Shipman Report* and provides for the creation of medical examiners to provide independent scrutiny of death certificates in England and Wales.[9] Other aspects of the legislation include plans to license the performance of non-surgical cosmetic procedures in

5 S 162 Health and Care Act 2022. This provision amends the title of the Healthcare (European Economic Area and Switzerland Arrangements) Act 2019 to the Healthcare (International Arrangements) Act 2019, with the intention that this will be broader in scope, facilitating arrangements concerning healthcare going beyond those consequent upon withdrawal from the EU. See also now the Healthcare (International Arrangements) (EU Exit) Regulations 2023, SI 2023/854.

6 S 171 and sch 17 of the Health and Care Act 2022.

7 See also Department of Health and Social Care, Consultation Outcome Gamete (Egg, Sperm) and Embryo Storage Limits: Response to Consultation (2021).

8 S 178 Health and Care Act 2022; for background on this area see A M Wilson, 'The Health and Care Act 2022: inserting telemedicine into the Abortion Act 1967' (2023) 31(1) Medical Law Review 158 and for the broader background on this area J Parsons and E C Romanis, *Early Medical Abortion, Equality of Access, and the Telemedical Imperative* (Oxford University Press 2021).

9 S 169 Health and Care Act 2022 and the Medical Examiners (England) Regulations 2024 (at time of publication of this special issue currently in draft form). The need for reform of the death certification scheme has long been the subject of recommendations: see eg *The Shipman Inquiry Third Report: Death Certification and the Investigation of Deaths by Coroners* (Cm 5854 2003) and see Department of Health and Social Care Guidance, *An Overview of the Death Certification Reforms* (updated 14 December 2023) and see further discussion in M Earle, 'Death' in J M Laing and J V McHale (eds), *Principles of Medical Law* 5th edn (Oxford University Press forthcoming 2024) paras 22.54–22.58.

England.[10] Further regulation of cosmetic procedures is also currently under consideration in Scotland.[11] Finally, there is a new role for NHS England to support the Competition and Markets Authority in its functions under the Competition Act 1998 and the Enterprise Act 2002,[12] both UK-wide pieces of legislation. While previous competition and marketisation reforms have focused on England, the underlying interaction between the NHS and private healthcare is UK-wide, and at least in Wales there has been clear evidence of closer interactions in responding to Covid-19 which may be further developed post-pandemic.[13]

Despite the aforementioned range of diverse aspects, the major structural reorganisation of health care delivery in England is one of the aspects of the Act which attracted considerable attention. The Act builds on recommendations for reform set out by NHS England in the 2019 NHS Long Term Plan[14] and was a Conservative Manifesto Commitment in the 2019 UK General Election. Changes of Secretary of State[15] and pandemic responses in that period also helped to shape the development of the 2022 Act. It is the second major reorganisation of the English NHS since the 2010 general election. It repeals aspects of the controversial Health and Social Care Act 2012 introduced by the then Secretary of State for Health, Andrew Lansley. One notable aspect of the 2012 Act was the reduction of ministerial oversight in favour of (then new) arms-length bodies, such as NHS England, NHS Improvement and Public Health England. Section 45 of the Act now reincorporates the Secretary of State's oversight functions over NHS

10 S 18 Health and Care Act 2022. For the background issues to regulation, see further M Latham and J V McHale, *The Regulation of Cosmetic Procedures: Legal Ethical and Practical Challenges* (Routledge 2020).

11 See Scottish Government, *Non-Surgical Cosmetic Procedures Regulation: Consultation Analysis – Final Report* (June 2022) and for background see A Malyon, Scottish Cosmetics Interventions Group (Scottish Government 2015).

12 S 82 Health and Care Act 2022.

13 M Guy, '(How) is Covid-19 reframing interaction between the NHS and private healthcare?' (2023) 23(2) Medical Law International 138.

14 Health and Care Act 2022, Explanatory Notes; NHS England, The NHS Long Term Plan (January 2019) 13.

15 Sajid Javid MP, Steve Barclay MP, Thérèse Coffey MP, Steve Barclay MP and, since 13 November 2023, Victoria Atkins MP.

England.[16] However, it does not necessarily follow that this represents a reversion to the pre-2012 Act NHS position given the continued existence – and indeed expansion – of NHS England. Moreover, some restructuring was already underway in the years leading up to the 2022 Act. Larger regional groups of service providers – integrated care systems (ICSs) – had been established with the intention of facilitating the integration of delivery of both health and social care. It was eventually agreed that legislation would be needed to enable the full implementation of the changes.[17] The Act replaces Clinical Commissioning Groups which undertook day-to-day commissioning of healthcare services at local level with Integrated Care Boards.[18] The new Boards cover larger areas than their predecessors and they will work as part of Integrated Care Partnerships – new statutory committees which also involve 'upper tier' local authorities.[19] The Act also provides for the sharing of anonymous NHS health and social care patient information for purposes relating to the functions of health and social care bodies.[20] In addition it established a review of the approach taken to disputes concerning the treatment of critically ill children in England.[21] The legislation also establishes the Health Services Safety Investigations Body which is a new statutory body concerned with internal NHS patient safety investigations operating in England.[22]

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16 These were added to the 2021 White Paper by the then Secretary of State for Health and Social Care, Matt Hancock MP. See further discussion in K Syrett, 'The organisation of healthcare' in J M Laing and J V McHale, *Principles of Medical Law* 5th edn (Oxford University Press forthcoming 2024) and NHS England, 'Creating coherent system leadership' (24 May 2018). NHS England was called the NHS Commissioning Body under the previous legislation but *de facto* was called NHS England. Its legal name was changed finally by s 1 of the Health and Care Act 2022. NHS Improvement is also now combined with NHS England.

17 See, generally, for the background development of ICSs, the Health and Social Care Select Committee Report, *Integrated Care Organisations, Partnerships and Systems* (HC 650 2018).

18 S 3 National Health Service Act 2006 as amended.

19 NHS England, 'What are integrated care systems?'.

20 S 96 Health and Care Act 2022.

21 S 177 and see also K Moreton, *Literature Review: Disagreements in the Care of Critically Ill Children: Causes, Impact and Possible Resolution Mechanisms* (Nuffield Council on Bioethics 2023) and Nuffield Council on Bioethics, *Disagreements: Critical Care Independent Review* (2023).

22 Part 4 Health and Care Bill, and see further, for background on this and on the reforms, J V McHale, 'Patient safety, the "safe space" and the duty of candour: reconciling the irreconcilable?' in J Tingle, C O'Neill and M Shimwell (eds), *Global Patient Safety: Law Policy and Practice* (Routledge 2018): O Quick, 'Duties of candour in healthcare: the truth, the whole truth, and nothing but the truth?' (2022) 30(2) Medical Law Review 324.

The Act also incorporates provisions in relation to social care in England. Section 163 extends the scope of the Care Quality Commission to review the provision of local authority adult social care functions provided for under part 1 of the Care Act 2014. Information is to also be provided by social care providers via the Capacity Tracker operated by the NHS in relation to such things as the number of social care staff, social care beds and Covid-19 vaccination status.[23] The legislation also made provision for the cap on care costs which the Government had signalled would take place.[24] At the time of writing the introduction of the cap on care costs has been delayed, and it remains uncertain as to whether it will ultimately be implemented.

This special issue offers UK-wide learning through its primary focus on a number of areas which received considerably less public attention in the lead-up to the passage of the legislation and yet which may leave a considerable legacy for health and social care in the future. The special issue begins with **Keith Syrett**'s paper 'Something in the water: opening the public health law policy window for fluoridation?' The debate over the fluoridation of water and the question of local versus national responsibility has a long history. Syrett critically examines impacts of the provisions in sections 175 and 176 of the 2022 Act concerning water fluoridation in England. He makes use of Kingdon's concept of a 'policy window' and suggests that public acceptance of the new measures may be greater post-Covid-19, but that this remains a contentious issue. **Connor Francis Macis** builds on Syrett's analysis in his commentary, 'Unearthing organic ideology in public health interventions: the case of water fluoridation provision in the Health and Care Act 2022'. He utilises the Gramscian concept of organic ideology as a lens to examine the state as protector in the context of public health interventions[25] and highlights the need in developing public health policy for policymakers to 'be mindful of the politico-philosophical underpinnings of public health law and policy'.[26]

Proper nutrition is an important part of effective recovery from illness. Yet the quality of hospital food has been criticised over many years and remains a matter of controversy. In her paper 'Hospital food standards in section 173 of the Health and Care Act 2022: political

23 S 277A of the Health and Social Care Act 2012. See also the Adult Social Care Information (Enforcement) Regulations 2022, SI 2022/1175.

24 See further Cabinet Office, Department of Health and Social Care and Prime Minister's Office 10 Downing Street, *Build Back Better: Our Plan for Health and Social Care* (updated 8 March 2022) and the *Autumn Statement*, Hansard 17 November 2022, col 844–856.

25 See further C Mouffe, 'Hegemony and ideology in Gramsci' in C Mouffe (ed), *Gramsci and Marxist Theory* (Routledge & Kegan Paul 1979).

26 See Macis below at page 764.

magic with a soggy bottom', **Ruth Stirton** reviews the changes envisaged by section 173 Health and Care Act 2022 regarding hospital food in England which enable regulation of nutritional standards and of the type of food and drink provided in hospitals. She explores the subsequent developments following the passage of the legislation. Drawing on Edelman's work on the symbolic uses of politics, the literature on policy fiascos, and Lasswell's definition of 'political magic', Stirton examines the extent to which this legislative provision will provide a substantive effective change in practice in the future.

The problem of delayed hospital discharge and patients being termed by the pejorative term 'bed blockers' has been a source of controversy for many years. At the same time, the safety of rapid hospital discharge has come under scrutiny, something tragically highlighted during the Covid-19 pandemic.[27] In her paper 'Choosing home: discharge to assess and the Health and Care Act 2022', **Jean McHale** examines the developments around hospital discharge law and policy since the 1990s, leading up to the Health and Care Act 2022. She critically examines the new statutory powers enabling rapid patient discharge by moving assessments of duties and powers relating to social care services provided to patients after leaving hospital to be undertaken after patients leave hospital and the challenges which remain. While this represents an English case study, this legislative approach may provide useful lessons for the rest of the UK.

The removal of the competition reforms contained in the 2012 legislation and subsequent shift towards integration in the English NHS is examined using the lens of claims of 'NHS privatisation' by **Mary Guy** and **Okeoghene Odudu** in their paper 'Understanding "NHS Privatisation": from competition to integration and beyond in the English NHS'. While concerns about an irreversible shift towards 'NHS privatisation' were a key feature of parliamentary debates preceding the 2012 Act, Guy and Odudu demonstrate how claims of privatisation can be linked to the wider interaction between the NHS and private healthcare in England,[28] so have not disappeared with the focus on integration of the Health and Care Act 2022. Furthermore, it appears that competition has been refocused, rather than removed, by the 2022 Act. This wider interaction between the NHS and private healthcare is also in evidence to varying degrees in Wales, Scotland and Northern

27 See further *R (Gardner and Harris) v Secretary of State for Health and Social Care and Others* [2022] EWHC 96.

28 It is recognised, of course, that concerns about 'NHS privatisation' in the sense of using private providers and also of paying for private treatment exist across the UK. See, respectively, '"Privatisation by stealth!" – Plaid blasts Welsh Government on NHS plans' *Tenby Observer* (Tenby 10 January 2023); and 'NI health: more people than ever paying for private healthcare' (*BBC News* 23 March 2023).

Ireland, so distinctions with the approach in England can be insightful.

The final piece in this volume, while not within the province of the 2022 Act itself, raises fundamental questions regarding an issue which may soon return for parliamentary consideration. In his commentary 'Assisted Dying Bill [HL]: ignorance within the House?' **Chay Burt** goes beyond the 2022 Act to examine the perennial question of assisted dying, an issue which Parliaments in Westminster and the devolveds may have to address in the near future if there is public pressure for them to follow the approach recently taken in Jersey[29] and in the Isle of Man where legislation on assisted dying is as of January 2024 currently in progress through the Tynwald.[30] Burt identifies lessons drawn from the Canadian medical assistance in dying legislation which may prove a valuable legacy when determining future reforms across the UK.

This special issue arose from a virtual symposium which took place in September 2021, as the Health and Care Bill was making its way through the House of Commons, and was organised by the Centre for Health, Law, Science and Policy (CHLSP) at the University of Birmingham. This event brought together researchers working on themes arising in the Bill to discuss the proposed legislation and share insights. Many of these discussions find reflection in the papers which comprise this special issue. The Guest Editors would like to express their thanks to Professor Mark Flear, Chief Editor of the *Northern Ireland Legal Quarterly* for supporting this special issue, Marie Selwood for her editorial assistance, the contributors of submissions, and finally the anonymous reviewers who very kindly read and provided feedback on the article drafts.

29 Government of Jersey, 'Assisted dying in Jersey' and see also R Huxtable, T Lemmens and A Mullock, *Assisted Dying in Jersey: Ethical Review Report* (Strategic Policy, Performance and Population November 2023).

30 Assisted Dying Bill 2023.

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# Something in the water: opening the public health law policy window for fluoridation?

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ABSTRACT

Alongside the more widely debated provisions relating to the organisation and delivery of healthcare services in the National Health Service in England, the Health and Care Act 2022 contains measures relating to public health. This article offers a critical examination of one of these, that relating to fluoridation of water supplies. The nature of this intervention as a response to problems of poor oral health is considered, and the changes made by the 2022 Act are explained. It is argued that there are clear reasons for altering the statutory framework, but that it is less immediately apparent why this development is taking place at this point in time. In order to answer this question, John Kingdon's concept of a 'policy window' is deployed as a framework for understanding agenda-setting in this context. Additionally, this can facilitate analysis of the future likelihood of use of the powers conferred by the 2022 Act in this controversial area of public health.

**Keywords:** Health and Care Act 2022; fluoridation; agenda-setting; policy window; evidence; ethics; legitimacy.

## INTRODUCTION

The Health and Care Act 2022 has attracted most attention for the manner in which it reconfigures delivery of healthcare in the National Health Service (NHS) in England, especially in respect of the move towards 'integrated care'.[1] However, buried in the 'miscellaneous' provisions contained in Part 6 of the Act are two measures which relate to public health, concerning less healthy food and drink, and fluoridation. The focus of this article is on the second of these matters, although brief reference will also be made to the first.

Fluoridation of water supplies is a public health intervention which dates from the mid-twentieth century.[2] However, it remains highly controversial, affording a useful case study in the political acceptability of such interventions. This article will explore the changes made by the

1 Health and Care Act 2022, Part 1.

2 See nn 37–38 below and accompanying text.

2022 Act, seeking to understand how this intervention has – perhaps somewhat unexpectedly – reappeared on the policy agenda, and its prospects of remaining there in the coming years.

## ORAL HEALTH AS A PUBLIC HEALTH ISSUE

Oral health has been described as a 'neglected' area of population health.[3] Globally, it affects over 3.5 billion people (about 44% of the world's population), and untreated dental caries is the most prevalent health condition worldwide.[4] It has been argued that oral healthcare in high-income countries remains rooted in an interventionist and technological paradigm in which the underlying social determinants of ill health are, at best, secondary considerations to the treatment of disease.[5] This stands in contrast to the dominant strand of recent thinking on public health typified by the work of Sir Michael Marmot.[6]

In England, the cost of treating oral health conditions to the NHS has been estimated at approximately £3.6 billion per year.[7] There is a particular problem in respect of children, with one quarter of five-year-old children having decay in primary teeth, and hospital admissions of children aged 0 to 19 due to avoidable decay being twice the level of the next most common cause for admission.[8] Poor oral health is also a matter of health inequality, with a social gradient existing across various indicators (such as dental caries, periodontal diseases and tooth loss),[9] similar to that observed in the famous 'Whitehall Study'.[10] There are also stark geographical variations,[11] particularly among children.[12]

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3 R Watt et al, 'Ending the neglect of global oral health: time for radical action' (2019) 394 The Lancet 261, 261.

4 Ibid.

5 Ibid 262.

6 See eg M Marmot and R Wilkinson (eds), *Social Determinants of Health* 2nd edn (Oxford University Press 2005); M Marmot et al, *Fair Society, Healthy Lives* (The Marmot Review 2010); M Marmot, *The Health Gap* (Bloomsbury 2015). Marmot led the World Health Organization's Commission on Social Determinants in Health and was co-author of the highly influential *Closing the Gap in a Generation* (World Health Organization 2008).

7 Public Health England, *Adult Oral Health: Applying All Our Health* (2022).

8 G Lowery and S Bunn, POST: Rapid Response: *Water Fluoridation and Dental Health* (2021).

9 See Public Health England, *Inequalities in Oral Health in England* (2021) 17–25.

10 For the original study, see D Reed et al, 'Cardiorespiratory disease and diabetes among middle-aged male civil servants' (1974) 303 The Lancet 469; and for the follow-up, see M Marmot et al, 'Health inequalities among British civil servants: the Whitehall II study' (1991) 337 The Lancet 1387.

11 Public Health England (n 9 above) 25–39.

12 Ibid 30–34.

There would therefore seem to be a strong case for some form of intervention to address problems of oral health in England. That is, poor oral health should be viewed as a matter of *public health* – understood as a matter which generates a normative obligation upon government to take action to ameliorate suffering and enhance wellbeing at a population level[13] – for at least four reasons.

First, and most broadly, oral diseases continue to cause 'pain, infection, and low quality of life',[14] and thus, in Sen's terms, limit 'the extent to which people have the opportunity to achieve outcomes that they value and have reason to value'[15] in their lives. Arguably, it is incumbent upon the state to seek to provide conditions that allow people to achieve good oral health through appropriate exercise of a 'stewardship' role.[16]

Relatedly, and second, the economic costs of poor oral health provide a basis for public health intervention because, in a publicly funded health system such as the NHS whose resources are necessarily finite, management of these conditions reduces the capacity to treat patients with other forms of illness. In a somewhat indirect sense, then, there is justification for intervention based around a Millian harm principle, since the poor oral health of person A may cause harm (for example) to diabetic person B by (say) making B wait longer for NHS treatment. However, beyond this, since the NHS can be regarded as an exemplar of 'joint work necessary to the interests of society of which [the individual] enjoys the protection',[17] state activity is permissible even on Mill's liberal account.[18]

Third, and to return to Mill, there is a rationale for intervening in order to protect vulnerable categories of individuals, since 'those who are still in a state to require being taken care of by others, must be protected against their own actions as well as against external injury'.[19]

13 See J Coggon, *What Makes Health Public? A Critical Evaluation of Moral, Legal, and Political Claims in Public Health* (Cambridge University Press 2012) especially ch 3; also L Gostin and L Stone, 'Health of the people: the highest law?' in A Dawson and M Verweij (eds), *Ethics, Prevention and Public Health* (Oxford University Press 2007).

14 Watt et al (n 3 above) 261.

15 A Sen, *Development as Freedom* (Alfred A Knopf 1999) 291.

16 See Nuffield Council on Bioethics, *Public Health Ethics* (2007) [2.41]–[2.44]. For critiques, see A Dawson and M Verweij, 'The steward of the Millian state' (2008) 1 Public Health Ethics 193; J Coggon, 'What help is a steward? Stewardship, political theory and public health law and ethics' (2011) 69 Northern Ireland Legal Quarterly 599; S Hølm, 'From steward to Stuart: some problems in deciding for others' (2011) 69 Northern Ireland Legal Quarterly 617.

17 J S Mill, 'On liberty' in S Collini (ed), *On Liberty and Other Essays* (Cambridge University Press 1989) 14.

18 See further Nuffield Council on Bioethics (n 16 above) [2.17].

19 Mill (n 17 above) 13.

In this regard, we may note the particular problems of poor oral health among children, who 'are susceptible to dental caries, are less able to make informed choices about their dental health, and are dependent on parents and carers to assist with or promote preventative measures such as tooth brushing'.[20]

Fourth, there are strong legal and ethical drivers for intervention based on the existence of inequalities in oral health. From the former standpoint, section 1C of the National Health Service Act 2006 imposes an obligation on the Secretary of State to 'have regard to the need to reduce inequalities between the people of England with respect to the benefits that they can obtain from the health service';[21] comparable duties are placed on NHS England,[22] and Integrated Care Boards.[23] From an ethical perspective, in light of the fact that 'health is among the most important conditions of human life and a critically significant constituent of human capabilities which we have reason to value',[24] inequalities in health are central to conceptions of justice. Avoidable inequalities in oral health may inhibit the attainment of fair equality of opportunity,[25] and Marmot notes that he has 'never heard anyone who subscribes to democracy, politician or academic, say that equality of opportunity is a bad thing'.[26]

However, the presence of rationales for a public health intervention in oral health does not in itself tell us *what form/s* such an intervention might most appropriately take. Famously, Gostin has provided a typology of legal interventions in public health,[27] some of which – such as strategies to alter the informational environment – might be considered to amount to 'law' only on a very expansive definition of

20 Nuffield Council on Bioethics (n 16 above) [7.17]. See also the statement of Nigel Carter, Chief Executive of the Oral Health Foundation, quoted in Department of Health and Social Care, Policy Paper, *Health and Care Bill: Water Fluoridation* (updated 10 March 2022): 'We believe that water fluoridation is the single most effective public health measure there is for reducing oral health inequalities and tooth decay rates, especially amongst children.'

21 As inserted by Health and Social Care Act 2012, s 4.

22 National Health Service Act 2006, s 13G, as inserted by Health and Social Care Act 2012, s 23.

23 National Health Service Act 2006, s 14Z35, as inserted by Health and Care Act 2022, s 25(2).

24 A Sen, 'Why health equity?' in S Anand, F Peter and A Sen (eds), *Public Health, Ethics, and Equity* (Oxford University Press 2006) 23.

25 See Nuffield Council on Bioethics (n 16 above) [7.19].

26 M Marmot, 'Capabilities, human flourishing and the health gap' (2017) 18 Journal of Human Development and Capabilities 370, 373.

27 See L Gostin and L Wiley, *Public Health Law: Power, Duty, Restraint* 3rd edn (University of California Press 2016) 27–33.

that term.[28] Similarly, albeit from a perspective more grounded in political philosophy, the Nuffield Council on Bioethics has developed a well-known public health 'intervention ladder':

> with progressive steps from individual freedom and responsibility towards state intervention as one moves up the ladder. In considering which 'rung' is appropriate for a particular public health goal, the benefits to individuals and society should be weighed against the erosion of individual freedom.[29]

The higher the rung on the ladder (which ranges from 'do nothing or simply monitor the situation' at the bottom to 'eliminate choice' at the top), the more there is intrusion on individual liberty, and the greater the justification which is said to be needed.

Most interventions adopted to date in England have had a behavioural and/or educational focus and have been most comprehensively developed in relation to children. They include oral health training for professionals (such as health visitors, teachers and pharmacists), media campaigns to promote the value of good oral health, healthy food and drink policies, supervised teeth-brushing schemes, facilitating access to dental services, and targeted community-based fluoride varnish programmes.[30] Such strategies can be considered to be 'softer forms of social control'[31] and since they involve relatively minimal intrusions upon individual liberty, would seem to require little in the way of justification. A 'harder' measure is the so-called 'sugar tax' (soft drinks industry levy) introduced in 2018,[32] although this was rationalised as a means of addressing obesity, particularly among children,[33] rather than being connected to oral health.[34]

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28 For a broad definition which incorporates 'softer means of social control', see J Coggon, K Syrett and A M Viens, *Public Health Law: Ethics, Governance and Regulation* (Routledge 2017) 67 and ch 4 generally.

29 Nuffield Council on Bioethics (n 16 above) [3.37].

30 See Public Health England, *Local Authorities Improving Oral Health: Commissioning Better Oral Health for Children and Young People* (2014) ch 3.

31 Coggon et al (n 28 above).

32 See Finance Act 2017, Part 2.

33 See HM Treasury, 'Soft drinks industry levy comes into effect' (5 April 2018).

34 See eg Nigel Carter, Oral Health Foundation, quoted in Oral Health Foundation, 'Launch of new sugar tax leaves "bitter taste" when it comes to oral health' (3 April 2018): 'The sugar tax falls short when it comes to oral health and it does not do enough to address the crisis we have seen develop as a result of excessive sugar consumption in the UK over recent years ... We want to see the sugar tax reviewed with a greater focus on oral health, it needs to cover more products and also must seriously consider putting some of the funds it generates into oral health preventive programmes in schools, which have been proved to be effective.'

## FLUORIDATION AS AN ORAL PUBLIC HEALTH INTERVENTION

Fluoride is the term given to various compounds of the element fluorine which occur naturally and are released from rocks into soil, air and water. It is present in almost all water (both salt and fresh) at varying levels.[35] It acts on teeth by stimulating remineralisation, thus making tooth enamel more resistant to the acid present in sugary foods and drinks, which can cause cavities.[36]

Epidemiological studies conducted in the United States (US) in the 1930s and 1940s demonstrated that, as the levels of fluoride increased, so the incidence of dental caries decreased, with no significant health side effects other than an increase in dental fluorosis (a developmental defect of dental enamel).[37] A community trial conducted in the city of Grand Rapids from 1945 onwards, in which fluoride was added to drinking water, had positive outcomes and, in 1951 the Surgeon General stated fluoridation to be an official policy of the US Public Health Service.[38] By 2018, 73 per cent of the US population had access to fluoridated water;[39] worldwide approximately 400 million people are covered by artificial fluoridation schemes, and another 50 million consume water with fluoride naturally occurring at similar levels.[40]

In England, approximately 6 million people live in areas covered by water fluoridation schemes, with a further one-third of a million being supplied with naturally fluoridated water.[41] The longest-standing community water fluoridation scheme is that established in Birmingham and Solihull in 1964, with several others in the north east and north west following before the turn of the decade. As of 2020, 26 unitary and upper-tier local authorities had schemes covering all or part of their geographical areas; this includes some large population centres such as Birmingham, Coventry, Newcastle-upon-Tyne and Wolverhampton.[42]

Notwithstanding the original twentieth-century US studies, there is continuing debate around the evidence basis of water fluoridation as a public health intervention. In its policy paper accompanying the

35 See Centers for Disease Control and Prevention, 'About fluoride'.

36 See Lowery and Bunn (n 8 above).

37 See M Lennon, 'One in a million: the first community trial of water fluoridation' (2006) 84 Bulletin of the World Health Organization 759, 759.

38 Ibid 760.

39 Centers for Disease Control and Prevention, 'Water fluoridation data and statistics'.

40 Department of Health and Social Care (n 20 above).

41 Public Health England, *Improving Oral Health: A Community Water Fluoridation Toolkit for Local Authorities* (2020) 7.

42 Ibid [2.3].

Health and Care Bill, the Department of Health and Social Care argued that 'evidence supports water fluoridation as an effective public health measure that has the ability to benefit both adults and children, reduce oral health inequalities and offer a significant return on investment', and noted that there is no evidence of health harms arising from areas with artificial or natural fluoridation in England.[43] However, it did make reference to studies reporting associations with adverse developmental neurological effects,[44] and to indications of other conditions, including bone cancer, Down's Syndrome and kidney issues, while somewhat glibly dismissing such concerns on the basis that 'various authoritative expert evaluations from different international organisations all agree that there is no convincing evidence that fluoride in drinking water at levels used in fluoridation schemes ... is harmful to general health'.[45]

A more comprehensive evaluation of the evidence was presented in a systematic review commissioned by the Department of Health under the Blair Government.[46] Although this prompted the enactment of the measures contained in the Water Act 2003 which are discussed in the next section of this article, the conclusions of the review were ambivalent. The researchers noted that 'although there has been considerable research in this area, the quality is generally low', that 'the miscellaneous other adverse effects studied did not provide enough good quality evidence on any particular outcome to reach conclusions', and that 'the association between water fluoridation, caries and social class needs further clarification'.[47] The Nuffield Council on Bioethics noted that this hesitancy was 'somewhat surprising, given that fluoridation has been implemented as a policy option for several decades'.[48]

Others have been more forthright. Cheng, Chalmers and Sheldon observe that 'while the quality of evidence on potential long term harms of fluoridated water may be no worse than that for some common clinical interventions, patients can weigh potential benefits and risks before agreeing to treatments',[49] in a manner which is much less open

43 Department of Health and Social Care (n 20 above).

44 On this, see further L Gravitz, 'The fluoride wars rage on' Nature Outlook (27 October 2021).

45 Ibid.

46 Department of Health, *Saving Lives: Our Healthier Nation* (Cm 4386 1999) [9.20].

47 NHS Centre for Reviews and Dissemination, *A Systematic Review of Water Fluoridation* (University of York 2000) [12.9], [12.4], [12.3].

48 Nuffield Council on Bioethics (n 16 above) xxix.

49 K Cheng, I Chalmers and T Sheldon, 'Adding fluoride to water supplies' (2007) 335 British Medical Journal 699, 700.

to them in the case of fluoridation.[50] They also argue that fluoride should be classified as a medicine,[51] and that as such:

> evidence on its effects should be subject to the standards of proof expected of drugs, including evidence from randomised trials. If used as a mass preventive measure in well people, the evidence of net benefit should be greater than that needed for drugs to treat illness.[52]

The authors enumerate various jurisdictions and locations in which fluoridation schemes have been withdrawn, including Germany, the Netherlands, Sweden, and Basel, Switzerland.[53] By contrast, fluoridation is mandatory in the Republic of Ireland.[54]

## THE LEGAL FRAMEWORK FOR FLUORIDATION SCHEMES IN ENGLAND: BEFORE AND AFTER THE 2022 ACT

Part III, Chapter IV of the Water Industry Act 1991, which incorporates the content of the Water (Fluoridation) Act 1985, permits the making of 'arrangements' to increase the fluoride content of water supplies by water companies. Any agreement incorporating such arrangements – a 'fluoridation scheme' – is made between the Secretary of State and the relevant water company or companies.[55] The latter are obliged to comply with a request to establish such a scheme by section 58 of the Water Act 2003, subject to provision of an indemnity against any liabilities arising therefrom.[56] This represents an important departure

50 For discussion of issues relating to the giving of consent, see nn 139–147 below and accompanying text.

51 There is support for this in an opinion of Lord Jauncey in the Court of Session, see *McColl v Strathclyde RC* 1983 SC 225, wherein he stated that he was satisfied that fluoride fell within the definition of a 'medicinal product' for the purposes of Medicines Act 1968, s 130. See also *New Health New Zealand Inc v South Taranaki DC* [2018] NZSC 59, in which it was held that fluoridation of drinking water constituted medical treatment for the purposes of New Zealand Bill of Rights Act 1990, s 11. See further the discussion at nn 142 and 147 below and accompanying text.

52 Cheng et al (n 49 above), 701.

53 Ibid, 700.

54 Health (Fluoridation of Water Supplies) Act 1960.

55 In Wales, by the Welsh Ministers. The Health and Care Act 2022 makes no substantial change to the position in Wales, and the Welsh Government has indicated that it has no present intention to fluoridate water supplies: see Senedd Cymru/Welsh Parliament WQ84109(e) (16 December 2021). Accordingly, this article focuses upon the position in England only; note that the provisions on fluoridation do not apply to Northern Ireland or Scotland.

56 Water Industry Act 1991, s 90.

from the 1991 legislation, under which the increase of fluoride content by water companies was a matter of their discretion.[57]

Responsibility for instigating action on schemes was conferred on local authorities in England by the Health and Social Care Act 2012, in consonance with the transfer of duties relating to public health to the local level of government under section 12 of that statute.[58] Hence, section 88 of the Water Industry Act, as amended by the 2012 Act,[59] empowers local authorities to make a 'fluoridation proposal' to the Secretary of State, defined as being one to 'enter into arrangements with one or more water undertakers to increase the fluoride content of the water supplied by the undertaker or undertakers to premises within such area or areas in England as may be specified in the proposal'.[60] Any such proposal requires consultation with the Secretary of State and water companies supplying water to premises within the affected area(s) and determination that the consequent arrangements would be 'operable and efficient'.[61] In a situation where other local authorities are affected by plans to proceed with a scheme, these are to be notified and given opportunity to decide for themselves whether further steps should be taken in relation to the proposal.[62] This carried important implications for the feasibility of this process, which will be noted in the subsequent section of this article.

In addition, and importantly, section 88E(2) of the 1991 Act provided that, prior to undertaking further steps to take forward a fluoridation proposal, the proposing local authority 'must comply with such requirements as may be prescribed in regulations made by the Secretary of State as to the steps to be taken for the purposes of consulting and ascertaining opinion in relation to the proposal'. These requirements were set out in the Water Fluoridation (Proposals and Consultation) (England) Regulations 2013.[63] The object of these, given that 'fluoridation is controversial', was to ensure that 'no decisions are taken on fluoridation until after a public consultation is conducted'.[64] There is an obligation to publish details of the proposal and the intended steps in appropriate local newspapers and other accessible local media and to provide a period of at least three months during which representations can be made by affected individuals and bodies with an interest in the proposal.[65] The regulations do not

57 Ibid s 87(1).
58 Inserting s 2(B) into National Health Service Act 2006.
59 S 36.
60 S 88B(2).
61 Ss 88C(2) and (3).
62 Ss 88D(2) and (3).
63 SI 2013/301.
64 Explanatory Memorandum to the Regulations, para [7.2].
65 SI 2013/301, reg 5.

specify a particular mechanism for determining the outcome of the local consultation process, although the accompanying explanatory memorandum states that 'government does not consider that decisions on fluoridation proposals should be determined solely by a count of the number of representations received or by local referendums'.[66] However, regulation 6 provides that a decision on whether to request the Secretary of State to make the necessary arrangements with water companies under section 87 must have regard to consultation responses with a view not only to assessing the level of support for the proposal, but also 'the strength of any scientific evidence or ethical arguments advanced'. Other factors which must be taken into account are any assessment of relevant needs contained in a joint strategic needs assessment and/or joint health and wellbeing strategies prepared under section 116 of the Local Government and Public Involvement in Health Act 2007; other available scientific evidence, including evidence of benefit to the health and wellbeing of affected individuals; and, significantly, the capital and operating costs of giving effect to the proposal.

The provisions on water fluoridation in the 2022 Act amount to just two sections,[67] 'slipped, virtually unnoticed, into the nether regions' of the statute.[68] The primary effect of these is to amend section 88 of the 2001 Act,[69] such that fluoridation schemes in England are now to be initiated (or varied or terminated) by *central government*, in the person of the Secretary of State for Health and Social Care, as distinct from local authorities. In so doing, the minister is obliged to consult with the relevant water companies as to whether the scheme would be operable and efficient,[70] as well as on a wider basis by virtue of an extension of the provisions of section 89 of the 2001 Act, which previously applied only to Wales.[71] To this end, the 2013 Regulations are revoked and replaced by broadly similar provisions made under section 89(3) of the 2001 Act.[72] The 2022 Act also transfers responsibility for meeting the capital and operating costs of any such scheme from local authorities to central government, although a power is conferred upon the Secretary of State to make regulations disapplying this obligation, and these may

66 Explanatory Memorandum (n 64 above) para [7.3].
67 Ss 175, 176.
68 HL Deb, 7 December 2021, vol 816, col 1869 (Lord Reay).
69 And, by extension, s 36 Health and Social Care Act 2012: see Health and Care Act 2022, s 175(7).
70 Water Industry Act 1991, s 87(11), as amended by Health and Care Act 2022, s 175(2)(g).
71 Health and Care Act 2022, s 175(5).
72 Water Fluoridation (Consultation) (England) Regulations 2022, SI 2022/1163.

also require public bodies to meet such costs which would otherwise be borne by government.[73]

## UNDERSTANDING THE CHANGES MADE BY THE 2022 ACT

As noted in the preceding section, the alterations to the provisions on water fluoridation contained in the recent Health and Care Act work against the grain of the approach to public health issues taken under the Health and Social Care Act 2012. That statute conferred responsibility on local government in England (with an additional role played by Public Health England at national level) to address matters of population health, as had also been the case prior to 1974. This was justified on the basis that local authorities had a natural population focus, the ability to shape services to meet local needs and to promote wellbeing, the capacity to influence the social determinants of health, and an ability to tackle health inequalities given their 'ample experience of the reality of health inequalities in their communities'.[74] Why, then, has the 2022 Act moved in a different direction?

The most straightforward answer to this question is that the previous legislation was wholly inefficacious in achieving the improvements in population health which the addition of fluoride to drinking water is intended to bring about.[75] Although approximately six million people in England live in areas covered by fluoridation schemes,[76] no such schemes have in fact ever been made under the statutory regime initially established by the Water (Fluoridation) Act 1985.[77] A number of related factors would appear to explain this inactivity.

First, there was the problem of a disparity between local authority boundaries and the areas covered by water companies, whose boundaries are determined by water distribution systems. This meant that instigation of a fluoridation scheme would frequently necessitate the engagement of several local authorities, and this rendered the process 'complex and burdensome'.[78] As noted above,[79] the Water

73 Water Industry Act 1991, ss 87(6)(A) and (B), as inserted by Health and Care Act 2022, s 175(2)(d).

74 Department of Health, *Factsheet: Public Health in Local Government: Local Government Leading for Public Health* (2011).

75 For further discussion of evidence on the health benefits of fluoridation, see n 37 above and accompanying text.

76 See Department of Health and Social Care (n 20 above).

77 See Public Health England (n 41 above) [4.4].

78 Department of Health and Social Care (n 20 above).

79 See n 62 above.

Industry Act 1991 required that other affected local authorities be notified on proposals for schemes, and their agreement secured for the undertaking of the necessary public consultation. Regulations set out the process for making decisions in situations where 'any local authority notifies the proposer … that it is not in favour of further steps being taken in relation to the proposal'.[80] In such circumstances, the progress of any fluoridation scheme was to be determined by a process of weighted voting across authorities, with each authority having a block vote, the size of which was calculated on the basis of the proportion of affected individuals resident in the authority's area.[81] For the proposal to proceed, a two-thirds (actually, 67%) majority of the block vote must be obtained.[82] The legislation then prescribes that further steps towards the establishment of the scheme, including the holding of public consultation, must be taken by an existing or specially established joint committee of the respective authorities,[83] or a Health and Wellbeing Board established by them.[84] Following consultation, decisions on whether or not to take the scheme forward were also to be determined by weighted block vote.[85]

This process was intended to secure suitable levels of democratic input from all affected authorities, local engagement being considered crucial for the legitimacy of this controversial form of intervention, as noted by the Nuffield Council.[86] However, it should be apparent from the preceding discussion of the relevant legislative provisions that securing the necessary agreement and progressing the scheme was a far from straightforward matter. The 2022 Act can therefore be seen as a means of 'streamlining the process for the fluoridation of water in England by moving the responsibilities for doing so, including consultation responsibilities, from local authorities to central government'.[87]

The second basis for moving responsibility for fluoridation schemes from local to central government relates to cost. Under the previous legislation, the operational costs entailed by any scheme were to be borne

80 Water Fluoridation (Proposals and Consultation) (England) Regulations 2013 (n 63 above), reg 3(7).
81 Ibid reg 4(1) and sch.
82 Ibid reg 4(2).
83 Water Industry Act 1991, s 88F(2).
84 Under Health and Social Care Act 2012, s 194.
85 Water Fluoridation (Proposals and Consultation) (England) Regulations 2013 (n 63 above), reg 7.
86 Nuffield Council on Bioethics (n 16 above) [7.40]. See further the discussion at n 160 below and accompanying text.
87 Department of Health and Social Care, White Paper, *Integration and Innovation: Working Together to Improve Health and Social Care for All* (2021).

by the affected local authorities,[88] although in practice these would have initially been paid by Public Health England and then charged back to the authorities.[89] Local authorities were also responsible for bearing the cost of feasibility studies and of the required public consultation prior to the decision to progress. Capital costs would have been met by Public Health England.

Obviously, these costs would be variable across the country, but as illustration, a scheme proposed by Hull City Council in 2017 was estimated to cost £330,000 per year,[90] while a proposed expansion of an existing scheme to cover the entirety of County Durham, also dating from 2017, was estimated to cost £156,000 annually.[91] These figures need to be set against the backdrop of declining local authority public health grant allocations from central government funds: these fell by 24 per cent, or approximately £1 billion, on a real-term *per capita* basis between 2015–2016 and 2021–2022.[92] Given these straitened financial circumstances, meeting the operation and consultation costs of fluoridation could be regarded as a 'burden'.[93] Thus, the transfer of responsibility for expenditure from local to central government, which is brought about by the 2022 Act,[94] appears more likely to push fluoridation forward than the previous approach.

This connects closely to the third driver, which is that, under the pre-2022 framework, local authorities were required to set poor oral health – and fluoridation as a potential intervention to address it – against numerous other demands upon the limited resources which were allocated to them for the purposes of public health. In light of the traditionally marginalised status conferred on oral health,[95] the low priority which it was accorded is scarcely surprising. The absence of clear evidence on cost-effectiveness in the case of adults provided further rationale for giving precedence to other interventions;[96] as

88 Water Industry Act 1991, s 88H.

89 Public Health England (n 41 above) 60.

90 See the Hull City Council Scheme. Net expenditure on public health for Hull City Council in 2017–2018 was £71,235,000: see Kingston Upon Hull City Council Statement of Accounts 2017–2018 at 17.

91 See Durham City Council, Health and Wellbeing Board, Oral Health Update (27 November 2017) para 29.

92 See The Health Foundation (Press Release 16 March 2021).

93 See Department of Health and Social Care (n 87 above).

94 See n 73 above.

95 See Watt et al (n 3 above) and accompanying text.

96 For discussion of the challenges of studying water fluoridation in adults, see D Moore et al, 'How effective and cost-effective is water fluoridation for adults? Protocol for a 10-year retrospective cohort study' (2021) 7(3) British Dental Journal Open.

for children, although evidence of cost-effectiveness does exist,[97] the long-term savings have to be set against the necessary short-term expenditure (and consequently, higher council tax bills) entailed in instigating and establishing a fluoridation scheme.[98]

Political considerations such as levels of electoral support are likely to be especially germane to decisions on whether to establish fluoridation schemes, given the considerable ethical controversy to which this activity gives rise (examined further below). Vocal, organised opposition to fluoridation will very likely persuade local decision-makers that proceeding is not worthwhile.[99] A vivid example of this is afforded by the proposal for a fluoridation scheme covering Southampton in 2008, which was withdrawn six years later following a vociferous campaign of opposition – including an (unsuccessful) judicial review challenge[100] – led by an *ad hoc* pressure group, Hampshire Against Fluoridation. As the Chair of this group stated in evidence to the Select Committee on Health and Social Care's inquiry into the White Paper which preceded the 2022 Act, 'local Councillors knew that they were likely to lose their seats if they imposed water fluoridation, so strong was the reaction against it'.[101]

Of course, transfer of responsibility from local to central government will not serve to eliminate the ethical and political controversy arising from fluoridation, but it does function to dissipate it in so far as the range of factors which determine political (un)popularity nationally will be much broader and varied than at local level, meaning that decisions on fluoridation carry less electoral weight on their own. This would therefore seem to offer greater possibility of advancement of the strategy than was the case with the previous framework. In this regard,

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97 For children aged five, the return on investment for every £1 spent on a water fluoridation scheme is estimated at £12.71 after five years and £21.98 after 10: see Public Health England, *Return on Investment of Oral Health Programmes for 0–5 Year Olds* (2016).

98 Of course, it is commonplace for public health interventions to show positive effects only after a lapse of a period of time, and thus not to correspond to the electoral cycle. On the matter in general, see W Nordhaus, 'The political business cycle' (1975) 42 Review of Economic Studies 169; and for public health in particular, see L Gostin, *Global Health Law* (Harvard University Press 2014) 422.

99 For discussion, see D Westgarth, 'Turning the taps on: is water fluoridation closer to becoming a reality?' (2021) 34 British Dental Journal in Practice 12.

100 *R (Milner) v South Central Strategic Health Authority* [2011] EWHC 218 (Admin).

101 Health and Social Care Committee, 'The Government's White Paper proposals for the reform of health and social care' (First Report, 2021–22, HC 20: written evidence submitted by John Spottiswoode, Chair of Hampshire Against Fluoridation (HSC0015)).

the Act might be seen as functioning to 'remove a barrier to delivery' of fluoridation, as stated in the accompanying White Paper.[102]

Taken overall, therefore, the effect of the 2022 Act is to facilitate the making of fluoridation schemes in England by shifting the task of instigating, progressing and funding them from local government to the centre. This would seem to render this a much more tenable mode of public health intervention in the future than was previously the case, not only because the obstacles identified above will prove much less awkward at national level than at local but also, more fundamentally, because 'for some time, it has been clear that water fluoridation is supported in Westminster'.[103] Notably, the then Secretary of State for Health and Social Care signified support for fluoridation,[104] reinforced by a statement from the UK's Chief Medical Officers that 'on balance, there is strong scientific evidence that water fluoridation is an effective public health intervention for reducing the prevalence of tooth decay and improving dental health equality'.[105]

## WHY NOW?

The discussion in the preceding section provides an explanation for the change in the legislative framework relating to fluoridation which the Health and Care Act 2022 has brought about. However, it does not account for the *timing* of this development. Why has fluoridation now secured a place on the political agenda in England, and arguably more prominently so than ever before (given that responsibility for this form of intervention had always previously rested with local decision-makers, whether in local authorities or the NHS)?

This raises the question of how the 'science' of public health becomes translated into legislative policy. One well-known model for analysis of this issue is presented by Richmond and Kotelchuck,[106] who identify three interdependent factors: knowledge base, social strategy and political will. The first of these consists of the epidemiological and health economic evidence; in this case, we may point to the research carried out in the US as long ago as the 1930s and 1940s,[107]

102 See Department of Health and Social Care (n 87 above).

103 'Barriers to water fluoridation to be demolished in radical NHS reforms' (*The Dentist* 9 February 2021).

104 See C Smyth, 'Fluoride will be added to drinking water' *The Times* (London 23 September 2021).

105 Department of Health and Social Care, 'Statement on water fluoridation from the UK Chief Medical Officers' (23 September 2021).

106 See J Richmond and M Kotelchuck, 'Political influences: rethinking national health policy' in C McGuire et al, *Handbook of Health Professions Education* (Jossey-Bass 1983).

107 See n 37 above and accompanying text.

complemented by more recent (albeit, somewhat ambivalent) evidence on cost-effectiveness.[108] The second factor refers to 'a blueprint for goals and how to reach them'.[109] In this instance, we may regard these as consisting of the improvement of oral health and the reduction of oral health inequalities (and thus overall health and wellbeing) through particular interventions which include fluoridation schemes, although as noted above there are other, behavioural, educational and fiscal strategies which can be, and have been, used.[110] 'Political will' denotes the desire and commitment to fund and implement (or modify) interventions. For the reasons identified in the preceding section, this has been absent in the case of fluoridation as regards *local* government, with whom responsibility previously rested. Accordingly, all of the conditions for policy reform have not previously been present, since 'deliberating on health policy in the absence of any one of these components is like trying to balance on a two-legged stool'.[111]

This model is useful in explicating that translation of public health research and evidence into legislative or other forms of intervention is not a straightforwardly linear matter, but rather turns on an interdependency of factors, not all of which have existed in the case of fluoridation. However, it does not provide a full response to the question of timing posed here. The distribution of power and responsibility to act on public health is a much more fluid matter in England than it is in the US,[112] which is the basis of the Richmond and Kotelchuck framework. Where local government cannot, or chooses not to, act, it remains legally open to central government to do so in its stead, if necessary by using its control of the Commons to secure legislative authorisation for its preferred form of intervention: this is, of course, precisely what has happened in this case. As noted above, there has been support for fluoridation at central government level for some time – so what is the reason for taking action now, rather than at an earlier stage?

Here, it is submitted that the multiple streams analysis and its familiar concept of the 'policy window' developed by John Kingdon is of assistance.[113] In a general sense, this connotes 'an idea whose

108 See nn 46 and 97 above and accompanying text.

109 Richmond and Kotelchuck (n 106 above).

110 See nn 30–34 above and accompanying text.

111 K Attwood, G Colditz and I Kawachi, 'From public health science to prevention policy: placing science in its political and social contexts' (1997) 87 American Journal of Public Health 1603, 1605.

112 For discussion of the state/federal divide on matters of public health, see Gostin and Wiley (n 27 above) ch 3.

113 This was initially set out in J Kingdon, *Agendas, Alternatives and Public Policy* (Little Brown 1984).

time has come'.[114] Rather than being a product of linear, rational decision-making from problem to solution, policy action emerges from the interplay between various, independent streams, and 'solutions largely chase problems rather than vice versa'.[115] When the three streams enumerated by Kingdon – problem (there is a policy issue which is framed as needing attention); policy (a feasible solution to that problem is available); and politics (decision-makers are receptive to transforming the solution into policy)[116] – converge, a window of opportunity opens, albeit that 'these policy windows, the opportunities for action on given initiatives, present themselves and stay open for only short periods'.[117] On this analysis, 'receptivity to an idea is more important than the idea itself',[118] and 'an idea's time arrives not simply because the idea is compelling on its own terms, but because opportune political circumstances favour it'.[119]

Kingdon's analysis helps us to understand that there has not been a recent conversion to the value of fluoridation as an oral health intervention which led to the changes made in the 2022 Act: as noted previously, this strategy has consistently been favoured by many Whitehall politicians over a period of time. Rather, there is enhanced receptivity to act on this policy which has come about as a consequence of an event which has made 'some things possible that were impossible before'.[120]

That event is the Covid-19 pandemic. Its impact as a precipitating factor for the changes made in the Health and Care Act 2022 can be clearly discerned from the documents which accompanied the Bill. The White Paper proclaimed, in general, that 'our legislative proposals capture the learning from the pandemic'[121] and, in respect of the proposals relating to public health (including those on fluoridation) in particular, stated that 'our experience of the pandemic underlines the importance of a population health approach: preventing disease, protecting people from threats to health, and supporting individuals and communities to improve their health and resilience'.[122] Similarly, the factsheet addressing the fluoridation proposals concluded with the

114 Ibid 1.

115 R Durant and P Diehl, 'Agendas, alternatives and public policy: lessons from the US foreign policy arena' (1989) 9 Journal of Public Policy 179, 180.

116 See also P Cairney, *Understanding Public Policy: Theories and Issues* 2nd edn (Red Globe Press 2020) 196–199.

117 Kingdon (n 113 above) 174.

118 Cairney (n 116 above) 202.

119 R Lieberman, 'Ideas, institutions and political order: explaining political change' (2002) 90 American Political Science Review 691, 709.

120 Kingdon (n 113 above) 152.

121 Department of Health and Social Care (n 87 above).

122 Ibid.

pronouncement that 'our experience of the pandemic underlines the importance of a population health approach, informed by the evidence, supporting individuals and communities to improve their health, including their oral health'.[123]

These statements indicate that the pandemic has motivated government to accord greater weight to public health approaches. Since these do not correspond well with the electoral cycle,[124] this may seem surprising; the more so given that then Prime Minister Boris Johnson had previously expressed criticism of so-called 'nanny state' health policies, consonant with his ideologically conservative position.[125] Johnson's shift to a stance more sympathetic towards interventions on population health can be attributed at a micro level to his personal experience of Covid-19 which was thought to be connected to his overweight status.[126] At a macro level, evidence emerged of a 'syndemic' – a 'set of closely intertwined and mutual enhancing health problems that significantly affect the overall health status of a population within the context of a perpetuating configuration of noxious social conditions'[127] – of Covid-19, chronic disease and health inequalities. That is, 'the prevalence and severity of the Covid-19 pandemic [was] magnified because of the pre-existing epidemics of chronic disease—which are themselves socially patterned and associated with the social determinants of health'.[128] In this sense, two of Kingdon's streams may be said to have been impacted by the pandemic; it visibly exposed poor population health and inequalities as a significant policy problem; and it motivated policy-makers to take steps to address that problem through specific interventions in population health so as to forestall future occurrences, especially to avoid the pressures that these might place on the NHS.

In the particular case of fluoridation, the problem stream might be viewed as somewhat less prominent than was the case for obesity, there being no specific evidence that poor oral health contributed to worse Covid-19 outcomes. That said, and as noted previously,[129] low standards of oral health connect to health inequalities and can therefore be regarded as a dimension of the broader problem which

123 Department of Health and Social Care (n 20 above).

124 See further n 98 above.

125 See eg G Rayner, 'Boris Johnson aims to put an end to the "nanny state" and its "sin taxes" on food' *The Telegraph* (London 3 July 2019).

126 See S Lister, 'Boris Johnson: "My health wake-up call – and why it's a wake-up call for the WHOLE of Britain' *Daily Express* (London 27 July 2020).

127 M Singer, 'A dose of drugs, a touch of violence, a case of AIDS: conceptualizing the SAVA syndemic' (2000) 28 Free Inquiry in Creative Sociology 13, 13.

128 C Bambra et al, 'The Covid-19 pandemic and health inequalities' (2020) 74 Journal of Epidemiology and Community Health 964, 965.

129 See nn 9–12 above.

was exposed by the pandemic. Furthermore, fluoridation schemes provided an established 'solution' to the problem, backed by evidence (albeit not universally accepted) and, at least in central government, political support. The window of opportunity for fluoridation was therefore easily opened when the pandemic provided the motivation for central government to act to improve population health.

## KEEPING THE POLICY WINDOW OPEN?

Kingdon's work also reminds us that the opportunity to implement policy change can be a very fleeting one: 'an idea's time comes, but it also passes'.[130] The window may shut just as swiftly as it opens, and for reasons which may be equally as unpredictable as those which precipitated the initial opening.

This is clearly demonstrated by developments relating to the second major area of population health addressed by the 2022 Act. Sections 172–174 of the Act contain measures which are intended to reduce the exposure of children to advertising of less healthy food and drink on television and online, by introducing a 9pm watershed for television and those on-demand services under the jurisdiction of the UK, and a restriction on paid-for advertising of such substances online and in on-demand services beyond the UK's jurisdiction. Here again, the pandemic provides the key to understanding how a government whose ideological orientation would ordinarily make it opposed to such forms of intervention became receptive to them, as the factsheet accompanying the Bill makes apparent:

> COVID-19 has brought the dangers of obesity into sharper focus, with evidence demonstrating that those who are overweight or living with obesity are at greater risk of being seriously ill and dying from the virus. We know that reducing excess weight is one of the few modifiable risk factors for COVID-19. Obesity is also associated with reduced life expectancy. It is a risk factor for a range of chronic diseases including cardiovascular disease, type 2 diabetes, some types of cancer, liver and respiratory disease. Therefore, the government has been clear that for the future resilience of the population, we need to address the risks obesity presents to our whole population now.[131]

The measures were intended to come into effect on 1 January 2023. However, in May 2022, it was announced that they would be delayed

130 Kingdon (n 113 above) 169.

131 Department of Health and Social Care, Policy Paper, *Health and Care Bill: Advertising of Less Healthy Food and Drink* (updated 10 March 2022).

by a year.[132] This was justified 'in light of [the] unprecedented global economic situation and in order to give industry more time to prepare for the restrictions on advertising'.[133] The delay was subsequently extended to (at least) 1 October 2025.[134]

We might therefore observe that the initial 'problem' stream of poor population health and inequalities has been trumped by another, relating primarily to the 'cost of living crisis' caused by rising rates of inflation.[135] Less explicitly, changes have also occurred in the 'politics' stream, with low poll ratings and a poor local election performance for the governing Conservative Party in early May 2022 alerting the leadership to the need to take steps to protect its electoral position. This was especially the case in areas which it had captured from the Labour Party in the December 2019 general election, whose low-income voters were among those most affected by inflation.[136] The confluence of these now differently flowing streams has led to a – purportedly temporary – closure of the policy window in respect of these interventions in population health.

The provisions on fluoridation in the 2022 Act are distinguishable from those relating to advertising of less healthy food and drink in that they are power-conferring in character: they facilitate the future establishment of fluoridation schemes by reallocating responsibility for them, but they do not constitute a direct public health intervention in themselves. Hence, in this instance the question is whether, having been furnished with these statutory powers, central government will choose to make use of them; or alternatively, whether there are reasons to predict that the window of opportunity may pass and that no further action on fluoridation is (ever?) taken.

While acknowledging, as previously noted, that the streams may change flow in unpredictable ways, there is certainly cause to doubt that the policy window for fluoridation will continue to stay open. The reason for this scepticism is that fluoridation is a highly controversial public health intervention. Certain of the drivers of this controversy

132 See Department of Health and Social Care, 'Government delays restrictions on multibuy deals and advertising on TV and online' (Press Release 14 May 2022). A delay was also announced to volume price promotions of less healthy foods (such as 'buy one get one free') and free refills for soft drinks as specified in the Food (Promotion and Placement) Regulations 2021, SI 2021/1368, regs 5 and 6.

133 Ibid.

134 Ministerial Statement, UIN HCWS 433 (9 December 2022).

135 For discussion, see D Harari and others, *Rising Cost of Living in the UK* (House of Commons Library Research Briefing 9428, 2022).

136 See ibid [4.3].

relate to the uncertain evidence base for the benefits of fluoridation and possible harms, and have been discussed previously in this article.[137] However, an important further dimension warrants exploration: that is, the ethical objections to fluoridation.

The salience of these is signalled by the fact that the 2007 report produced by the Nuffield Council on Bioethics devotes an entire chapter to fluoridation as a case study in public health ethics.[138] The most potent ethical argument against this intervention is that it is not wholly consonant with the principle of consent which 'is rightly at the centre of clinical medicine',[139] and which underpins the concept of autonomy which is fundamental to contemporary bioethics and medical law.[140] The problem is that fluoridation is an intervention which affects the entirety of the population in the geographical area which falls within the scope of the scheme in question, and it is therefore not feasible to obtain the consent of all of those affected. Hence:

> considerations about consent could ... be used to argue that the measure should not be introduced either where some individuals, however few, were opposed to it, or where individuals who had not agreed to it might be affected by it, such as those from outside the area.[141]

Rhetorically, this is most potently captured in the assertion by opponents of fluoridation that it amounts to 'mass' or 'forced medication', with the weight of this claim in part resting on the disputed question of whether fluoride should be classified as a medicine.[142]

These arguments surfaced in the committee debates on the Bill: for example, the UK Freedom from Fluoride Alliance stated that 'when deciding what we want to eat and drink as individuals in a democratic society, we should be free to decline or accept a medicine added to our drinking water, just as we can with any other medicine';[143] the chair of the group which had opposed the earlier Southampton scheme claimed that 'it is a basic human right to be able to say "no" to forced

137 See nn 43–52 above and accompanying text.

138 Nuffield Council on Bioethics (n 16 above) ch 7.

139 Ibid [2.24]. See also General Medical Council, *Decision-Making and Consent* (General Medical Council 2020).

140 For a valuable discussion of the relationship of the concepts of consent, autonomy and liberty, see J Coggon and J Miola, 'Autonomy, liberty and medical decision-making' (2011) 70 Cambridge Law Journal 523.

141 Nuffield Council on Bioethics (n 16 above) [7.20].

142 See n 51 above. The Nuffield Council observes that the Medicines and Healthcare Products Regulatory Authority considers it not to be a medicinal product: ibid 130. See further the comments of Lord Reay (n 147 below).

143 Public Bill Committee, Health and Care Bill 2021: written evidence submitted by UK Freedom from Fluoride Alliance, HCB 47.

medication';[144] and the group Bromsgrove for Pure Water asserted that 'individual choice is subsumed by the urge to treat us as a mass. We are individuals and we should have the right (according to the NHS Constitution) to refuse compulsory treatment.'[145] Concerns were also expressed in the House of Lords debate on the Bill, with a Green Party peer stating that 'this is about not mass medicating without consent',[146] while Lord Reay, a Conservative, argued that:

> If fluoridated water were treated as a medicine, individuals would then have the absolute right to refuse the administration of water fluoridation by choice, and industrial-grade fluoridating chemicals would not be allowed. Of course, if it were defined as a medicine, it could not be administered without consent. When fluoride is delivered via toothpaste, the individual has a choice in the matter. When it is carried through the public water supply, there is no individual choice and the ingested fluoride goes to every tissue in the body, including those of the unborn child.[147]

Additionally, the Nuffield Council delineates two further ethical objections to fluoridation which may be advanced irrespective of whether this intervention is considered to be akin to mandatory medical treatment. These are closely connected: first, that individuals should be able to exercise choice over what they place within their bodies; and second, that individuals should not be coerced into leading healthy lives.[148] Both of these speak to the primacy accorded in a liberal society to autonomy, as self-governance.[149]

The weight of these arguments, especially the first, raises questions as to the likelihood of the policy window for fluoridation remaining open. Returning to Kingdon's work, we might surmise that the third, politics, stream reflects not only an enhanced motivation for government to act on poor oral health as a consequence of the pandemic, but also a belief that such action will be more likely to be comprehended and accepted by a public which is now attuned to the need to take measures to protect and improve population health as a result of its experience of Covid-19 and the subsequent vaccine rollout. Expressed differently, the assumption is that public health interventions such as fluoridation will have greater *legitimacy* post-pandemic than was the case prior to 2020. However, whether this outcome will eventuate is, at best, uncertain. It seems clear from the contributions to the debates on the

144 Health and Social Care Committee: written evidence submitted by John Spottiswoode (n 101 above).
145 Ibid: written evidence submitted by Bromsgrove for Pure Water, HSC0020.
146 HL Deb, 31 January 2022, vol 818, col 703 (Baroness Bennett of Manor Castle).
147 Ibid, col 682 (Lord Reay).
148 Nuffield Council on Bioethics (n 16 above) [7.21]–[7.22].
149 Ibid [2.10].

Bill that were noted above that dissenting voices will continue to make themselves powerfully heard on this issue. It is, therefore certainly plausible that any future proposal to introduce fluoridation schemes will be confronted with such significant opposition – of the type seen in the Southampton case[150] – that central government will be dissuaded from acting on the powers which it has acquired under the 2022 Act.

Of course, this is not to say that it is impossible to construct contrary ethical claims to these (as distinct from those ethical arguments *in favour of intervening to improve oral health* which were noted earlier).[151] The Nuffield Council delineates one important counter-argument in stating that 'requirements for individual consent can sometimes be over-emphasised in the context of public health'.[152] In pointing towards a distinction between ethics in population health and in clinical medicine, this (albeit obliquely) connects to potentially differing conceptualisations of autonomy in the former context. It is beyond the scope of this article to explore this matter in detail, but in short it has been argued that a relational understanding of autonomy is more apposite to the mission of public health,[153] and that the Nuffield Council itself has adopted a conception of liberty and autonomy which is too thin and negative,[154] as the underpinning for its intervention ladder.[155]

In a situation, such as this, where competing ethical perspectives are at play and there is no consensus as to which most appropriately applies in order to determine the best way forward, there is often a turn to procedural justice as 'an appropriate means of reconciling different preferences within a population, even if the final policy does not meet with everyone's approval'.[156] The model of 'accountability for reasonableness' which was originally developed in the context of allocation of scarce healthcare resources, is the most widely applied

150 See n 100 above and accompanying text.

151 See nn 14–26 above and accompanying text.

152 Nuffield Council on Bioethics (n 16 above) [7.38]. For further discussion of the specific issue of consent in the public health context, see J Berg, 'All for one and one for all: informed consent and public health' (2012–2013) 50 Houston Law Review 1.

153 See eg J Owens and A Cribb, 'Beyond choice and individualism: understanding autonomy for public health ethics' (2013) 6 Public Health Ethics 262; F Zimmerman, 'Public health and autonomy: a critical reappraisal' (2017) 47 Hastings Center Report 38.

154 See P Griffiths and C West, 'A balanced intervention ladder: promoting autonomy through public health action' (2015) 129 Public Health 1092.

155 See n 29 above and accompanying text.

156 Nuffield Council on Bioethics (n 16 above) [7.39].

framework for securing legitimacy via procedural justice.[157] This model is specifically cited by the Nuffield Council in relation to fluoridation,[158] as well as more generally for public health.[159] To this end, the Council emphasises the importance of implementing consultation processes to justify fluoridation policy in lieu of securing individual consent: it recommends that these should occur at a local level, 'because the need for, and perception of, water fluoridation varies in different areas'.[160]

As noted above, the 2022 Act preserves the requirement for public consultation to take place.[161] However, the Consultation Regulations 2022 do not restrict eligibility to respond to those affected by the proposal (ie those who reside or work in the area in question), although the Secretary of State is obliged to consider whether representations made by such individuals and/or bodies with an interest should be accorded additional weight.[162]

This commitment to national, rather than purely local, consultation would seem likely to give greater scope to those who are most vociferously opposed to fluoridation on principle to continue to feed into the decision-making process for proposed new schemes. Moreover, discussion of fluoridation, comparably to Covid-19 and vaccines for it,[163] has often been characterised by 'misinformation'.[164] Taken overall, it therefore seems probable that the procedure will not be characterised by the type of rational deliberation on benefits and harms which the Nuffield Council believes will follow from requiring 'accountability for reasonableness' in this context.[165] Far from

157 For discussion, see N Daniels and J Sabin, *Setting Limits Fairly* 2nd edn (Oxford University Press 2007). For a powerful critique, see R Ashcroft, 'Fair process and the redundancy of bioethics: a polemic' (2008) 1 Public Health Ethics 3.

158 Nuffield Council on Bioethics (n 16 above) [7.41].

159 Ibid [2.25].

160 Ibid [7.40].

161 See n 71 above and accompanying text.

162 Water Fluoridation (Consultation) (England) Regulations 2022 (n 72 above), reg 5(1)(b).

163 Analogies between Covid-19 'anti-vaxxers' and opponents of fluoridation are drawn in J Ashton, 'Covid-19 and the anti-vaxxers' (2021) 114 Journal of the Royal Society of Medicine 42, 42; D Westgarth 'Fluoridation: a cost-effective, simple solution' (2021) 34 BDJ in Practice 10, 10; Science Media Centre, 'Expert reaction to statement from the UK Chief Medical Officers on water fluoridation' (23 September 2021) (Dr J Morris).

164 See eg R Arcus-Ting, R Tessler and J Wright, 'Misinformation and opposition to fluoridation' (1977) 10 Polity 281; Gravitz (n 44 above); Ashton (n 163 above). For a discussion relating to the UK in the 1960s, when 'vocal anti-fluoridators carried the day in terms of policy', see C Sleigh, Fluoridation of Drinking Water in the UK, c 1962–7: A Case Study in Misinformation before Social Media (2021) 2.

165 Nuffield Council on Bioethics (n 16 above) [7.41], [7.50].

resolving any 'legitimacy problem' which persists following the 2022 Act,[166] the proposed procedure may serve instead to exacerbate it, and thus to contribute to the closure of the policy window on fluoridation as the matter becomes too much of a political hot potato for any government to handle.

## CONCLUSION

This article has explored the range of difficult questions concerning evidence, ethics and legitimacy which lie beneath the two sections of the Health and Care Act 2022 dealing with fluoridation of water supplies in England. While experience of the Covid-19 pandemic raises the possibility of enhanced public acceptability of this legislative strategy, it is argued that, in practice, it is likely to remain highly contentious, although the full extent of the controversy is unlikely to become apparent unless and until a proposal to establish a new fluoridation scheme eventuates under the powers accorded to central government by the Act.[167]

The present discussion should serve as an important reminder that, irrespective of the existence of 'scientific' evidence for a population health intervention (albeit that this itself is a matter of debate in this context), such interventions remain profoundly political in character.[168] As such, in order to understand how they come to be adopted (and dropped), whether through law or via other forms of regulation, it is necessary to appreciate the inherent messiness and contingency of the policy-making process. This article has sought to demonstrate that the multiple streams approach and policy window metaphor developed by Kingdon offers a valuable mechanism in this regard. Scholars in this field may wish to give consideration as to how best to make use of this framework to enhance their future analysis of public health law and policy.

166 For the connection between problems of legitimacy, deliberation and accountability for reasonableness, see N Daniels and J Sabin, 'Limits to health care: fair procedures, democratic deliberation and the legitimacy problem for insurers' (1997) 26 Philosophy and Public Affairs 303; Daniels and Sabin (n 157 above).

167 For a possible candidate, see Nottinghamshire County Council, 'Nottinghamshire County Council champions expansion of water fluoridation schemes' (Press Release, 24 July 2023).

168 See Coggon (n 13 above).

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# Hospital food standards in section 173 of the Health and Care Act 2022: political magic with a soggy bottom

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ABSTRACT

This article argues that section 173 of the Health and Care Act 2022 is a purely symbolic provision that will not effect any positive change to hospital food quality. In order to make this argument, I explore Murray Edelman's work on the symbolic uses of politics and the literature on policy fiascos to explain why section 173 features in the 2022 Act at all. This is followed by a close analysis of what section 173 purports to do, which concludes that there is no substantive change to day-to-day practice as a result. This meets Lasswell's definition of 'political magic'. The article concludes with the argument that the only way to actually improve hospital food is to set aspirational standards and increase the budget to allow institutions to approach food provision in a holistic manner.

**Keywords:** hospital food; regulation; symbolic uses of law; healthcare.

## INTRODUCTION

The quality of NHS hospital food in England and Wales has been the subject of numerous reform attempts and campaigns by celebrity chefs to improve the standard of food served in hospital. In 2013, Sustain – the organisation responsible for the Campaign for Better Hospital Food – published a report on hospital food in the UK.[1] It demonstrated that between 1992 and 2013 there had been 21 voluntary initiatives focused on improving hospital food, many involving celebrity chefs. These had cost £54 million and had resulted in no significant change to the quality of hospital food in the UK. Heston Blumenthal has been involved in several projects to spice up hospital food[2] alongside researchers at the University of Reading. James Martin worked on Operation Hospital Food and produced a toolkit and

1 Sustain, 'Twenty Years of Hospital Food Failure' (2013).

2 H Briggs, 'TV chef takes on hospital food' (*BBC News* 30 April 2010); 'Heston gives taste to hospital meals' (*BBC News* 23 December 2013); 'Heston Blumenthal's children's hospital' (IMDb Documentary January 2011).

recipes to be used in hospital catering.[3] The project was supported by the British Dietetic Association (BDA) and the Campaign for Better Hospital Food. Loyd Grossman, Albert Roux, Mark Hix, John Benson-Smith and Anton Edelmann had all spearheaded projects intended to improve hospital food. Sustain was very clear in its report that nothing less than mandatory standards would improve hospital food.[4]

In 2013, Baroness Cumberlege introduced the Health and Social Care (Amendment) (Food Standards) Bill into the House of Lords. The Bill proposed a panel of experts to be convened to write a set of hospital food standards that would become a condition of continued registration with the Care Quality Commission (CQC). The Bill completed its second reading in the House of Lords and was not taken further in the Commons.[5]

Hospital food standards were put into the legislative framework in England and Wales when the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (the 2014 Regulations) included provisions on meeting nutritional and hydration needs.[6] This regulation remains in force today, and is backed by a criminal offence carrying a fine of £50,000 if harm or risk of harm occurs as a result of a breach of the nutrition and hydration standards.

Alongside the standards in regulation 14, there is also a suite of standards that are built into the NHS standard contract that covers all purchases into the NHS in England. For our purposes, this means that all food and food services suppliers must act in compliance with the terms of the NHS standard contract if they wish to retain their contracts. These include four sets of standards that are directly related to improved nutrition for patients:

1 Ten Key Characteristics of Good Nutritional Care (Nutrition Alliance);
2 Nutrition and Hydration Digest (BDA);
3 Malnutrition Universal Screening Tool (MUST) (British Association of Parenteral and Enteral Nutrition); and
4 the Government Buying Standards for Food and Catering Services from the Department of Environment, Food and Rural Affairs (GBS).[7]

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3 Operation Hospital Food (BBC 2011–2014).
4 Sustain, 'Loyd Grossman and celebrity chefs join calls for hospital food standards' (2013).
5 Health and Social Care (Amendment) (Food Standards) Bill [HL] (2013–2014).
6 SI 2014/2396, reg 14.
7 Department of Health and Social Care, Report of the Independent Review of Hospital Food (2020) 59.

The first, second and third sets of standards are largely focused on the infrastructure around eating, rather than the food itself. For example, the *Ten Key Characteristics* require patients to be screened, and personal plans to be put in place. The *Digest* focuses on the role of the dietician. *MUST* is a screening tool which healthcare professionals can use to assess a patient's risk of malnutrition. The *Government Buying Standards* are related to the procurement of food and encourage sustainable procurement and the use of British produce from British farmers.

Contract law ordinarily provides a very strong tool for ensuring that standards are met.[8] However, In 2017, when compliance with these standards was reviewed, it was found that only around half of hospitals were actually compliant.[9] A subsequent review of compliance has not been carried out. It is not known whether any actions in contract have been brought against hospital food suppliers.

This brings us to the heralded changes in section 173 of the Health and Care Act 2022, which put hospital food standards on a statutory footing in England and Wales for the first time, and therefore 'will deliver for the first time, mandatory minimum standards for the provision of good hydration and nutrition in the NHS'.[10]

This article argues that section 173 of the Health and Care Act 2022 is a purely symbolic provision that will not effect any positive change to hospital food quality. In order to make this argument, I explore Murray Edelman's work on the symbolic uses of politics and the literature on policy fiascos to explain why section 173 features in the 2022 Act at all. This is followed by a close analysis of what section 173 purports to do, which concludes that there is no substantive change to day-to-day practice as a result. This meets Lasswell's definition of 'political magic'. The article concludes with the argument that the only way to actually improve hospital food is to set aspirational standards and increase the budget to allow institutions to approach food provision in a holistic manner.

## SYMBOLIC USES OF POLITICS AND LEGAL ANALYSIS

When engaging in any type of analysis of legal measures, it is crucial to remember that these are political acts and events. Statutory provisions achieve their final formulation through a political process, hence the

8 T T Arvind, *Contract Law: Unfold the Problem, Reveal the Law, Apply to Life* (Oxford University Press 2017) 4.

9 Department of Health and Social Care (n 7 above).

10 Department of Health and Social Care, Integration and Innovation: Working Together to Improve Health and Social Care for All (White Paper CP 381, 2021) [5.165].

need to examine Hansard. This article is part of a long-established research approach which situates law in its social and political context. It takes the view that the impact of law cannot be properly understood if the social and political aspects are not considered.[11]

A fundamental part of the politics of law is the symbolic effects of the legal change in question. Murray Edelman discusses the value of symbols in law and politics and explains that the condensation symbol is one where the emotions evoked by the political event become synonymous with that event.[12] He suggests that 'every political act that is controversial ... evokes a quiescent or aroused mass response because it symbolises a threat or reassurance'[13] and, particularly in a democracy, 'men may dislike ... a law ... yet be reassured by the forms of the legislature'.[14]

The reassuring effect of a statutory solution is particularly evident in the context of healthcare regulatory changes following policy fiascos. If we look at the recommendations in public inquiries following healthcare policy fiascos, many of them call for legislative change and the use of the criminal law as an enforcement mechanism supporting the provision.

One of the particularly challenging aspects of healthcare fiascos is that they often involve death or serious harm. The more serious fiascos, such as Harold Shipman, Mid Staffordshire, Bristol Heart Surgery, and Alder Hey involved deaths of and serious harm to a lot of people. Harold Shipman was a sole general practitioner (GP) who murdered around 250 of his elderly patients. He was convicted of 15 counts of murder in 2000. This led to significant changes to the oversight of GPs in England and Wales.[15] Both the Mid Staffordshire and the Bristol Heart Surgery fiascos became apparent from increased rates of routine death reporting. In Stafford Hospital, this was a general issue across the whole institution, while Bristol related to increased deaths in babies who had undergone heart surgery. In Mid Staffordshire, the public inquiry[16] found a failure of care at all levels of the organisation including the regulatory body, the Healthcare Commission. This was the driver

11 For further discussion of this theoretical perspective on law, see L Mather, 'Law and society' in K Whittington, R Keleman and G Caldeira (eds), *The Oxford Handbook of Law and Politic* (Oxford University Press 2008) 681–697.

12 M Edelman, *The Symbolic Uses of Politics* (University of Illinois Press 1985) 6.

13 Ibid 7.

14 Ibid 12.

15 Shipman Inquiry, *The Fifth Report – Safeguarding Patients: Lessons from the Past – Proposals for the Future* (9 December 2004).

16 Robert Francis QC, Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry: Executive Summary (Stationery Office 2013)

for updated standards for the provision of healthcare.[17] The Bristol public inquiry[18] found that there had been failures in the surgical care of infants and uncovered the generalised practice of retaining tissue and organs from deceased people in England and Wales. A witness in the inquiry, Professor Anderson, commented appreciatively about the extent of the collection of retained organs at Alder Hey Children's Hospital in Liverpool.[19] The revelations were a shock to the general public, and the subsequent inquiry at Alder Hey[20] found that there had been major failings in oversight of practices around hospital-based and coronial-ordered post-mortems. This, along with the Shipman report,[21] led to changes in the regulation of coroners' post-mortems[22] in England and Wales. All of these fiascos involved unexpected and unnecessary deaths, and significant psychological harm to relatives and the wider population. Fiascos or crises of this seriousness are followed by a sense that the public consciousness has been deeply affected. The public outpouring of grief following the crisis evokes a sense of shared trauma for those who are affected, and fear in those who might have been affected. These emotional responses are significant and need to be reconciled so that the public can move forward and so that changes can be made to prevent recurrences. This is one of the motivating factors underpinning the use of Truth Commissions in the aftermath of significant rights abuses.[23] As Allan and Allan highlight, people who have experienced trauma 'need to tell their stories and to have their experiences validated'.[24] Once this collaborative truth-gathering exercise has reached its end, work can be done to offer some redress, and to start the process of ensuring that the events do not occur again. It is no coincidence that the Retained Organs Commission – which was established in 2001[25] to address the revelations from the Alder Hey inquiry that organ retention from deceased bodies without consent was a widespread practice considered to be generally uncontroversial

17 The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014/2936.

18 Bristol Royal Infirmary Inquiry, *The Report of the Public Inquiry into Children's Heart Surgery at the Bristol Royal Infirmary 1984–1995: Learning from Bristol* Cm 5207 (Department of Health 2001).

19 Ibid annex C.

20 The Royal Liverpool Children's Inquiry Report (House of Commons 30 January 2001).

21 Shipman Inquiry (n 15 above).

22 Coroners and Justice Act 2009.

23 A Allan and M Allan, 'The South African Truth and Reconciliation Commission as a therapeutic tool' (2000) 18 Behavioural Sciences and Law 459–477.

24 Ibid 462.

25 The Retained Organs Commission Regulations SI 2001/748.

by medical professionals in England and Wales – used a truth and reconciliation model before working on proposed legal changes.[26]

In the context of patient safety, Karen Yeung and Jeremy Horder have argued that legislation and new or strengthened enforcement mechanisms, often using criminal law, create a feeling of safety in the public and a sense that that sort of atrocity or harm cannot happen again. The reassurance offered by the law here is the symbol that the public needs to see in order to feel safe again.[27] Edelman considers the value of this type of symbol creating safety in relation to repealing a law:

> The laws may be repealed in effect by administrative policy, budgetary starvation, or other little publicized means; but the laws as symbols must stand because they satisfy interests that are very strong indeed: interests that politicians fear will be expressed actively if a large number of voters are led to believe that their shield against a threat has been removed.[28]

The stability and longevity of statute law is intertwined with the political barriers to repealing or amending it. A law relating to a controversial issue, such as patient safety, faces significant political barriers in any attempt to repeal or amend it. While the Government might propose a new piece of legislation, it is very likely to remain unchanged after the multiple readings and debates in Parliament. Given this, the symbolism of legislation is made more potent by the symbolism of the legislative and parliamentary processes around enactment.

Where there has been a policy fiasco and people have died or been harmed, the legislation – with its guarantee of longevity – acts as a tombstone to the victims. It has a dual purpose of changing the environment such that the same fiasco will not occur in the future, but also acting as a memorial for the victims of the crisis. Mary Dixon Woods writes of these tombstones 'cast[ing] long shadows'[29] in that they prove difficult to change even where they have become unhelpful in the wider regulatory sense. A classic example of this is the Dangerous Dogs Act 1991,[30] which created a new regulatory approach based on specific breeds of dog being deemed to be dangerous. However, the

26 M Brazier, 'Retained organs: ethics and humanity' (2002) 22 Legal Studies 550.

27 K Yeung and J Horder, 'How can the criminal law support the provision of quality in healthcare?' (2014) 23 British Medical Journal Quality and Safety 519.

28 Edelman (n 12 above) 37.

29 M Dixon Woods, 'The tombstone effect: long shadows and the pursuit of comfort' in R Dixon and M Lodge (eds), *Explorations in Governance: A Collection of Papers in Honour of Christopher Hood* (Institute for Government 2014) 32, 33.

30 M Lodge and C Hood, 'Pavlovian policy responses to media feeding frenzies? Dangerous dogs regulation in comparative perspective' (2002) 10 Journal of Contingencies and Crisis Management 1.

new legislative framework could not adapt to a change in problematic dog ownership where dogs were used as weapons. This phenomenon cannot be linked only to breed because it is also affected by training and the relationship between dogs and their owners. This change in practice was not captured by the legislative approach taken in the Act. In the healthcare context, the Human Tissue Act 2004 was the legislative response to the retained organs scandals. This Act created a significant legal and regulatory framework, and a new regulator, the Human Tissue Authority. Its central tenet – that human tissue from the deceased or the living cannot be used without consent – has remained largely unchanged since its enactment, except for consequential amendments to take account of changes made by other legislation, such as the Civil Partnership Act, which adds civil partner to the spouse or partner definition of relatives. The biggest change to the Act was the Organ Donation (Deemed Consent) Act 2019, which gave effect to the new rules relating to opt-out consent for organ donation. The 2019 Act preserves the central tenet that human tissue cannot be used without consent, albeit a slightly different form of consent. The Human Tissue Act 2004 has a significant substantial effect on the legal landscape, but it certainly also has a significant symbolic presence in that it acts as a memorial to all those whose organs were removed without consent, and the relatives who were also affected by this policy. I would argue that the success of the Human Tissue Act is due to its dual substantive and symbolic function. There has to be some substantive effect to show that things have changed in order for the public to continue to believe in the law. Without the substantive aspect of a new legal framework, it is unlikely that the symbolic aspects of the law could carry the public's confidence on its own.

## WHY NOW?

Regulatory change in the NHS often follows a policy fiasco. Many of these fiascos are extremely complex, and addressing them takes significant time and energy to unravel the issues and identify how best to prevent them happening again. For example, the retained organs scandal in the late 1990s and early 2000s was addressed through various public inquiries[31] and a new legislative framework in the Human Tissue Act 2004. The Mid Staffordshire scandal was addressed

31 Bristol Royal Infirmary Inquiry (n 18 above); Royal Liverpool Children's Inquiry (n 20 above) (2001); Retained Organs Commission, *Remembering the Past, Looking to the Future: The Final Report of the Retained Organs Commission* (29 March 2004).

through several public inquiries,[32] the Francis Review,[33] and the new standards for care included in the 2014 Regulations. These included the introduction of the duty of candour. This is found in regulation 20 of the 2014 Regulations and requires NHS institutions to explain and apologise for any events which cause or could have caused death or serious harm to a patient. The first prosecution for breach of the duty of candour was brought in September 2020 and related to failures to appropriately disclose details about a patient who died from a perforated oesophagus following an endoscopy.[34]

What these, and other NHS scandals, have in common is the sheer complexity of the situations that have arisen. In most NHS scandals, many people are affected, and there are demonstrable failings at all levels of the service, from the lowest grade member of staff, up to the regulator itself. As such, the process of changing the law in response to these fiascos does not usually follow the classic dangerous dogs knee-jerk response pattern.[35] In these cases, the fiasco is simple – a dog bites a person, often a child. There is a media and public outcry, and a quick legislative solution is brought in, for example, the Dangerous Dogs Act 1991. Everyone agrees that dogs should not be allowed to bite children and that the proposed legislation will solve the problem. In the NHS cases, the complexity of the crisis means that there is not a single focus for any public or media outcry, and there is no simple legislative response that will address all the concerns. Instead, there is often a lengthy public inquiry process which provides time and space for the panel to create substantive recommendations for complex legal change.[36]

In 2019 there was a hospital food safety disaster involving listeria. In April to June 2019, there were nine confirmed cases of listeria originating from sandwiches supplied to a hospital. Seven of these patients died. Listeria is a notifiable illness, and notification triggers an investigation by Public Health England into the source of the outbreak. In this case, Public Health England's report found that the outbreak had originated from a sandwich manufacturer, which sourced

32 There is a comprehensive timeline of inquiries related to Mid Staffordshire published by *The Guardian*. It provides details of the inquiries and the findings. Denis Campbell, 'Mid Staffs hospital scandal: the essential guide' *The Guardian* (London 6 February 2013).

33 Francis (n 16 above).

34 CQC, 'Care Quality Commission prosecutes University Hospitals Plymouth NHS Trust for breaching duty of candour regulation following patient death' (Press Release 23 September 2020).

35 Lodge and Hood (n 30 above).

36 R Stirton, 'The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: a litany of fundamental flaws?' (2017) 80 Modern Law Review 299–324.

its ingredients from another supplier.[37] Following that report, all the sandwiches produced by the relevant manufacturer were withdrawn from sale and use for patients across the whole NHS estate in England, and all 'ready to eat' meat products from the relevant supplier were withdrawn from use across the whole NHS estate in England. The sandwich manufacturer was closed for decontamination and has since ceased trading. The ingredient supplier underwent a voluntary closure and has since ceased trading. Listeria is not a common illness, and it is caused by a food-borne pathogen which grows where there is contamination and inadequate storage. This is why the Public Health England investigation was able to target the source of the outbreak and stop it spreading further.

In legal and political analysis terms, this was a very simple fiasco which shone a light on poor food safety practices in the NHS. It was the NHS equivalent of the 'dog bites child' fiasco. There was a single incident – an outbreak of listeria – and a small number of casualties. There was also a media outcry with a flurry of articles in all the relevant media outlets.[38] The usual response to this sort of fiasco is a knee-jerk legislative change which goes some way to addressing the problem, but can also leave some challenges for the future.[39] Since food safety regulation already applies to suppliers and manufacturers in the hospital catering industry, it would have been a simple response to strengthen it, such that suppliers of food to hospitals faced harsher penalties, or had to meet higher standards. This is something that falls within the remit of the Food Standards Agency. An investigation was carried out, and the Food Standards Agency confirmed in 2022 that all of the suppliers in the chain had ceased trading and that the outbreak had been contained.[40]

It is unlikely that this incident alone would have been sufficient to trigger a change in the law in the Health and Care Act 2022. The existing food safety systems (the Food Standards Agency and Public Health England) and the existing legal obligations were more than adequate to address the problem. However, in addition to the listeria report, in early 2019, the trade union Unison had surveyed its members for their views on hospital food, and the results had made for unpleasant reading: 'More than half of hospital staff in England

37 Public Health England, Investigation into an Outbreak of Listeria Monocytogenes Infections Associated with Hospital-provided Preprepared Sandwiches, UK May to July 2019 (Public Health England 2020).

38 'Hospital patients die in sandwich listeria outbreak' (*BBC News* 7 June 2019); 'Sixth person dies from listeria outbreak linked to NHS sandwiches' *The Guardian* (London 1 August 2019).

39 Lodge and Hood (n 30 above).

40 'Update on investigation into food supply chain linked to listeria' (Food Standards Agency 9 May 2022).

wouldn't eat food served to patients because it's unhealthy and of poor quality.'[41] The survey also raised concerns about the provision of food to staff who referred to inadequate preparation areas, a lack of healthy food, and food that did not allow for religious and cultural needs. With the listeria outbreak following the Unison statement that over half of NHS staff would not eat the food served to patients, it is perhaps more understandable why Matt Hancock, then Secretary of State for Health, announced an independent review of hospital food,[42] which reported in October 2020.[43] By offering up the whole NHS food provision system for review, Matt Hancock demonstrated a commitment to addressing the wider problems in hospital food that have been rumbling on since the early 1990s.

The review panel advisor was Prue Leith, well known for her roles in *The Great British Menu* and *The Great British Bake Off*. The final report from the review panel made recommendations in relation to eight areas. However, for our purposes the most important of these recommendations was that there should be:

a) Ambitious NHS food and drink standards for patients, staff and visitors to be put on a statutory footing and inspected by the CQC, with appropriate resources for the CQC to be able to do so.
b) Standards to apply to patient, staff and visitor food, food manufacturers, food retailers and vending machines; including requirements for appropriate facilities to support patients and staff to eat well 24/7 when in the hospital environment.[44]

This recommendation was addressed in section 173 of the Health and Care Act 2022. Legally and substantively, food safety and nutrition are wholly distinct, in that there is already a very strong regulatory framework around safety. However, in this instance, I would argue that the substantive situation was less important than the optics. Patients in hospital have no real choice whether to eat the food that is provided to them. The listeria outbreak put many patients at unnecessary risk of serious harm or death. This was combined with a damning statement from people who could choose not to eat this food. In this fiasco, the safety and nutrition issues have become intertwined. The fact that the proposed solution focused on the nutritional aspects of the problem is a reflection of the strength and robustness of the food safety regulation.

41 Unison, 'Hospital staff say patient meals not fit to eat' (Press Release 9 April 2019).

42 Department of Health and Social Care, 'Hospital food review announced by government' (23 August 2019).

43 Department of Health and Social Care (n 7 above).

44 Ibid 9, recommendations 6a, 6b.

## SECTION 173 – DOES IT HAVE A SOGGY BOTTOM?

A favourite criticism of Prue Leith in pastry week on *The Great British Bake Off*[45] is that of the 'soggy bottom'. For those who are not avid fans of the show, the soggy bottom is a problem with pies. The pie might look beautiful from the top, but once a piece has been removed, and the bottom pastry crust can be inspected, the fear is that the bottom piece will be soggy and damp, rather than the beautiful crisp pastry that is expected. For a Great British Baker, the 'soggy bottom' is a devastating blow to their chances of success in the competition.

The authors of the Report of the Independent Review of Hospital Food[46] devoted chapter 6 to their vision of the hospital food and drink standards that they wanted enshrined in statute. However, the report did not clearly set out what the 'ambitious standards' would be. Instead, the recommendation was for the establishment of an expert group to work on the appropriate standards. The main focus of chapter 6 was on the existing standards currently found in the standard contract for supplying food and food services to the NHS in England. As noted above, these are: the Ten Key Characteristics of Good Nutritional Care; the Nutrition and Hydration Digest; the MUST; and the GBS. With the first, second and third focused on the infrastructure around eating and the fourth[47] on procurement.

The panel's concerns about these sets of standards does not seem to have been their content, but rather the lack of compliance with and the poor monitoring of compliance with the standards. The aim of the recommendation around hospital food standards was to increase compliance, hence the recommendation of statutory force.

Given these expectations, there is no doubt that section 173, the heralded statutory hospital food standards, has a very soggy bottom. Section 173 amends section 20 of the Health and Social Care Act 2008 (the 2008 Act) to enable the Secretary of State to:

> (a) Impose requirements in connection with food or drink provided or made available to any person on hospital premises in England …;
> (b)(a) Specify nutritional standards, or other nutritional requirements, which must be complied with;
> (b)(b) require that specified descriptions of food or drink are not to be provided or made available.

It is merely an enabling provision which allows the Secretary of State to make whatever regulations they so choose. However, section 20 of the

45 See *The Great British Bake Off*.

46 Department of Health and Social Care (n 7 above).

47 Department for Environment, Food and Rural Affairs, 'Sustainable procurement: the GBS for food and catering services' (1 July 2014).

2008 Act already offered a wide discretion to the Secretary of State to make regulations applying in England and Wales relating to food and nutrition. Section 20 enabled the Secretary of State to 'make provision as to the manner in which a regulated activity is carried on',[48] and 'make provision as to the fitness of premises'.[49] The regulations that are already in force, having been made under the authority granted in section 20, are the 2014 Regulations. Regulation 14 provides that 'the nutritional and hydration needs of service users must be met'. These regulations are to remain in force until 31 March 2025.[50]

Section 173 of the Health and Social Care Act 2022 makes no substantive change to the law. Hospitals in England and Wales must meet the nutritional and hydration needs of their patients, by virtue of regulation 14. This is one of the fundamental standards that a hospital must demonstrate that it is meeting in order to remain a registered provider of healthcare services.[51] If a hospital were found not to be meeting the fundamental standards, then there is a range of enforcement actions that the CQC can use to ensure improved performance including criminal penalties as necessary and, ultimately, the withdrawal of registration to continue providing healthcare services. These standards were strengthened, as were the enforcement actions, in the 2014 Regulations, which were enacted after the Mid Staffordshire crisis, and the Francis Inquiry.[52]

If we look at the White Paper relating to the Health and Care Act 2022, we can see the rationale for including the provisions that became section 173, even though they make no substantive change to the law. Paragraphs 5.165 to 5.167 explain that 'statutory standards will … instil greater confidence in the public that the NHS is committed to deliver appropriate levels of nutrition and hydration, as well as good quality food'.[53] What is particularly striking here is that there is not even any attempt to sugar-coat this. The purpose of section 173 is not to improve hydration and nutrition, or to increase the quality of hospital food. Instead, it is to *instil confidence in the public* that the NHS is committed to providing appropriate levels of nutrition.

This is an explicit engagement of Cass Sunstein's expressive function of law.[54] Theoretically, statutory provisions combined with enforcement action should work together to improve standards overall.

48 S 20(3)(b).
49 S 20(b)(e).
50 SI 2022/179.
51 2008 Act, ch 2.
52 For a detailed discussion of these changes see Stirton (n 36 above).
53 Department of Health and Social Care (n 10 above).
54 C Sunstein, 'On the expressive function of law' (1996) University of Pennsylvania Law Review 2021.

Elsewhere, in relation to hospital food provision, I have argued that this is entirely unlikely to be a successful strategy.[55] The reason for this position is the chronic underfunding of the NHS, and of its regulator, the CQC. The imperative to cost-save while still providing good quality healthcare to patients is a powerful factor in budget allocation at the hospital level. Food provision is a 'safe' place to conserve budgets in the wider business of the hospital. It is much safer to reduce food budgets than it is to reduce cardiac surgery services, for example. This position was recognised in the parliamentary debates about section 173 when Alex Norris asked how the Government intended to resource the changes: 'We do not want pressure on hospital settings … to make cuts elsewhere. It would be a pyrrhic victory if the clause led to better nutrition but worse care.'[56]

Edward Argar, the Health Minister speaking on behalf of the Government in this debate, did not address the question of resourcing section 173, instead saying that 'giving the Secretary of State powers to place hospital food standards on a statutory footing sends a clear message about the importance of standards for the provision of good hydration and nutrition in the NHS'.[57] He went on to say that section 173 is 'a key part of our policy to improve public confidence in hospital food'. The Government has continued to push the position laid out in the White Paper, that the aim of section 173 is to send a message to the public, to demonstrate that hospital food is important. This is not the same as saying that hospital food quality is important and should be improved.

There were further attempts to amend section 173 in the House of Lords. Lord Hunt of Kings Heath, who is also president of the Hospital Caterers Association, made a very astute point that 'lip service has always been paid to good standards of hospital food and nutrition, unfortunately the boards of NHS organisations have often found it difficult to provide the resources to enable that to happen'.[58] Lord Hunt's proposed amendment would have required a board-level director to ensure that the nutrition and hydration standards were properly implemented at their hospital. He also proposed additional training requirements for staff involved in hospital food service. Ultimately, it is this resources point that seems to carry the arguments. Appointing a board member responsible for food provision costs money. Implementing training standards across the sector costs money. This money is not available from the ordinary sources. Lord Hunt withdrew his proposed amendments after the

55 Stirton (n 36 above).

56 Health and Care Bill HC Deb 26 October 2021, vol 702, col 680, Alex Norris.

57 Ibid col 681, Edward Argar.

58 HL Deb 7 March 2022, vol 819, col 1230, Lord Hunt.

response from Baroness Penn on behalf of the Government, who said that the Government was working with NHS England on updating the food standards – those currently included in the NHS standard contract – and that those standards would include a requirement that a hospital board member must have responsibility for food provision.

NHS England published its updated hospital food standards on 3 November 2022.[59] The first of the eight standards in section one requires organisations to have a board member responsible for food and drink and for reporting on compliance with the standards to be a standing agenda item at board meetings.

Ultimately, despite these attempts to add substance, section 173 has retained the *status quo* as regards hospital food standards. It enables the Secretary of State to make regulations about nutrition and hydration – a power that was already provided in the 2008 Act, and had already been made use of in the 2014 Regulations. The only difference is that nutrition and hydration are explicitly included in statute, rather than being hidden away in secondary legislation and the NHS standard contract.

## ACTUAL CHANGE OR POLITICAL MAGIC?

In 1960, Harold Lasswell wrote: 'The number of statutes which pass the legislature … but which change nothing in the permanent practices of society, is a rough index of the role of magic in politics.'[60]

I have argued that the only change that has happened as a result of section 173 is that the nutrition and hydration standards currently included in the NHS standard contract have been moved into the legislative and regulatory framework.

The new standards for healthcare food and drink are in four separate sections. All NHS organisations in England must comply with sections 1 (all healthcare food and drink) and 4 (sustainable procurement and food waste). Section 2 covers patient food and drink while section 3 deals with staff, visitor and retail provision.[61] Section 1 includes eight standards requiring that NHS organisations in England must:

1. have a board member responsible for compliance and reports at every board meeting;
2. have a food and drink strategy;
3. consider input from a named food service dietician;

59 NHS England, National standards for healthcare food and drink (3 November 2022).

60 H Lasswell, *Psychopathology and Politics* (University of Chicago Press 1960) 195.

61 Sections 3 and 4 are outside the scope of this article because they do not relate specifically to patient nutrition and hydration.

4 have a food safety specialist;
5 have a high-calibre workforce and properly remunerated chefs and food service teams;
6 demonstrate that they have a training and development programme for food service staff;
7 monitor and reduce waste; and
8 demonstrate an appropriate 24/7 food service provision.

While these map closely on to the recommendations of the Independent Review of Hospital Food,[62] it is worth looking closely at the impact assessment to identify whether these standards are expected to make substantive change. Seven of the eight standards are described as having no cost *because the provision should already be in place*. The evidence for this conclusion has not been provided, but the fact that the Independent Review of Hospital Food made specific recommendations relating to several of these standards suggests they are not already in place across the board. The only expected change is around monitoring food waste.

Section 2 of the new standards requires NHS organisations in England to demonstrate their compliance in five areas:

1 the Ten Key Characteristics of good nutrition and hydration care;
2 the BDA's Nutrition and Hydration Digest;
3 implementation of a digital ordering system aligning with patient care plans and dietary information;
4 a ward-based quality assurance system; and
5 a nutrition and hydration quality improvement programme.

The first two of these areas were already included in the previous standards, and therefore amount to no substantive change. However, areas three, four and five are new and do require the development of new processes with accountability and improvement built in at the level of ward staff. This is where the responsible board member will have new work to do to explore how to develop and implement these frameworks.

MUST, mentioned above, should still be used in accordance with the NICE guidance on nutrition support for adults, and the GBS, mentioned above, are included in section 4 of the new standards.

Although relatively small, this substantive change to the standards should be welcomed. It aims to ensure that there is greater accountability within NHS organisations in England in relation to food provision. It has been just over one year since these standards were published, so it is too early to see evidence of the impact of any shift in practice. It is

62 Department of Health and Social Care (n 7 above).

clear that there is scope for change and improvement around patient food provision.

Although there has been a minor substantive change, it is crucial to consider whether the change in enforcement mechanism – from contract law to regulatory enforcement by the CQC – amounts to an actual change to the law, or political magic. In addition, given that the Hospital Food Review Report was particularly concerned about increasing compliance with the standards, there is a second question about whether this change can increase compliance, or whether section 173 does in fact have a soggy bottom.

## Monitoring compliance

Decent information-gathering mechanisms are a fundamental component of an effective regulatory framework. It is essential to know whether the standards are being complied with in order to make any subsequent decision about undertaking enforcement action.

Prior to section 173, when the hospital food standards were contained within the NHS standard contract, compliance was monitored under the Patient Led Assessments of the Care Environment (PLACE)[63] scheme. The Hospital Food Review Report indicates concern that 'current monitoring processes have become a "tickbox" process for some trusts and may not accurately reflect reality, and not all the food standards are included in PLACE'.[64] PLACE is an assessment mechanism which involves an internal assessment of the relevant site. At least 50 per cent of the assessment team must be patient assessors. One of the domains that an institution is inspected against is 'nutrition and hydration'. The approach taken in the 2018 PLACE report relied on by the Hospital Food Review[65] was to ask whether the institution had assessed its compliance with specific standards. In relation to the nutrition and hydration standards, only 49 per cent of the 53 institutions inspected were fully compliant with the BDA's Nutrition and Hydration Digest. This is standard 2 in the list of nutrition standards in the NHS contract. This means that approximately 24 institutions were fully compliant with the Digest, which has been a mandatory standard since 2014.[66] The PLACE scheme has undergone a review since the 2018 publication, and the 2019 report presents the data in a different way. The most important change is that many more inspections are carried out – 1068 institutions were included in the 2019 assessment. However, the

63 NHS Digital, 'Patient-led assessments of the care environment (PLACE)' (2023).
64 Department of Health and Social Care (n 7 above) 59.
65 Ibid 60.
66 Department of Health and Age UK, 'The Hospital Food Standards Panel's report on standards for food and drink in NHS hospitals' (2014).

2019 assessment still only considers compliance with MUST (92%), the Ten Key Characteristics (91%) and the Nutrition and Hydration Digest (88%).[67] While this is an improvement on the previous PLACE model, it still only asks for compliance information on three of the four standards relevant to food for patients. This does present a much rosier picture of compliance with the mandatory standards than the 2018 PLACE assessment because it offers a more complete picture, and it asks whether the institution is compliant with the relevant standards rather than whether the institution has assessed its compliance. While PLACE was carried out in 2022, there has been no significant change to the model used, and the data collection and results were affected by the Covid-19 pandemic. Given these factors, it is more appropriate to focus on the 2019 results.

However, compliance with these standards has been mandatory since 2014. While some settling-in issues are to be expected, one would also expect that five years after compliance was made mandatory, the rates of compliance would be closer to 100 per cent rather than 90 per cent. It is even more concerning when we consider that these are not high standards. They are not aspirational standards, they are baseline standards.

A significant criticism of PLACE is that it is self-reported data,[68] and, while there have been changes to PLACE for the 2019 assessments onwards, it is still self-reported data by an internal assessment team. The problem with self-reported data is that it is difficult to ensure that the report matches the patient experience in the institution. There is a recommendation that an independent person is included in the assessment team, and this offers some guarantee that the questionnaire is answered honestly, however, the accuracy of the data is largely dependent on the integrity and knowledge of the assessment team. To use Baldwin's taxonomy of regulatees, teams which are ill-intentioned or ill-informed may inflate the reporting of their compliance with mandatory standards.[69] There is no way of knowing how many of the 1068 assessment teams are either ill-intentioned or ill-informed. As such, there is no way of verifying the veracity of the data.

Section 173 moves the compliance monitoring for hospital food standards into the purview of the CQC. The CQC has a team of inspectors who travel around the country making announced and unannounced inspections of registered institutions. The inspectors will gather information from patients, staff and other service users. They will collect data from comment cards and will review documentation,

67 NHS Digital, 'Patient led assessments of the care environment (PLACE) 2019 England' (2020).

68 Department of Health and Social Care (n 7 above) 61.

69 R Baldwin, *Rules and Government* (Clarendon Press 1995) 148.

including patient notes, at an institution. The inspectors will also undertake observations of the activities in the registered institution.[70] The purpose of the inspection is to consider whether the service is safe, effective, caring, responsive to people's needs and well-led.[71] Each of the five questions is rated as outstanding, good, requires improvement or inadequate, and the institution is given an overall rating, which it must share publicly.[72] The CQC writes a report, which is made available on its website, and publicises the ratings given.

It is worth exploring how regulation 14, the existing nutrition and hydration standards, is currently inspected in order to consider how the CQC might inspect in relation to the standards newly added to its remit. In relation to each of the five overall questions, there are several sub-questions which relate to specific regulations. One aspect of the nutrition standards is their responsiveness to patients' cultural needs. This forms part of the 'caring' question. The main space where nutrition is addressed is in the effectiveness part of the inspection, in which the inspectors consider this question: 'E1.5 How are people's nutrition and hydration needs (including those related to culture and religion) identified, monitored and met? Where relevant, what access is there to dietary and nutritional specialists to assist in this?'[73] This is an extremely broad question that gives the inspectors scope to explore the application of regulation 14, which provides that nutrition and hydration needs must be met. The relevant needs include 'suitable and nutritious food … adequate to sustain life and good health', parenteral nutrition and dietary supplements as necessary, the meeting of any cultural or religious needs, and support with eating where necessary.[74]

One of the issues about regulation is that framing is everything. The way that standards are framed affects the decision about how to gather information about those standards, and how to enforce the standards. John and Valerie Braithwaite demonstrated this very clearly with their nursing home research comparing Australia and the United States.[75] If the standards are written in a 'closed' manner, ie, 'Are the beds changed daily?' or 'Is a MUST assessment carried out on every patient?' then the answers are yes or no. This is a tickbox exercise. Collecting this information does not require an inspection team to observe practices on a ward. The best way to collect this information is to provide a

70 CQC, 'What we do on an inspection' (25 August 2022).
71 CQC, 'The five key questions we ask' (25 August 2022).
72 CQC, 'Ratings' (5 April 2023).
73 CQC, 'Assessing needs and delivering evidence-based treatment (healthcare services)' (12 May 2022).
74 2014 Regulations 14(4).
75 J Braithwaite and V Braithwaite, 'The politics of legalism: rules versus standards in nursing-home regulation' (1995) 4 Social and Legal Studies 307.

questionnaire for someone internal to the organisation to complete. They are in the best place to know the answers to the questions and, also, in the best place to do something if the answers are no. These roles are already present in NHS institutions. The Quality and Governance Teams have compliance roles. For example, the Compliance Manager at an NHS Foundation Trust is expected to:

> lead the organisation in ensuring all services are registered correctly with the Care Quality Commission (CQC) and ensure processes are in place to continuously monitor compliance. You will be the Trust link with CQC and co-ordinate all correspondence to and from them.[76]

A member of the compliance team would be best placed to answer the questionnaire regarding compliance with the standards previously assessed through PLACE.

Unless the hospital food standards are significantly rewritten, in such a way that they are 'open' rather than closed statements, the information-gathering exercise will remain the same, albeit under the authority of a different organisation – the CQC rather than PLACE, which is administered by NHS Digital. The best way to get this information is from self-reporting because the compliance team, or similar, are best placed to know the information. The expectation of the Hospital Food Review Panel that enshrining the standards in law would change the monitoring framework seems to have been misguided. In that respect, it seems that section 173 is an example of political magic.

## Enforcement practices

Once again, the decisions around enforcement practices are connected to the manner in which the standards are formulated[77] as well as the types of regulatees affected by the rules.[78] Since the Hospital Food Review Panel was concerned that the incentives and penalties for non-compliance were not working,[79] it might have been a more useful exercise to scrutinise why they were not working before recommending that statutory enforcement would be more effective.

When considering the optimal nature of law enforcement, Steven Shavell argued that the stage at which the legal intervention occurs is a fundamental dimension of enforcement.[80] The advantage of

76 Quote taken from a job description advertised on NHS Jobs. These adverts are removed when the closing date has passed but similar job descriptions are available. See NHS Jobs.

77 See R Baldwin, M Cave and M Lodge, *Understanding Regulation: Theory, Strategy and Practice* (Oxford University Press 2011) 230.

78 Baldwin (n 69 above)

79 Department of Health and Social Care (n 7 above) 61.

80 Steven Shavell, 'The optimal structure of law enforcement' (1993) 36 Journal of Law and Economics 255, 257.

the NHS Standard Contract as an enforcement mechanism is that it plays both a preventative role and a restorative role. The contract is a preventative measure because the parties to the contract have to sign it in advance, with knowledge of its contents. The consequences of breaching a contract are sufficiently significant that no serious commercial enterprise would sign a contract that it did not intend to abide by. In that sense, the contracting process works as a filtering system. Non-professional enterprises would not get to the stage of even signing the contract to provide food, or any other services, to the NHS. Given that the NHS Standard Contract for 2022–2023 has 81 pages of service conditions, and 53 pages of particulars, as well as any additional local particulars which are agreed with the local Commissioners,[81] it is inconceivable that any food preparation company would sign the contract without seeking proper legal advice on the obligations it would be accepting.

In relation to quality of service, paragraph 3.3 of the service conditions provides that where a contracting party has fallen below the expected national quality thresholds, the Commissioners can enforce performance without the need to appear in court. They may issue a contract performance notice, which requires the service provider to comply with the quality standards. Alternatively, they can remove any or all patients from that provider's care. There is no requirement to start with a performance notice, so the Commissioners can go straight to full removal. In the context of food provision, this means that the food supplier would be removed from the NHS estate, and the contract would in essence be cancelled. This is what happened in the case of the listeria-contaminated sandwiches. The Public Health England inquiry demonstrated that companies in question were non-compliant with food safety law. Compliance with the law is another term of the NHS Standard Contract in paragraph 1.1 of the service conditions. Their contracts were withdrawn, and they are no longer able to supply food to the NHS.

Supplying products to the NHS is likely to be a significant revenue stream for any food company. The consequences of the withdrawal of that contract are dramatic. For example, both companies implicated in the listeria outbreak have ceased trading completely. As a preventative enforcement mechanism, contract law has considerable symbolic power, and, in the case of an actual breach of the contract, it has considerable substantive power as well.

The contract is a powerful mechanism for protecting the rights of those who have been affected by a breach of that contract. The other contracting party, in these cases, the NHS Commissioners, can

81 NHS, 'NHS Standard Contract 2022/23 Particulars, Service Conditions and the General Conditions' (2 March 2022).

withdraw the contract without the need to appear in court. This keeps costs down and means that breaches can be remedied quickly. This is both a restorative intervention after a breach has occurred, but also a deterrence symbol for other organisations considering taking on NHS contracts. As an enforcement mechanism, I would argue that the NHS contract is a very powerful tool.

How do the CQC enforcement practices measure up to the power of the contract? The 2014 Regulations changed the enforcement measures available to the CQC and made it easier for their enforcement team to choose the appropriate enforcement mechanism for the regulatory failure in question. The 2014 Regulations also removed the previous formality requirements so that inspectors were not bound by waiting periods or a need to provide a warning notice alongside an improvement period before a prosecution could be brought.[82] However, as I have argued elsewhere, the 2014 Regulations pushed the CQC into a deterrence approach to enforcement – the need to use the more significant penalties in order to deter regulatees from non-compliance. This created a mismatch between the role of CQC inspectors in maintaining ongoing relationships with the institutions they inspect, and support through any period of change and improvement.[83]

Two significant differences between the CQC enforcement actions and the NHS contractual enforcement mechanisms is the speed with which action can be taken, and the entity at which the enforcement action is targeted. These are intertwined. Most food service and provision is contracted out to private companies. If, on inspection, hospital food provision was found to fall below the standards required by regulation 14, then the CQC inspectors would start with some informal negotiations about improvement, or one of the enforcement notices requiring significant improvement. This would include a time period over which the improvement would have to take place, and possibly a second inspection would be carried out. Crucially though, these actions would be taken against the regulated institution – the hospital – not against the food provider or supplier, which would fall outside the CQC's remit. It would then be up to the hospital to decide how to approach the deficit. Would it work with the food supplier to improve standards, or could the hospital simply withdraw the contract? If the contract were to be withdrawn, this is the same result as the contractual enforcement mechanism, but it has taken longer because the CQC report can only be addressed to the hospital. It adds an additional layer of bureaucracy that must be navigated for the same outcome.

82 Stirton (n 36 above) 317.
83 Ibid 319.

Putting these mechanisms side by side, it is clear that there is no substantive change to the potential outcomes of enforcement action. A food supply contractor can still have its contract withdrawn. But under the CQC enforcement model this takes longer than it does under the contractual model. I would argue that the move to CQC enforcement is likely to be less effective than the enforcement mechanisms inherent in the NHS contract.

## CONCLUSION: A TRIUMPH OF SYMBOLISM OVER SUBSTANCE

This argument has moved from the expressive functions of law, and symbolic uses of political acts such as law-making. It has traversed the heady issues of political magic and soggy bottoms. One conclusion to reach from this discussion is that the symbolism of a legal or political act is important in its own right, irrespective of whether there is also a substantive effect of that same act. In the case of hospital food, statutory standards have been the 'prize' that all eyes have been on since the early 1990s with the Campaign for Better Hospital Food's work. Now this has been achieved, there is a sense from the activist groups that the work is complete. Sustain has archived its Campaign for Better Hospital Food website.[84] In that sense, the symbolism means something.

This might be that it provides concrete evidence that the Government supports improvement and development of hospital food. This has been supported by public commitments from the then Prime Minister Boris Johnson that the Government would improve hospital food when the review was announced.[85] However, these commitments were made when Matt Hancock was Health Secretary, and, as the minister who ordered the Hospital Food Review, there was some demonstrable commitment to improving hospital food at least at that stage. Matt Hancock resigned his office before the Health and Care Bill was introduced to Parliament, and Sajid Javid replaced him. This role has since been transferred to Steve Barclay and Thérèse Coffey. Victoria Atkins became the Secretary of State for Health and Social Care in November 2023. While a change in minister does not automatically mean a change in priorities, it is worth noting that the public-facing discussion about the food provisions in the Health and Care Bill at the time focused on the food advertising provisions:

84 Sustain, 'Campaign for better hospital food'.

85 See this video of Prue Leith and Boris Johnson discussing the aims of the hospital food review.

> Supporting the introduction of new requirements about calorie labelling on food and drink packaging and the advertising of junk food before the 9pm watershed to level up health across the country. The pandemic has shown the impact of inequalities on public health outcomes and the need for government to act.[86]

When the Health and Care Act 2022 received royal assent the press release mentioned food advertising and tackling obesity through regulating food advertising, but nothing else.[87] The first statutory hospital food standards provisions did not merit public comment.

I have argued that a closer look at the impact of the hospital food standards provision in section 173 indicates that there is likely to be no change at all to compliance monitoring practices, and if there is a change in enforcement it is likely to be for the worse rather than the better. This is because the CQC enforcement practices are much more complex than the enforcement of the NHS Standard Contract. It is also crucial to recognise that adding additional responsibilities onto the CQC will necessitate an increase in funding to support its work. It is far from clear that this will be forthcoming. Harold Lasswell's political magic that makes no change to day-to-day practices is the better case scenario here.

Ultimately, the problem with hospital food is that it is often unappetising and of low quality. It is cheap food. This is an entrenched problem that activists have been fighting for at least 20 years. There is no quick fix to this. It is all very well having a symbolic legal provision that demonstrates the government's commitment to improvement, but this is just the latest in a long line of symbolic acts to address the problem. Every time a celebrity chef gets involved, there is a flurry of government and media interest in improving the situation, but ultimately, nothing really changes.

There are two elements that need to be addressed if there is a genuine commitment to improving hospital food. First, the current standards are extremely low. They are baseline standards that providers should not fall below. If we want improvements in hospital food, then the content of these standards needs to be explored and changed. One option would be to create high standards that organisations need to work to meet. The recommendations in the Hospital Food Report offer a holistic and aspirational set of measures that would, if implemented, improve hospital food. The recommendations include things such as training requirements, improved grading of hospital food staff and

86 Department of Health and Social Care, NHS England, Rt Hon Sajid Javid MP, 'Health and Care Bill introduced to Parliament' (6 July 2021).

87 Department of Health and Social Care, Rt Hon Sajid Javid MP, 'Health and Care Bill granted Royal Assent in milestone for healthcare recovery and reform' (28 April 2022).

technological solutions. Interestingly, one of the panel's focuses was on knowledge throughout the organisation. The report suggested that 'it is important that boards and chief executives are regularly eating the same meal as patients'.[88] This is a really simple way of ensuring that those at the top of the institution know what is happening for their service users. If the standards are written in a way that requires implementation of these recommendations then it is possible that hospital food will improve. The enforcement mechanisms need to be written around the standards. The form of enforcement measures are related to the content and the form of the standard being enforced. Ensuring that the two match up is an important part of regulatory success.

The other aspect of improving hospital food is funding. Currently, the median spend per patient meal is £4.56.[89] This includes all overheads. This amounted to 0.6 per cent of the total NHS budget in 2018–2019.[90] When we consider the number of people involved in food provision, and the cost of kitchens and utilities, this is a tiny amount of money. Combined with increasing the substance of the standards, it is essential to increase the budget allocated to food provision.

Unless these two things are addressed properly – substantive change to the standards, and increased budget – there is only a very slim possibility that hospital food will improve. If section 173 does not lead to these changes, then the only conclusion it is possible to reach is that it is political magic with a soggy bottom.

88 Department of Health and Social Care (n 7 above) 14.

89 NHS Digital, 'Estates Returns Information Collection Summary page and dataset for ERIC 2018/19' (17 October 2019).

90 Department of Health and Social Care (n 7 above) 9.

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# Choosing home: discharge to assess and the Health and Care Act 2022

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ABSTRACT

In the early stages of the coronavirus pandemic National Health Service hospitals were instructed to rapidly discharge patients from wards with consequences which, in the case of some care homes, has been claimed to be catastrophic due to lack of effective testing and isolation. These tragic events also highlight a longer-term issue, namely hospital discharge policies and their relationship with obligations placed on local authorities to assess needs of individuals under the Care Act 2014. Concerns have been expressed for some time regarding the delays in getting patients discharged from hospitals – with them being labelled inappropriately as 'bed blockers'. The Health and Care Act 2022 includes new statutory measures concerning discharge to facilitate rapid discharge of patients from hospitals. This can be seen as a solution to a major resource problem, but could this ultimately undermine choice and respect for individual wellbeing?

The article explores the background to the recent controversies concerning hospital discharge decisions and their relationship with the Care Act 2014. It demonstrates that, while the current debates and controversies regarding hospital discharge decisions are nothing new and pre-date the pandemic by decades, hospital discharge processes accelerated during the pandemic and have left a problematic legacy. It interrogates the Health and Care Act 2022 discharge provisions and whether these will be an effective integration of health and social care provision going forward or whether there is a real risk of undermining individual autonomy, the Care Act 2014 obligations concerning promotion of well-being and a person's choice of their 'home'.

**Keywords:** hospital discharge; NHS; Care Act 2014; Health and Care Act 2022; patients; Covid.

## INTRODUCTION

In the early stages of the coronavirus pandemic National Health Service (NHS) hospitals were instructed to rapidly discharge patients, including into care homes, to increase hospital capacity. The consequences of this approach were, in the case of some care

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homes, claimed to be catastrophic, resulting in seeding infection with consequent high death rates.[1] But these tragic events also highlighted what is a much broader and longer-term issue, namely the policies regarding discharge from hospital and their relationship with obligations placed on local authorities to assess the needs of individuals under the Care Act 2014, or as to whether patients are entitled to continuing funded NHS Continuing Healthcare (NHS CHC) outside the hospital.

Discharge from hospital can be seen as essentially an administrative task for the NHS trust and social services, in terms of bed management and a matter for the patient in terms of the next stage in their recovery and where this will be best facilitated. But the very process of discharge itself ought to be one which ideally should enable an individual to be able to make choices about 'home', where, ultimately, they want to recuperate and indeed live. Difficulties regarding patient discharge decisions long pre-date the pandemic. Over decades, the problems of patients being unable to be rapidly discharged from hospital even though clinically fit to be discharged – whether back to their own homes, or to respite care or to a permanent care home – have been highlighted, and successive governments have sought to address this issue. Frequently, the emotive language of 'bed blocker' has been used to describe such patients.[2] It has been suggested that this terminology, which today has been rightly criticised as being dehumanising and discriminatory, originated amongst clinicians in the 1950s.[3]

Major concerns remain regarding the shortage of hospital beds. Comparisons with the availability of hospital beds in other jurisdictions are notable. As the British Medical Association has commented: 'The average number of beds per 1,000 people in OECD EU nations is 5, but the UK has just 2.4. Germany, by contrast, has 7.8' and furthermore:

> Prior to the pandemic, the total English NHS hospital bed stock reduced by 8.3% between 2010/11 and 2019/20 as the average daily total of available beds fell from 153,725 to 140,978.[4]

Section 91 of the Health and Care Act 2022 has introduced new measures amending section 74 of the Care Act 2014 which are aimed at facilitating more rapid discharge of patients from hospital through what is known as a 'discharge to assess' model. Duties and powers which

1 See further *R (Gardner and Harris) v Secretary of State for Health and Social Care and Others* [2022] EWHC 967.

2 'Hundreds of "bed blockers" at University Hospitals Dorset every day' *Bournemouth Echo* (23 November 2022); 'Isle of Wight awarded £2m to help discharge bed-blockers' (*BBC News* 24 January 2023).

3 Johnny Marshall, 'They're not bed blockers, just older people who want to get home' *The Guardian* (30 August 2016).

4 British Medical Association, *NHS Hospital Bed Data Analysis* (December 2022).

may come into operation on discharge from hospital are placed on local authorities under the Care Act 2014 to provide care and support for patients. Care which is funded by local authorities is subject to means testing. In some instances, as we shall see below, there is provision for NHS health and care support on discharge under NHS CHC. In contrast to social care, NHS CHC is not subject to means-tested provision. However, in practice access to NHC CHC is exceedingly difficult to be awarded.[5] The aim of the 2022 Act provisions will be to speed up the hospital discharge process and move these decisions regarding assessment of the care and support needed for individuals to be made post discharge outside hospital. This can also be seen as part of the broader move of integration of health and social care under the 2022 Act. But what longer term will be the impact of the 2022 Act proposals and further enhanced measures for rapid discharge? Will this facilitate effective delivery of hospital care or is there a real risk of undermining patient choice and ultimately patient health? People are, of course, not simply parcels; being moved to an unexpected location whether within a hospital, a sudden move overnight to a different ward or to a new care facility outside hospital can be disorientating and indeed at times frightening for an ill and vulnerable person.

This article first explores the statutory requirements regarding the provision of care and support to patients post discharge, both in relation to the NHS and the assessment obligations set out in the Care Act 2014. Secondly, it examines the backdrop to the 2022 Act provisions. It demonstrates that, while the current debates and controversies regarding hospital discharge decisions are nothing new and pre-date the pandemic by decades, hospital discharge processes accelerated during the pandemic and left a problematic legacy. Thirdly, the article then interrogates the provisions in the Health and Care Act 2022 regarding hospital discharge. It considers the extent to which these provisions can be seen as part of an effective integration of health and social care provision going forward or whether there is a real risk of undermining patients' autonomy, and respect for their needs and their choice of 'home'. The focus of this article is upon the question of discharge decisions in relation to adults. While discharge decisions concerning children and those with mental illness give rise to many separately challenging issues, word constraints mean that they cannot be explored further in this particular article.

5 See further L Clements with K Ashton, S Garlick, C Goodhall, E Mitchell and A Pickup, *Community Care and the Law* 7th edn (Legal Action Group 2019) ch 13, 'NHS continuing healthcare responsibilities'.

## PROVIDING CARE AND SUPPORT TO PATIENTS POST DISCHARGE – THE INTERFACE BETWEEN HEALTH AND SOCIAL CARE

While some patients are able to be discharged after hospital treatment without the need for further care and treatment, this is by no means the case for all patients, and some patients post discharge will need continuing healthcare and/or social care support. Although since its inception in 1948 health care provided by the NHS has been free at the point of delivery – albeit with some exceptions, for example prescriptions[6] – social care from the National Assistance Act 1948 onwards has been treated differently. Social care provision is subject to means testing.[7] The issue of the extent to which social care should be subject to charge and, if so, or at what level remains a matter of ongoing controversy, the precise details of which go beyond the scope of this article.[8] The assessment of whether care after leaving hospital falls under the category of NHS CHC or that of social care is thus a major financial issue for the patient and their relatives but also potentially for the NHS funders.[9] The Care Act 2014 imposes a range of duties and powers in relation to the provision of social care services. This is rooted in the 'wellbeing concept'. Section 1 of the 2014 Act places a general duty upon local authorities to promote an individual's wellbeing in relation to matters including personal dignity, their physical and mental health and emotional wellbeing, protecting them from being subject to abuse and neglect, care and support which is provided to them, their social and economic wellbeing and the suitability of their living accommodation. Furthermore, section 1(3) provides that when local authorities are exercising relevant functions under the legislation they need to work from the assumption that it is the person themselves who is best placed to ascertain what is their own wellbeing,[10] the person's views, wishes, feelings and any beliefs which they may have,[11] and their involvement 'as fully as possible' in decisions and provision of information enabling them to participate in

6 S 1(4) National Health Services Act 2006.

7 See further Cabinet Office, Department of Health and Social Care and Prime Minister's Office, Policy Paper Adult Social Care Charging Reform: Further Details (Updated 8 March 2022).

8 See further HM Government, *Build Back Better: Our Plan for Health and Social Care* (CP 506 September 2021).

9 See further Clements et al (n 5 above) ch 5 'Hospital discharge'. See also *R v North and East Devon Health Authority ex p Coughlan* [2000] 2 WLR 622; *R(Grogan) v Bexley NHS Care Trust and Others* [2006] EWHC 44; *R (Gossip) v NHS Surrey Downs CCG* [2019] EWHC (Admin).

10 Care Act 2014, s 1(3)(a).

11 Ibid s 1(3)(b).

those decisions.[12] There is emphasis placed upon the importance of preventing or delaying the development of needs for care and support, or needs for support, and of reducing needs of either kind that already exist.[13] Furthermore, restrictions on rights or freedom of action are to be 'kept to the minimum necessary' in the specific context.[14]

The Care Act 2014 places duties upon local authorities to assess whether an adult or carer has eligibility for support for care and support needs or, in the case of a carer, for support needs.[15] If they come under the threshold of eligibility there is then a duty to assess those care and support needs.[16] If individuals are assessed as eligible and have such needs then local authorities are placed under a duty to meet those needs for adults requiring care and support needs[17] and for carers with support needs.[18] In addition, a care and support plan must be provided.[19] There are also related obligations regarding the need to undertake financial assessments.[20] A financial assessment is practically very important as it provides advance information to the individual and their family as to what real choices are available to them with regard to what social care services they will be able to afford.

In addition to the Care Act 2014, statutory provisions enable provision of NHS care and support for free following hospital discharge through NHS CHC.[21] This scheme was introduced by the NHS and Community Care Act 1990. The development of such care could be seen alongside the movement away from 'indefinite' long-stay hospital patients and to a growth towards more 'personalised care'.[22] If an individual falls within the category for such care and treatment, this is classified as NHS care, and then, unlike for social care, the patient is not charged for this care. Inevitably, if it were the case that this scheme was very generous, then it would have a substantial impact on the budget of NHS Commissioners. In practice over time the criteria of

12 Ibid s 1(3)(e).
13 Ibid s 1(3)(g).
14 Ibid s 1(3)(h).
15 Ibid s 13.
16 Ibid s 9 and s 10.
17 Ibid s 18.
18 Ibid s 20 concerning carers needing care and support.
19 Ibid s 24.
20 Ibid s 17.
21 The National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012, SI 2012/2296 (as amended), pt 6. See further discussion in Clements et al (n 5 above) ch 13; and T Powell, *NHS Continuing Healthcare in England* (House of Commons Library 7 February 2023).
22 See further D Oliver 'NHS continuing care is a mess' (2016) 354 British Medical Journal Online (5 August).

this scheme have been notably tightened, and accessing NHS CHC has proved increasingly challenging,[23] and it has been claimed that access to funding is less likely now than before the pandemic.[24]

Today NHS CHC[25] applies to individuals who have a 'primary health need'[26] which is ascertained by looking at the 'totality of all health needs'.[27] This is assessed by a multidisciplinary team using what is called the 'National Decision Support Tool'. The tool looks at a range of needs which are listed as breathing, nutrition – food and drink – continence, skin and tissue viability, mobility, communication, psychological and emotional needs, cognition, behaviour, drug therapies etc, altered states of consciousness, and other significant care needs. The needs are assessed with reference to levels from low to severe, or, in the case of some, such as breathing or behaviour, the highest level is that of 'priority'. If it is determined there is such a primary health need then the NHS itself will have the responsibility to undertake the commissioning of that patient's care package to address those 'assessed health and associated social care needs'.[28] This will, for example, include covering the cost of such things as washing and dressing the patient. However, those granted NHS CHC have a right to access and use their own personal health budget, and where they are receiving care in their own home there is an expectation they will use their own budget.[29] There is also a special 'fast track' for NHS CHC which operates where patients are suffering very serious deterioration in health, for instance, due to terminal illness. Ultimately, what constitutes nursing services which fall within a local authority's remit

23 See for example the discussion in National Audit Office Report by the Comptroller and Auditor General, *Investigation into NHS Continuing Healthcare Funding* (HC 239, Session 2017–2019 5 July 2017) and for criticism of the operation of the scheme in the pre-pandemic period focusing on complaints received by the Parliamentary and Health Service Ombudsman between April 2018 and July 2020: Parliamentary and Health Service, *Ombudsman Continuing Healthcare: Getting it Right First Time* (HC 872 3 November 2020). For further reflections on the scheme, see NHS Federation Report, *NHS Continuing Healthcare: Delivering Excellence* (1 June 2020).

24 P Gallagher, 'Adults with serious healthcare needs "less likely to receive NHS funding than before Covid pandemic"' (*I News* 11 February 2022).

25 See further NHS Regulations 2012 (n 21 above) and the Department of Health and Social Care Guidance, National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care (28 November 2012, updated 14 July 2023).

26 National Framework (n 25 above) para 4.

27 Ibid para 56.

28 Ibid para 5.

29 See further NHS England, Personal Health Budgets in NHS Continuing Healthcare (CHC).

and those of the NHS remains a matter to be determined on a case-by-case basis.[30]

The duties in relation to NHS CHC are imposed on NHS England, the body which leads the NHS in England, Integrated Care Boards, which are now the primary commissioners of healthcare at local level,[31] and also on local authorities. In addition, as the National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care states, it is the case that:

> If a person does not qualify for NHS Continuing Healthcare, the NHS may still have a responsibility to contribute to that individual's health needs – either by directly commissioning services or by part-funding the package of support. Where a package of support is commissioned or funded by both a local authority and an ICB, this is known as a 'joint package of care'.[32]

Today the new Integrated Care Boards have obligations to comply with and deliver the National Framework for NHS Continuing Healthcare, the governance arrangements for eligibility for promotion of and commissioning of packages, and decisions on eligibility.[33] They have the task of consulting:

> so far as is reasonably practicable, with the relevant social services authority before making a decision on a person's eligibility for NHS Continuing Healthcare (the Care and support statutory guidance should be used to identify the relevant social services authority).[34]

Other obligations relate to the implementation of good practice and quality standards.[35] Specific obligations are also placed on local authorities to refer persons who may be eligible for NHS CHC to Integrated Care Boards.[36]

Thus these obligations exist to assess in relation to individual needs concerning care and support under the Care Act 2014 and in relation to NHS CHC. The new Discharge to Assess provisions introduced under the Health and Care Act 2022, as its name suggests, mean that, rather than undertaking these assessments of needs while patients are in the hospital, assessment of long-term needs will be undertaken once they have been discharged. We explore the implications of this below.

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30 See *Coughlan* (n 9 above).
31 Established under the Health and Care Act 2022.
32 National Framework (n 25 above) para 20.
33 Ibid para 22(a)–(c) and (e).
34 Ibid para 22(d).
35 Ibid para 22 (i) and (j).
36 Ibid para 26.

## HOSPITAL DISCHARGE DECISIONS – THE BACKDROP TO THE HEALTH AND CARE ACT 2022

Delays regarding hospital discharge decisions have long been the subject of controversy both for the very fact that these delays existed but also for what reasons patients were occupying hospital beds for a long period of time. Concerns about the impact of an ageing population and lack of suitable provision outside hospital for older patients resulting in beds being 'blocked' were raised in the mid-1970s.[37] There was criticism of use of this as a term. In 2000 Scott argued that 'bed blocker': 'must cease to be used as it creates a negative attitude towards elderly people in hospital and propagates ageism which is already widespread in the NHS'.[38]

There was also the question as to whether delays in discharge should be seen as an administrative matter or whether these could, at least in part, be attributed to problems in the approach to hospital clinical care. In relation to elderly surgical patients, Gwyn Seymour and Pringle writing in 1982 suggested that, concerning this group of patients and also younger patients, their length of stay in hospital was a matter relating to clinical concerns and stay could be shortened by an improvement in treatment approaches, for example, a reduction in postoperative complications such as sepsis.[39] Patients may have faster rehabilitation outside a hospital setting.

There was high-level discussion as to the impact of delayed hospital discharge on the NHS and NHS funding in the 1990s. McCoy et al stated that:

> The National Audit Office (NAO) reported that 2.2 million bed days could be attributed to delays in discharge in England in 1998/99 costing the NHS £1 million a day. The House of Commons Health Committee concluded that delayed discharges affected 6% of all acute beds and cost the NHS £720 million in 2001/02.[40]

It appears that until 2001 there was no standard definition as to what constituted a 'delayed discharge'.[41] In that year the Department of Health stated that:

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37 See discussion in S G Rubin and G H Davies, 'Bed blocking by elderly patients in general hospital wards' (1975) 4 Age and Ageing 142.

38 H Scott, 'Elderly patients: people not "bed-blockers"' (2000) 9(9) British Journal of Nursing 528.

39 D Gwyn Seymour and D Pringle, 'Elderly patients in a general surgical unit: do they block beds?' (1982) 284 British Medical Journal 1921.

40 D McCoy, S Godden, A M Pollock and C Bianchessi, 'Carrot and sticks? The Community Care Act (2003) and the effect of financial incentives on delays in discharge from hospitals in England' (2007) 29(3) Public Health 281.

41 See discussion in the House of Commons Health Committee Report, *Delayed Discharges* (Third Report of Session 2001–2002 HC 617-1) para 1.

> A delayed transfer occurs when a patient is ready for transfer from a general and acute hospital bed but is still occupying such a bed. A patient is ready for transfer when:
>
> — a clinical decision has been made that the patient is ready for transfer
>
> — a multi-disciplinary team decision has been made that the patient is ready for transfer
>
> — the patient is safe to discharge/transfer.[42]

The Health Select Committee Report, *Delayed Discharges*, in 2001 noted that despite the definition being produced in practice there was considerable lack of clarity in relation to what precisely constituted a delayed discharge.[43] It also noted concerns in relation to lengthy discharge of older patients which could have consequent adverse impacts on their health. Reasons for delay were cited in the Select Committee Report as including individuals waiting assessment of care needs, finding an appropriate place for care (including care home placements) and awaiting domiciliary care packages such as home adaptations. Further reasons given were the need to resolve social services funding for care, patients needing further NHS care or patient and family choosing further care settings.[44]

The Blair Labour Government attempted to address the problem of the delayed discharge during its second term in the period 2001–2005. Alan Milburn, the Secretary of State for Health, speaking in the House of Commons on 18 April 2002, stated that:

> Reductions in waiting times to get into hospital must, of course, be accompanied by cuts in waiting times to get out. Older people are the generation that built the health service, and they have supported it all their lives. This generation owes that generation a guarantee of dignity and security in old age. Bed blocking denies both.[45]

Various interrelated policy measures were taken forward at the time. These included the creation of the role of liaison nurse or discharge coordinator and of 'discharge lounges' in hospitals, with funded initiatives (with the aim of diversion of patients from accident and emergency) enabling 72-hour 'emergency care packages' for community support.'[46]

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42 Cited in ibid, para 1.

43 House of Commons Health Committee Report (n 41 above) paras 3–8.

44 Ibid para 9.

45 Rt Hon Alan Milburn, Secretary of State for Health 2002, 'Speech on the NHS Plan' (House of Commons 18 April 2002).

46 J Roll and K Wright, *The Community Care (Delayed Discharges etc) Bill 4 of 2002–2003* (House of Commons Research Paper 02/66 22 November 2002).

The Wanless Report in 2001 had recommended that the Government look into financial incentives in relation to hospital discharge.[47] Local authorities had received funding to support delayed discharges, but the problem still remained.[48] The Community Care (Delayed Discharges) Act 2003[49] enabled the NHS to charge social services where individuals did not need acute hospital beds but were unable to be safely discharged from hospital without the involvement of local authorities, and consequent delays had resulted. There was some evidence that while, this reduced initial delays, this movement to rapid discharge was then accompanied by a related increase in emergency readmissions.[50]

Ultimately, the 2003 Act was replaced during the Conservative and Liberal Coalition Government (led by David Cameron)[51] by section 74 and schedule 3 of the Care Act 2014 and related regulations. This also included some provision for payments by local authorities. These concerned those patients receiving 'acute care', which was defined as being 'intensive medical treatment provided by or under the supervision of a consultant that lasts for a limited period after which the person receiving the treatment no longer benefits from it'.[52] Excluded from this category was the care of expectant or nursing mothers, mental health and palliative care, short-term home care support, and recuperation or rehabilitation care.[53]

Discharge under the Care Act 2014 provisions was operated by the relevant NHS trust serving notice on the local social services department that the patient was likely to be ready for discharge on a particular date. The social services department was then required within two days to examine the patient's needs. In addition, the NHS issued discharge notices with one day's notice of required discharge. In a situation in which the patient could not be discharged because it was the case that the local authority had not undertaken relevant

47 *Securing our Future Health: Taking a Long-Term View* (The Wanless Report, HM Treasury 2002) para 6.45.

48 See discussion in House of Commons Health Committee Report (n 41 above) pt III, para 6: 'The use of the Cash for Change resources appears to have been successful in enabling authorities to meet the target of a more than 20% reduction in delayed discharges since September 2001. However, we accept that funding activity in this way may not be sustainable or desirable in the longer term, and that the increase of funding to social services of 6% per annum in real terms over the next three years offers a positive opportunity for longer term planning.'

49 Ibid.

50 See further Godden et al (n 40 above).

51 This Government operated between 2010 and 2015.

52 Care and Support (Discharge from Hospital) Regulations 2014, SI 2014/2823, reg 7(6).

53 Ibid reg 7(7).

assessments or put in place arrangements for meeting 'some or all' of the relevant needs, then the local authority would become liable for payments. The difference, however, with the previous legislation was that, while under the 2003 Act such charges were mandatory, this was not now the case.[54] Ultimately, the intention was to foster joint working between the NHS and local authorities. In a situation in which a patient or carer decided to refuse a package which was offered to them, then it was the case that the local authority was no longer liable for the costs.

The effectiveness of the statutory discharge measures and the operation of discharge by NHS and social services in the period between when the 2014 Act came into force and the beginning of the pandemic was subject to criticism. While there was pressure to stop individuals remaining in hospital for longer than clinically indicated, there were also concerns that the process of discharge itself and some related discharge decisions were problematic with, in some instances, patients being placed at risk of harm. The issue of what constitutes a 'safe discharge', while addressed in principle in earlier guidance in 2010 and 2015, was not defined. As Clements et al note, a protocol produced in 2003 set out three criteria which needed to be present for a safe discharge.[55] These were that there was a clinical decision that this patient was ready for discharge, that there was a multidisciplinary team decision also to that effect, and also that the patient was safe to discharge and transfer. Furthermore, these criteria were to be 'addressed at the same time whenever possible'.[56]

The Parliamentary and Health Service Ombudsman's Report of investigations into unsafe discharge from hospital in 2016 stated that:

> Failures in these areas severely undermine people's trust and confidence in the NHS. As the relative of an older woman who complained about her treatment told us: 'Surely when family members have made their concerns 100% clear and a vulnerable, virtually immobile 93-year-old is sent home alone, something is very wrong somewhere.'[57]

The Healthwatch England Report 'Safely home: what happens when people leave hospital and care settings' published in 2015 noted that, of the trusts included in its report, 1 in 10 trusts had not as a matter of routine told carers and relatives that people would be discharged.[58]

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54 Sch 3, para 4(1) provided that 'the NHS body responsible … may require the relevant authority to pay the specified amount'.

55 Clements et al (n 7 above) 176–177.

56 Ibid 176.

57 Parliamentary and Health Service Ombudsman, *A Report of Investigations into Unsafe Discharge From Hospital* (2019).

58 Healthwatch, *Safely Home: What Happens When People Leave Hospital and Care Settings Report* (21 July 2015).

In addition, 1 in 8 people discharged had reported being unable to cope on discharge. Similarly, the Red Cross, in its report, *Home to the Unknown: Getting Hospital Discharge Right* in 2019 stated that:

> Some people came home to houses that had not been prepared for their return, with no hot water or heating on. Others returned to homes that were unsuitable or inappropriate for their recovery and their changed or changing needs. This ranged from struggling with a single step up to a front door, to feeling unable to get upstairs to the toilet.[59]

An already problematic situation of undertaking hospital discharge decisions was amplified still further by events during the pandemic. As part of the pandemic planning exercises undertaken in the two decades prior to the Covid pandemic, concerns were raised as to the potentially serious adverse impacts of a major pandemic on health and social care provision.[60] It was suggested as a consequence that provision could be made for some statutory provisions to be suspended or 'eased' during this period, commonly referred to as 'easements' in various guidance documents.[61] Provision was made in the 2020 Act to enable the pausing of statutory obligations concerning NHS CHC and including Care Act 2014 assessments.[62] All NHS CHC assessments were suspended in the early stages of the pandemic and then were restarted from 1 September 2020.[63] When the Guidance was withdrawn on 19 September 2021, it was stated that 'all deferred assessments had been completed'.[64]

The situation was more problematic in relation to suspension of Care Act duties. The guidance required that where higher-level easements were used, such as suspending certain provisions under the 2014 legislation, these needed to be notified to the Department of Health and Social Care.[65] Such higher-level easements were only formally applicable in a very small number of local authorities and for a very short period of time – between April 2020 and June 2020.[66] However,

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59 British Red Cross, *Home to Home to the Unknown: Getting Hospital Discharge* Right (2019) 12.

60 Exercise Cygnus Report: Tier One Command Post Exercise Pandemic Influenza 18 to 20 October 2016 (Public Health England 2017).

61 Ibid 8.

62 Ss 14 and 15 Coronavirus Act 2020.

63 Department of Health and Social Care, Guidance: Reintroduction of NHS Continuing Healthcare (NHS CHC) 21 August 2020 (Guidance withdrawn on 19 September 2021).

64 Ibid.

65 Department of Health and Social Care, *C*are Act Easements: Guidance to Local Authorities (Updated 29 June 2021).

66 Birmingham City Council, Coventry City Council, Derbyshire County Council, Solihull Council, Staffordshire County Council, Sunderland City Council, Warwickshire County Council and Middlesborough Council operated these for one week and then withdrew them.

there is evidence that there were changes in the way in which services were provided in some local authorities even though formal statutory easement practices were not applicable.[67] The statutory easement powers were finally withdrawn in 2021.[68]

Rapid discharge of patients from hospital was seen as a critical measure to facilitate the ability of the NHS to save lives in the pandemic. In March 2020 the need for rapid hospital discharge came into sharp focus. Instructions were issued on 19 March 2020 with the aim of clearing as many hospital beds as possible to provide space for Covid-19 patients.[69] The intention was to free up some 15,000 beds between 19 and 27 March 2020. Both acute and community hospitals were required to discharge all patients as soon as they were clinically safe to do so. Procedures were put in place to facilitate such a rapid discharge. There was to be a clinical review in the early morning ward round to identify those patients who were seen as suitable for discharge. In addition there was to be a review twice per day of all those patients in acute beds to ascertain who was not 'required to be in hospital' and who could be discharged. Within an hour of the actual decision to discharge was made, patients were to be discharged to a designated discharge area and the discharge should happen as soon as possible after that, normally within two hours. Hospitals were to keep a list of those who are subject to discharge and to discharge and report on the number of those patients. Social care personnel were involved in ward reviews. Local authorities deployed teams of social workers to work in hospitals to facilitate discharge. Patients were given information such as the direct number of the ward to call back and get advice. They were also to receive a phone call the following day to provide reassurance and advice.[70] In addition, provision was made to request a follow-up by a community nurse. From April 2020, the discharge to assess process was combined with free care for patients where needed in the form of rehabilitation or reablement for a period of up to six weeks. There was specific government funding put in place to facilitate discharge. In the period between 19 March 2020 to 31 March 2021 the cost of care for persons waiting assessment was covered by an emergency Covid-19 fund of £1.3 billion.[71] There was

67 See further J V McHale and L Noszlopy, Adult Social Care Provision under Pressure: Lessons from the Pandemic (Research Report, University of Birmingham, 2021); and see also J V McHale and L Noszlopy, *Adult Social Care Law and Policy: Lessons from the Pandemic* (Bristol University Press forthcoming 2024).

68 Coronavirus Act 2020 (Early Expiry) Regulations 2021, para 4.

69 Department of Health and Social Care, 'Coronavirus (COVID-19) Hospital Discharge Service Requirements' (19 March 2020).

70 Ibid para 3.1.

71 See discussion in D Foster, *Coronavirus: Adult Social Care Key Issues and Sources* (House of Commons Library 14 February 2022) para 5.3.

then subsequent funding through the National Discharge Fund until 31 March 2022. The funding was, however, ultimately reduced from a period of six to four weeks. Further funding was announced in autumn of 2023. One concern which has been raised is that of funding being non-recurrent and its impact on planning. The King's Fund Institute, in its 2023 report, notes the words of one respondent from an NHS Trust who stated that:

> All non-recurrent money is effectively useless in my view. Unless you want to pilot something quite whizzy with an uncertain outcome, kind of prove the concept before you then make a case for long-term investment … Non-recurrent money for four months is very hard to use.[72]

These hospital discharge decisions remain the source of incredible controversy concerning the rapid decision to discharge patients. The then Secretary of State for Health and Social Care, Matt Hancock, talked of a 'protective ring' having been cast around care homes.[73] Others have, however, argued that this was far from the case and that rapid discharge decisions in the early weeks of the pandemic effectively 'seeded' the virus into the care homes through the lack of sufficient testing[74] and these discharge decisions were unlawful.[75] The broader issues around these events are currently the subject of the Covid-19 UK Inquiry and go beyond the scope of this article.[76] There were also reports in the early months of the pandemic that in certain areas NHS trusts were discharging patients into hotels,[77] in one report these were called 'Nightingale Care Homes'.[78] It is difficult to evaluate the effectiveness of this as a measure from the information available. However, as we shall see below, the problems in hospital overcrowding led to discharge of patients to hotels in 2023.

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72 A Bayliss, S Bottery, L Tirratelli, S Benniche and L Wenzel, Hospital Discharge Funds: Experiences in Winter 2022–2023 (King's Fund Institute 2023).

73 See UK Covid-19 Inquiry.

74 See eg discussion in M Daly, 'COVID-19 and care homes in England: what happened and why?' (2020) 54(2) Social Policy and Administration 985; S Rajan, A Comas-Herrera and M McKee, 'Did the UK government really throw a protective ring around care homes in the COVID-19 pandemic?' (2020) Journal of Long-Term Care 185.

75 See further *R (Gardner and Harris)* (n 1 above) and V L Moore and L D Graham, 'R (Gardner and Harris) v Secretary of State for Health and Social Care and Others' [2022] EWHC 967: Scant regard for Covid-19 risk to care homes' [2022] 30 (4) Medical Law Review 734.

76 T George, 'Care home being used to look after coronavirus patients leaving hospital' *Manchester Evening News* (4 May 2020).

77 See eg 'Reading Council partners with Holiday Inn to help residents out of hospital' (Reading Borough Council 6 May 2020).

78 H Pidd, 'Care room with a view: UK hotels offer respite to non-Covid patients' *The Guardian* (London 3 May 2020).

Healthwatch, working with the British Red Cross, produced the report '590 people's stories of leaving hospital during Covid-19' which was published in October 2020.[79] The report highlighted a number of advantages to the discharge process which was adopted. These included that of reduced bureaucracy and dedicated funding.[80] There was also more collaboration and 'joined-up' working practices.[81] It noted that information provided regarding the discharge process was clear.[82] There was also praise for the caring nature of the hospital staff. However, despite the rapid discharge processes, in practice delays still remained. These were due to patients having to wait for medication, to problems with transport arrangements, waiting for discharge letters or waiting to see a doctor, all of these being problems which had been highlighted prior to the pandemic.[83] This report also stated that there was no requirement to test on discharge when guidelines came into force until 15 April 2020 and, as they commented, that information, if available, should have been included in discharge information.[84] Sixty per cent of those surveyed had been able to discuss where they were going to be discharged to and were discharged to their preference.[85] Some 28 per cent did not have such conversations regarding placements and what would be their preferred location.[86] There were mixed reports of the ability of families to communicate with hospitals and be involved in discharge decisions.[87] Eight per cent of those surveyed were discharged at night.[88] Of these, some 64 per cent were not asked as to whether they would have liked transport support.[89]

It was also the case that, although the existence of follow-up visits was stressed along with ongoing assessments for health needs, this was not the case for the majority. The British Red Cross 2020 report noted that 82 per cent of those surveyed did not receive a visit from a health or care professional after discharge and some 18 per cent of that group reported that they had 'unmet needs'.[90] An ongoing concern

79 Healthwatch England and British Red Cross, '590 people's stories of leaving hospital during Covid-19' (2020).
80 Ibid 9.
81 Ibid.
82 Ibid 9.
83 Ibid 26.
84 Ibid 28–30.
85 Ibid.
86 Ibid.
87 Ibid 22.
88 Ibid 13, defined as 'after 8pm'.
89 Ibid 8. Hospital transport systems enabling patients to attend scheduled appointments in hospitals or to facilitate hospital discharge operate separately from standard ambulance services.
90 Ibid 18.

also related to the viability of the care home market itself and whether care homes would have the necessary capacity. Thus, while the Covid pandemic provided on its face a highly effective illustration as to how rapid hospital discharge could be undertaken in terms of patients leaving hospital, it also provided a notable cautionary tale of the risks of rapid discharge processes without facilitating strong support and undertaking very careful risk assessments and the need for follow-up in relation to patients' needs.

## HOSPITAL DISCHARGE DECISIONS 'POST PANDEMIC' AND THE HEALTH AND CARE ACT 2022

Reform of the law concerning hospital discharge was introduced in the form of section 91 of the Health and Care Act 2022 introducing a new section 74 into the Care Act 2014. This provision came into force on 1 July 2022.[91] It also needs to be read in conjunction with the Hospital Discharge and Community Support Guidance. This was originally published on 31 March 2022 and was then revised in January 2024.[92] What will this mean for patient choice and ensuring individual wellbeing as required by the Care Act 2014?

Section 74 of the Care Act 2014 as amended by the 2022 Act places a new duty upon NHS trusts and NHS Foundation Trusts to involve carers and patients, including young carers, when undertaking discharge planning.[93] This duty applies where the adult patient is likely to need care and support after discharge and where the hospital Trust considers it appropriate to involve them or their carers in planning for discharge. This should be done as soon as feasible. The current Hospital Discharge and Community Support Guidance places emphasis upon a model best meeting local needs in the light of the affordability of existing budgets.[94] The Guidance also highlights the prospect of access to additional funding mechanisms such as the Better Care Fund, which may facilitate integration of health and social care.[95] The Guidance takes forward the discharge to assess model. The aim is to ensure that existing funding arrangements are put in place in accordance with statutory duties.[96] The aim is to involve multidisciplinary teams in

91 The Health and Care Act 2022 (Commencement No 2 and Transitional and Saving Provision) Regulations 2022, SI 2022/734, s 2(a).

92 Department of Health and Social Care, The Hospital Discharge and Community Support Guidance updated 26 January 2024.

93 Care Act 2014, s 74(1).

94 Ibid.

95 Better Care Fund.

96 In addition to the Care Act and NHS CHC provisions, there is also a need to consider provision of services under the Mental Health Act 1983.

the discharge process and also to work along with social workers. The Guidance also stresses the need for the relevant infrastructure to be developed in local areas to support discharge[97] which can be seen in light of the statutory obligations for NHS and local authorities to co-operate together in safeguarding population health and welfare.[98] It is also stated that discharge 'requires active risk management across the system'.[99] There is also emphasis on the need for information-sharing by NHS and social care teams 'in a secure and timely way to support best outcomes'.[100]

The Guidance states in section 2 that both NHS and local authorities 'should ensure that where appropriate, unpaid carers and family members are involved in discharge decisions'. There is emphasis placed on asking individual who they want to be informed and also included in relation to such decisions and give their consent.[101] It also notes the need for effective systems to be utilised to identify if there are young carers involved and the obligations on local authorities to undertake their statutory obligations to young carers' needs.

At the heart of decision-making is the need to recognise the choice of the person being discharged yet this can also be qualified in a particular situation. The National Health Service Act 2006 also states in section 14Z37 that there is a 'duty as to patient choice' which provides that:

> Each integrated care board must, in the exercise of its functions, act with a view to enabling patients to make choices with respect to aspects of health services provided to them.

The Hospital Discharge Guidance engages with the question of choice. It emphasises the need for early conversations regarding where an individual should be discharged to with discharge planning to begin on either admission or before procedures elective in nature take place.[102]

Discharge planning includes information regarding the range of post-discharge care. The essence of this Guidance, as with the previous Guidance is the aim of discharge 'to the right place, at the right time and with the right support'.[103] Moreover, NHS providers and local authorities are to 'support people to be discharged in a timely and safe way as soon as they no longer require care in NHS acute hospitals, NHS community hospitals and virtual wards', but the Guidance stresses that

97 Department of Health and Social Care, The Hospital Discharge and CommunitySupport Guidance updated 26 January 2024, s 5.

98 National Health Service Act 2006, s 82.

99 2024 Guidance (n 97 above), s 9.

100 Ibid s 11.

101 Ibid s 2.

102 Ibid s 3.

103 Ibid s 4.

'No person should be discharged until it is safe to do so.'[104] As with the previous Guidance Annex B of the latest Guidance sets out four main 'pathways' for hospital discharge which draw upon the approach adopted to discharge categories during the Pandemic.[105] Pathway 0 is seen as essentially straightforward discharge home. This will not require involvement of a Care Transfer Hub. Pathway 1 relates to home discharge coordinated by the Care Transfer Hub which involves, for example, short-term intermediate care for such things as reablement. It can also extend to returning to an existing care home placement where the patient will receive 'time limited, short-term care'.[106] Pathway 2 concerns again discharge coordinated through the Care Transfer Hub 'to a community bedded setting with dedicated health and /or social care and support',[107] this is for a limited time period with the aim of facilitating rehabilitation and recovery. The final category, that of Pathway 3, concerns 'In rare circumstances, for those with the highest level of complex needs, discharge to a care home placement.'[108] Again this is to be coordinated by the Care Transfer Hub.[109] The difference from the previous Guidance was that the earlier version had included the estimated percentage of patients to be allocated to a specific pathway.[110] However, the Guidance does not provide very specific tight time limits for each part of the discharge process in contrast to the approach taken earlier in the Pandemic.

In relation to needs assessments, it is stated in section 8 of the Guidance that:

> It is best practice to determine a person's immediate recovery needs and put in place a plan on how to meet them prior to discharge. It is best practice to initiate assessments of longer-term health and/or social care needs during the period of recovery and complete them only once a point of recovery and stability is reached.[111]

The approach taken in relation to palliative and end of life care assessments can be different, particularly where life expectancy is cut short and in such situations 'personalized care plans' are to be provided and regularly updated.[112] This may mean, for example, that a person

104 Ibid s 7.
105 Ibid annex B.
106 Ibid.
107 Ibid.
108 Ibid.
109 Ibid.
110 In the original Guidance: Pathway 0 was initially anticipated to be minimum of 50% of those discharged; pathway 1, a minimum 45%; Pathway 2 a maximum of 4%; and Pathway 3 no more than 1%.
111 2024 Guidance (n 97 above), s 8.
112 Ibid s 10.

with days to live is discharged with plans for 24-hour nursing care and/or a hospital bed for use at home.

Discharge decisions can be challenging if they lead to disputes as to what ultimate destination for the patient is appropriate. The Guidance states that:

> Even where a professional (including medical professionals and social care professionals) disagrees with a person's choice, in most cases a person who has mental capacity to decide what care and support they would like on discharge will make the final decision. If an individual with the relevant capacity refuses the provision of care then ultimately this decision should be respected.[113]

The need to respect a decision made with capacity is reinforced elsewhere in the Guidance.[114] Interestingly, there is also reference that NHS and social care professionals:

> should ensure that safety netting is provided whereby the individual is provided with advice on discharge. The person should be given the contact details of someone who they can talk to about their discharge and advised to make contact if they are concerned about anything.[115]

It is hoped that these systems do work effectively given concerns noted as discussed earlier in this article suggesting problems in this element of the discharge process.

In terms of choices as part of discharge planning, the Guidance recognises that these are to be seen as those which are "suitable for a person's short-term recovery needs and available at the time of discharge".[116] Early planning conversations are to take place following personalised care principles, with the patient being given support to make such choices. Discharge decisions can be challenging if they lead to disputes between family members as to what ultimate destination for the patient is appropriate. The Guidance states that:

> Where there is disagreement between a person and their unpaid carers or family members and the appropriate professional has no reason to consider that the person lacks capacity to make decisions relevant to their discharge then the matter will need to be resolved, hopefully through informal agreement.[117]

This is an interesting departure from the previous Guidance document which states that:

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113 Ibid s 4.
114 Ibid s 9.
115 Ibid.
116 Ibid s 12.
117 Ibid.

> If there is disagreement between that person and carers and family members—their own decision is to be respected.[118]

There are also other ways in which a choice at this point may be seen as at least constrained. The patient is essentially marooned in hospital. It will be their relatives or friends who will be, for example, undertaking viewings of care homes and then providing that information back to the person in the ward. The precise choice available will be reflected as to whether this is a self-funded service or whether it is funded through social services. The cost of certain care homes may be seen as prohibitive and will not fall within the amount local authorities would fund. Moreover, even if local authority funding is available, care homes may ask relatives to pay an additional sum of money in the form of what is known as a 'top up' fee.[119] The other difficulty is that, due to facilitating a rapid discharge, a patient may be moved to a specific temporary location until a more permanent solution can be found, even though the patient themselves may be unhappy about this.

The Guidance highlights that choice may also be limited in some situations such as including "times of extreme operational pressures-for example if a level 4 (national incident) is declared".[120] In such a situation the Guidance states that a record should be produced setting out the criteria needing to be taken into account in such a situation.[121] The Guidance also highlights that:

> People do not have the legislative right to remain in a hospital bed if they no longer require care in that setting, including to wait for their preferred option to become available.[122]

The limits of patient choice and that patients cannot insist they remain in their hospital bed where it is not clinically appropriate for them to remain was confirmed in the case of *University College London Hospitals NHS Foundation Trust v MB* in 2022 where a patient was challenging a decision that they should be discharged to local authority accommodation which had been specifically adapted along with a care package.[123]

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118 Hospital Discharge and Community Support Guidance 31 March 2022, 25.

119 Clements et al (n 5 above) paras 9.260–9.266.

120 Ibid para 12.

121 Ibid.

122 Ibid.

123 *University College London Hospitals NHS Foundation Trust v MB* [2022] EWHC 882 (QB). See also the earlier cases of *Barnett Primary Care Trust v X* [2006] EWHC 787 QB and *Sussex Community NHS Foundation Trust v Price* [2016] EWHC 3167.

> The present situation does not involve a comparison of the needs of two identified patients. But the decision to withdraw permission for MB to remain in the Hospital is still a decision about the allocation of scarce public resources. Decisions of this kind are a routine feature of the work of hospitals and local authorities, even when there is no public health emergency.[124]

The court also confirmed that this situation was not changed by reference to the Human Rights Act 1998. Chamberlain J held that when taking into account respect for the patient's rights to home and family life under article 8 of the European Convention on Human Rights reference is made to the margin of appreciation which is 'even wider when … the issues involve an assessment of the priorities in the context of the allocation of limited state resources' and that in this situation evidence was such that:

> the interference was justified in order to protect the rights of others, namely those who, unlike MB, need in-patient treatment. Bearing in mind the broad discretionary area of judgment applicable to decisions of this kind, there is no prospect that MB will establish the contrary.[125]

While the legal position is clear, this perhaps understates the emotional complexity which can arise in relation to some of these decisions. Some individuals may be content for a rapid discharge decision to perhaps an interim care facility: others may indeed find this overwhelming. This decision may also relate to circumstances where a patient when originally entering hospital expected to be discharged back to their own home but where, due to changes in clinical circumstances, this will now not be clinically appropriate. This is likely to be exceedingly emotionally challenging for some individuals. Decision makers need also to always bear in mind the importance to the individual themselves in being able to choose ultimately what is their 'home'. Home is a very powerful concept, as Mallett in her extensive and excellent review of the literature highlights.[126] It can be a haven, a place for family and, critically, a place for self-identity and being. In terms of hospital discharge, we see decisions and choices through a clinical and administrative pragmatic frame. This frame is constrained by resource allocation decisions. Yet, it is the case that decision-making, both in discharge decisions and also in the needs assessment process outside hospital, would be enriched by truly engaging with what the individual patient themselves sees as being 'home'.

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124 *University College London Hospitals* (n 123 above) para 56.

125 Ibid.

126 See further S Mallett, 'Understanding home: a critical review of the literature' (2004) 52(1) Sociological Review 62.

A further issue is the extent to which hospital staff themselves will be happy with this process and indeed the extent to which decisions sit effectively with their professional roles. What was notable was that the Healthwatch and British Red Cross Report findings stated that:

> Hospital staff reported that the removal of patient choice over where they were to be discharged to made them feel uncomfortable, due to their inability to accommodate patient and family preference and some patients being distressed at being placed in unfamiliar settings.[127]

It is too early to say whether this will also be felt under the new Health and Care Act provisions, but this must surely be a real concern and something where there will need to be further review going forward.

Specific reference is also made to discharge decisions concerning persons who may lack mental capacity.[128] If an assessment is made where someone lacks capacity, as the Guidance notes, then the decision taken must be in that person's best interests.[129] The Guidance states: 'No one who lacks mental capacity should be discharged to somewhere assessed to be unsafe, and the decision maker should make a record of the decision.'[130]

Furthermore, it goes on to provide that:

> Onward care and support options which are not suitable (for example, those not considered clinically appropriate) or available (for example, placements which are not available) at the time of hospital discharge should not be considered in either mental capacity assessments or 'best interests' decision making.[131]

Choice is, thus, choice within the options which are determined appropriate and available. The Guidance also makes reference to the fact that an independent advocate appointed under the Mental Capacity Act 2005 may also be involved in this process.[132]

How effective the new statutory provisions will be in facilitating rapid discharge from hospital while facilitating patient choice as far as possible remains to be seen. The early period of the legislation was not propitious. Hospitals in winter 2022–2023 were again overwhelmed by the numbers of patients with consequent shortages of available beds which led to the Government announcing that it was providing:

> up to £200 million of additional funding to immediately buy short-term care placements to allow people to be discharged safely from hospitals

127 Healthwatch England and British Red Cross (n 79 above) 25.
128 2024 Guidance (n 97 above), s 9.
129 Ibid.
130 Ibid.
131 Ibid.
132 Ibid.

into the community where they will receive the care they need to recover before returning to their homes.[133]

Further evidence of the demands experienced by hospitals in winter 2022–23 was demonstrated in press coverage at that time which included January 2023 reports that in a number of areas in England – those of Bristol, Cornwall and Devon – individuals were being discharged into hotel accommodation, so called 'care hotels'.[134] Bristol, North Somerset and South Gloucestershire Integrated Care Board indicated that these would be operational until the end of March 2023, provided by Abicare – a registered provider of home care services – and also NHS rehabilitation and primary care staff. It will be interesting to see if this is followed in the future.[135] The Health Foundation, in its March 2023 report 'Why are delayed discharges from hospital increasing? Seeing the bigger picture', indicated that far from the position improving, delayed discharges were increasing.[136] It noted that in December 2022 there were 13,000 beds occupied by patients who were fit for discharge of the approximately 100,000 beds in English hospitals, and this was a 57 per cent increase compared with 2020. It found that the key issue in delay was not in fact social care with the percentage of patients who were still waiting for social care remaining at around 37 per cent between February 2022 and December 2022. The Health Foundation saw the issue of delayed discharge being related to a range of reasons which it suggests relate to NHS pressures which in turn impact on capacity to undertake discharge assessments, plans and co-ordination of discharge itself. The report said that a high level of bed occupancy and pressures on non-acute care, along with discharge processes operating sequentially rather than in parallel, were inhibiting the discharge process.[137]

A further very important issue highlighted in earlier reports and events, as noted above, is the need to ensure that discharges are safe. The Guidance emphasises that discharges should be safe, and there is to be 'active risk management across the system'. It acknowledges

133 Department of Health and Social Care, Helen Whately MP and Rt Hon Steve Barclay MP, 'Up to £250 million to speed up hospital discharge' (Press Release 9 January 2023).

134 Denis Campbell, 'Hospitals in England discharging patients into '"care hotels"' *The Guardian* (London 5 January 2023).

135 It is interesting that the fact that these hotels are part hospitals/care facilities as well as hotels is highlighted in reviews in Trip Advisor in relation to one of the hotels in Plymouth which was included as a 'care hotel'. See 'Half hotel/half hospital' and 'Fine, but be aware it's a part time hospital'.

136 F Cavallaro, F Grim, L Allen, J Keith and C Tallack, 'Why are delayed discharges from hospital increasing? Seeing the bigger picture' (Health Foundation 3 March 2023).

137 Ibid.

that there were problems in the past regarding discharge but states that 'individuals and local factors will determine how best to manage risks'.[138]

Safety is clearly critical to ensure that there is not a repeat of some of the unsafe discharge decisions highlighted, for example, in the Healthwatch and British Red Cross report discussed above. It is, of course, important that these decisions are rooted in clinical considerations and not unduly influenced by other policy concerns. In April 2023, Portsmouth NHS Trust faced a media backlash after offering 'Easter goodies' to staff who facilitated rapid discharge of patients in the lead-up to Easter and the planned junior doctors strike in early April, with nurses in the trust expressing anxiety about the prospect of patients being discharged before they were ready.[139] There will be an inevitable concern to ensure that rapid discharge is not in the future associated with emergency readmission, which in itself can impose notable strains on the NHS.[140] The issue of safe discharge was again highlighted in a Healthwatch survey (published in November 2023) of 583 people – patients and carers – who had been involved in hospital discharge in the previous 12-month period.[141] This gave further illustrations not only of continued delayed discharge but of lack of reablement support and patients being discharged in the early hours of the morning in freezing conditions with no care from relatives or others being put in place.

## CONCLUSIONS

As we have seen, policy decisions regarding the approach taken to hospital discharge decisions have a long and problematic legacy. While the Covid years facilitated fast discharge from NHS hospitals, they also raised challenging questions as to the nature of safe and effective discharge decisions. Moreover, as we have seen, 'fast' does not necessarily equate with effective discharge if it ultimately results in unduly rapid readmission to hospital. The need for safe discharge

138 2024 Guidance (n 97 above) 22.

139 J McKay, 'Hospital faces backlash after offering chocolates to discharge patients rapidly' (*Nursing Notes* 7 April 2023).

140 This in turn relates to questions as to factors which correlate with emergency re-admission which is a complex issue. In addition it has been argued that lower rates of emergency admission were also related to patients' ability to access their GP surgery by phone and their ability to see their preferred GP; and see also the findings of the Health Foundation in its briefing, S Deeny, T Gardner, S Al-Zaidy, I Barker and A Steventon, *Reducing Hospital Admissions by Improving Continuity of Care in General Practice* (Health Foundation 2017).

141 'NHS urged to do more to help patients leave hospital safely' (*Healthwatch Blog* 20 November 2023).

in general is critical, and this remains an ongoing concern as reports such as those of Healthwatch and the Red Cross have highlighted. The question of effective resourcing for this exercise is, in addition, clearly critical with the need for appropriately planned funding. Linked to this is the importance of reablement in attempting to avoid subsequent readmission, and this in turn relates to whether there are effective resources made available in the community for this to be undertaken at a time when there are notable staffing shortages in health and social care.

The various legislative measures over the last two decades regarding hospital discharge only address one part of the issue. Hospital discharge decisions are not simply a question of procedures to move people beyond the walls of a hospital as fast as possible once it is clinically determined that they should no longer remain there, but relate to a myriad of other issues. Why did the patient receive hospital treatment, and, indeed, could this have happened earlier but in a community setting through the work of general practitioners (GPs)? NHS workforce capacity remains a real challenge with a shortage in the number of GPs and other health and social care professionals.[142] As the King's Fund has noted, the number of NHS hospital beds has itself halved over the last 30 years in a period of increasing population growth.[143] As we have seen, since the 1970s concerns have been raised in relation to the challenges which may result from an ageing population with complex comorbidities but, despite large amounts of academic engagement, there is a still a lack of comprehensive effective policy to address this question. While people who are 60 years old may no longer be generally regarded as 'elderly', the broader question of how to facilitate healthy ageing remains.[144] Access to social care itself is a major concern. The provision of social care by local authorities has been exacerbated by some 13 years of austerity policies from central government,[145] and the financial position of some local authorities in relation to delivery of services is at a critical level.[146] Whether

142 'The GP shortfall in numbers' (Health Foundation 30 June 2022); see also H Alderwick and A Charlesworth, 'Editorial: A long term workforce plan for the English NHS' (2022) British Medical Journal 377:o1047.

143 L Ewbank, J Thompson, H McKenna, S Anandaciva and D Ward, 'NHS hospital bed numbers: past, present, future' (King's Fund Institute 5 November 2021) originally published in 2017 and updated in both 2020 and 2021.

144 See eg University of Birmingham Policy Commission, Healthy Ageing in the 21st Century (2014).

145 S Warren, 'Austerity 2.0: why it's critical for our health that the government learns the lessons of Austerity 1.0' (King's Fund Institute 1 November 2022).

146 See eg B Rose, 'Bristol care proposals: disabled people fear losing right to live at home' (*BBC News* 22 September 2023); J Murray, 'Birmingham city council declares itself in financial distress' *The Guardian* (London 5 September 2023).

establishing Integrated Care Boards and the broader work of Integrated Care Partnerships in facilitating the work of health and social care will by itself be enough remains to be seen. It is notable that very similar arguments and expectations around integration of health and social care were advanced in the 1990s and early 2000s in relation to Primary Care Trusts.[147] As the Health Foundation report of March 2023 notes, currently the overall broader pressures facing NHS hospitals on a day-to-day basis may mean that in practice this also constrains the ability to undertake rapid discharge.[148]

Finally, where the Health and Care Act 2022 model of discharge to assess may also be particularly problematic relates to what can be tensions between rapid discharge needs and respecting individual patient choice. Lacking full autonomy in relation to discharge decisions, albeit that these may be a temporary move into a specific care setting, can be seen as being very disorientating and frightening for both patients and families. The use of 'care hotels' brings other challenges as to whether individuals will effectively rehabilitate in such an environment. It remains unclear as to whether the push to rapid discharge will lead to more disputes over whether discharge of certain patients should actually take place.[149] When we consider how hospital discharge decisions are undertaken, we need to engage further with the fact that these decisions are not simply a matter of making hospital beds available for others but are critically part of personal choice and the question of choosing 'home'.

147 House of Commons Health Committee Report (n 41 above).

148 Cavallaro et al (n 136 above).

149 Healthwatch England and British Red Cross (n 79 above) 25 found that: 'Care home staff often encountered families refusing to accept their relatives discharge placement as they found it difficult to explain that people no longer had a choice about where they went to after leaving hospital.'

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# Understanding 'NHS privatisation': from competition to integration and beyond in the English NHS

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ABSTRACT

References to National Health Service (NHS) 'privatisation' can be found in UK parliamentary debates since the early 1980s, but it remains not well understood as a concept and can certainly be distinguished from the standard definition of 'privatisation', meaning taking into private ownership. Nevertheless, it is possible to say that the characteristics of 'NHS privatisation' include clear links with the evolving interaction between the NHS and private healthcare, a relationship which can be traced back to the inception of the NHS in 1948.

By juxtaposing primarily the debates of the Health and Social Care Act 2012 (HSCA 2012) and the Health and Care Act 2022 (HCA 2022), it becomes possible to gain at least two insights into 'NHS privatisation' in the English NHS. Firstly, it enables us to understand whether, and if so, how, 'NHS privatisation' may be changing with the reversal of the controversial HSCA 2012 competition reforms by the shift to integration now enshrined by the HCA 2022. Secondly, we gain a greater understanding of how 'NHS privatisation' has developed as a criticism capable of being invoked by diverse political parties and thus able to shape the development and implementation of NHS reforms. Thirdly, 'NHS privatisation' may operate to inhibit more radical NHS reform in opposing directions by reference to the NHS Bill and the NHS (Co-funding and Co-payment) Bill. Finally, 'NHS privatisation' can be understood in terms of questions of accountability and the dynamic between market and state.

**Keywords:** NHS; privatisation; 'NHS privatisation'; Health and Social Care Act 2012; Health and Care Act 2022; competition; integration; private healthcare.

## INTRODUCTION

Debates of healthcare reform across the UK frequently include references to National Health Service (NHS) 'privatisation', particularly in England, where the relationship between the NHS and private healthcare has evolved with successive marketisation and competition reforms since the 1980s. As a term, 'NHS privatisation' is so politically charged that governments – and opposition parties – routinely deny categorically that proposed reforms would amount to privatisation,[1] since this is to make 'an ideological attack on the [NHS], an attack on the founding principle of free healthcare at point of need'.[2]

Despite its prevalence at the level of activism[3] and its persistent use since the early 1980s in UK parliamentary debates, 'NHS privatisation' remains poorly understood. For example, it is often couched – crudely[4] – in terms of 'Americanisation'[5] which can overlook both clear differences between the two systems,[6] and the difficulty of modifying

1 A recent example being concerns attributed to the UK Prime Minister and former Chancellor of the Exchequer Rishi Sunak that more people seeking private treatment amounts to 'privatisation by the back door'. Isabel Hardman, 'Can Rishi Sunak heal the NHS?' *The Spectator* (London 23 July 2022). See also Labour's proposals in 2023 to make further use of private sector delivery of NHS services. Rachel Wearmouth, 'Wes Streeting: "NHS privatisation could not be further from my aims."' *New Statesman* (London 7 March 2023).

2 Jill Mountford, 'The future of the NHS – irreversible privatisation? Interview with Dr Lucy Reynolds' (2013) 346 British Medical Journal f1848.

3 See further, David I Benbow, 'Commentary: the Boy Who Cried Wolf or Cassandra? A consideration of the correct characterization of critics of neoliberal reforms to the English NHS' (2023) 53(2) International Journal of Social Determinants of Health and Health Services 239–242. For an interesting policy mobilities perspective on activism and the links with 'Americanisation', see Colin Lorne, 'Repoliticising national policy mobilities: resisting the Americanization of universal healthcare' (2022) 0(0) Environment and Planning C: Politics and Space.

4 Colin Lorne and Michael Lambert, '"Protecting the NHS" – and its limits' (2023) 2022(82) Soundings – A Journal of Politics and Culture.

5 On perceptions of US healthcare reform influence on the NHS marketisation reforms from the 1980s to the HSCA 2012 and the HCA 2022, see, respectively, L Reynolds and M McKee, 'Opening the oyster: the 2010–11 NHS reforms in England' (2012) 12(2) Clinical Medicine 128; and Peter Roderick and Allyson M Pollock, 'Dismantling the National Health Service in England' (2022) 52(4) International Journal of Health Services 470–479.

6 For comparison of the differing approaches between the US and UK healthcare systems, see S K Germain, *Justice and Profit in Health Care Law: A Comparative Analysis of the United States and the United Kingdom* (Hart 2019).

a taxation-funded model.[7] The increased prevalence of private-sector delivery of state-funded (NHS)[8] (clinical and ancillary) services since the 1980s represents a narrow definition of 'NHS privatisation', but it is arguably the most common.[9] Media coverage suggests that 'NHS privatisation' can encompass a diversity of issues, including increased interest in accessing private healthcare due to frustration with NHS waiting lists; charges for treatments not offered by the NHS; and a 'postcode lottery' for certain treatments being available in some parts of England but not others.[10] While 'NHS privatisation' can thus be anchored primarily in questions of rationing and resource allocation, further complexity arises when this is linked – implicitly or explicitly – to wider questions about health outcomes[11] and patient safety.[12]

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7 It is widely considered that 'Beveridge'-style taxation-funded healthcare systems are notoriously difficult to reform in light of the 'compact' between government and taxpayers to provide healthcare. See, for example, Ewen Speed and Jonathan Gabe, 'The reform of the English National Health Service: professional dominance, countervailing powers and the buyers' revolt' (2020) 18 Social Theory and Health 33–49.

8 The phrasing 'state-funded (NHS)' is used at various points in this article to indicate the relevance of funding to the present discussion. It can be considered that the phrase 'NHS' elides funding and the wider system which may be unhelpful in some contexts. However, it is clear across the range of sources cited – from parliamentary debates to CMA reports – that 'NHS' is frequently used as shorthand for 'state-funded', with no clear distinction being drawn between funding and the wider healthcare system.

9 Mary Guy, 'Between "going private" and "NHS privatisation": patient choice, competition reforms and the relationship between the NHS and private healthcare in England' (2019) 39(3) Legal Studies 479–498.

10 See variously, Kat Lay, 'Young go private amid frustration at NHS care' *The Times* (London 9 October 2023); Sian Elvin, 'WW2 veteran denied medication by NHS which could stop him going blind' *Metro* (London 31 July 2020); and Ella Pickover, 'World's first IVF baby calls out "postcode lottery" of care' *The Independent* (London 22 June 2022).

11 Benjamin Goodair and Aaron Reeves, 'Outsourcing healthcare services to the private sector and treatable mortality rates in England, 2013–20: an observational study of NHS privatisation' (2022) 7(7) The Lancet Public Health e638-e646.

12 The Ian Paterson case highlighted different governance approaches in the NHS and private healthcare sector. Kieran Walsh and Naomi Chambers, 'Clinical governance and the role of NHS boards: learning lessons from the case of Ian Paterson' (2017) 357 British Medical Journal j2138; Patrick Leahy, 'A private matter: why have politicians ignored private surgical standards for so long?' (2018) 100(5) The Bulletin of the Royal College of Surgeons of England 197. More recently, a *Sunday Times* investigation has indicated a range of more general concerns: S Lintern, 'You can pay for private healthcare – but can you trust it?' *Sunday Times* (London 10 September 2023).

These myriad considerations contribute to views that 'NHS privatisation' has become 'a general "boo word"' and a 'factoid'.[13] This is particularly concerning as its invocation by diverse political parties[14] belies important implications for political debate and the shaping of legislation: 'NHS privatisation' becomes key to questions concerning the extent to which decisions about resource allocation are to be juridified rather than politicised or resolved in the professional paradigm.[15]

This article makes an original contribution by examining 'NHS privatisation' in the macro level context[16] of the debates and implementation of the Health and Social Care Act 2012 (HSCA 2012) and the Health and Care Act 2022 (HCA 2022). The HSCA 2012 enacted controversial competition reforms, seen by some as a mechanism for 'NHS privatisation', especially in light of the explicit link with 1980s utilities liberalisation reforms.[17] The HCA 2022 rescinded aspects of these competition reforms and enshrined the intervening policy shift

13 Respectively, M Powell and R Miller, 'Privatizing the English National Health Service: an irregular verb?' (2013) 38(5) Journal of Health Politics, Policy and Law 1051; and S Iliffe and R Bourne, 'The myths of NHS privatisation: a commentary on factoids, policy zombies and category errors' (2021) 114(12) Journal of the Royal Society of Medicine 578.

14 An example beyond perhaps anticipated debates between Labour and Conservative MPs was found with the exchange between the former Scottish National Party leader and First Minister Nicola Sturgeon and Conservative Member of the Scottish Parliament Douglas Ross during 'First Minister's Question Time' on 24 November 2022.

15 Although beyond the scope of this article, much remains to be explored and understood about how 'NHS privatisation' and NHS–private healthcare interaction may affect the professional paradigm in a variety of senses, from distinctions between medical professionals who may, or may not, be in favour of working in the NHS, or engaging in 'dual practice' with both private and NHS patients. On the latter, see, for example, W Whittaker and S Birch, 'Provider incentives and access to dental care: evaluating NHS reforms in England' (2012) 75 Social Science and Medicine 2515–2521.

16 Implications of NHS–private healthcare interaction have also been identified with regard to the micro level of the doctor–patient relationship. See, for example, S Ost and H Biggs, *Exploitation, Ethics and Law: Violating the Ethos of the Doctor–Patient Relationship* (Routledge 2022) ch 3.

17 Chris Smyth, 'Gas and power markets are a model for the health service' *The Times* (London 25 February 2011). For more detailed interrogation of the influence of the utilities regulation model on the HSCA 2012 reforms, see Lindsay Stirton, 'Back to the future? Lessons on the pro-competitive regulation of health services' (2014) 22(2) Medical Law Review 180–199.

towards service integration. This posed the question of whether the changes would reverse or encourage 'NHS privatisation'.[18]

Juxtaposing these two pieces of legislation makes it possible to consider whether the extent of 'NHS privatisation' is changing, the mechanisms by which 'NHS privatisation' occurs, and whether this can also exist outwith the policy foci of competition and integration.

The article's starting point is to outline discussion of 'NHS privatisation' within English healthcare in general terms, and more specifically within parliamentary debates since the 1980s. This scene-setting is framed by reference to 'four categories of English healthcare' which span various aspects of the NHS and private healthcare interaction. Further context is given by the opposing visions for NHS reforms presented by the NHS Bill and the National Health Service (Co-funding and Co-payment) Bill, with the latter, but not the former, indicating connections with 'NHS privatisation'. The HSCA 2012 and the associated secondary legislation, the National Health Service (Procurement, Patient Choice and Competition) Regulations (No 2) 2013 (the 2013 Regulations) are then analysed. The apparent removal of competition law mechanisms by the policy shift to integration envisioned by the HCA 2022 and implications for 'NHS privatisation' are then examined. Finally, some concluding remarks are provided.

## DEFINING AND LOCATING 'NHS PRIVATISATION' IN ENGLISH HEALTHCARE AND UK PARLIAMENTARY DEBATES OF NHS REFORMS

It is acknowledged that 'NHS privatisation' debates are at least 'three dimensional' and concern issues of ownership, finance and regulation.[19] This would seem to situate 'NHS privatisation' within definitions found within distinct, but arguably related, strands of more general literature on public ownership and privatisation.[20] It also goes beyond the idea that 'NHS privatisation' is a debate about 'taking into private

18 See Allyson Pollock and Peter Roderick, 'If you believe in a public NHS, the new Health and Care Bill should set off alarm bells' *The Guardian* (London 7 December 2021); and Mark Dayan and Helen Buckingham, 'Will the new Health and Care Bill privatise the NHS?' (*Nuffield Trust Blog* 15 July 2021).

19 See Powell and Miller (n 13 above).

20 See, respectively, Rhys Andrews, George A Boyne and Richard M Walker, 'Dimensions of publicness and organizational performance: a review of the evidence' (2011) 21(3) Journal of Public Administration Research and Theory: Special Issue: Dimensions of Publicness and Organizational Performance 301–319; and Mislav Radic, Davide Ravasi and Kamal Munir, 'Privatization: implications of a shift from state to private ownership' (2021) 47 Journal of Management 1596–1629.

ownership'.[21] Rather, the debate about 'NHS privatisation' is instead one about the mechanism of provision, and associated accountability, which is often focused in narrow terms relating to the marketisation reforms connected with the HSCA 2012.[22]

To begin to understand 'NHS privatisation', it is necessary to consider the relationship between the NHS and private healthcare in existence since 1948. This relationship emerges as a result of a concession necessary to implement the NHS: namely, that consultants could continue private practice alongside their NHS workload, and that hospital provision would be made available for this.[23] While this has given rise to complex framings and political campaigns,[24] it also indicates a difficulty if 'NHS privatisation' is to be defined in apposition to 'nationalisation', because it prompts the question of the extent to which the NHS was ever fully nationalised.

A 'fully nationalised' health service might be considered to comprise three dimensions: state ownership of essential infrastructure; state-employed or contracted clinicians; and state determination of the scope (and price) of the services provided. Already at the inception of the NHS in 1948 each of these three dimensions appears challenged by the aforementioned underlying NHS–private healthcare interaction, as well as the independent status of general practitioners (GPs).

It would therefore follow that any development which did not serve to 'complete' the nationalisation of the health service could be criticised as 'privatisation' of the NHS. Indeed, far from 'completing' the nationalisation of the NHS, the focus has been instead on managing the contradiction and conflicts posed by the coexistence of state-funded (NHS) and private healthcare. This can be seen in two main ways.

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21 The limited experiment with franchising may be the nearest development to this with the notable example being the short-lived private management of an NHS hospital in Cambridgeshire. 'Hinchingbrooke Hospital asks for £9.6m bailout as Circle withdraws' (*BBC News* 10 February 2015). For further discussion, see Peter Scourfield, 'Squaring the Circle: what can be learned from the Hinchingbrooke franchise fiasco?' (2015) 36(1) Critical Social Policy 142–152.

22 Benbow (n 3 above) relies on a definition of privatisation attributed to the World Health Organization in 1995: 'a process in which nongovernmental actors become increasingly involved in the financing and/or provision of healthcare services'. Jeff Muschell, *Health Economics Technical Briefing Note: Privatization in Health* (World Health Organization 1995) 3. However, it should be noted that the very next sentence of Muschell's text reads 'A distinction should be made between the process of privatization and the public/private mix in the health sector', thus underscoring the difficulty of adopting a narrow definition.

23 See, specifically, ss 5 and 6 National Health Service Act 1946.

24 Notably the distinction between 'NHS amenity beds' and 'NHS pay-beds'. See Aneurin Bevan, 'A free health service' in Aneurin Bevan, *In Place of Fear* (Quartet Books 1978) ch 5; and specifically on the latter, 'Hospital pay beds', HC Deb 5 May 1975, vol 891 cols 1084–1149.

Firstly, by the levying of prescription and other charges ('co-payments') being permitted.[25] Secondly, and in contrast, by the prohibition on 'co-funding', which has long circumscribed the scope for combining state-funded (NHS) and private healthcare to avoid (even perceptions of) the NHS subsidising private healthcare.[26] However, this approach has evolved over time to enable, for example, 'top-up' payments for cancer drugs.[27]

Nevertheless, 'NHS privatisation' – as a distinct phrase, or even concept – is more recent. The first UK parliamentary record we find of the term 'NHS privatisation' in England relates to the outsourcing of cleaning services in 1984.[28] While this may seem to indicate a link with the wider privatisation reforms by the Conservative Governments of the 1980s, we also see references to 'privatisation' of the NHS emerging in connection with charges being levied for specific services.[29]

## Locating 'NHS privatisation' within English healthcare

While it may seem intuitive to link 'NHS privatisation' with the competition reforms from the NHS internal market of the late 1980s onwards, it is useful to recall how the fundamental separation of purchasing and providing functions makes this possible. The combination of NHS–private healthcare interaction and the separation of purchasing and providing functions can be illustrated by reference to 'four categories', thus:[30]

25 Department of Health, 'Guidance on NHS patients who wish to pay for additional private care' (23 March 2009); NHS Commissioning Board (now NHS England), 'Commissioning policy: defining the boundaries between NHS and private healthcare' (NHSCB/CP/12, April 2013).

26 Department of Health (n 25 above).

27 Ibid para 4.2; and Mike Richards, *Improving Access to Medicines for NHS Patients* (Department of Health 2008). For discussion, see E Jackson, 'Top-up payments for expensive cancer drugs: rationing, fairness and the NHS' (2010) 73(3) Modern Law Review 399; K Syrett, 'Mixing private and public treatment in the UK's National Health Service: a challenge to core constitutional principles?' (2010) 17 European Journal of Health Law 235.

28 In comments by the Labour MP Jeremy Corbyn, 'National Health Service (privatisation)', HC Deb 21 December 1984, vol 70, cols 686–694. It appeared earlier with regard to Scotland in a question by Dennis Canavan while a Labour MP in 1983: 'NHS (privatisation)', HC Deb 13 May 1983, vol 42, col 549W.

29 For example, 'National Health Service', HC Deb 21 October 1991, vol 196, col 662.

30 See further, for example, Mary Guy, *Competition Policy in Healthcare – Frontiers in Insurance-Based and Taxation-Funded Systems* (Intersentia 2019).

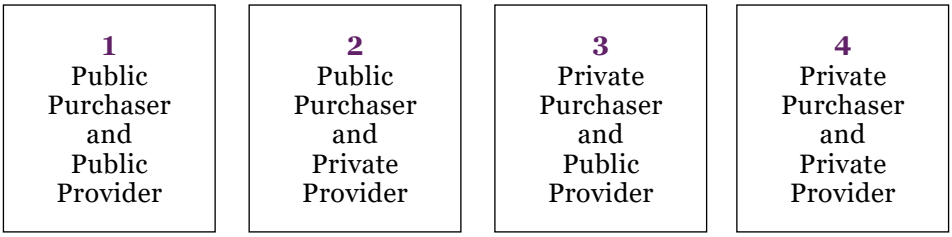


*Figure 1: Relationship between the NHS and private healthcare sectors as demonstrated by the purchaser/provider separation.*

As two extremes, category 1 encapsulates the situation where NHS patients are treated by NHS bodies (eg NHS Trusts or NHS Foundation Trusts), and category 4 the situation where private patients are treated by private providers.

A shift between categories 1 and 4 may seem to be properly described as 'privatisation', and the reverse as 'nationalisation'. This language, however, does not well account for categories 2 and 3. Certainly categories 2 and 3 represent different understandings of 'NHS privatisation', comprising respectively, the outsourcing of state-funded (NHS) services to private providers (category 2) and the private provision of services and treatments by the NHS, most recently via private patient units (category 3). Thus the New Labour choice and competition reforms, which combined the expanding recourse to private providers with patient choice policies (category 2 activity), often underpins claims of 'NHS privatisation'. In contrast, the development of the private healthcare market contemporaneously[31] with the HSCA 2012 reforms which included removal of the private patient income cap[32] (enabling more category 3 activity) appears to have received less attention. The ability to distinguish categories 2 and 3 in this way demonstrates that there is no clear sense that these link to each other, nor that they point directly towards an expansion of category 4.

## Locating and defining 'NHS privatisation' within UK parliamentary debates of NHS reforms in England

While 'NHS privatisation' can be understood as a broadly open-ended criticism of various dimensions of NHS–private healthcare interaction, some attempt at clarification is evident in parliamentary debates. This is because, broadly speaking, the two main political parties – Labour and the Conservatives – have both had to contend with the underlying NHS–private healthcare relationship while needing to differentiate

31 CMA, *Private Healthcare Market Investigation Final Report* (CMA25 2 April 2014).

32 S 165 HSCA 2012. This was anticipated to enable an expansion of private patient units.

their approaches to it. Thus we have seen claims by Conservative Members of Parliament (MPs) that Aneurin Bevan, by introducing charges for prescription and dental services, may have been the father of 'NHS privatisation',[33] and that Labour introduced more 'NHS privatisation' than the Conservatives.[34] In contrast, New Labour MPs in particular have attempted more nuance: 'NHS privatisation' is not 'commercialisation' or 'market mechanisms', but it is the 'bad competition' found in connection with United States (US) healthcare.[35]

An explanation for the sense of lack of inevitability in any process of 'NHS privatisation', and indeed arguably circular criticisms between the Labour and Conservative parties, may be attributed to theories of 'path dependency', which have been used to analyse the marketisation reforms from the mid-1980s, and more generally explain why healthcare system reform is so difficult.[36] Path dependency may also go a long way to explaining the limited evolution of the underlying NHS–private healthcare interaction in view of relatively stable governments, albeit with political shifts between Labour and the Conservatives.[37] Thus the stability of the New Labour Government, particularly in 1997, could in theory have heralded a decisive reformulation of the interaction between the NHS and private healthcare, and certainly a move away

33 See comments by the Conservative MP William Waldegrave, indicating the heated debates between Labour and the Conservatives regarding nascent marketisation reforms in the 1980s, HC Deb 21 October 1991, vol, 196 col 662: 'Let us examine some of the new definitions [of "privatisation"]. One line is that having charges for some items of service in the NHS is privatisation. In that case, the very founder of the NHS invented privatisation. It was Aneurin Bevan who passed the legislation for prescription charges, and it was a Labour Government who introduced charges for teeth and spectacles.'

34 See, for example, debates on NHS pay: HC Deb 13 September 2017, vol 628. The then Conservative MP Anna Soubry asked for confirmation that Labour 'privatisation' amounted to 5%, whereas the 'privatisation' under the Conservatives was 1%. This was responded to with a discussion of the distinction between GPs and pharmacists (as private enterprises), and other kinds of private-sector involvement in delivering NHS services.

35 With the Labour MP Ben Bradshaw responding to connections drawn by the Independent MP Dr Richard Taylor between the New Labour reforms and those of the NHS internal market: HC Deb 24 February 2009, vol 488, col 66WH.

36 D Wilsford, 'Path dependency, or why history makes it difficult, but not impossible to reform health care systems in a big way' (1994) 14(3) Journal of Public Policy 251–283. I Greener, 'Understanding NHS reform: the policy-transfer, social learning, and path-dependency perspectives' (2002) 15(2) Governance: An International Journal of Policy, Administration, and Institutions 161–183. See also G Bevan and R Robinson, 'The interplay between economic and political logics: path dependency in health care in England' (2005) 30(1–2) Journal of Health Politics, Policy and Law 53–78.

37 M Guy, '(How) is COVID-19 reframing interaction between the NHS and private healthcare?' (2023) 23(2) Medical Law International 138–158.

from the market reforms of the previous Conservative Governments, but did not.[38]

In order to locate – and thus attempt to assess the type and extent of – 'NHS privatisation' in the HSCA 2012 and HCA 2022, it is useful to briefly consider two Private Members' Bills which offer wildly opposing visions for NHS reform.

The National Health Service Bill[39] was initially introduced by the Green MP Caroline Lucas, during the 2014–2015 and the 2015–2016 parliamentary sessions before being reintroduced subsequently by the Labour MPs Margaret Greenwood, in the 2016–2017 parliamentary session, and Eleanor Smith during the 2017–2019 parliamentary session. This Bill articulated a vision of the NHS reminiscent of how it existed prior to the 1980s, with a more centralised structure and greater ministerial oversight, and attempting to situate the NHS as a public service completely exempt from European Union (EU) law and World Trade Organization rules.[40] As such, the NHS Bill might be seen as firmly within category 1, and also the nearest attempt to 'complete' the nationalisation of the health service, thus, would be expected to avoid any suggestion of 'NHS privatisation'.

In contrast, the National Health Service (Co-funding and Co-payment) Bill was introduced by the Conservative MP Sir Christopher Chope in almost every parliamentary session between 2017 and 2023. This Bill aimed to relax the prohibition on co-funding, and expand co-payment which would have the effect of facilitating access to private healthcare for NHS patients and enabling more out-of-pocket expenses to be levied. Whether this might be cast in terms of an expansion of category 4 is moot, but it might certainly be expected to invite criticisms of 'NHS privatisation'.

A striking common feature of both Bills is their failure to gain traction: neither progressed to a second reading, let alone committee debates. Of course this may be explained in part by prioritising of parliamentary business and technicalities regarding the status of Private Members' Bills. However, this merely underscores the apparent unwillingness of government to engage with radical NHS reform – be this seemingly further towards, or away from, claims of 'NHS privatisation'.

The HSCA 2012 and the HCA 2022 then start to assume a middle ground between the NHS Bill and the National Health Service (Co-funding and Co-payment) Bill. This is because neither can be said to advocate for either a radical rejection, or embrace, of 'NHS

38 Path dependency may also explain the current approaches being taken by the Sunak Government and the Labour Party under Sir Keir Starmer's leadership.

39 Also known as the NHS (Reinstatement) Bill.

40 Although beyond the scope of this article, it can be noted here that even category 1 activity would not necessarily be considered so exempt.

privatisation', but nevertheless involve aspects which, to varying degrees, are subsumed within definitions of 'NHS privatisation'. By juxtaposing the NHS and National Health Service (Co-funding and Co-payment) Bills it thus becomes possible to frame and attempt to assess the extent and evolution of 'NHS privatisation' within the HSCA 2012 and HCA 2022 accordingly.

## COMPETITION AND 'NHS PRIVATISATION': THE EXPERIENCE OF THE HSCA 2012

The HSCA 2012 competition reforms comprised three convoluted dimensions: the reduction of ministerial oversight via the involvement of the Competition and Markets Authority (CMA) and the establishment of NHS England and Monitor/NHS Improvement; enshrinement by the 2013 Regulations of the New Labour choice and competition reforms; and an attempt to align competition regulation in the NHS with the experience of other sectors. This was intended to reflect the 1980s utilities liberalisations via economic regulation and a licensing regime as enforcement mechanisms. All three – individually as well as in combination – indicate a fertile environment for claims of 'NHS privatisation', based on the wide-ranging definitions identified above, and unsurprisingly the ambition of the initial White Paper[41] met with a range of sceptical responses.[42] Furthermore, the introduction of primary legislation with the seeming intention of making the market in the NHS 'more real'[43] further underscored scope for 'NHS privatisation' to be seen as an inevitable process, a setting in train of an irreversible direction.[44]

Thus, scope for a disruptive, detrimental influence might be inferred from the HSCA 2012 being subject to a lengthy passage through

41 Department of Health, 'Equity and excellence: liberating the NHS' (Cm 7881 July 2010).

42 Including from the former Prime Minister, David Cameron, who is quoted as saying: 'It was like an artist unveiling a piece he'd spent years on, and everyone wondering what on earth it was.' Alistair McLellan, 'The bedpan: David Cameron's autobiography' *Health Service Journal* (London 20 September 2019).

43 A C L Davies, 'This time, it's for real' (2013) 76(3) Modern Law Review 564–588.

44 Ibid and further on the 'juridification' of these reforms see the various subsequent responses to Davies' article. Dorota Osipovič, Pauline Allen, Marie Sanderson, Valerie Moran and Kath Checkland, 'The regulation of competition and procurement in the National Health Service 2015–2018: enduring hierarchical control and the limits of juridification' (2019) 15(3) Health Economics, Policy and Law 308–324; David Benbow, 'Juridification, new constitutionalism and market reforms to the English NHS' (2019) 43(2) Capital and Class 293–313; Mary Guy, 'Dealing with "unworkable ideas in primary legislation": juridifying and dejuridifying competition in the English National Health Service' (2023) Public Law 57–80.

Parliament (January 2011–March 2012), and the recollection that the Conservative/Liberal Democrat Coalition Government was obliged to pause the passage of the Health and Social Care Bill and conduct a 'listening exercise' in the spring and early summer of 2011 to engage with the concerns which arose, particularly in connection with the 'choice and competition' aspects.[45]

Concerns about 'NHS privatisation' were dismissed in this context by the Clinical Forum of the NHS Confederation Partners Network taking the view that the proportion of NHS work carried out by private providers would be unlikely to change.[46] This 'listening exercise' concluded with a report by the specially constituted NHS Future Forum, which led to notable amendments and an apparent scaling-back of the Coalition Government's ambitions. Two examples are the reconfiguring of the role for Monitor (subsequently NHS Improvement) as no longer 'promoting competition', but rather 'preventing anti-competitive behaviour',[47] and the wider refocusing of competition away from price competition to competition on quality. In the Coalition Government's response to this report, a further important concession was made, namely to enshrine existing New Labour policy guidance on choice and competition rather than design new rules.[48] Further amendments were made to the competition provisions of the HSCA 2012 when debates reconvened, right up to enactment.[49] It is therefore possible to consider separately how 'NHS privatisation' featured in the debates of the Health and Social Care Bill, and how it was in evidence in the implementation of the HSCA 2012.

## 'NHS privatisation' and Health and Social Care Bill debates

We find references to 'NHS privatisation' featuring particularly in the Commons debates preceding the NHS Future Forum report, as well as in the Lords debates subsequently. At least three aspects of 'NHS privatisation' can be identified.

### *'NHS privatisation' as a general and vague concept*

This framing contributes to the representation of 'NHS privatisation' as something to be avoided, and therefore something which is distinct from what the Health and Social Care Bill set out to do, in

45 NHS Future Forum, *Choice and Competition – Delivering Real Choice* (NHS Future Forum June 2011).

46 Ibid 6. The report further notes that this network represented some 45,000 clinicians carrying out NHS work from the independent sector.

47 S 62(3) HSCA 2012.

48 Department of Health, 'Government response to the NHS Future Forum report' (CM8113, 22 June 2011) 44, para 5.16 .

49 For detailed examination of these, see Guy (n 30 above).

a manner reminiscent of the defensiveness surrounding New Labour reforms.[50] Thus, at various stages across the Health and Social Care Bill's passage, we see distinctions such as '[e]xtending choice and increasing competition is not about privatisation'.[51] We also see long-standing inconsistencies being highlighted – for example, that general practice has been essentially a privately run, profit-making activity since 1948 yet never seen as incompatible with NHS principles.[52] In a similar vein, companies partly or wholly owned by the Secretary of State and established to provide services or facilities to persons exercising functions under the National Health Service Act 2006 (such as NHS Professionals or Dr Foster Intelligence) are not a 'prelude to privatisation', but a means of allowing private-sector investment and expertise to be brought in as required.[53]

Attempts at further clarification are seen in consideration of conflicts of interest for the (then) new Clinical Commissioning Groups (CCGs), with the concern that:

> the entire commissioning function will be contracted out over time to private companies and there will be no proper scrutiny or accountability.[54]

This led to further discussion of the operation of private providers more generally, but also eventually to clarification of how to manage conflicts of interest within CCGs, for instance between financial interests of being a director or shareholder of a private company, and conducting clinical private practice.[55]

### *'NHS privatisation' as a process*

There is a continuing sense from parliamentary debates of 'NHS privatisation' being a process, albeit with indistinct start and end points. For example, the New Labour policies of developing NHS Foundation Trusts (to have greater autonomy from central government) and expanding private-sector delivery of state-funded (NHS) services had been accepted. In the early stages of the Health and Social Care Bill, however, once concern was that enshrinement of these policies would amount to '[holding] the door open for the vandals who are now

50 See n 35 above.

51 See comments by Earl Howe in the 12th Sitting: HL Deb 13 December 2011, col 1144.

52 See comments by Professor Chris Ham, PBC Deb (Bill 132) 9 February 2011, col 42.

53 See comments by Simon Burns MP, PBC Deb (Bill 132) 1 April 2011, col 1277.

54 See comments by Grahame Morris MP, PBC Deb (Bill 132) 9 March 2011, col 564.

55 Initially published in 2013, then updated: NHS England, 'Managing Conflicts of Interest: Revised Statutory Guidance for CCGs' (2017).

marching through [and leading to] wholesale de facto privatisation'.[56] Later stages of the Health and Social Care Bill saw additional facets of 'NHS privatisation' being elaborated, with the emphasis on NHS Foundation Trusts treated in essence as private entities, subject to failure regimes.[57]

The idea of 'NHS privatisation' as a process gained further momentum, and even consolidation, with discussion of the applicability of 'competition law':[58]

> No-one is suggesting that the Bill instantly leads to the privatisation of the NHS. What it does, however, is lay the foundations for gradual, creeping erosion of the public provision of NHS services and allows a challenge to the NHS by private providers, through the opening up under competition law.[59]

A further dimension to this was added by linking questions of applicability of *EU* (as distinct from *UK*) competition law:[60]

> If the full weight of EU competition law applied to the NHS, as if it were a standard service industry, the process of privatisation, which Opposition members are concerned about and the Government have indicated that they are opposed to, could not only be accelerated but might become entirely irreversible.[61]

While a range of general questions were asked about whether the proposals would expose the NHS to EU competition law, more concrete concerns were articulated in terms of cross-subsidy in the context of private patient units in NHS hospitals and the implications of this in connection with the EU state aid rules.[62]

Writing in 2023, with the benefit of hindsight post-Brexit, it is striking how concerns about EU-level influence over the English NHS were manifest in the Health and Social Care Bill debates given these now appear overstated.[63]

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56 See comments by Owen Smith MP, PBC Deb (Bill 132) 15 February 2011, col 232.

57 See comments by Derek Twigg MP, PBC Deb (Bill 132) 24 March 2011, col 1009.

58 It can be noted that 'competition law' as used by MPs appears to conflate the distinct aspects of procurement and competition (if understood eg as the prohibitions on anti-competitive agreements and abuse of dominance).

59 See comments by Owen Smith MP, PBC Deb (Bill 132) 15 March 2011, col 755.

60 See further on the effects of EU competition law on the HSCA 2012 reforms more generally, Guy (n 44 above).

61 See comments by Grahame Morris MP, PBC Deb (Bill 132) 17 March 2011, col 864.

62 See comments by Grahame Morris MP, PBC Deb (Bill 132) 24 March 2011, col 1084.

63 See Guy (n 44 above).

*'NHS privatisation': connections with utilities liberalisation?*

These concerns were initially seen in Monitor/NHS Improvement being reconceptualised as an 'economic regulator' (akin to OFCOM or OFGEM) with a duty to 'promote competition',[64] and a shared competence with the CMA, *inter alia*, to apply competition law.[65] The connection between the two was highlighted by Monitor/NHS Improvement's role[66] and led to statements such as 'Healthcare should not be treated in the same way as the privatised utilities', with distinctions being drawn between the two.[67] Further examinations led to the suggestion that 'giving Monitor concurrent powers[68] to the Office of Fair Trading [now the CMA] opens the gateway to wholesale privatisation'.[69]

It is also useful to note that these amendments did not mark the end of controversy surrounding the HSCA 2012 competition reforms, with further concerns emerging about the associated secondary legislation (the National Health Service (Procurement, Patient Choice and Competition) Regulations (No 2) 2013), which similarly reflected the sense of vagueness and process attaching to 'NHS privatisation'. These regulations raised claims of 'NHS privatisation' via the view that they required mandatory tendering of all services.[70] What emerges from the Lords debates of the 2013 Regulations appears to be that provision (whether by NHS or private providers) is a characteristic feature of 'NHS privatisation'. This may explain the divergence of opinion – among charities and professional associations, as well as parliamentarians – about whether the 2013 Regulations would lead

64 Following the NHS Future Forum report and the recommendations to refocus competition within the Health and Social Care Bill, Monitor's status was redesignated as a 'sectoral regulator', and, as noted previously, its focus confined to 'preventing anticompetitive behaviour'. See further on these changes, Guy (n 30 above).

65 Outside the scope of the parliamentary debates, it can further be seen in the development of a licensing regime for providers delivering state-funded (NHS) services – again, in reflection of other sectors. For a good overview of the comparisons and contrasts – and a suitable urging of caution – see Stirton (n 17 above).

66 See comments by Liz Kendall MP, PBC Deb (Bill 132) 15 March 2011, col 690.

67 See comments, *inter alia*, by Karl Turner MP, PBC Deb (Bill 132) 16 March, 2011 col 730.

68 In essence, a shared competence.

69 See comments by Karl Turner MP, PBC Deb (Bill 132) 17 March 2011, col 868. Although beyond the scope of the present discussion, such references to economic regulation and competition can again be interpreted as conflating distinctions which are drawn elsewhere regarding economic governance and law (eg between different aspects of competition, such as price-setting, and procurement activity).

70 See comments by Lord Clement-Jones, HL Deb 24 April 2013 vol 744, col 1483.

to 'NHS privatisation'.[71] However, a strikingly different view of 'NHS privatisation' – based on funding, rather than provision – was found in the citing of Care Quality Commission feedback of 'the best NHS experience I have ever had in my life' being unpacked to clarify that the patient had been unaware that the NHS service had been delivered by a private provider.[72] This led to the conclusion:

> So privatisation is not about the provider; it is about reaching into your wallet to pay for the service for which the state should pay. That is the fundamental ethic of the NHS.[73]

## How did implementation of the HSCA 2012 reforms affect 'NHS privatisation'?

The extent to which the HSCA 2012 reforms can be said to have facilitated 'NHS privatisation' is moot. Claims of 'NHS privatisation' could, for example, attach to concerns about conflicts of interest within the membership of CCG boards. These conflicts emerge in view of the procurement functions of CCGs and the involvement of private companies delivering CCG-commissioned care, such as community services.[74] Other concerns about 'NHS privatisation' relate to the structural changes to the NHS oversight landscape with the incorporation of bodies such as the CMA and Monitor/NHS Improvement in view of questions of applicability of competition law and the UK general merger control regime. Certainly, what emerged was either an ambivalence about, or even lack of, enforcement activity regarding the competition provisions, which suggested that the fear of putting in place structural prerequisites to deliver expansion of 'NHS privatisation' have proven unfounded.

With regard to the competition law provisions[75] it was thought at the time of the Health and Social Care Bill that, once competition law

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71 See comments by the cross-bench life peer, Lord Walton of Detchant, HL Deb 24 April 2013, vol 744, col 1495.

72 See comments by Baroness Cumberledge, HL Deb 24 April 2013, vol 744, col 1503.

73 Ibid.

74 This has been considered in various literature. See, for example, National Audit Office, 'Managing conflicts of interest in NHS clinical commissioning groups' (11 September 2015); Valerie Moran et al, 'How are clinical commissioning groups managing conflicts of interest under primary care co-commissioning in England? A qualitative analysis' (2017) 7 British Medical Journal Open e018422.

75 That is, the prohibitions on anticompetitive agreements and abuse of dominance, as distinct from the public procurement rules.

was confirmed to be applicable, it would increasingly be applied.[76] The passage of time and non-enforcement led to considerations that applicability is a largely theoretical question distinct from actual *application*, which might be inhibited by various factors, including prioritisation of CMA workload, and the political sensitivities which could have attached to competition law cases involving the NHS.[77] Ongoing controversy and sensitivity about the HSCA 2012 reforms also offer an explanation for the institutional enforcement void left by the *de facto* reclassification of Monitor/NHS Improvement as separate from regulators such as OFCOM and OFGEM,[78] and the removal of CMA oversight[79] amid wider review of the UK competition landscape.[80] Ongoing controversy can also explain limited recourse to the 2013 Regulations, together with the consideration that these did not add anything to the general procurement regime.[81]

Arguably, the most visible activity to emerge from the HSCA 2012 reforms was assessment of NHS Trust and Foundation Trust mergers between 2013 and 2020. If a merger was felt to substantially lessen competition, it could proceed only if 'relevant patient benefits' were identified by Monitor/NHS Improvement before determination by the CMA. This merger assessment approach of section 79 HSCA 2012 received surprisingly little attention in the Health and Social Care Bill debates, but was intended primarily to facilitate NHS Trusts establishing themselves as NHS Foundation Trusts with greater autonomy from central government. This suggests primarily concerns regarding accountability which feature less amid claims of 'NHS privatisation'. These NHS Foundation Trust mergers were assessed

76 O Odudu, 'Are state-owned healthcare providers undertakings subject to competition law?' (2011) 32(5) European Competition Law Review 231. This article was cited by Davies (n 43 above) to underscore concerns about accountability with regard to the involvement of bodies such as the CMA. However, it can be noted that the possibility of private enforcement of competition law via the courts did not receive much attention at this point.

77 See further Guy (n 30 above).

78 Ibid 135–139.

79 While theoretically this modification did not affect the conducting of market investigations under s 83 HSCA 2012, the lack of recourse to this can arguably be attributed to the ongoing controversy.

80 Via the Enterprise and Regulatory Reform Act 2013 and the associated Competition Act 1998 (Concurrency) Regulations 2014.

81 S Smith, E Heard and D Bevan, 'New procurement legislation for English healthcare bodies – the National Health Service (Procurement, Patient Choice and Competition) (No 2) Regulations 2013' (2013) 4 Public Procurement Law Review 109.

between 2013 and 2020,[82] although the shift in policy towards integration might explain the CMA questioning the role ascribed to it in the 2017 Manchester Hospitals merger:[83]

> Competition in the NHS is only one of a number of factors which influence the quality of services for patients and we have found in this inquiry that it is not the basic organising principle for the provision of NHS services. More important are considerations such as the increasing demand for NHS services and greater degree of clinical specialisation being sought, and the regulatory, policy, and financial context within which such services are provided.

Taking together the varying implementation of the competition law and merger control provisions of the HSCA 2012, it might be considered that the structural prerequisites for expanding 'NHS privatisation' did not materialise as had been feared. This also highlights a notable disconnect between legislative frameworks and policy shifts which may offer insights for current and future implementation of the HCA 2022.

## INTEGRATION AND 'NHS PRIVATISATION': THE EXPERIENCE OF THE HCA 2022

The shift in NHS policy focus away from competition and towards integration can be traced to approximately 2015, and solidified with the 2019 NHS Long-Term Plan (NHS LTP), which outlined legislative proposals for repealing the HSCA 2012 reforms since these were seen as inhibiting the policy shift. Presenting competition and integration as opposites is a false dichotomy,[84] but emphasis on more collaborative

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82 A period bookended by mergers involving the same hospital, with the first merger being banned, and the second approved. Competition Commission, *Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust/Poole Hospital NHS Foundation Trust Merger Inquiry* (Competition Commission 17 October 2013); *Anticipated Merger between The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust and Poole Hospital NHS Foundation Trust Decision on Relevant Merger Situation and Substantial Lessening of Competition* (CMA, ME/6875-19 27 April 2020).

83 CMA, *Central Manchester University Hospitals/University Hospital of South Manchester Merger Inquiry Final Report* (1 August 2017) 2, para 7.

84 Reforms in Dutch healthcare indicate that it is possible to incorporate aspects of both competition and integration, and the Dutch competition authority has produced guidance on how and why competition law may not be applicable to partnerships and collaborations: The Netherlands Authority for Consumers and Markets (ACM), ACM Policy Rule on arrangements as part of the movement called 'The right care in the right place' Case no ACM/19/034968, Document no ACM/UIT/524798. See further, Mary Guy, 'Rethinking competition in healthcare – reflections from a small island' (2021) (*Competition Policy International Antitrust Chronicle* May 2021).

forms of working has been welcomed.[85] The 2019 NHS LTP thus consolidated the shift in NHS policy towards 'triple integration' between primary and secondary care, the NHS and social care, and mental and physical health, which has evolved into the enshrinement of integrated care systems (ICS) across England by the HCA 2022.[86]

While neither the 2019 NHS LTP, nor the subsequent policy documents relating to its implementation[87] explicitly reference 'NHS privatisation' as a motivation, we see some related features. For example, the NHS LTP seemed to reaffirm a previous distinction between 'bad' and 'good' competition insofar as it envisaged, respectively, the removal of the 'counterproductive effect' of the HSCA 2012 reforms (specifically the CMA's oversight role and NHS Improvement's competition powers) on the one hand, but on the other hand, the retention of the CMA's 'critical investigations work in tackling abuses and anti-competitive behaviour in health-related markets such as the supply of drugs to the NHS'.[88]

In contrast, the outlining of legislative proposals to support the move towards ICS in the 2019 NHS LTP generated concerns in parliamentary debates about 'NHS privatisation' regarding the scope for integrated care provider (ICP) contracts to be awarded to private providers.[89] The concerns reflected apparent inconsistencies between concessions made to the Health and Social Care Committee, that '[t]o privatise in the sense of handing over the assets and staff to a private contractor is a theoretical possibility',[90] and the Secretary of State's denial of 'NHS privatisation' taking place. This was further complicated by the inhibiting effect of the HSCA 2012 competition framework on this transition to a very different system of care models, with acknowledgment that the combined effects of the HSCA 2012, the 2013 Regulations and procurement rules meant that it was not effectively within the Secretary of State's gift to categorically rule out

85 Marie Sanderson, Pauline Allen, Dorota Osipovič, Christina Petsoulas, Olga Boiko and Colin Lorne, 'Developing architecture of system management in the English NHS: evidence from a qualitative study of three integrated care systems' (2023) 13(2) British Medical Journal Open e06599.

86 For a brief overview, see NHS England, 'The journey to integrated care systems in every area'.

87 Health and Social Care Committee, *NHS Long-Term Plan: Legislative Proposals* (HC 2017-19, 15).

88 NHS England, The NHS Long Term Plan, January 2019.

89 See comments, *inter alia*, by the MPs Stephen Hammond and Jonathan Ashworth. 'NHS 10-Year Plan', HC Deb 19 February 2019, vol 654.

90 By Nigel Edwards (then Chief Executive of the Nuffield Trust), cited by Jonathan Ashworth MP in a debate on 'Integrated Care Regulations': HC Deb 18 March 2019, vol 656, col 871.

concerns about 'NHS privatisation' in light of long-term and high-value contracts.[91]

In the move from the NHS LTP to the White Paper[92] preceding the HCA 2022, the proposals were characterised as amounting to 'deregulation, not demarketisation'.[93] Where 'demarketisation' might suggest a removal of markets[94] and thus a lessening of concerns about 'NHS privatisation', 'deregulation' seemed to imply removal of clear oversight mechanisms, while the underlying market aspects (such as the recasting of the purchaser/provider separation in combination with the interaction between the NHS and private healthcare) remain intact. This has led to concerns being raised both with regard to competition[95] and procurement[96] frameworks.

A further point to note about the NHS LTP proposals is that these were drafted by NHS England, and made no mention of plans to reincorporate Secretary of State oversight, merely the amendment of CMA oversight and refocusing of NHS Improvement's role.[97] Reincorporation of ministerial oversight – including with regard to mergers and procurement – was added to the White Paper by the then Secretary of State for Health Matt Hancock MP, and was retained by his successor Sajid Javid MP during the passage of the Health and Care Bill.

As with the HSCA 2012 reforms, it is possible to consider how 'NHS privatisation' featured in the debates preceding the Health and Care Act 2022 and in the implementation to date of the legislation.

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91 Ibid col 872.

92 Department of Health and Social Care, 'Integration and innovation: working together to improve health and social care for all' (11 February 2021).

93 Health and Social Care Committee (n 87 above) 16, citing written evidence by Andrew Taylor, former Director of the Cooperation and Competition Panel for NHS-funded Services.

94 Which had been implicit in earlier attempts to repeal the HSCA 2012 competition reforms, notably the National Health Service (Amended Duties and Powers) Bill, as well as the aforementioned NHS Bill. See further, Mary Guy, 'Demarketisation, deregulation, dejuridification: removing competition from the English NHS with the Health and Care Bill' (Lancaster University Law School Working Paper September 2021).

95 Ibid. See also Okeoghene Odudu and Catherine Davies, 'Enforcing competition law in the English Healthcare System' (2021) (*Competition Policy International Antitrust Chronicle* May 2021).

96 Albert Sánchez Graells, 'Are there any gains to be had from the proposed new provider selection model for NHS commissioning?' (*University of Bristol Law School Blog* 23 August 2021).

97 S 33 HCA 2022 provides for the abolition of Monitor/NHS Improvement and the incorporation of its functions into NHS England.

## 'NHS privatisation' and the debates of the Health and Care Bill

In the debates of the Health and Care Bill, we saw consideration of the current wider-ranging nature of concerns, such as the scope for 'privatisation' to be extended via reciprocal healthcare access agreements post-Brexit,[98] and the effects of significant changes in England on Welsh healthcare.[99] 'NHS privatisation' is further identified in aspects as diverse as private equity companies in the care sector and the NHS paying twice (for research and for procurement).

With regard specifically to the development of integrated care, the narratives surrounding 'NHS privatisation' might be seen primarily in terms of concerns about the effects of private activity (including on reduced scope for training of future clinicians, as well as on the ability of private providers to exit NHS service delivery after two years with limited accountability),[100] and questions of accountability and 'who runs the NHS'. Significant discussion focused on attempted amendments to restrict private provider representation on the new integrated care boards (ICBs) in view of the inherent conflict of interest this can generate, and the need for private providers to be paid at the NHS tariff (now re-cast as the 'NHS payment scheme')[101] to avoid suggestions of price competition.[102] The former concern has received limited acknowledgment in instructions about the constitution of ICBs:

> The constitution must prohibit a person from appointing someone as a member ('the candidate') if they consider that the appointment could reasonably be regarded as undermining the independence of the health service because of the candidate's involvement with the private healthcare sector or otherwise.[103]

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98 See comments by Dr Phillippa Whitford during PBC Deb (Bill 140) 26 October 2021, col 642, and by Lord Sharkey during HL Deb 7 March 2022, vol 819, col 1164.

99 See comments by Hywel Williams MP during PBC Deb (Bill 140) 21 September 2021, cols 319–320. These concerns have been given more concrete form recently by the Minister for Health and Social Services, Eluned Morgan MS, proposing new legislation regarding procurement in connection with the Welsh NHS. See the Senedd Health and Social Care Committee, Health Service Procurement (Wales) Bill: Stage 1 Report, April 2023.

100 See comments by Dr Chaand Nagpaul during PBC Deb (Bill 140) 9 September 2021, cols 89, 95.

101 S 77 HCA 2022.

102 See comments by Edward Argar MP during PBC Deb (Bill 140) 23 September 2021, col 452.

103 See sch 2 HCA 2022, s 1 amendments to the NHS Act 2006 relating to 'Membership' and also identical wording to prohibit appointment to the ICB under 'Arrangements for discharging functions'.

It is striking that the growing attention paid to the complexity of governance and regulatory arrangements may in itself provide a further dimension to what is understood by 'NHS privatisation'. This might be inferred from comments by Lord Davies of Brixton in highlighting the disconnect between governmental promises to avoid 'NHS privatisation' and concerns about increasing numbers of US-owned private companies[104] delivering services for the NHS:

> Even with the amendments to limit private companies being represented on integrated care boards, there is absolutely nothing here to stop private companies playing a part in other ways – for instance, clearly at the sub-system level via place-based partnerships and provider collaboratives. There is this whole word salad of different ways of describing these organisations operating at that level below, for or with the integrated care boards in providing services. This is the Trojan horse that will bring private provision within the walls of our publicly-provided NHS.[105]

This additional dimension to concerns about 'NHS privatisation' is exacerbated by the lack of certainty offered by the HCA 2022 changes regarding the new Secretary of State oversight powers, as noted by Lord Hunt:

> It seems rather extraordinary that we are taking out the marketisation sections from current legislation only to replace them with an open-ended power and a procurement regime when we simply do not know what it will be.[106]

Outside the focus of integrated care, there are ongoing developments regarding wider aspects of 'NHS privatisation'. A notable example is longer-standing concerns about availability of state-funded (NHS) services, particularly dentistry, and how markets are created as more people 'go private' and take out dental insurance: 'This is what privatisation looks like.'[107] While this latter example appears not to find express recognition in the HCA 2022, there has been notable discussion relating to patient movement between the NHS and private healthcare – which is arguably less commonly acknowledged as 'NHS privatisation'. This occurred in the context of developing provisions regarding information standards and parity of information disclosure between NHS and private providers[108] – acknowledged as a response

104 Thus reinvoking misunderstood claims that 'NHS privatisation' contains an 'Americanisation' element.

105 HL Deb 11 January 2022, vol 817, col 1062.

106 HL Deb 24 January 2022, vol 818, col 107.

107 See comments by Alex Norris MP during PBC Deb (Bill 140) 2 November 2021, col 900.

108 See in particular ss 98 and 100 HCA 2022.

to the Ian Paterson inquiry which affected both NHS and private patients.[109]

## 'NHS privatisation' and the implementation of the HCA 2022

Writing in 2023, it is possible to start to reflect on the implementation of the HCA 2022 and tentatively identify where further concerns about 'NHS privatisation' may arise following repeal of the HSCA 2012 competition reforms. At least three observations arise.

A first consideration is the re-incorporation of Secretary of State oversight powers.[110] The incorporation of the CMA in particular by the HSCA 2012 reforms highlighted a tension between accountability to the market, and political accountability regarding matters of public policy including recourse to private providers delivering state-funded (NHS) services.[111] The NHS Bill had proposed strengthening ministerial oversight in a manner which appeared to reinforce political accountability, and, as noted previously, this Bill would appear to be less likely to attract criticisms of 'NHS privatisation'. In contrast, the reincorporation of ministerial oversight by the Health and Care Act 2022 leaves open questions about how this can be understood in light, *inter alia*, of ministerial conduct in managing the Covid-19 pandemic.[112] This more complex oversight landscape[113] arising with the HCA 2022 – involving both NHS England and ministerial oversight – ought to reinvigorate discussions of what political accountability now means *vis-à-vis* the NHS in England. Certainly it seems not to be a simple reversion to ministerial oversight as it would have been understood in 2011, prior to the HSCA 2012.[114]

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109 See comments by Edward Argar MP during PBC Deb (Bill 140) 19 October 2021, col 522.

110 Including a power of direction: investigation functions (s 44 HCA 2022); a general power to direct NHS England (s 45 HCA 2022); and intervention powers regarding reconfiguration of services (s 46 HCA 2022).

111 See Davies (n 43 above).

112 Further clarity of understanding this new style of ministerial oversight has thus far been impeded by the presence of no fewer than five Secretaries of State for Health and Social Care holding office since April 2022, when the HCA 2022 received royal assent, and the time of writing in late 2023. The office holders are, in chronological order: Sajid Javid MP, Steve Barclay MP, Thérèse Coffey MP, Steve Barclay MP, and currently Victoria Atkins MP.

113 Already flagged in connection with NHS England and CCGs and the residual role of the Secretary of State for Health by cases such as *R (Hutchinson) v Secretary of State for Health and Social Care* [2018] EWHC 1698 (Admin), 21 CCL Rep 446 and *Khurana v North Central London Clinical Commissioning Group & Another* [2022] EWHC 384 (Admin) (23 February 2022).

114 See Guy (n 44 above).

Secondly, there are two provisions in the HCA 2022 which have relevance to considerations of 'NHS privatisation', which appear to have passed under the radar, but may actually suggest a refocusing of competition, rather than a removal.[115]

Section 83 HCA 2022 stipulates that mergers involving 'NHS enterprises' (defined as NHS Trusts and NHS Foundation Trusts) and private providers are subject to the general UK merger control regime.[116] While this merely reframes part of the merger control regime of section 79 HSCA 2012,[117] it remains unclear what kind of interaction may be intended to be captured here. The express exclusion of this from the new test for 'NHS mergers' might, however, suggest further expansion of NHS providers in the private healthcare market, for example via private patient units, thus category 3 activity.

Section 82 HCA 2022 imposes an apparently new duty for NHS England to provide assistance to the CMA with its activities under the Competition Act 1998 and the Enterprise Act 2002. This provision would seem to target NHS activity in the private healthcare sector (thus category 3 activity), but may also relate to assessments of private activity within the private healthcare market (given that some private providers also undertake NHS work). Some action has been taken by the CMA against NHS providers in this regard following the CMA's 2014 Private Healthcare Market Investigation.[118]

Thirdly, concerns about conflicts of interest in ICBs in connection with the combining of NHS and private roles are thought to extend beyond those articulated in connection with CCGs in light of the still more complex governance frameworks which have evolved.[119] While this may be considered a fundamentally new concern which feeds into a wider picture of 'NHS privatisation', at its core, arguably, is the unresolved tension evidenced by the concession of permitting NHS clinicians to continue private work which was necessary to implement the NHS in 1948.

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115 See Guy (n 94 above).

116 Pt 4 Enterprise Act 2002.

117 This interaction would have been covered by s 79(3) HSCA 2012.

118 CMA, 'Private Healthcare Market Investigation Order (as amended)' (28 February 2017), pt 4, 'Information', para 21.1. CMA, 'Directions to Royal Devon and Exeter NHS Foundation Trust issued under the Private Healthcare Market Investigation Order' (31 August 2017).

119 See further on this point, Roderick and Pollock (n 5 above) and Benbow (n 3 above).

## CONCLUDING REMARKS

While the shift in NHS policy focus from competition as reflected in the HSCA 2012 towards integration as reflected in the HCA 2022 marks a key moment in NHS reform, both have taken place against the backdrop of claims of 'NHS privatisation', a phrase used persistently in UK parliamentary debates for the past 40 years. While competition/marketisation and integrated provision may be seen as antithetical, the development of both relies on the underlying interaction between the NHS and private healthcare which has evolved, but can nevertheless be traced to the inception of the NHS in 1948. The broad definition of 'NHS privatisation', which goes beyond the marketisation reforms from the 1980s and culminating in the HSCA 2012, illustrates the sheer range and flexibility of the concept in light of the distinctions which can be drawn with more general understandings of 'privatisation'. Thus 'NHS privatisation' has been shown to embody a sense of vagueness and an open-ended process, with the implication that this may never be complete. The HSCA 2012 and HCA 2022 enable claims of 'NHS privatisation' to be made concrete, and questions of accountability within the resulting system emerge as paramount. Secretary of State oversight and governance of CCGs, and now ICSs, show that there are no easy answers to questions of whether the HSCA 2012 or the HCA 2022 generated more or less 'NHS privatisation'. These factors also reveal that the real concern is one of accountability, as the nature, rather than the quantity, of 'NHS privatisation' may change.

By anchoring an examination of 'NHS privatisation' in UK parliamentary debates including and beyond the HSCA 2012 and HCA 2022, it becomes possible to see how 'NHS privatisation' has a curious power. Insofar as 'NHS privatisation' forms an inevitable backdrop to NHS reform, then it may also underscore overall governmental preference for a more central ground, as indicated by the failure of the opposing visions of the NHS Bill and the National Health Service (Co-funding and Co-payment) Bill to gain traction. In this regard, 'NHS privatisation' may seem to provide an important check on how the direction for NHS reform can be shaped. This is a vital consideration given the NHS's taxation-funded status. Furthermore, claims of 'NHS privatisation' highlight questions of who is accountable for whether and how treatment is provided or denied, and how that accountability is manifested. In this regard, 'NHS privatisation' reflects a dimension of wider tensions between market and state.

Ultimately, however, 'NHS privatisation' as a criticism can be seen as fundamentally problematic for at least two reasons. Firstly, its broad nature means that significant, and conceptually distinct, issues become conflated in a kind of 'white noise' where more specific, even individual attention may be needed. Thus a claim of 'NHS privatisation'

may conflate concerns about, for example, access to NHS dentistry and conflicts of interest within the new integrated care boards. Both generate justifiable concern, but the possible policy levers needed to address these issues may differ considerably. Secondly, the ability of 'NHS privatisation' to operate as an effective warning against undesirable reform becomes impeded at the level of parliamentary debate[120] by the need for opposing parties to differentiate themselves while developing NHS reform within the same landscape of NHS and private healthcare interaction. This leads to a curious situation in which 'NHS privatisation' might – counterintuitively – be seen to inhibit discussion of more radical questions of healthcare reform, be these who should pay for healthcare, or whether a fully funded public healthcare system can be implemented.

120 This is distinct from the ability of 'NHS privatisation' to operate effectively at the level of activism.

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# Unearthing organic ideology in population health interventions: the case of water fluoridation provision in the Health and Care Act 2022

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ABSTRACT

Departing from Keith Syrett's article in this issue, this commentary critically considers the place of organic ideology in population health interventions, using water fluoridation provisions contained in the Health and Care Act 2022 as an example. It demonstrates that liberal capitalist and neoliberal capitalist conceptions of the state as protector ground these provisions and, in so doing, it shows that population health interventions must be grounded in resonant politico-philosophical ideas prior to considerations around the opening of a policy window. This comment concludes by noting the need for further work to grasp the positive and negative role of appealing to organic ideology in public health law, regulation and policy.

**Keywords:** population health; water fluoridation; organic ideology; liberalism; neoliberalism.

## INTRODUCTION

Some years ago, Lawrence O Gostin stated that 'the public health community takes it as an act of faith that health must be society's overarching value. Yet politicians do not always see it that way, expressing preferences, say, for highways, energy, and the military.'[1] Today, however, as Keith Syrett explores in his article,[2] the Covid-19 pandemic has drawn politicians' attention to the value of population health interventions. Syrett demonstrates that the metaphorical policy window has been opened to population health interventions; how long this window can remain open is a matter of question, and he is surely correct to advise that grasping the disorder and contingency

1 Lawrence O Gostin, *Public Health Law: Power, Duty* (University of California Press 2008) 36.

2 Keith Syrett, 'Something in the water: opening the public health law policy window for fluoridation?' (2024) 74(4) Northern Ireland Legal Quarterly 664–688.

of the policy-making process is necessary to fully appreciate the ways that such interventions come to be received (and renounced).

In this commentary, I depart from Syrett's analysis in an effort to unearth one element of the politico-philosophical foundation of population health interventions – that of the state as protector – using the provision on water fluoridation in England contained in the Health and Care Act 2022 as an example. In so doing, I demonstrate that population health policy must be grounded in resonant politico-philosophical ideas prior to considerations around the opening of a policy window. To do this, I employ the Gramscian concept of organic ideology as a lens through which to analyse the aforementioned foundation. The utility of this Gramscian concept is that it facilitates a politico-philosophical understanding of policy and, therefore, the revelation of this pre-analytical assumption in the opening of the policy window.

First, I move to explain the Gramscian idea of organic ideology. At this juncture, it should be noted that Gramscian theory is not an undisputed *dictum*;[3] my reading and iteration of Gramsci's work here is one that is useful to this commentary rather than an exploration of the various interpretations. Following this, I consider the population health intervention of water fluoridation in England as contained in the Health and Care Act 2022 in relation to organic ideology. Following the logic of organic ideology, I suggest that it is self-evident that population health interventions should be founded in liberal capitalist ideas, but rhetoric around the measures on water fluoridation in the Act point to a contrary politico-philosophical underpinning. I review the measures and rhetoric against the idea of the state as protector – in its still prescient liberal capitalist articulation and in its reformulation in the *neo*liberal paradigm. I conclude this comment with a brief remark on the utility of using the ideological element of the state as protector to drive population health interventions.

3 Compare, for example: Christine Buci-Glucksmann, *Gramsci and the State*, David Fernbach (tr) (Lawrence & Wishart 1980); Perry Anderson, *The Antinomies of Antonio Gramsci* (Verso 2017).

## ORGANIC IDEOLOGY: A GRAMSCIAN LENS

Hegemony is often cited as the cornerstone of Gramscian theory and can be thought of as the central concept to which all other Gramscian concepts stand in relation.[4] Briefly, hegemony describes the idea of 'a common material and meaningful framework for living through, talking about, and acting upon social orders'.[5] Organic ideology is a major component of hegemony – it is the ensemble of ideas from the various elements of society that come together to form a single, unified worldview through which people exercise thought, live and struggle; hence, it is 'organic'. These ideas – hereafter referred to as elements of organic ideology – do not possess class characteristics in and of themselves. Rather, it is through their articulation to a hegemonic principle that the elements come together and acquire class characteristics. Herein lies the malleability of organic ideology: ideology is not posited in an epiphenomenal or reductionist fashion, instead, organic ideology is formed from various elements that are carried from previous paradigms, co-opted from subordinate classes, and continually reformulated in the struggle for hegemony. Gramsci exemplifies this by explaining that the feudal classes have become economically absorbed into the capitalist class but retain their social and cultural characteristics.[6] Organic ideology is therefore not simply the dominance of a particular class's ideas, but an

> intellectual and moral direction exercised by a fundamental class in a hegemonic system [that] consists in providing the articulating principle of the common world-view, the value system to which the ideological elements coming from the other groups will be articulated in order to form a unified ideological system, that is to say an organic ideology.[7]

People become aware of the class nature acquired by elements of ideology when hegemonic principles conflict, hence Gramsci refers to organic ideology as 'the terrain on which men move, acquire

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4 Thomas R Bates, 'Gramsci and the theory of hegemony' (1975) 36 Journal of the History of Ideas 351; John Hoffman, *The Gramscian Challenge: Coercion and Consent in Marxist Political Theory* (Blackwell 1984); Joseph A Woolcock, 'Politics, ideology, and hegemony in Gramsci's theory' (1985) 34 Social and Economic Studies 199; Joseph V Femia, *Gramsci's Political Thought: Hegemony, Consciousness and the Revolutionary Process* (Clarendon 1987).

5 William Roseberry, 'Hegemony and the language of contention' in Gilbert M Joseph and Daniel Nugent (eds), *Everyday Forms of State Formation: Revolution and the Negotiation of Rule in Modern Mexico* (Duke University Press 1994) 361.

6 Antonio Gramsci, S*elections from Prison Notebooks of Antonio Gramsci*, Quintin Hoare and Geoffrey Nowell-Smith (trs) (Lawrence & Wishart 2003) 269–270.

7 Chantal Mouffe, 'Hegemony and ideology in Gramsci' in Chantal Mouffe (ed), *Gramsci and Marxist Theory* (Routledge & Kegan Paul 1979) 193.

consciousness of their position, struggle etc'.[8] Though this appears to be highly abstract, he explains that people reflect on ideology as 'the diffuse, uncoordinated features of a generic form of thought common to a particular period and a particular popular movement'.[9] People also encounter the materialisation of organic ideology in everyday life, for it is 'a conception of the world that is implicitly manifest in art, in law, in economic activity and in all manifestations of individual and collective life'.[10] These materialisations are superstructural components that Gramsci labels the 'hegemonic apparatus, in so far as it creates a new ideological terrain, determines a reform of consciousness and of methods of knowledge'[11] – they are therefore 'the instruments for the exercise of hegemony'.[12] It is important for any Marxist analysis to be mindful that 'ideologies would be individual fancies without the material forces'.[13]

## UNEARTHING ORGANIC IDEOLOGY IN THE WATER FLUORIDATION PROVISIONS CONTAINED IN THE HEALTH AND CARE ACT 2022

Given the pervasiveness of liberal capitalism, it follows, from a Gramscian perspective, that population health interventions should be founded in liberal capitalist organic ideology, yet this association is not immediately apparent. Outwardly, such interventions seem to be a collectivist undertaking that are juxtaposed to common understandings of liberal capitalist philosophy since they confer power to the state and restrict individual freedom of choice. Indeed, in the case of water fluoridation measures provisions contained in the Health and Care Act 2022,[14] power is pointedly shifted away from English local authorities to the Secretary of State for Health and Social Care in Westminster and central government assumes responsibility for funding water fluoridation provision (though, as explained by Syrett, this can be disapplied). Furthermore, the rhetoric in the government-published factsheet on fluoridation[15] and the White Paper[16] that

8 Gramsci (n 6 above) 377.
9 Ibid 330.
10 Ibid 328.
11 Ibid 365.
12 Woolcock (n 4 above) 206.
13 Gramsci (n 6 above) 365.
14 Ss 175, 176.
15 Department of Health and Social Care, 'Integration and innovation: working together to improve health and social care for all' (2021).
16 Department of Health and Social Care, 'Health and Care Bill: water fluoridation' (2021).

preceded the Health and Care Bill drew on ideas around government responsibility for population health following the pandemic: both stated that 'our experience of the pandemic underlines the importance of a population health approach'. As Syrett notes in his article, Boris Johnson, former Prime Minister and ideologue of the liberal capitalist state, has previously criticised a population health approach on the grounds it amounts to a 'nanny-state'.[17] Whilst, as Syrett has also observed, Johnson has since come to adopt a more sympathetic attitude to population health interventions,[18] Johnson's reasoning is more akin to what John Coggon refers to as 'the face of public health as a political tool'[19] than a reformulation of the elements of organic ideology. So, it remains unclear that population health intervention on water fluoridation is founded in liberal capitalist organic ideology.

Still, it was claimed that liberal capitalist organic ideology 'is implicitly manifest in art, in law, in economic activity and in all manifestations of individual and collective life'[20] and, for this statement to hold, it must be unearthed from the measures contained in the Health and Care Act 2022. To unpack the role of organic ideology, it is essential to first consider the motivation for water fluoridation. Syrett specifies the public health benefits of water fluoridation in his article, but they can be summarised by reciting the words of the former Secretary of State for Health and Social Care, Matt Hancock: 'water fluoridation … will improve the health of the nation'.[21]

This desire to improve health outcomes subtly draws on liberal capitalist organic ideology, namely, the ideological element of the state as protector. First, this element should be briefly traced historically. The state as protector is found initially in Roman political philosophy; the Romans established public authorities to deal with common concerns of society in a manner that is akin to the state as protector.[22] The idea is later reencountered in foundational liberal texts[23] – themselves derived from the authors' reception of Roman sources – in which it is

17 See, for example: G Rayner, 'Boris Johnson aims to put an end to the "nanny state" and its "sin taxes" on food' *The Telegraph* (London 3 July 2019).

18 See S Lister, 'Boris Johnson: "My health wake-up call – and why it's a wake-up call for the WHOLE of Britain"' *Daily Express* (London 27 July 2020).

19 John Coggon, *What Makes Health Public? A Critical Evaluation of Moral, Legal, and Political Claims in Public Health* (Cambridge University Press 2012) 48–52.

20 Gramsci (n 6 above) 328.

21 Matt Hancock, quoted in G Lowery and S Bunn, 'Rapid response: water fluoridation and dental health' (*POST* 24 August 2021).

22 For a detailed discussion, see Raymond Geuss, *Public Goods, Private Goods* (Princeton University Press 2009).

23 See, for example, Thomas Hobbes, *Leviathan*, John Charles Addison Gaskin (ed) (Oxford University Press 1998); Jean-Jacques Rousseau, *The Social Contract*, George Douglas Howard Cole et al (eds), new edn (Dent 1993).

envisioned that individuals cede power to a sovereign (that is, a state) for protection from the so-called 'state of nature'. Work has already been done to establish how the state as protector has historically been extended to matters of public health, for instance:

> the policing functions of societies were directed towards enforcing general rules of hygiene, such as the water supply and the cleanliness of the streets. The notion of the state as protector of the people, in exchange for the relinquishing of certain rights on the part of its citizens – the 'social contract' – lay behind the concept of the medical police.[24]

The motivation for the measures on fluoridation is founded on a similar belief: individuals cede rights to the state for protection from population health threats. Whilst this element is not uniquely liberal and/or capitalist, since its roots are in Roman thought, its presence in the population health intervention on water fluoridation can be said to founded on a core politico-philosophical element of liberal capitalism. Employing Gramscian phraseology, it is possible to refer to the state as protector as an ideological element that has been reformulated around the liberal capitalist articulating principle.

Turning to the specific provisions on water fluoridation contained in the Health and Care Act 2022 and the precisely *neo*liberal capitalist paradigm, a reformulation of the ideological element of the state as protector is apparent. As Syrett details,[25] the rationale for the power-conferring legislation discussed earlier includes discrepancies around the boundaries of water companies and the boundaries of local authorities that made the previous legislation ineffective, as well as problems related to costs and funding. In short, this legislation intends to make water fluoridation more efficient and more cost-effective. These intentions draw on a *neo*liberal capitalist state as protector. The *neo*liberal capitalist state as protector does not eliminate the salience of the state as protector as previously outlined – recall, organic ideology is formed from various elements that are carried from previous paradigms, co-opted from subordinate classes, and continually reformulated in the struggle for hegemony. Rather, this reformulation bounds the state as protector by a *neo*liberal (or 'market') logic, here realised as efficiency and cost-effectiveness. Hence, writing in different contexts, this reformulated ideological element has been labelled 'state

24 Deborah Lupton, *The Imperative of Health: Public Health and the Regulated Body* (Sage 1995) 24; for further discussion, see Dorothy Porter and Roy Porter, 'The enforcement of health: the British debate' in Elizabeth Fee and Daniel M Fox (eds), *AIDS: the Burdens of History* (University of California Press 1988) 99–113.

25 Syrett (n 2 above).

as protector of private property'[26] and 'state as protector of private persons and property'.[27] In a similar vein, as part of a study on the social investment discourse by the European Commission, Francesco Laruffa concludes that

> the promotion of social policy under social investment is largely informed by logics that make this agenda compatible with the epistemological and distributive aspects of the neoliberal framework: the application of economic rationale and the cost-benefit logic to all domains of society.[28]

This liberal and *neo*liberal capitalist worldview is found too in the institutions of public health that can be characterised in Gramscian phraseology as components of the hegemonic apparatus. One such component is the Office for Health Improvement and Disparities (OHID), which is tasked by the Government to monitor and report annually on the health effects of people living in areas already covered by fluoridation schemes,[29] further serving to reinforce, unify and stabilise organic ideology. This is still more apparent when the Government uses the annual report on water fluoridation by the OHID to justify its fluoridation intervention[30] – here, recollect Gramsci's writing that the hegemonic apparatus 'creates a new ideological terrain, determines a reform of consciousness and of methods of knowledge'.[31] Finally, organic ideology is apparent in the advocation of population health measures. For instance, public health academics deploy the ideological element of the state as protector in asserting the Government's responsibility for health[32] and promote specific measures in language associated with the *neo*liberal state as protector[33] – this is an *appeal* to organic ideology that further emphasises the validity of the ideological element, the state as protector.

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26 Joanna Fax, 'Vulnerability as hegemony: revisiting Gramsci in the age of neoliberalism and tea party politics' (2012) 53(3) Culture, Theory and Critique 323, 324.

27 Brenda Chaflin, 'Cars, the customs service, and sumptuary rule in neoliberal Ghana' (2008) 50 Comparative Studies in Society and History 424, 447.

28 Francesco Laruffa, 'Studying the relationship between social policy promotion and neoliberalism: the case of social investment' (2022) 27(3) New Political Economy 473–489.

29 See, for example' OHID, 'Water fluoridation health monitoring report 2022' (OHID 21 March 2022)

30 See, for example' UK Government, 'New report confirms fluoridation can reduce tooth decay among children' (Press Release 21 March 2022).

31 Gramsci (n 6 above) 365.

32 Lawrence O Gostin et al, 'The Shibboleth of human rights in public health' (2020) 5 The Lancet Public Health e471.

33 See, for example: Lowrey and Bunn (n 21 above).

## CONCLUSION

This commentary has sought to briefly draw out one element of the politico-philosophical foundation of population health interventions on water fluoridation using the Gramscian concept of organic ideology. It seems that this analysis can be extended from water fluoridation to population health interventions more broadly to assert that population health measures are founded in the liberal and *neo*liberal capitalist notion of state as protector. Syrett states that scholars should make use of the policy window metaphor to enhance future analysis of public health law and policy – I believe that they should also be mindful of the politico-philosophical underpinnings of public health law and policy.

The degree to which those of us interested in advancing population health should employ this ideological element is uncertain. On the one hand, it is clear from this analysis that an appeal to the state as protector can advance specific measures to improve population health. On the other hand, appealing to the state as protector has also been said to reinforce, unify and stabilise the liberal and *neo*liberal capitalist hegemony. It must be noted that this hegemony has been shown to have a detrimental impact on health.[34] Whilst further critical work is always required to understand and appreciate the effects of liberal capitalism on public health – the ways in which public health law, regulation and policy are limited, as well as the ways they are promoted – we must be willing to immediately recognise the political nature of an appeal to the state as protector. I do not have the space in this commentary to make a thoroughly reasoned comment on the utility (or lack thereof) of appealing to the current formulation of the state as protector, but I should conclude by rhetorically asking the public health community whether the short-term gain of individual measures on population health offsets the damage done to population health by liberal and *neo*liberal capitalist hegemony.

34 See, for example, Ronald Labonté and David Stuckler, 'The rise of neoliberalism: how bad economics imperils health and what to do about it' (2016) 70 Journal of Epidemiology and Community Health 312; Sudan K Sell and Owain D Williams, 'Health under capitalism: a global political economy of structural pathogenesis' (2019) 27(1) Review of International Political Economy 1.

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# Assisted Dying Bill [HL]: ignorance within the House?

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ABSTRACT

Another assisted dying Bill has come and gone in the Parliament of England & Wales. The Assisted Dying Bill [HL] 2021–2022 was debated in the second reading of the House of Lords and amendments were being considered in the Committee Stage before the Bill ran out of time in the parliamentary session. Identical to previous attempts to permit assisted dying, it would have allowed patients to receive assistance to end their own life if they have a terminal illness, are expected to die naturally within six months and (among other criteria) are experiencing unbearable suffering. In light of developments within other foreign jurisdictions, the similarities and, perhaps more significantly, differences between legislative measures provide an interesting comparative discussion. The Canadian Medical Assistance in Dying legislation has been in force since 2016 and has experienced several amendments. As Canada is somewhat further down the 'legal road' in regulating assisted dying, it may prove a fruitful endeavour to use the Canadian developments to evaluate attempts to change the law in England & Wales. Features of the Bill reflected similar provisions that have been adjusted or removed in the Canadian legislation, features that are of significant importance and solemnity in the context of those wishing to access assistance in dying. Evaluating the approach taken in England & Wales using the precautionary principle can demonstrate where the road to implementing an effective assisted dying framework can be made less arduous, particularly with help from international comparisons.

**Keywords:** assisted dying; assisted suicide; euthanasia; health; healthcare law; law reform; Canada; comparative law; precautionary principle.

## INTRODUCTION

This commentary argues that a poor understanding of assisted dying in England & Wales is producing legislative Bills which would create an ineffective permissive framework. The latest legislative attempt to permit assisted dying, the Assisted Dying Bill [HL] 2021–2022 (henceforth referred to as the ADB) had the same route of failure of previous Bills in England & Wales. There are significant differences between the ADB and Canada's medical assistance in dying (MAiD)

legislation, initially passed in 2016 and which has been amended since. The amendments to the original Canadian legislation demonstrate how the practical realities of providing assistance in death have been confronted: such as the removal of waiting periods, the inclusion of those whose death is not reasonably foreseeable, and amended safeguards. An analysis of these differences shows that England & Wales would benefit from paying more attention to global developments in assisted dying regulation, if creating a permissive framework is a serious objective. Furthermore, the precautionary principle will be employed to show that, although there are justified concerns of potential harms, the absolute prohibition of assisted dying is ineffective, inconsistent and disproportionate.

## COMMONWEALTH COMPARATORS

The intersection between healthcare law and comparative law continues to be very prominent within academic research. Due to the nature of healthcare law research, it is a natural companion to comparative considerations and the assessment of similarities and differences of other legal systems. Although contextual factors cannot, and should not, be discounted, the issues within healthcare law can be found to be common across seemingly similar and strikingly different societies and communities. Meaning that a comparative analysis of issues such as assisted dying can provide effective insight. For example, individuals will always be engaged in a discourse regarding bodily and personal (in its more abstract meaning) autonomy,[1] and this is where the contextual influences can be accounted for. Comparisons of different approaches to healthcare regulation can be found very easily amongst the literature.[2] Therefore, it is perhaps time to give appropriate consideration to the comparative methodology that healthcare law research might employ. Being mindful of the issues comparatists are attempting to reconcile could prove beneficial in providing effective and meaningful comparative healthcare research.

It is prudent to identify the essential elements of this comparative objective. A functionalist approach to evaluating the recent ADB[3]

1 Peter De Cruz, *Comparative Healthcare Law* (Taylor & Francis 2001) xxviii.

2 Maurice Adams and Herman Nys, 'Comparative reflections on the Belgian Euthanasia Act 2002' (2003) 11(3) Medical Law Review 353; Ruth Stirton, 'The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: a litany of fundamental flaws?' (2017) 80(2) Modern Law Review 299; Margaret Brazier and Jonathan Montgomery, 'Whence and whither "modern medical law"?' (2019) 70(1) Northern Ireland Legal Quarterly 5; Cressida Auckland and Imogen Goold, 'Resolving disagreement: a multi-jurisdictional comparative analysis of disputes about children's medical care' (2020) 28(4) Medical Law Review 643.

3 ADB 13.

can provide a good framework to evaluate Parliament's attempt to regulate assisted dying. The functionalist approach is recognised as the first comparative method, put forward by Zweigert and Kötz in their seminal piece, *An Introduction to Comparative Law*.[4] As the first, somewhat, comprehensive method for conducting comparative legal research, it is of no surprise that the scope of its focus is narrow. The objective, using this approach, will be to assess the effectiveness of legal rules and/or institutions. This tends to be to the exclusion of societal, political, economic, constitutional and other contextual factors that may influence the operation of a legal rule. The isolation of the ADB and the Canadian MAiD federal legislation from the contextual factors is necessary for the focus of this commentary. Although these factors are extremely significant for successful regulation of an issue such as assisted dying, when evaluating specific pieces of legislation or parliamentary Bills we can engage in a fruitful investigation of the specifics of regulation, and this is the intention of the comparative enquiry of this discussion as a pragmatic approach.

The starting point is establishing a '*praesumptio similitudinis*'[5] – a presumption of similarities. This presumption underpins the approach to argue that 'the only things which are comparable are those which fulfil the same function'.[6] England & Wales and Canada have produced measures which intend to permit and regulate forms of assisted dying, with different degrees of success between the jurisdictions. The pivotal elements of the debate on assisted dying regulation will be a consideration of a patient's right to make choices about their life (including their death, if that right exists) and the protection of those that may be vulnerable to a permissive regime of assisted dying.[7] The extent in which Canada has achieved this balancing exercise can be assessed through the legislative measures that have been produced. Although the substance has already been said to be different between

4 Konrad Zweigert and Hein Kötz, *An Introduction to Comparative Law*, Tony Weir (tr), 3rd edn (Oxford University Press 1998).

5 Ibid 34.

6 Ibid.

7 Within the context of the Commonwealth, other jurisdictions have also recently experienced legal change in their stance on assisted dying. Namely, Australia and New Zealand have passed legislation permitting voluntary active euthanasia and assisted suicide in the last two years. While the comparative discussions made in this commentary could also be relevant for these jurisdictions, the focus remains on Canada due to the development of the assisted dying framework and amendments that have been made to the legislation. Canada, as a case study, provides a more substantial legal analysis and therefore a preferred comparative enquiry.

the two jurisdictions, the 'basis of comparison' can be established as similar.[8]

So, the final question to justify the comparative enquiry becomes: why compare England & Wales and Canada? Within healthcare law research legal systems are often compared regardless of whether they are similar or different; this is not an issue for comparative enquiries. However, the decision to choose similar or different legal systems will largely affect or depend on the objective of the comparative enquiry.[9] The differences between the MAiD legislation and the ADB elicit questions regarding the justification as the two legal systems are seemingly similar. Both are historical and prominent members of the Commonwealth of Nations (the Commonwealth), ensuring the advancement and development of human rights. They also belong to what is coined as a 'legal family'.[10] Comparative literature shows that there is often a recognition of a family of English common law systems,[11] within which that of England & Wales is considered the parent legal system. The Canadian system was initially created from the English common law system and has shown very similar characteristics even in the modern era.[12]

The comparative stage is set. On a macro level England & Wales and Canada are sufficiently similar legal systems through their membership of the same 'legal family'. The question then becomes, why have differences emerged through the respective legislative measures of the legal systems? If these intrinsically human issues are prevalent across all societies, why is Parliament not being prudent in taking valuable lessons from more experienced jurisdictions?

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8 In his description of the three stages of a comparative enquiry, Gerhard Danemann explains that identifying the 'basis of comparison' and the legal systems to be compared constitute the first stage: selection. See Gerhard Danemann, 'Comparative law: study of similarities or differences?' in Mathias Reimann and Reinhard Zimmermann (eds), *The Oxford Handbook of Comparative Law* 2nd edn (Oxford University Press 2019) 411–415. There is strong agreement amongst comparatists that at this stage (selection) of the comparative enquiry one should strive for similarity.

9 See n 7 above.

10 Uwe Kischel, *Comparative Law* (Oxford University Press 2019) 201. The benefit of classifying legal systems into families, for the healthcare comparatist, is that it makes conducting comparisons less burdensome in that there is less work to be done to establish a connection between the legal systems: see Peter De Cruz, *Comparative Law in a Changing World* 3rd edn (Routledge-Cavendish 2007) 27.

11 Zweigert and Kötz (n 4 above) 63–67; De Cruz (n 10 above) 35; Jaakko Husa, 'Legal Families' in Jan M Smits (ed), *Elgar Encyclopedia of Comparative Law* 2nd edn (Edward Elgar 2012).

12 Zweigert and Kötz (n 4 above) 221–222.

## KEY DIFFERENCE BETWEEN THE ASSISTED DYING BILL [HL] AND THE MAiD LEGISLATION

With the comparative objective established, focus shifts to the content analysis of the two legislative measures to show how assisted dying regulation is being approached from the perspective of England & Wales and Canada. Without the capacity in this commentary to bring other significant factors for successful regulation into the fore, the key differences between the ADB and the MAiD legislation can still help to determine where Parliament should be paying more attention to global developments.

The ADB is the fourth attempt in the recent history of England & Wales to reform the law and decriminalise some form of assistance in dying. It was introduced in 2021 and officially fell in May 2022 due to running out of time in the parliamentary session. Introduced by Baroness Meacher, a life peer in the House of Lords, the ADB contained provisions and clauses that strongly resembled previous attempts such as Lord Falconer's Bill.[13] Canada experienced a similar history of several failed assisted dying Bills introduced in 2005, 2006 and 2009. However, following the decision in *Carter* (2015)[14] that the ban on assisted dying was unconstitutional, the Canadian Bill C-14[15] found success in reforming the federal law. The two legislative measures contain a collection of differences, but some stand out to show a significant divergence of understanding of the issue of assisted dying. Where some deal with practical challenges of a permissive framework, others confront the difficulties of balancing rights and providing adequate protection. Some issues are not easily reconcilable and, despite Canada's progress in the global space of assisted dying regulation, solutions may ultimately have to be contextual. The approach taken by a jurisdiction may be justifiable against the wider societal context which the law is operating within. Various panels, committees and groups formed in Canada have discussed some of the problematic elements of assisted dying regulation in an attempt to assist the formation of legislation.[16]

However, there are some differences between the legislative measures which seem to be more arbitrary or misguided, specifically

13 Assisted Dying Bill [HL] (2014–2015) 6.

14 *Carter v Canada (Attorney General)* [2015] SCC 5.

15 Bill C-14, *An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying)* 1st session, 42nd Parliament, 2015.

16 Provincial-Territorial Expert Advisory Group on Physician-Assisted Dying, *Final Report* (November 2015); Special Joint Committee on Physician-Assisted Dying, *Medical Assistance in Dying: A Patient-Centred Approach* (February 2016); Health Canada, *Final Report of the Expert Panel on MAiD and Mental Illness* (2022).

in the context of the *Annual Reports on Medical Assistance in Dying*[17] published by the Canadian Minister of Health as required by the MAiD legislation. These reports provide insightful and significant statistical data on the engagement with MAiD services provided in Canada, making it seemingly more difficult for Parliament to justify the approach taken in the ADB.

## Assisting suicide, not dying

The most striking and obvious difference between the two is that the ADB proposed only to permit health professionals to provide assistance to a patient to end their own life, where the patient performs the final act themselves.[18] Approval for assistance in dying would also have to be given by the High Court (Family Division). Initially, this distinction between a patient self-administering and the final act being performed by a health professional might not seem that problematic. I would argue that it conveys a misunderstanding from Parliament as to why patients seek assistance. Furthermore, the practical implications this has on patients who are attempting to access the provision of assistance in dying could be monumental in the broader context of their battle with the medical challenges they are facing.

Canada, even from the first draft of the MAiD legislation, defines 'medical assistance in dying' to include situations where the patient and the medical/nurse practitioner could perform the final act.[19] The *Annual Reports* providing data on the engagement of MAiD in Canada show that nearly all cases of MAiD were administered by a medical/nurse practitioner.[20] In 2020, there were still fewer than seven cases of self-administered MAiD deaths, despite a 34 per cent increase of total MAiD deaths compared to the previous year.[21] The data provided by the *Annual Reports* is overwhelming in the context of how the final act is performed, almost to the point that we could question the necessity of a framework that allows the patient to self-administer. A determination that this option is unnecessary would still be an incorrect one to make. Despite almost all Canadians who accessed MAiD requesting the medical professional to administer the medication, the option for the

17 Health Canada, *First Annual Report on Medical Assistance in Dying in Canada 2019* (2020); Health Canada, *Second Annual Report on Medical Assistance in Dying in Canada 2020* (2021).

18 ADB 13, cl 4(4)(c).

19 Bill C-14: *An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying)* SC 2016, c 3, s 241.1. For the purposes of this commentary, 'medical assistance in dying' refers to the final act of the medical professional or the patient administering the life-ending medication.

20 Health Canada, *First Annual Report* (2020) (n 17 above) 18; Health Canada, *Second Annual Report* (2021) (n 17 above) 13.

21 Health Canada, *Second Annual Report* (2021) (n 17 above) 13.

patient to self-administer has important symbolic implications. This is to communicate that, throughout the process, the patient has respected notions of autonomy, control and dignity.[22] Therefore, this must be the minimum. On the other hand, to not provide the option for a medical professional to perform the final act causes more complications than it provides effective safeguarding. In a purely practical argument, allowing medical professionals to perform the final act means that there is a significantly lower chance of the procedure going wrong. Although the patient would be supervised in situations of self-administration, this would not eliminate that possibility. In the scenario where an issue does occur while the patient is self-administering, and the medical professional must intervene to correct the patient, would this be enough to incur liability? Furthermore, the act of self-administering will not be an easy one to perform as the patient is entirely aware of the purpose of the procedure and the purpose being fulfilled by the substance being used. The patient would likely experience more comfort and relaxation during the procedure if they were not required to end their own life.

There may also be specific complications caused by the nature of the patient's condition. For example, there will be a proportion of patients that will be afflicted with conditions or diseases that will affect their cognitive and motor ability. These patients may be forced to end their lives prematurely as they must ensure that they can physically perform the final act. Patients could continue to live what they consider a meaningful life after losing physical abilities but when the time comes that they are suffering unbearably, they will be forced to endure that suffering. The time period that could exist between these two situations may be short. However, it would be time taken away from patients in a situation where every minute could be extremely valuable. The ADB gives the impression that Parliament is accepting that assistance in dying is an important right to recognise but is reluctant to take all the responsibility in giving the option for doctors and nurses to administer the assisting substance. A justification for this approach cannot be obviously seen, particularly when there are practices that are considered 'good' or 'common' within the field of medicine that

22 Lord Mance, in the second reading of the ADB, highlights that the principles of 'autonomy and dignity in life and in dying' are essential to recognise and protect in the conversation of assisted dying. As one of the presiding judges in the case of *Nicklinson* (*R (Nicklinson) v Ministry of Justice* [2014] UKSC 38), heard in England & Wales, he expresses his support for a change in the law with a carefully considered and informed approach to the issue: HL Deb 22 October 2022, vol 815, col WA409.

are not ethically distinct from assisted dying, such as measures used in palliative care.[23]

## The devil is in the (lack of) detail

Overall, a comparison of similar sections of the ADB and the MAiD legislation give further indication that the understanding of assisted dying in Parliament is misguided. Firstly, one of the largest sections in the ADB gives details regarding the declaration to be given by the High Court (Family Division) after an application has been given for a patient to receive assistance in dying. The section detailed the necessity of obtaining a declaration from a patient, the requirements of the countersignature and who may provide the countersignature for the patient's declaration, what the response is to be in the event of doubt as to the patient's consent and other small details about the process.[24] Whereas, when we look to where the ADB describes the qualification for assisted dying, there is not as much detail. The ADB, in two sub-points, states that a person must have a 'terminal illness' which is defined as 'an inevitably progressive condition which cannot be reversed by treatment' and as a result the patient is 'reasonably expected to die within 6 months'.[25] This is in conjunction with the requirement that the person has capacity, is 18 or over and has been ordinarily resident in England & Wales for at least one year.[26] Despite the ADB setting out that death is reasonably expected to occur within six months, the circumstances are not as clear as the MAiD legislation. Even in the original MAiD legislation an arbitrary timeframe of six months was not included, simply that 'death be reasonably foreseeable' – which could be interpreted in a way so that the unbearable suffering experienced by a patient would not be simply dismissed by a qualifying time-period.[27]

Within the ADB there is no consideration of the patient's suffering. This is central to the framework in Canada as, once having met all the

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23 The principle of 'double effect' is well-established in allowing medical practitioners to hasten the death of a patient for the primary purpose of the relief of suffering: see Jonathan Glover, *Causing Death and Saving Lives: The Moral Problems of Abortion, Infanticide, Suicide, Euthanasia, Capital Punishment, War and Other Life-or-death Choices* (Penguin 1990) 86–91. Furthermore, it can be argued that the use of continuous deep sedation (CDS) and the refusal of artificial hydration and nutrition is another method that cannot be ethically or morally distinguished from acts of euthanasia: see Clive Seale, 'Continuous deep sedation in medical practice: a descriptive study' (2010) 39(1) Journal of Pain and Symptom Management 44.

24 ADB 13, cl 3.

25 Ibid cl 2.

26 Ibid cl 1.

27 Bill C-14 (n 19 above) c 3.

other elements of the eligibility criteria, it is the patient's decision alone shaped by the acceptability of possible treatment or symptom relief whether their life is no longer worth living, regardless of any discernible timeframe with their condition. The ADB only required a person to be terminally ill and be expected to die soon. A speech given in the second reading of the ADB by Baroness Fraser of Craigmaddie provided a good explanation on how this perspective is problematic, using examples of those suffering from conditions such as motor neurone disease: 'The ADB implies that if you cannot speak, eat, dress yourself or move around without assistance and you require intimate personal care, your life is less worthy than others.'[28] It is arguable when comparing the difference in perspectives of the legislative measure that the ADB is misguided. Firstly, a prognosis of a patient's likely death is notoriously unreliable and puts medical professionals in a difficult position in being forced to predict a timeframe. Secondly, and more importantly, the reasons a patient will engage with assisted dying are often intrinsically connected to notions of personhood and quality of life. The mere existence of a terminal illness that may bring about a person's death within six months does not automatically mean that the patient determines their life is no longer worth living. The amendments in Canada have shifted the focus from arbitrary time periods which cannot be argued to be reflecting the essential principles for allowing people to receive assistance in death. A framework should be respecting autonomy. All the while more importance is placed on death occurring within six months than a patient's subjective decision about their life and their condition, England & Wales is drafting legislation in ignorance.

## Waiting periods of prolonged suffering

The ADB contained a requirement that the medicines can be given to the patient after a period of at least 14 days, unless the patient is expected to die within one month in which case it can be reduced to six days.[29] Interestingly, Canada's framework included a similar waiting period of 10 days after approval was given before providing assistance to the patient. Initially, a waiting period after receiving approval for assistance in dying seems to be a sensible and logical safeguard for patients. It could provide the opportunity for the patient to reflect on their decision and the process to ensure they believe this is the right decision for them. Furthermore, it could allow certain arrangements to be put in place for the patient personally and the medical professionals facilitating the patient's assisted death. However, this has since been removed from the Canadian Criminal Code in the first set of

28 HL Deb 22 October 2022, vol 815, col WA428.
29 ADB 13, cl 4(2)–(3).

amendments made to the MAiD legislation in March 2021.[30] Data from the *Annual Reports* gives an insight as to the practical effectiveness of a waiting/reflection period after being approved. Of the patients that had submitted a written request for MAiD and died of another cause, over 50 per cent died in less than 10 days prior to when they were due to receive MAiD or self-administer.[31] Additionally, around 23 per cent of these patients died between 11 to 30 days prior.[32] These statistics could contain cases where patients had had their request for MAiD approved but died before a scheduled later date for MAiD. However, what this shows is that, despite the provision of assistance in dying, it can become counterproductive if the patient is forced to endure unnecessary suffering in a waiting period. With the proposed waiting period of 14 days in the ADB, there is the potential for a significant number of patients to die before receiving medical assistance. In comparison to the benefits that may be experienced from having a waiting period, the process of being assessed and approved to receive MAiD can be burdensome. The physicians and medical practitioners must be sufficiently confident that the patient meets all of the criteria, including those that speak to the patient's genuine and informed desire to end their life. Before the supply or administration of the medicines to the patients there will always be a final question asked to the patient if they still want to go through with the procedure which, after the extensive process of being granted assistance in dying, should be sufficient without a waiting period.

Canada has responded appropriately to the data that has been collected from patients engaging with MAiD in that country to remove the unnecessary waiting period. Perhaps introducing a framework that does not contain any safeguards ensuring that the patient's wishes are definite is not minimising the risks to those that are at a heightened risk of ending their life. A waiting or reflection period, however, would not serve this purpose. The process of ascertaining the patient's wishes, taking into account the full extent of their condition (including areas of their lives that are adversely affected such as their social and financial abilities) can ensure that the risks to vulnerable people are minimised.

## 'Foreseeability of death', a dark and narrow corridor

Perhaps one of the biggest developments to occur within Canada's MAiD regulation is the introduction of safeguards allowing patients to access

30 Bill C-7: *An Act to amend the Criminal Code (medical assistance in dying)* SC 2021, c 2.

31 Health Canada, *First Annual Report* (2020) (n 17 above) 37; Health Canada, *Second Annual Report* (2021) (n 17 above) 33–34.

32 Health Canada, *First Annual Report* (2020) (n 17 above) 37; Health Canada, *Second Annual Report* (2021) (n 17 above) 33–34.

assistance in dying when their death is not reasonably foreseeable.[33] This introduction is a stark contrast to the ADB's proposition that a person is expected to die within six months which, I have argued above, is an arbitrary line drawn to qualify a person's suffering.

Along with other amendments made in Canada's 2021 C-7 Bill, such as the removal of a waiting period for those whose death is reasonably foreseeable, this addition seems to be more accurately reflecting the rationale behind key decisions in the Canadian Supreme Court.[34] Unsurprisingly, in this context of requesting assistance in dying there are more stringent safeguards. For instance, there must be a waiting period of 90 days, a specialist or expert in the patient's condition must be consulted, and that the alternative options of symptom relief or trial treatments for the patient be discussed and seriously considered (this includes counselling and support services that focus on living with the condition in an acceptable way).[35] These safeguards are designed to allow the medical professionals dealing with a patient's request to assess their condition holistically and take into account all aspects of the patient's life. I think the safeguards for these circumstances are justified in their stringency. When death is not foreseeable, there will be more risk management involved with providing assisted dying to the patient. However, the mere existence of risk should not preclude the creation of a framework or legislation in the face of scientific uncertainty.[36] What should be of central importance is if the patient is suffering in a way that cannot be relieved or cured – which can be appropriately assessed in the 90-day period with the evaluation of at least one medical professional specialising in the patient's condition. The decision to require a patient's death to be reasonably foreseeable or expected to occur within six months (as proposed by the ADB) is arbitrary. Lord Morrow, in the second reading of the ADB, highlighted how this qualification for assisted dying is misguided by using an example of a diabetic who could be deemed as having six months to live without treatment.[37] Suddenly, the ADB sought to include those who most would agree should not even be considered for an assisted death.

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33 Bill C-7 (n 30 above) c 2.

34 Following the case of *Carter* (n 14 above), the initial C-14 Bill was heavily critiqued as the narrow eligibility criteria would not have permitted Kay Carter from being able to access assisted dying. Furthermore, the case of *Truchon v Canada (AG)* [2019] QCCS 3792 challenged the 'reasonable foreseeability of natural death' and 'end of life' requirements in the federal and Quebec legislations.

35 Bill C-7 (n 30 above) c 2.

36 Nicolas de Sadeleer, *Environmental Principles: From Political Slogans to Legal Rules* 2nd edn (Oxford University Press 2021); Anne-Marie Farrell, *The Politics of Blood: Ethics, Innovation, and the Regulation of Risk* (Cambridge University Press 2012) 168.

37 HL Deb 22 October 2022, vol 815, col WA416.

This is the absurdity that an arbitrary requirement such as a projected timing of the person's death can lead to. There is a thin line to tread, but the legislation must be composed with a well-founded and vigilant core understanding of the issue of suffering and autonomy, which is what assisted dying is centrally concerned with.

It is particularly problematic when considering that a patient's natural death being reasonably foreseeable may be satisfied due to their age alone. Of those who received MAiD in Canada in 2020 (data is before the implementation of additional safeguards for patients whose death is not reasonably foreseeable), 95 per cent of patients were over 56 years old with around 50 per cent being over 76 years old.[38] Furthermore, those between the ages of 18 and 45 who received MAiD accounted for only 6 per cent.[39] In light of the ADB's proposition that a patient's death be foreseeable within six months, two significant events will occur. First, the six-month requirement would create a group of people who will be specifically vulnerable by prognosis to over-inclusion, alongside meeting the rest of the eligibility criteria. Second, patients within that group may apply to receive assisted dying for reasons that should not be permitted. Patients whose death can be predicted to occur within six months that do not consider themselves to be suffering unbearably, although still suffering by some qualification, may be motivated because they do not want to continue to be a burden on their family, friends, or carers. Coupled with inadequate safeguards, this is merely one example of how problematic providing assistance in dying can be if the focus within the framework is not properly aligned with the issue.

## MEASURES OF PRECAUTION?

The opposition to the ADB in the House of Lords, and opposition to permitting assisted dying generally, is largely characterised by the fear of potential harm that may be inflicted to those who are considered vulnerable.[40] The employment of the precautionary principle not only calls into question the data showing possible dangers to vulnerable people, but also presupposes that proactive action can still be taken

38 Health Canada, *Second Annual Report* (2021) (n 17 above) 19.

39 Ibid.

40 In the second reading of the Bill in the House of Lords the word 'vulnerable' is referenced 72 times. The references are a mixture of those arguing that in the proposed Bill there is adequate protection of vulnerable people, there is inadequate protection of vulnerable people, and other general references to vulnerable groups in the context of assisted dying.

'notwithstanding the absence of full scientific certainty about the nature and scope of such threats'.[41]

The origins of the precautionary principle can be found in environmental policy regulation of the 1970s and has even gone as far as to obtain recognised legal status in the European Union.[42] The principle is naturally congruous with health law research, specifically when the threat of harm is gravely serious or irreversible, making it especially appropriate to use in the context of assisted dying.[43] Risk regulation and risk management are the key objectives related to the assessment of precautionary measures, then specifically trying to reach some reconciliation in regards to risk acceptability.[44] In 'highly politicised environments' where decisions have to be made about how to balance competing rights of different groups of people and what risks can be minimised or permissible, both morally and practically, the precautionary principle in this sense can help bridge the gap between the political and the scientific.[45] However, one of the criticisms of the principle is that it can lead to legislators adopting an 'all or nothing' approach that is informed by speculation and fear rather than appropriate risk assessments.[46] It can be argued that this is the current situation in England & Wales based on the analysis of the ADB. An observation of the debates in the House of Lords on the ADB shows this sentiment of fear and uncertainty all too plainly. The use of case examples from other jurisdictions permitting assisted dying in the debates does not show a rational discussion about how to minimise risk and avoid the pitfalls that other countries have made. Rather that there is speculative evidence of some problems that are deemed impossible to circumvent or to eradicate, and this should defeat any attempt to permit assisted dying.[47]

So, what should be the appropriate utilisation of the precautionary principle for assisted dying regulation? Friderik Klampfer uses David Resnik's criteria for employing the precautionary principle (considering certain principles such as effectiveness, consistency

41 Farrell (n 36 above) 168.

42 For a description of the origins and background of the precautionary principle, see Sonja Boehmer-Christiansen, 'The precautionary principle in Germany ± enabling government' in T O'Riordan and J Cameron (eds), *Interpreting the Precautionary Principle* (Taylor & Francis 1994); Sadeleer (n 36 above).

43 John Harris and Søren Holm, 'Precautionary principle stifles discovery' (1999) 400 Nature 398.

44 Communication from the Commission on the precautionary principle COM/2000/0001.

45 Farrell (n 36 above) 167.

46 Cass Sunstein, *Laws of Fear: Beyond the Precautionary Principle* (Cambridge University Press 2005) 5.

47 HL Deb 22 October 2022, vol 815, col WA411.

and proportionality) to assess the merits of the ban on assisted dying generally.[48] Performing a similar exercise as Klampfer allows us to determine that the prohibition of assisted dying in England & Wales is unnecessarily precautionary, to the extent that it is counterintuitive. Empirical evidence shows that permitting active euthanasia or assisted suicide does not necessarily lead to an increase in other unacceptable forms of assisted dying (eg involuntary/non-voluntary euthanasia), nor is there an increase in the deaths of those among vulnerable groups.[49] This does not mean there do not exist flawed systems and ineffective ways to create a permissive regime, however, legislators should not be fear-mongered beyond rationality.[50] Naturally, as the empirical evidence shows, through the introduction of a permissive framework for assisted dying there will be an increase in assisted deaths. This is to be expected as those who need assistance in death can access this service, but, if legislation is properly informed to the nature of the issue, what will follow will not be an influx of over-inclusion of those who should not be encouraged to end their lives. Furthermore, the statistics will begin to show the transition of assisted dying practices conducted 'in the shadows' to practices that will then be medically supervised or facilitated. To subject those who are in unbearable suffering and are not expected to die within six months is a disproportionately precautionary measure against the possible, but uncertain, risk that there will be abuse towards the vulnerable groups. The objective of this commentary is not to establish that the concern of over-inclusion of vulnerable groups is unfounded. It is absolutely essential that robust and effective safeguards be of primary importance in a permissive framework. However, the prohibition is not effective, consistent or proportionate and therefore cannot be validly established as justifiably precautionary.

A global observation of assisted dying regulation shows that jurisdictions move through various stages of precautionary measures that occur at various points creating a precautionary timeline. England & Wales and Canada have, up to this point, experienced very similar stages where Canada is further along the timeline. Initially, the theoretical debate will wrestle with competing rights both for and against permitting assisted dying practices, with the main arguments

48 Friderik Klampfer, 'Euthanasia laws, slippery slopes, and (un)reasonable precaution' (2019) 18(2) Prolegomena 121, 133–143.

49 Margaret Battin et al, 'Legal physician-assisted dying in Oregon and the Netherlands: evidence concerning the impact on patients in "vulnerable" groups' (2007) 33 Journal of Medical Ethics 591, 597; Klampfer (n 48 above) 128.

50 John Keown critiques the Belgium and Dutch systems and describes them as examples of slippery slopes: see John Keown, *Euthanasia, Ethics and Public Policy: An Argument against Legalization* 2nd edn (Cambridge University Press 2018).

being person's abstract right to die against the sanctity of life argument. Through case law, both jurisdictions have moved beyond this debate to recognise that a person's right to choose the manner in which they die can be found.[51] The difference between the two jurisdictions is that Canada has been successful in passing legislation to create a permissive framework for assisted dying, whereas England & Wales has not produced a parliamentary Bill that has come close to changing the law.[52] An explanation given by Agnes van der Heide in 2019 insightfully demonstrates how legislators are forced to pass restrictive and conservative versions of the law against political, religious and cultural opposition.[53] However, this arduous and prolonged route to legislation can be shortened by taking heed of how and why Canada has removed 'irrational obstacles' from the MAiD framework.[54] Legislators in England & Wales must employ precautionary measures sensibly and effectively and use the advantage of being able to learn from the developments in Canada to understand where measures will prove to be unnecessarily precautionary.

## CONCLUSION

There have been various failed attempts at galvanising a change in the law in England & Wales to permit any form of assisted dying. Parliamentary Bills in England & Wales continue to present themselves as being oblivious to the global engagement with assisted dying regulation. The domestic courts are also not willing to declare that the criminalisation of any form of assisted dying unjustifiably infringes a person's right to fully choose and control the manner in which they conduct their life – including the manner in which they choose to end their suffering. With the publication of the Director of Public Prosecution's Guidelines[55] for prosecuting those who assist someone in death coupled with medical practices that are not ethically or morally distinguishable from assisted dying, the excuses for not

51 Within England & Wales, a person's right to choose the manner in which they die was found to be protected by art 8 of the European Convention on Human Rights respecting a person's right to their 'private and family life'. In Canada, a similar right was found to be protected by s 7 of the Canadian Charter of Rights and Freedoms which protected the right to 'life, liberty, and security of the person'.

52 Bills introduced in England & Wales such as the Assisted Dying Bill [HL] (2014–2015) 25, the Assisted Dying (No 2) Bill (2015–2016) 7 and the ADB 13 all failed to progress past the 2nd reading in their respective Houses.

53 Klampfer (n 48 above) 131.

54 Ibid 131.

55 See n 56 below.

creating a permissive framework are weak.[56] This commentary does not propose that the Canadian system is faultless. The widening accessibility of MAiD is currently being criticised as creating a slippery slope.[57] However, the relevance of the comparative analysis is not compromised as core understandings of key elements of assisted dying can still be extracted. The conclusion is that the ADB does not give any indication that Parliament is serious about permitting people to receive assistance in their death to relieve them of unbearable suffering. Moreover, there is only little indication that the true nature of this issue is being understood. To only allow circumstances where the patient performs the final act communicates cowardice, and the continued prohibition of assisted dying cannot be said to be justifiably precautionary. Unwillingness to face the realities of those who are in the position that forces them to consider ending their own life can only lead to unimaginable, unnecessary and prolonged suffering.

56 For the guidelines, see Director of Public Prosecutions, 'Policy for prosecutors in respect of cases of encouraging or assisting suicide' (CPS 2010, updated 2014) published following the case of *Purdy – R (on the application of Purdy) v Director of Public Prosecutions* [2009] UKHL 45.

57 Jocelyn Downie and Udo Schuklenk, 'Social determinants of health and slippery slopes in assisted dying debates: lessons from Canada' (2021) 47 Journal of Medical Ethics 662.