Health and Social Care Bill 2011

House of Lords – Committee stage, 25 October 2011

BRIEFING ON CLAUSE 1

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1. Introduction

The Committee stage of the Health and Social Care Bill begins on Tuesday 25 October 2011, with consideration of Clause 1.

Clause 1 impacts on the legal framework underpinning a comprehensive and universal national health service.

The briefing is intended to assist peers supporting any of the amendments designed to restore the current statutory framework, although our preferred option is to omit Clause 1 and revert to the wording of the National Health Service Act 2006.

In three sections below, we outline the legal effect of Clauses 1 and 10 on the Secretary of State's duties, set out our concerns and questions relating to their impact on patients and services, and conclude with the key health policy issues raised by these clauses.

[The briefing does not discuss the various amendments that have been tabled to Clause 1. Readers are referred to a legal analysis of these undertaken on behalf of 38 degrees.[1] Our preference is to omit Clause 1 and to revert to section 1 of the 2006 Act.]

2. The legal effect of Clauses 1 and 10 on the Secretary of State's duties

Clause 1 of this Bill proposes to change the fundamental legal basis of the NHS in England which has been in place since 1946. This is unacceptable to many.
It was:

- not mentioned in any manifesto

[1] http://blog.38degrees.org.uk/

- not voted for
- not part of the coalition agreement.

Under section 1(2) of the 2006 Act, the Secretary of State must provide or secure the provision of services in accordance with the Act for the purpose of promoting a comprehensive health service which s/he has the duty to promote under section 1(1). Under section 3(1) of the 2006 Act, s/he must provide throughout England, to meet all reasonable requirements, the key NHS services that are listed in that subsection, such as medical, nursing and ambulance services, and hospital accommodation.

Clause 1 proposes to change section 1(2), so the Secretary of State would no longer have the duty to provide or to secure provision of services in accordance with the Act, but would have to exercise his or her functions so as to secure that services are provided in accordance with the Act. In addition, Clause 10 proposes to change section 3(1) so that the Secretary of State's duty to provide the key NHS services throughout England will be replaced with a duty on the scores – indeed perhaps hundreds - of individual clinical commissioning groups (CCGs) to make arrangements for provision for persons for whom they are responsible.

One of the key problems with these changes – and this was picked up by the Constitution Committee – is the severance problem. If the government has its way, the body with the duty to promote a comprehensive health service will not be the same as the body which has to make arrangements for provision. At the moment, as Lord Woolf said in the Court of Appeal in the *Coughlan* case, the Secretary of State "has the duty to continue to promote a comprehensive free health service and he must never, in making a decision under section 3, disregard that duty". The scores of CCGs will not have that duty.

The government has tried to argue in Earl Howe's letter to Baroness Jay on 10 October 2011 in response to the Constitution Committee that the CCGs will have to have regard to that duty. But the Bill does not say that, and it does not give CCGs that duty.

The government keeps saying that currently the Secretary of State does not actually provide and everything is delegated to the primary care trusts. But this is not the point. Section 3(1) is a unifying duty applying throughout England, and everything flows from that. If that starting point is discarded, then the core part of the current statutory basis for the NHS will also go.

3. What will this mean for patients and services?

The implications for patients and services can be considered in four respects.

Firstly, the Secretary of State's duty to provide is throughout England, and the PCTs and strategic health authorities are area-based, and these areas are contiguous. The CCGs will be 'person-based' or 'group-based', largely drawn from GP registrations, but neither the area nor the population are clearly defined. CCGs are supposed to cover all of England (Clause 22: new section 14A(2)), but

there is no requirement that within the CCG all their patients live in one particular area, so a CCG area can comprise (say) a part of London, a part of Hampshire and a part of Cumbria. It is impossible to see how planning, monitoring of needs, and equity of access and service use can be safeguarded when the populations are segmented, fragmented and dispersed in this way.

In effect, now, the entire population of a given area is covered by the NHS and PCT areas are contiguous. In future, this will not be the case: it will depend on what each CCG decides.

Under current plans resource allocation formula will change from an area-based formula, to one based on GP registrations (GP lists) with all the problems that will bring. These problems which are well documented include, unstable denominators and numerators due to enrollment, disenrollment of persons and turnover of patients, complex risk adjustment methods, and incentives to risk select or cherry pick[2]. This will adversely affect public health functions including the measurement of access to services, health service needs and equity of resource allocation and funding[3].

Clause 1, in conjunction with Clause 10, will therefore mean that patients in one particular area will not be provided for in the same way that they are at present.

Secondly, each CCG will decide for itself what the reasonable requirements for services of those persons registered are. They will also decide (Clause 10(2)(b)) what services or facilities are appropriate as part of the health service for the care of pregnant women, women who are breastfeeding and young children (section 3(1)(d)); and for the prevention of illness, the care of persons suffering from illness and the after-care of persons who have suffered from illness (section 3(1)(e)). These two discretions given to each CCG mean there will be different provision for different patients with similar needs, depending on each particular CCG.

The government says that this is the case under the PCTs now. But the crucial difference is that currently the core legal and unifying duty of the Secretary of State under section 3(1), linked to section 1(1) by section 1(2), is still in place. Currently everything stems from the Secretary of State's duty to provide. In future, it won't.

Thirdly, because of the Secretary of State's duty to provide, the PCTs are in effect responsible for everybody in their area, underpinned by the resource allocation formula. This will change, and what will happen in future is unclear to us.

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[2] McKee M et al. In defence of the NHS: why writing to the House of Lords was necessary. BMJ 2011; 343:6535.

[3] Pollock AM, Price D. Submission to the Delegated Powers and Regulatory Reform Committee, House of Lords 10 October 2011.

Under the NHS Functions Regulations,[4] PCTs must make sure services are provided for people on GPs lists, and for persons usually resident in its area, or resident outside the United Kingdom who are present in its area, and who are not on GPs' lists. And under, for example, The National Health Service (General Medical Services Contracts) Regulations 2004, the PCTs prepare and maintain GP lists, and **can assign patients to them**, subject to a dispute resolution procedure. In other words, although there is never 100% coverage, the intention is that the PCTs ensure that all residents within their geographic area obtain access to GP services and are registered with a GP.

PCTs must also ensure that certain specified services must be provided for the benefit of **everybody** in a PCT area, namely (i) accident and emergency services and ambulance services, (ii) services provided at walk-in centres, (iii) facilities and services for testing for, and preventing the spread of, genito-urinary infections and diseases and for treating and caring for persons with such infections or diseases, (iv) medical inspection and treatment of pupils, (v) services relating to contraception, (vi) health promotion services, (vii) services in connection with drug and alcohol misuse, and (viii) any other services which the Secretary of State may direct.

In future, a CCG will only be responsible for persons provided with primary medical services by a member of that CCG and those who usually reside in the CCG area (Clause 10(3): new section 3(1A)). Temporary residents, visitors, and workers not on those lists will not be covered. Regulations can be made to extend this (new section 3(1B)), and those regulations must cover everybody in the CCG area as far as facilities and services for emergency care are concerned (new section 3(1C)). Regulations may provide that some persons can be excluded from CCG responsibility, including those provided by a particular type of primary medical services (new section 3(1D)).

We have a number of concerns with new section 3(1A) – (1D), which we have set out below in the form of questions that peers may wish to ask the government:

- Why is CCG responsibility for persons not made definitive on the face of the Bill?
- Who, in future, will have the task of ensuring all residents and temporary residents can be registered with a local GP? And what will happen if GPs refuse to accept, or strike off, patients? Who will allocate problem patients, and patients with learning difficulties, severe disabilities, or complex mental health or physical health problems? What about asylum seekers, and the homeless and those of no fixed abode?
- Why is emergency care to be covered by regulations, not on the face of the Bill? Why are accident and ambulance services not mentioned?
- Will any of the other services currently to be provided for the benefit of all people present in a PCT have to be arranged by the CCGs? It is intended that some services will move with public health services to local

[4] The National Health Service (Functions of Strategic Health Authorities and Primary Care Trusts and Administration Arrangements) (England) Regulations 2002.

authorities, but the government should explain, category by category, what is to happen, and why is each of these services not also on the face of the Bill.
- Why is it necessary to give the government the power to exclude some persons from the health service (new section 3(1D))?
- More specifically, what categories of primary service provider does the government wish to be able to exclude from the health service? For example, new section 3(1D) would allow the Secretary of State to make regulations which took out of the health service persons receiving medical services under Alternative Personal Medical Services contracts – the one of the three basic GP contract types which is open to multinational health companies, such as United Health.

Fourthly, we are concerned that services currently considered part of the health service by PCTs (under direction from the Secretary of State) will in future not be considered as part of the health service by CCGs – namely the six services and facilities referred to above for pregnant women, women who are breastfeeding, and young children, and for the prevention of illness, the care of persons suffering from illness, and after-care. If a CCG so decides, these might fall out of the health service. This would mean that the qualified guarantee of free access in section 1(3) would not apply, and so charges could be made for services that are currently free.

This possibility arises because Clause 1 would amend section 1(3). At present, section 1(3) of the 2006 Act reads: "(3) The services **so provided** must be free of charge except in so far as the making and recovery of charges is expressly provided for by or under any enactment, whenever passed."

Under Clause 1, this would read: "(3) The services **provided as part of the health service in England** must be free of charge except in so far as the making and recovery of charges is expressly provided for by or under any enactment, whenever passed."

The proposed new section 1(3) should not be supported, and the government asked:

- How will the government prevent services that are currently free for pregnant women, young children, and others (as above) from being charged for?

4. Health policy issues raised by these clauses

Clauses 1 and 10 of the Bill, considered together, demonstrate that the fundamental principle informing the Health and Social Care Bill is the substitution of the current mandatory system with a discretionary one.

The net effect of the Bill's provisions is that, unlike PCTs, which act *on behalf of* the Secretary of State, CCGs exercise functions *in place of* the Secretary of State and in the absence of a clear primary legislative framework. Thus, the Secretary

of State is unable to discharge his or her duty to promote a comprehensive health service throughout England because the commissioning bodies which will control the majority (around 80%) of the NHS budget bodies do not collectively have a duty to cover all patients and in addition they have discretion over the services they provide and discretion to redefine eligibility and entitlements to NHS care. As a result there will be growing inequalities in access to care and NHS entitlements and erosion of progressive tax based funding for health care.

Furthermore, the loss of area-based population responsibilities has serious implications for the stability and accuracy of measurement of needs and the equity of resource allocation and funding and service provision. This also affects the availability and nature of information to plan for health care needs and services and for monitoring access, service use, and health outcomes, all of which are essential to securing a comprehensive service.