Health and Social Care Bill 2011
Briefing
House of Lords

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Clauses 1, 10, 11 and 172

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Summary

Certain delegated powers in the Health and Social Care Bill entail replacing the current mandatory system with a discretionary one.

Whereas primary care trusts (PCTs) act ***on behalf of*** the Secretary of State, clinical commission groups (CCGs) will exercise functions ***in place of*** the Secretary of State but without a clear primary legislative framework.

Henceforth it will be almost impossible for parliament to hold health bodies accountable for the various elements of their expenditure and despite retaining the wording with respect to the Secretary of State's principal duty to promote a comprehensive health service throughout England the mechanisms whereby it can be given effect are radically weakened.

Main points

- Under the Bill discretionary, non-universal, non-geographical powers will be the basis of commissioning functions and not as now comprehensive, universal, geographical duties.
- The Government deliberately avoids legislating for Commissioning Groups duties with respect to the services that must be provided and the groups to whom they must be provided[1].
- The Government claims that regulations on commissioners serve the same function as they do at present[2]. This is wrong. New regulations do not cover all persons in an area but only "persons for whom it [the CCG] has responsibility". Nor do they cover all services currently part of a comprehensive health system.

[1] Department of Health. Health and Social Care Bill 2011 Memorandum for the House of Lords Delegated Powers and Regulatory Reform Committee (updated to reflect the Bill as introduced in the House of Lords). Paragraphs 56 and 57.
[2] Department of Health. Health and Social Care Bill 2011 Memorandum for the House of Lords Delegated Powers and Regulatory Reform Committee (updated to reflect the Bill as introduced in the House of Lords), paragraph 57.

For example, accident & emergency and ambulance services are not an explicit CCG responsibility under these proposals.

- CCGs do not have areas in the same sense as PCTs. This is because they do not have to provide for all residents and because they may be made up of GP registrations from practices anywhere in the country.

- CCGs are only required to have "***a sufficient geographic focus"*** but the term is not defined.

- Loss of geographic area-based structures means that population needs assessment and equity of resource allocation will be seriously impaired if not rendered impossible.

- CCGs may assess whether a hospital should close. However, CCGs are not in a position to make this judgment because their responsibilities are not geographically focused and population-based.

- Henceforth it will be much more difficult for parliament to hold health bodies accountable for the various elements of their expenditure and despite retaining the wording with respect to the Secretary of State's principal duty to promote a comprehensive health service throughout England the mechanisms whereby it can be given effect are radically weakened.

Submission to the Delegated Powers and Regulatory Reform Committee, House of Lords

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Clauses 1, 10, 11 and 172

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We set out below our reservations about clauses 1, 10, 11 and 172 of the Health and Social Care Bill. We argue that delegated powers in these clauses should be on the face of the Bill in order that the Secretary of State may discharge his or her duty of promoting a comprehensive health service throughout England.

We first explore the fundamental principle informing the Health and Social Care Bill 2011, namely replacing the current mandatory system with a discretionary one.

Rationale

Clause 1 retains the duty of the Secretary of State to ***promote*** in England a comprehensive health service, and removes the duty for that purpose to ***provide or secure provision*** of health services in accordance with the Act. Clause 10 removes the duty on the Secretary of State to provide listed services throughout England and requires commissioning groups instead of the Secretary of State to determine the "reasonable requirements of the persons for whom it has responsibility". Clause 11 gives commissioning groups discretion over the services and people for whom they commission. Clause 172 gives commissioners the power to assess whether hospitals should be closed.

Taken together these clauses conflict with the principal duty of the Secretary of State to promote comprehensive health services. This is because:

- Commissioners' duties with respect to persons, services and areas are not set out in primary legislation.
- Regulations as to commissioners' functions will no longer be made with reference to a duty to secure the provision of specified services "for the benefit of all persons present in their area".

Basic reform principle

The fundamental principle informing the Health and Social Care Bill 2011 involves replacing the current mandatory system with a discretionary one. Under the Bill discretionary, non-universal, non-geographical powers will be the basis of commissioning functions and not as now comprehensive, universal, geographical duties.

<u>The current system</u>

Under sections 1(1) and 1(2) of the National Health Service Act 2006 the Secretary of State must promote in England a comprehensive health service for the people of England. For that purpose, the secretary of state must "provide or secure the provision of services in accordance with the Act".

The universal nature of this obligation is repeated in Section 3(1) of the NHS Act 2006, according to which the Secretary of State's duty applies "*throughout England*". This section also lists the services that shall be provided as part of a comprehensive service where "necessary to meet all reasonable requirements".

Under sections 7 and 8 of the NHS Act 2006 the Secretary of State may direct any of four health bodies to exercise his or her functions. These bodies are

(a) Strategic Health Authorities

(b) Primary Care Trusts (PCTs)

(c) NHS trusts

(d) Special Health Authorities.

Section 18 of the NHS Act 2006 makes clear that PCTs are established with responsibility for specific geographic areas and all the resident population within those areas.

Under NHS Functions regulations[3] PCTs must exercise their (delegated) functions in order to provide or secure provision ***"for the benefit of all persons present in their area"*** in six specified categories of services (emphasis added).

Area-based formulae are used to distribute resources fairly among the "local populations", "catchments" or "resident populations" of PCTs:[4]

> "Primary care trusts (PCT)s are responsible for funding NHS hospitals, GPs and other health care services for their local populations.
>
> "The Government, through the Department of Health, provides the money to all of the 151 PCTs across the country to fund these health services.
>
> "The Department sets PCTs' budgets in advance, mainly on the basis of a formula to calculate each PCT's fair share of the total available budget for England.
>
> "In 2011-12, the total health budget for PCTs was £89 billion and the Department has to find a way for splitting this up between PCTs in a fair way."

[3] Regulation 3(7)(a) of The National Health Service (Functions of Strategic Health Authorities and Primary Care Trusts and Administration Arrangements) (England) Regulations 2002 requires PCTs, as regards providing or securing the provision of services to patients (other than those in specified categories), to exercise their (delegated) functions for the benefit of the practice patients of GPs, and persons usually resident in its area, or resident outside the UK who are present in its area, and who are not GP practice patients.

[4] http://www.dh.gov.uk/en/Managingyourorganisation/Financeandplanning/Allocations/DH_125268

Since its inception, the NHS has been based on the principle of "equal access for equal need". This principle is embodied in two longstanding objectives for resource allocation from the centre to local health services:

- To distribute resources based on the relative need of each area for health services. Currently, this objective is to enable PCTs to commission the same levels of health services for populations with similar needs;

- In addition, to contribute to the reduction in avoidable health inequalities[5].

The resource allocation formula devised to meet these objectives includes

- the age profile of the population (localities with more elderly populations have higher needs, all else being equal);
- additional need over and above that relating to age (localities with less healthy populations and higher levels of deprivation have higher needs, all else being equal); and
- unavoidable geographical differences in the cost of providing services - the Market Forces Factor (MFF) (it costs more to provide the same level of services in high cost areas such as London and the South East).

From 2008 onwards, a separate component has been included in the formula to meet the objective of contributing to avoidable health inequalities. The indicator is:

- disability-free life expectancy (DFLE), which is the number of years from birth a person is expected to live which are free from limiting long-term illness and disability. DFLE exhibits a strong socio-economic gradient, decreasing with increasing deprivation, making it a reasonable choice of indicator in relation to health inequalities

<u>The proposed system</u>

Under the Health and Social Care Bill 2011 the Secretary of State's principal duty remains unchanged and under Clause 10(2) the duty to "arrange for the provision of services to such extent as it considers necessary… to meet …. reasonable requirements" is transferred to commissioning groups.

However, the Department of Health Memorandum to the Delegated Powers and Regulatory Reform Committee (paragraphs 53 and 57)[6] states that the intention of Clauses 10 and 11 is to allow commissioning groups discretion with respect to the selection of patients and services and that this discretion will be limited by regulation.

> "53. Clause 11 inserts new section 3A into the NHS Act 2006 and makes provision for discretionary powers of clinical commissioning groups to commission certain health services. Clause 10 inserts regulation-making powers at subsections (1B) and (1D) of section 3 of the NHS Act 2006. The powers in these new subsections of section 3 apply also to the discretionary power conferred by new section 3A, inserted by clause 11. The clinical commissioning group will also be responsible

[5] Department of Health. Resource Allocation: weighted capitation formula 7th edition. March 2011.
[6] Department of Health. Health and Social Care Bill 2011 *Memorandum for the House of Lords Delegated Powers and Regulatory Reform Committee (updated to reflect the Bill as introduced in the House of Lords)*

for ensuring anyone in their geographical area has access to emergency care if they need it.

"57. Delegating the power avoids the need to set out in primary legislation detailed provisions about the services to be provided and the groups to whom they must be provided. It also means that those details can be kept up to date without the need to wait for primary legislation. Regulations made under these powers would fulfil a similar function to the current NHS Functions Regulations."

Therefore contrary to the Memorandum the regulations referred to in para. 57 do not have the same function as current regulations, first because they do not apply to all persons in an area but only "persons for whom it [the CCG] has responsibility"; secondly, because they do not cover all services deemed part of a comprehensive health system. For example, accident & emergency and ambulance services are not an explicit CCG responsibility under these proposals since new section 3(1C) refers to "emergency care services" only.

Moreover, clinical commissioning groups (CCGs) do not have responsibility for all the people resident in defined geographic in the same sense as PCTs. This is because they neither include all persons in their 'area' and because a CCG may be made up of GP registrations from practices in non-contiguous areas.

This principle of flexibility with respect to services, persons and areas was set out by the Government in the White Paper[7] that preceded the Bill:

"Practices will have flexibility within the new legislative framework to form consortia in ways that they think will secure the best healthcare and health outcomes for their patients and locality"[8].

Although the Secretary of State has instructed the Advisory Committee on Resource Allocation (ACRA) from 2013 to switch from PCT and area- based populations to GP registrations in deriving its new formulae this is highly problematic. CCGs will not have the same geographical basis as PCTs, because they are able to include GP registrations from GP practices which could be anywhere in England. They are only required to have "***a sufficient geographic focus*** to be able to take responsibility for agreeing and monitoring contracts for locality-based services (such as urgent care services), to have responsibility for commissioning services for people who are not registered with a GP practice, and to commission services jointly with local authorities"[9]. However, "sufficient geographical basis" is not otherwise defined.

'Fair allocation' objectives need to be embodied in the new NHS system, but it is made almost impossible by the loss of responsibility for a defined geographic population. It is unclear, for example, if and how a measure such as DFLE could be derived for clinical commissioning groups, given their irregular, non-geographic overlapping mosaic of footprints.

[7] Department of Health. *Equity and excellence: liberating the NHS*. Cm7881. Stationery Office, 2010.
[8] Department of Health. *Equity and excellence: liberating the NHS*. Cm7881. Stationery Office, 2010, p28.
[9] Department of Health. *Equity and excellence: liberating the NHS*. Cm7881. Stationery Office, 2010, 29.

Under Clause 172 (Objective of trust special administration) dealing with the failure regime, commissioners may assess whether a hospital trust closes. A new section 65DA requires that criteria to be met include an assessment of whether closure would "(a) have a significant adverse impact on the health of persons in need of the service or significantly increase health inequalities, or (b) cause a failure to prevent or ameliorate either a significant adverse impact on the health of such persons or a significant increase in health inequalities." However, CCGs are not in a position to make these judgments because their responsibilities are not geographically focused and population-based.

Implications

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 to whom.

Furthermore, the loss of area-based population responsibilities has serious implications for the stability and accuracy measurements of needs and the equity of resource allocation and funding. This in turn will affect equity of service provision as well as the availability of information for monitoring and to plan for health care needs, services and health outcomes, all of which are essential to securing a comprehensive service.

The duty to provide a comprehensive health service throughout England is dependent on the ability to monitor health care needs, plan services and allocate funds on a geographical basis.

Under the new system funding will cease to be allocated for all the population in a defined geographic area. Instead CCG funding will be based on the GP registrations on patient lists of their constituent general practices. This allocation system will be the responsibility of the NHS Commissioning Board and not, as now, the Secretary of State.

According to the independent body responsible[10], there is currently no reliable method for allocating funds fairly on a person basis rather than a population basis. The principle is in any event undermined by CCG discretionary powers, so even were a funding formula available on an individual basis not all services would be included and the person-based budget would have to be fragmented among different payers. There is no precedent for such a system in England or the United Kingdom. Moreover the Government's advisory committees have highlighted the serious risks of adopting this approach[11].

Loss of geographic area-based structures combined with a switch to registered patients

[10] Department of Health. Advisory Committee on Resource Allocation summary of recommendations. 2010. www.dh.gov.uk/en/Managingyourorganisation/Financeandplanning/Allocations/index.htm.
[11] http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_091483.pdf
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_124199.pdf

of CCGs with irregular, non-geographic footprints means that population needs assessment and equity of resource allocation will be seriously impaired if not rendered impossible . This has major implications for equity of access and universal coverage. The population to be covered and the basis of funding will no longer be clear and area- and service-based expenditure monitoring such as is undertaken by PCTs will no longer be possible.

Henceforth it will be almost impossible for parliament to hold health bodies accountable for the various elements of their expenditure and despite retaining the wording with respect to the Secretary of State's principal duty to promote a comprehensive health service throughout England the mechanisms whereby it can be given effect are radically weakened.