Health and Social Care Bill 2011
House of Lords Committee Stage

Second Briefing on clause 1 for day 1, 25 October 2011
in the light of evidence from Professor Malcolm Grant

This briefing explains the impact of the Health and Social Care Bill 2011 on the legal framework underpinning a comprehensive and universal national health service.

It adds new information to the earlier briefing sent out on 22 October in the light of evidence to the House of Commons Health Committee (Appointment of the Chair of the NHS Commissioning Board: eleventh report, 20 October 2011).

In his evidence, Professor Grant, the government's candidate to chair the NHS Commissioning Board, said the Health and Social Care Bill **involves "an extraordinary transfer of responsibility"**, but that the Bill was **"completely unintelligible".**

In this briefing we show how clause 1 will fundamentally change the NHS for the worse.

A number of amendments and proposals have been put forward for Day 1 that would restore the existing duties of the Secretary of State. However, clause 1 and the amendments to it cannot be debated in isolation. If any of these are carried, other amendments will be needed later on. The most important of these clauses is clause 10, and it is the relationship between clauses 1 and 10 that is the focus of this briefing.

The briefing is divided into three main sections. These are

A The effect of clause 1 on the existing duties of the Secretary of State;
B The effect of clauses 1 and 10 of the Bill on patients and services;
C Health policy issues raised by these clauses.

A The effect of clause 1 on the existing duties of the Secretary of State: the duties to 'promote' and to 'provide or secure and provide'

The current legal framework is set out in section 1(1) of the National Health Service Act 2006 (Secretary of State's duty to promote health service). This places on the Secretary of State the duty to

> continue the promotion in England of a comprehensive health service designed to secure improvement (a) in the health of the people of England and (b) in the prevention, diagnosis and treatment of illness.

For that purpose, the Secretary of State has the duty under section 1(2) to 'provide or to secure the provision of' health services in accordance with that Act.

Under section 3(1) of that Act, (Secretary of State's duty as to provision of certain services), the Secretary of State also has the duty '*throughout England*' to provide certain

listed health services *'to such extent as he considers necessary to meet all reasonable requirements*.' These three provisions – in sections 1(1), 1(2) and 3(1) have been essentially unchanged, since 1948.

Clause 1 (Secretary of State's duty to promote comprehensive health service):

The effect of clause 1, taken together with clause 10, is threefold

1 Section 1 of the 2006 Act will continue to require the Secretary of State to 'promote' the NHS but he or she will **no longer** be under a duty to 'provide or secure the provision of' services as there is a new but diluted duty on clinical commissioning groups (CCGs).

Our case is that there will be much less of an NHS to, as it were, be promoted and that if this clause is agreed, the NHS will not be comprehensive in the way that it is today.

2 By clause 10, the duty of the Secretary of State to provide certain listed services throughout England to meet all reasonable requirements is removed from the 2006 Act and replaced by a duty on an unknown and essentially unrestricted number of CCGs each to arrange provision '*to such extent as it considers necessary meet the reasonable requirements of the persons for whom each has responsibility'.*

Our case is that if this clause is agreed, the NHS will not be universal.

3 There will be a severance of the duty to promote in section 1(1) from the duty to provide specified services in section 3(1), so that the person with the latter duty would not have the former duty.

Our case is that the severance of these duties will mean the Secretary of State will no longer be accountable to Parliament for the provision of services to patients in the new NHS.

> Effectively, the duty to provide a **national** health service would be lost if the Bill becomes law. It would be replaced by a duty on an unknown number of commissioning consortia with only a duty to make or arrange provision for that section of the population for which it is responsible. Although some people will see this as a good thing, it is effectively fragmenting a service that currently has the advantage of national oversight and control, and which is politically accountable via the ballot box to the electorate.
> (Counsel's opinion for pressure group 38 Degrees)
> http://38degrees.3cdn.net/75856a0564e9244f2a_rum6i66sh.pdf

The House of Lords Constitution Committee made a similar point:

> We are concerned that the Bill, if enacted in its current form, may risk diluting the Government's constitutional responsibilities with regard to the NHS.
> (House of Lords Select Committee on the Constitution. Eighteenth Report of Session 2010 - 12: Health and Social Care Bill. HL Paper 197).
> http://www.publications.parliament.uk/pa/ld201012/ldselect/ldconst/197/19702.htm

Note also that by clause 6, section 1 of the 2006 is Act is to be amended to subject the new NHS Commissioning Board to a concurrent 'duty to promote', except for public health functions. It remains to be seen how this will work.

B The effect of clauses 1 and 10 of the Bill on patients and services

i Clinical commissioning groups

Clinical commissioning groups (CCGs) are established by clause 7, which inserts a new section 1F into the 2006 Act. CCGs will be given what is left of the Secretary of State's duty to provide services. By section 1F(2), each clinical commissioning group has the function of arranging for the provision of services for the purposes of the health service in England in accordance with the (amended) 2006 Act. The use of the word 'arrange' here may not make much difference.

ii Clause 10 (Duties of clinical commissioning groups as to commissioning certain health services)

Clause 10 amends section 3 of the 2006 Act (Secretary of State's duty as to provision of certain services).

The existing arrangements are set out in section 3(1) of the 2006 Act. This places a duty on the Secretary of State to

> provide throughout England, to such extent as he considers necessary to meet all reasonable requirements—
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> (a) hospital accommodation,
> (b) other accommodation for the purpose of any service provided under this Act,
> (c) medical, dental, ophthalmic, nursing and ambulance services,
> (d) such other services or facilities for the care of pregnant women, women who are breastfeeding and young children as he considers are appropriate as part of the health service,
> (e) such other services or facilities for the prevention of illness, the care of persons suffering from illness and the after-care of persons who have suffered from illness as he considers are appropriate as part of the health service,
> (f) such other services or facilities as are required for the diagnosis and treatment of illness.

A new concept in NHS legislation is the departure from contiguous area based responsibilities where all residents are covered to membership based organisations based on GP registrations. Under Clause 10(3), four new subsections would be inserted into section 3 of the 2006 Act to deal with it.

The new s.3(1A) added by clause 10 provides that a CCG has responsibility for

(a) persons who are provided with primary medical services by a member of the group, and

(b) persons who usually reside in the group's area and are not provided with primary medical services by a member of any clinical commissioning group.

So a CCG would not necessarily be responsible for anybody else, such as temporary residents, visitors, or workers who had not registered with a member of the group. This is clear from the other powers in the new sections 3(1B) to 3(1D) added by clause 10. These provisions contain important powers to allow the Secretary of State to make regulations.

The proposed move away from area-based healthcare delivery will be severely detrimental to public health. The effect of the proposed new regulations on public health is uncertain. We say that these powers are too important to be left to regulations.

New subsection (1C) provides that the regulation-making power in new subsection (1B) must be exercised to make it clear that CCGs are responsible for providing emergency care to everyone present in their area. This suggests that CCGs are not automatically to be responsible for emergency care or indeed for the range of services currently provided by PCTs – and implies that the regulations setting out these services will need to be repealed.

Note also new subsection (1D) of this clause, by which regulations may provide that CCGs do not have responsibility for certain people or cases that would otherwise meet the criteria in subsection (1A). This would allow regulations to disapply section 3(1A) in relation to persons of a prescribed description (which may include a description framed by reference to the primary medical services with which the persons are provided) in prescribed circumstances.

These powers would allow the Secretary of State to exclude CCGs from providing certain services and from providing certain primary medical services to certain citizens and visitors in certain circumstances. For example, Regulation 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.

This discretion to CCGs in the new section 3 inserted by clause 10 as to what services to provide could have an impact on charges for services.

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.

If the bill is enacted, services for the care of pregnant women and women who are breastfeeding, for example, under section 3(1)(d) of the 2006 Act, will no longer be provided as part of the Secretary of State's duty. **They could be provided free as part of the health service but it would be open to a CCG to provide them for a charge outside the health service.**

We are concerned that CCGs will provide fewer services and to fewer persons than PCTs and GPs do now.

C 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 primary care trusts, 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 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. 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.

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