

Health & Social Care Bill 2011 House of Lords report stage

Briefing note 15

How the Health and Social Care Bill would lead to fewer NHS services, new charges, and people being excluded: clauses 10, 11, 12, 17, 49, and 103

Summary

We explain in this briefing how the Bill would establish the legal basis

for providing fewer services than those commissioned by Primary Care Trusts (PCTs) under their **duty** to provide, by proposing to give local authorities only **discretionary powers** to commission 20 categories of services, namely:

- public health services for children and young people aged 5-19
- public mental health services
- dental public health services
- accidental injury prevention
- tobacco control and smoking cessation services
- alcohol and drug misuse services
- the National Child Measurement Programme
- interventions to tackle obesity such as community lifestyle and weight management services
- locally-led nutrition initiatives
- increasing levels of physical activity in the local population
- NHS Health Check assessments
- population level interventions to reduce and prevent birth defects
- behavioural and lifestyle campaigns to prevent cancer and long-term conditions
- local initiatives on workplace health
- supporting, reviewing and challenging delivery of key public health funded and NHS delivered services such as immunisation and screening programmes
- local initiatives to reduce excess deaths as a result of seasonal mortality
- the local authority role in dealing with health protection incidents, outbreaks and emergencies
- public health aspects of promotion of community safety, violence prevention and response
- public health aspects of local initiatives to tackle social exclusion

- local initiatives that reduce public health impacts of environmental risks.¹

for providing fewer services that are currently part of the NHS, by giving the power to clinical commissioning groups (CCGs) to decide if provision is appropriate as part of the health service, namely

- for pregnant women
- women who are breastfeeding
- young children
- the prevention of illness
- the care of persons suffering from illness and the after-care of persons who have suffered from illness

and thus permitting commercial considerations to influence what would be regarded as appropriate as part of the health service;

for introducing charges for services that are currently free under the NHS, including charges on individuals for all the services listed in the above two bullet point lists where they become public health services and are provided through the local authority; and

for excluding people from health services, through secondary legislation and, possibly, under mandated but unclear patient eligibility and selection criteria which require urgent clarification.

The picture is made more uncertain by the Bill proposing to give responsibility for services or facilities for the prevention, diagnosis or treatment of illness to the Secretary of State and to local authorities, as well as this being the responsibility of CCGs. Given this overlap of powers and duties, it is impossible to state precisely where responsibility for care will lie in the future or what will remain funded as part of the NHS with respect to the provision of these services or facilities.

Recent amendments put forward by the Liberal Democrats do not address these issues.

¹ HM Government. Healthy lives, healthy people: update and way forward. Cm 8134, July 2011, , p27 <http://www.official-documents.gov.uk/document/cm81/8134/8134.pdf> (accessed Feb 29, 2012).

Introduction

In this briefing we focus on the legal framework for service provision and charging that the Health and Social Care Bill if enacted would introduce. We show how the Bill would legalise policies not currently legal and allow organisations to exclude services and persons from NHS services.

Replacing the Secretary of State's duty to provide the NHS with, mainly, discretionary powers for CCGs and local authorities to commission services from providers who must set patient eligibility and selection criteria are the cornerstone of the new framework. CCGs are not PCTs by another name. Basically, a PCT must provide or secure provision of services for everyone in a defined geographical area. CCGs will not have that duty, and nor will their responsibilities be area-based.

The government has not so far explained the need for this huge legal change. It has argued – in the same letter – on the one hand that the Bill “will change little” and on the other that the changes are “vital”.²

Here we show that the changes are only vital to the creation of a system that would abolish or seriously undermine the model of tax-financed universal health care on which the NHS is based and facilitate a transition to the mixed financing model of the USA.

1 How the Bill would legalise provision of fewer NHS services

There are two ways in which this would happen.

i **Regulations which specify the services a PCT must provide or secure for everybody in its area will be revoked**

Under current law, the Functions Regulations³ require a PCT to provide or secure provision of the following services for everybody in its area:

- 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 (sexual health services)

² Earl Howe to Baroness Jay of Paddington, 10 October 2011. Health and Social Care Bill: 18th Report of Session 2010-12. Earl Howe asserts both that “changing the 2006 Act is vital” (paragraph 25) and that “In practice, the Bill will change little” (paragraph 8).

³ National Health Service (Functions of Strategic Health Authorities and Primary Care Trusts and Administration Arrangements)(England) Regulations 2002 S.I 2002/2375, Regulation 3(7).

- 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
- viii any other services which the Secretary of State may direct.

Under the Bill, Clause 12 would require CCGs only to arrange for “ambulance services” and “emergency care”.⁴ They would not be required to arrange services relating to genito-urinary infections and diseases, medical inspection and treatment of pupils, contraception, health promotion, and drug and alcohol misuse (ie., those listed in (iii)-(vii) above.

These five categories of service – currently provided free of charge under the NHS – will therefore fall out of the NHS.

- ii **Weaker legal duties as regards services for pregnant women, young children, and others would lead to provision of these services not being arranged by CCGs.**

Under current law,⁵ the Secretary of State must provide such of the following services or facilities to meet all reasonable requirements throughout England that he or she **considers appropriate as part of the health service**:

- i the care of pregnant women
- ii women who are breastfeeding
- iii young children
- iv the prevention of illness
- v the care of persons suffering from illness
- vi the after-care of persons who have suffered from illness.

This test of appropriateness does not apply to hospital accommodation, or to medical, dental, ophthalmic, nursing, and ambulance services.

Under the Bill, the appropriateness test would be carried out by the CCGs, but it highly unlikely that this would be done only by clinicians. GPs are not competent to carry out procurement procedures. The Bill therefore allows those with expertise in these procedures – such as management consultants and law and accounting firms - to sit on CCG committees in order to carry out CCG commissioning (Clause 24, and Schedule 2). In this way a tension between clinical judgment and commercial

⁴ We remain concerned that it has still not been made clear why the current wording in the Functions Regulations of “accident and emergency services” has been changed in Clause 12 to “emergency care”. We are also unclear on the fate of services provided in walk-in centres.

⁵ Section 3(1)(d) and (e) of the National Health Service Act 2006.

interests is built into CCGs, which will influence how CCGs decide to spend the money given them by the NHS Commissioning Board.

It is reasonable to assume that the combined effect of the increased legal room for manoeuvre around the provision of these six categories of services, and this CCG clinical-commercial structural tension would result in services not being commissioned by CCGs. The extent to which this would happen is unclear, not least because the Bill would allow variation among CCGs in the levels of care considered appropriate in these respects. Care not considered appropriate may fall under the “public health functions” of the Secretary of State or of local authorities (see further below). But if they do not – or if the weaker public health functions fail to deliver the services – they would become the responsibility of individual patients and their families.

Thus the Bill is setting the legal basis for fewer services being provided as part of the NHS, firstly by not transferring to CCGs the “universal provision” duties of the PCTs under the Functions Regulations (except for “emergency care”), and secondly by structuring CCGs so as to give commercial interests a role in determining the appropriateness of certain services.

Some services no longer arranged by CCGs – as result of (1) or (2) above – may be provided under the new so-called “public health functions” of the Secretary of State or local authorities but there would be no legal requirement to make or arrange this provision on the face of the Bill.

The Secretary of State would have duties to take appropriate steps to protect the public from disease or other health dangers, and to improve the health of the people of England (Clause 10: new s.2A(1), and Clause 11: new s.2B(2), respectively). Local authorities would have a duty to take appropriate steps to improve the health of local people. (Clause 11: new s.2B(1)). Regulations may require local authorities to carry out the Secretary of State’s duties (Clause 17: new s.6C(1)).

The Bill lists various “steps” that “may be taken”, but the only services that are expressly mentioned as *possibly* being provided in pursuance of these duties are (under new s.2A) microbiological or other technical services; vaccination, immunisation or screening services; and other services or facilities for the prevention, diagnosis, or treatment of illness; and (under new s.2B) services or facilities designed to promote healthy living; services or facilities for the prevention, diagnosis or treatment of illness; and making available the services of any person or any facilities.

There is therefore ***no legal requirement*** under new ss.2A and 2B for ***any*** of the services that fall out of the NHS under (1) or (2) above to be taken up by the public health functions of the Secretary of State or local authorities.

In its December 2011 Public Health in Local Government fact sheet, the Department of Health stated that local authorities would have commissioning responsibilities in 21 categories:

Local authorities will be responsible for:

- *tobacco control and smoking cessation services*
- *alcohol and drug misuse services*
- *public health services for children and young people aged 5-19 (including Healthy Child Programme 5-19) (and in the longer term all public health services for children and young people)*
- *the National Child Measurement Programme*
- *interventions to tackle obesity such as community lifestyle and weight management services*
- *locally-led nutrition initiatives*
- *increasing levels of physical activity in the local population*
- *NHS Health Check assessments*
- *public mental health services*
- *dental public health services*
- *accidental injury prevention*
- *population level interventions to reduce and prevent birth defects*
- *behavioural and lifestyle campaigns to prevent cancer and long-term conditions*
- *local initiatives on workplace health*
- *supporting, reviewing and challenging delivery of key public health funded and NHS delivered services such as immunisation and screening programmes*
- *comprehensive sexual health services (including testing and treatment for sexually transmitted infections, contraception outside of the GP contract and sexual health promotion and disease prevention)*
- *local initiatives to reduce excess deaths as a result of seasonal mortality*
- *the local authority role in dealing with health protection incidents, outbreaks and emergencies*
- *public health aspects of promotion of community safety, violence prevention and response*
- *public health aspects of local initiatives to tackle social exclusion*
- *local initiatives that reduce public health impacts of environmental risks.*

The fact sheet continues:

Only some of the above services are to be mandated. The commissioning of other services will be discretionary, guided by the Public Health Outcomes Framework,

the local joint strategic needs assessment and the joint health and wellbeing strategy.

In other words, local authorities will not be required to provide or arrange for the majority of these services.

According to the same fact sheet, of these 21 categories of services, only sexual health services are stated as being subject to mandatory commissioning (under secondary legislation). Commissioning of services for children is apparently to be divided until 2015 between the NHS Commissioning Board (from birth to five years of age) and to local authorities from six years of age. The government has changed its mind, and says that it is to keep abortion services in the NHS, subject to consultation.

In previous briefing notes we posed the following questions:

What services will local authorities be expected to provide in terms of immunisation, child health services, public mental health services and other services as yet to be identified? How will these be defined and commissioned?⁶

The government replied to this earlier this month:

Whilst local authorities will become the lead local body for many public health services, where appropriate we will ask the NHS Commissioning Board to commission specific services funded from the public health budget. These services will include immunisation programmes, contraception in the GP contract, screening programmes, public health care for those in prison or custody and children's public health services from pregnancy to age 5 (including health visiting).⁷

This statement by the government confirms that, **on the face of the Bill, there is neither a duty on the NHS Commissioning Board to commission the services in question nor a duty on local authorities to provide them.**

By not imposing on the Secretary of State or local authorities a duty to provide or to arrange the provision of services that would fall out of the NHS – with sexual health services to date the only stated exception - **the Bill establishes the legal basis for not providing those services.**

The picture is made more uncertain by the Bill proposing to give responsibility for services or facilities for the prevention, diagnosis or treatment of illness to the

⁶ See [Briefing Note 6](#) (11th November 2011) and [Briefing Note 11](#), Appendix (9th January 2012).

⁷ This answer was provided by the government in a document attached to an email sent on 1st February 2012 by John Foster from the Department to Health to Graham Winyard. The document itself is undated, but saved with a title which includes "240112".

Secretary of State (under new s.2A) and to local authorities (under new s.2B), as well as this being the responsibility of CCGs under section 3. Given this overlap of powers and duties, it is impossible to state precisely where responsibility for care will lie in the future or what will remain funded as part of the NHS with respect to the provision of these services or facilities.

2 How the Bill would legalise introduction of charges for services that are currently free under the NHS

Services that would fall out of the Functions Regulations or which a CCG would decide were not “appropriate as part of the health service” – which are currently provided free of charge – would, if the Secretary of State or a local authority decides to provide them or to arrange for their provision, be subject to new charging powers.

This would be achieved through Clause 49 of the Bill, entitled *Charges in respect of certain public health functions*. That Clause would insert a new s.186A into the NHS Act 2006, which would allow the Secretary of State to make charges “in respect of any step taken under section 2A” calculated on such basis as he or she considers appropriate.

This power would therefore apply to services which would be provided – whatever they might be – pursuant to the Secretary of State’s public health functions in relation to protection from disease or other health danger. New s.186A(2) would prevent such charges applying to the provision of a service to an individual, or the taking of any other step in relation to an individual, for the purpose of protecting the individual’s health.

In addition, regulations may provide for the making and recovery of charges in respect of the taking of prescribed steps by a local authority under s.2B and under s.2A by virtue of regulations under new s.6C(1).

Thus where local authorities would provide services or have services provided pursuant to their own public health duty, or where such services were being provided by or through them pursuant to the Secretary of State’s delegated duty, regulations would be able to allow charging, including charging individuals.

Accordingly the Bill would establish the legal basis for charging individuals for services that are currently free, including, if they are provided through the local authority services:

- for pregnant women, women who are breastfeeding, young children, drug misuse, sexual health, the prevention of illness, the care of persons suffering from illness and the after-care of persons who have suffered from illness, where a CCG decides the appropriateness test is not met; or
- relating to sexual health, contraception, alcohol and drug misuse and medical inspections in schools.

3 How the Bill would legalise exclusion of people from health services

Current law⁸ does not permit the exclusion of anybody from the health service. However, the Bill proposes one clear mechanism for doing so, and proposes another which could have that effect.

i The government wants the power to allow CCGs not to arrange provision for persons on GP lists

At the moment, PCTs are responsible for everybody in an area. In future, only “emergency care” would have to be arranged by CCGs (under secondary regulations), and CCGs would otherwise only be responsible for people on the lists of the GPs who are members of a particular CCG, or are usual residents not on any CCG member’s list. The people for whom a CCG must arrange provision can be restricted by regulations under new s.3(1D).⁹

This remarkable power undermines the fundamental intention behind the NHS to provide for everyone throughout England.

The government has said that it

*is intended that this power will be exercised, for example, in order that people who are resident in Scotland, but registered with a practice that is a member of a CCG are not the responsibility of a CCG for these purposes. This could also apply to people who are receiving primary medical services as ‘temporary residents’.*¹⁰

Aside from whether the two examples are justified – why, for example, should temporary residents who have registered with a GP be capable of being excluded? – as currently drafted new s.3(1D) is much more widely cast than the examples suggest and sets the legal basis for excluding people from health services.

It could, for example, permit the Secretary of State to make regulations to take out of the health service persons receiving primary medical services under particular types of contract – such as a large corporate provider.

⁸ Section 3 of the NHS Act 2006.

⁹ Clause 12 would insert a new s.3(1D) into the NHS Act 2006, as follows: “Regulations may provide that subsection (1A) does not apply— (a) 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); (b) in prescribed circumstances.” S.3(1A) states: “For the purposes of this section, a clinical commissioning group 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.”

¹⁰ Explanatory Notes to the Bill, paragraph 124.

This is bad in principle: lawmakers should not give the executive more power than it needs to implement its policies.¹¹

ii Providers would not have to provide for everybody

Clause 103 appears to be capable of excluding people from receiving health services.

This unclear provision would require all providers of health care services, as a condition of their licence, to set patient eligibility and selection criteria, which must be transparent. Such criteria would be used for determining “whether a person is eligible, or is to be selected, to receive health care services provided by the licence holder for the purposes of the NHS”.

These criteria would then have to be applied “in a transparent way” in circumstances where patients have a choice of provider. Access to NHS services would therefore be a function of the selection and eligibility criteria of providers from which CCGs commission services as well as, or in addition to, a function of a CCG’s determination of services “to such extent as it considers necessary to meet the reasonable requirements of the persons for whom it has responsibility” under Clause 12.

The government explains these provisions, and implicitly admits that there will be ‘cherry-picking’ by providers, as follows:¹²

The effect of this clause is to require Monitor must include (sic) a standard condition in all licences, which requires licence holders to act transparently in the setting and application of criteria for determining patient eligibility for particular services, for accepting or rejecting referrals, or determining the manner in which services are provided to that person. This transparency requirement will only operate wherever those services are subject to patient

¹¹ Attempts have been made to curtail the new power. Amendments have been tabled to Clauses 24 and 25 by Baroness Williams of Crosby, Lord Marks of Henley-on-Thames, Baroness Baker and Lord Clement-Jones. Amendment 75 would insert a new sub-section into new s.4A, and Amendment 95 would insert a new s.14PA. These amendments appear to be an oblique attempt to plug the gap caused by Clause 12 removing the duty of the Secretary of State to provide services throughout England and failing to give any other body a provision duty with national coverage. They are also messy amendments, however, which do not go very far: CCGs would arrange provision of services, not provide them; and provision of any services would appear to constitute compliance. More importantly, the problems with CCG service and patient coverage needs to be dealt with in the Clause that causes those problems, Clause 12. These amendments would leave Clause 12 intact, and do not address the fundamental structural problems which flow from removing the government’s duty to provide and the shift from area-based to list-based responsibilities. More detail is provided in [Briefing Note 14](#).

¹² Explanatory Notes to the Bill, paragraph 779.

choice of provider. This will enable Monitor to minimise the scope for providers to make extra profits by 'cherry picking'- i.e. delivering a service only in less complex cases – by requiring them to be transparent about their patient eligibility and selection criteria.

The criteria could, it seems, for example require hospitals to refuse admission, to control patient discharge, and to determine the boundaries between free and chargeable health care, and between free health care and chargeable social care.

Removing or increasing the private patient cap would also impact on the extent to which these criteria would entitle NHS patients to receive hospital treatment.

There are many unanswered questions, however, about the applicability and operation of this Clause, and the government should provide clear answers to these questions as a matter of urgency. For example:

- How does this Clause affect the duty of CCGs to arrange provision of services to meet the reasonable requirements of the persons for whom they have responsibility?
- What constitutes patient choice in this regard? If a patient's CCG has contracted with a single provider with eligibility and selection criteria that that patient does not meet, does the Clause apply? If a patient's CCG has contracted with two providers and the patient only meets the eligibility criteria of one of them, what choice is that? If a patient's CCG has contracted with two providers and the patient does not meet the criteria, how would that patient be provided for?
- Who decides if a patient is eligible, who makes the selection, what recourse does a patient have if he or she is not eligible or is not selected, and how quickly could such recourse be obtained?
- Under what circumstances could patients be turned away or denied care?
- What guidance would be given on eligibility and selection criteria?
- How would the effects of removing or increasing the private patient cap on a provider's eligibility and selection criteria be (i) determined; (ii) controlled, and (iii) monitored?
- Would patients whose CCGs have no contract with a provider be turned away from a hospital or refused a referral if they request it?
- Would providers be able to set criteria according to:
 - a socio-demographic variables?

- b co-morbidities?
 - c CCG commissioning decisions?
 - d provider decisions on scope of NHS coverage?
- Would providers be able to offer insurance or co-insurance or to charge for any service which by reason of the criteria would not be available to a particular patient from that provider as an NHS service?

Finally, for the avoidance of doubt, we wish to make clear that amendments recently tabled by Liberal Democrat peers and appearing in the Fourth Marshalled List of Amendments (28th February 2012) do not address the issues raised in this briefing.

Allyson Pollock, Professor of Public Health Research and Policy at Queen Mary University of London
David Price, Senior Research Fellow at Queen Mary University of London
Peter Roderick, public interest lawyer

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