How the Health and Social Care Bill 2011 would end entitlement to comprehensive health care in England

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The National Health Service (NHS) in England has been a leading international model of tax-financed, universal health care. Legal analysis shows that the Health and Social Care Bill currently making its way through the UK Parliament[1] would abolish that model[2] and pave the way for the introduction of a US-style health system by eroding entitlement to equality of health-care provision. The Bill severs the duty of the Secretary of State for Health to secure comprehensive health care throughout England and introduces competitive markets and structures consistent with greater inequality of provision, mixed funding, and widespread provision by private health corporations. The Bill has had a turbulent passage. Unusually, the legislative process was suspended for more than 2 months in 2011 because of the weight of public concern.[3] It was recommitted to Parliament largely unaltered after a "listening exercise". These and more recent amendments to the Bill do not sufficiently address major concerns that continue to be raised by Peers and a Constitution Committee of the House of Lords,[4,5] where the Bill now faces one of its last parliamentary hurdles before becoming law.

Fundamental to the Bill are provisions that transform a mandatory system into a discretionary one with structures that permit the introduction of charging for services that are currently free under the NHS, as well as a system in which much delivery would be privatised. Under the current statutory framework the Government has a legal duty to secure comprehensive health care, whereas, under the new system, substantial discretionary powers will instead be extended to commissioners and providers of care. These measures will increase inequalities of provision.

Clauses 1 and 12 of the Bill will dismantle key sections of the 1946 founding legislation of the NHS by repealing the unifying duty from which all other legislative powers and functions flow.[6] This unifying duty is currently laid down in Sections 1 and 3 of the National Health Service Act 2006. It requires the Government to promote a comprehensive health service by providing or securing the provision throughout England of a list of specified NHS services and hospital accommodation in ways that meet all reasonable requirements. Accordingly, since 1948, most NHS hospital and community-based provision has its own facilities and NHS staff. The whole system has been publicly administered and funded on the basis of contiguous geographical areas by bodies, now called primary care trusts (PCTs), that act on behalf of the Secretary of State and have responsibility for the health-care needs of everyone in their area. Experiments with internal and external markets since 1990 have taken place within this overarching geographical framework.

The Bill creates two new bodies with responsibility for managing care: an NHS Commissioning Board and Clinical Commissioning Groups (CCGs), the number of which remain unclear. PCTs will be abolished and not replaced. Powers currently exercised by the Secretary of State for Health will be transferred to each CCG, which, in contrast to PCTs, will act in place of, and not on behalf of, the minister. The NHS Commissioning Board will exercise its functions at a distance from the Secretary of State and have oversight of CCGs. These changes will repeal the minister's core duty to provide or secure provision of specified health services.

Clause 12 of the Health and Social Care Bill repeals the Secretary of State's "duty to provide" specific services.

***Panel*: Red lines to protect the NHS**

1 The Secretary of State must have the duty to secure provision of comprehensive and equitable health care for the whole of the population of England, taking action whenever there are problems.
2 CCGs, operating on behalf of the Secretary of State, must make sure that comprehensive and equitable health care is available for everyone and be responsible for all residents living in single geographically defined areas that are contiguous, without being able to pick and choose patients.
3 Nothing must be done that undermines the ability of the Secretary of State to fulfil the duty to secure provision of comprehensive and equitable health care, by bringing more of the NHS within the scope of EU competition law so that, in particular:
- There must be no increase in the commercial contracting of health services;
- The current authorisation system for central regulation of Foundation Trusts must be retained;
- Statutory functions of CCGs must be carried out by NHS staff, with CCG finances being used solely for the benefit of patients;
- Statutory and enforceable codes of conduct must be laid down for all NHS bodies, underpinned by sanctions that are rigorously policed;
- Information about commercial contracting, including the planning, procurement, financing, and monitoring, must be available as a matter of course.

CCGs=Clinical Commissioning Groups.

Instead, a "duty to arrange" provision is imposed on each of the many CCGs that will also have transferred to them the power to determine what care is necessary to meet all reasonable requirements. However, CCGs will not have the duty to promote a comprehensive free health service. Amendments suggested by the Government in a letter to Peers from the responsible minister dated Jan 12, 2012, do not restore the duty.[7] Thus, the link between the duty to promote comprehensive care and the duty to provide would be severed.

Although the Government has said that its intention is to "reinforce" the overarching duty to promote a comprehensive health service,[8] the creation of bodies that are independent of the Secretary of State for Health to support a lesser duty fundamentally affects the minister's duty. This is because the test of whether the Secretary of State is discharging his or her duty to promote a comprehensive health service will no longer depend on whether a comprehensive service is actually provided.

As well as transferring powers from the Secretary of State to other bodies, the Bill leaves each CCG free to choose the patients for whom they have responsibility. Unlike PCTs, CCGs will not be responsible for all residents within contiguous geographical areas. CCGs select patients, initially assembling their patient populations on the basis of general practitioners' (GPs) lists; they will not have to cover everyone in a geographical area but only "persons for whom it [the CCG] has responsibility". Nor will they be required to arrange for the provision of all the services that are currently part of the comprehensive health system. For example, accident and emergency services are not an explicit CCG responsibility under these proposals. Only a new category "of services or facilities for emergency care" will have to be provided for people in a CCG's area, which need not consist of adjoining or indeed whole electoral districts, as is the case with PCTs.

Another organisation, known as Monitor and with the functions of a regulator, is independent of the Secretary of State for Health, and will have oversight of providers (public and private) in the new system. However, it will not have a duty to promote a comprehensive service—a crucial consideration given that its decisions about the extent of competition will affect the financial viability of local services. In a parallel move, NHS hospitals that currently get most of their funding from NHS sources will be free to obtain almost half their income from private patients.

Although there are provisions in the Bill giving the Secretary of State for Health power to regulate the new system through secondary rather than primary legislation, that power is limited by a new clause (Clause 4), under which the minister has a duty to observe the autonomy of commissioners and providers. The autonomy clause means that commercial providers can bring legal challenges against a minister who chooses to curtail their discretion. Furthermore, the adoption of compulsory market competition will bring more NHS activity under the jurisdiction of EU competition law. Competition law is designed to limit government powers of intervention and will provide a further check on secondary regulation.

These changes will have substantial legal consequences. First, the duty to provide a national health service throughout England would be lost if the Bill became law.[9] It would be replaced by a duty on an unknown number of CCGs, not GPs, to arrange provision as they see fit for various sections of the population for which they are separately responsible. Second, CCGs would not be bound by the "duty to continue to promote a comprehensive free health service" when exercising their functions. Under present law, according to a judgment of the Court of Appeal, the Secretary of State "has the duty to continue to promote a comprehensive free health service and he must never, in making a decision [about services provided], disregard that duty".[10] Third, the Secretary of State's accountability to Parliament for the provision of services to patients in the new NHS will be diminished.[4,11]

At the same time, a new parallel system of public health services will be established at the local level. Under this system, the provision of a range of public health services will be assigned to local authorities, including immunisation, screening, mental health, dental health, children's services, sexual health, drug and alcohol services, and health protection programmes. However, neither services nor funding have been defined.[12] Moreover, in this new system local authorities will have considerable discretion to define and decide what services are provided and how. As with the social services they provide, these services may be chargeable.

All these factors will increase inequality in service access, provision, and uptake. The abolition of PCTs and loss of overall political control will impair, or take away altogether, current information systems used to monitor inequalities at area level. The new structures for CCGs and public health create such a multiplicity

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of denominators, resource flows, populations, and fragmented responsibilities for care and data that systematic inequalities will cease to be identifiable and no body will have overall responsibility for an area. Furthermore, the loss of area-based population responsibilities has serious implications for the stability and accuracy of measurement of needs and equity of resource allocation and service provision. Loss of geographical population data and area-based structures and responsibilities will impair, or take away altogether, the capacity to plan health services by monitoring needs, access, service use, and health outcomes.

The Government has not disclosed the radical nature of this reform. The Leader of the House of Lords, Earl Howe, told the Lords that the Bill reinforces and does not "dilute the Secretary of State's overarching duty…Let me be clear: the Bill's provisions would in no way dilute the Secretary of State's overarching duty. Indeed, they are intended further to reinforce the promotion of a comprehensive health service rather than to undermine it."[7] Legal analysis of the Bill shows this is not the case. Recent amendments raised for consideration in a letter of Jan 12, 2012, from Earl Howe to Peers do not substantially change the situation.[7]

In the USA, opposition to health reforms under both the Clinton and Obama administrations is articulated as erosion of personal freedom by increasing government powers.[13] Conversely, pro-market reforms of universal health systems in Europe are often justified on the grounds that they increase personal freedom by transferring powers from government to non-governmental or commercial bodies and by increasing choice. Citizens' rights in democracies are underpinned not just by limitations on government powers but also by legal duties imposed on governments, such as those that guarantee citizens access to health care. The Bill would withdraw this legal underpinning.[14] As the Bill enters its final critical stages it is crucial that Peers observe three red lines for the NHS (panel)[15] and are fully aware of the key parts of the legislation that would abolish core NHS functions, if they are to safeguard the NHS for future generations.

*Allyson M Pollock, David Price, Peter Roderick, Tim Treuherz, David McCoy, Martin McKee, Lucy Reynolds

Centre for Primary Care and Public Health, Queen Mary, University of London, London E1 4NS, UK (AMP, DP); 101 Weavers Way, London, UK (PR); 5 Hobson Road, Oxford, UK (TT); Inner North West London Primary Care Trusts, London, UK (DM); and European Centre on Health of Societies in Transition, London School of Hygiene and Tropical Medicine, London, UK (MM, LR)
a.pollock@qmul.ac.uk

PR is a London-based public interest lawyer who has supported 38 Degrees on an unpaid basis. TT is a non-practising barrister and formerly Head of Legal Services, Vale of White Horse District Council. The other authors declare that they have no conflicts of interest.

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