

# National Health Service Bill

## Legal and Policy Briefing for the Second Reading in the House of Commons, on 11<sup>th</sup> March 2016

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*The National Health Service Bill is intended to restore the founding principles of the NHS in England. These have been eroded over many years, most recently and comprehensively by the Health and Social Care Act 2012. This briefing for MPs provides a legal and policy perspective on the Bill. The authors of this Briefing are the co-authors of the Bill.*

### Background

The NHS in England is being dismantled. This is the result of Parliament over 25 years applying market ideology. The main Acts which made this happen were the:

**NHS and Community Care Act 1990:** introduced the internal market into the NHS; split purchasers from providers, so that the planning and delivery of services was to be undertaken by separate bodies, with the money flowing between them; ended direct management of services by health authorities with the creation of 'NHS trusts' as self-governing accounting centres (bodies corporate) with borrowing powers, and their own finance, human resources and PR departments; brought in GP fund-holding, which delegated budgets to individual GP practices enabling them to be commissioners or purchasers of services and to retain surpluses.

**NHS (Private Finance) Act 1997:** empowered NHS trusts to enter into externally financed development agreements;

**Health Act 1999:** introduced Primary Care Trusts;

**Health and Social Care (Community Health and Standards) Act 2003:** introduced NHS foundation trusts and their regulator, Monitor;

**NHS Act 2006:** de-coupled the Secretary of State's duty to provide and secure services in accordance with the Act, from the duty to promote a comprehensive health service;

**Health and Social Care Act 2012:** abolished the duties of the Secretary of State to provide and secure services in accordance with the Act, and to provide listed health services throughout England, replacing the latter with a duty on over 200 new clinical commissioning groups to make contracts for those services for persons for whom each CCG is responsible; established the NHS Commissioning Board (NHS England); prospectively abolished NHS trusts, with the intention of them all becoming NHS foundation trusts; allowed NHS foundation trusts to receive 49% of their income from outside the NHS; created "public health" functions as two legal categories split between the Secretary of State and local authorities, and carved them out of the NHS; introduced virtually compulsory contractual tendering for providing NHS services; extended Monitor's role as an economic regulator with functions aimed at preventing anti-competitive practices.

## Summary of main Clauses of the NHS Bill

### ***Clause 1: restoring the founding principles and excluding EU and international trade, competition and competition rules***

The Bill would reinstate the Secretary of State's legal duty to provide the NHS in England, abolished by the Health and Social Care Act 2012 (Clause 1(1)). It would be delegated to local Health Boards, to NHS England with its regional committees and to local authorities (see especially Clauses 6, 8 and 9 below).

Taken together, these and other provisions of the Bill will have the effect of taking the market and pricing tariff out of the NHS. The uncoupling of resource allocation from service provision through the pricing system and market competition would be discontinued, and resource allocation would return to being on the basis of all-inclusive geographic populations, not membership of a group. Commissioning would focus on the essential tasks of assessing needs, planning to meet those needs, setting clinical standards, matching funding to delivery, capturing information to support the various stages of the cycle, and ensuring accountability, without commercial contracting except in the most exceptional circumstances when absolutely required. At the same time the billions of pounds saved from administration of the market will enable new positions to support and enhance planning information and direct clinical care including employing more doctors, nurses, therapists and support staff and restoring much needed services such as mental health and therapy services.

Clause 1(3) provides a primary legislative framework for integrating health and social care services (see further Clause 9 below).

Clause 1(4)(a) declares the NHS to be a "non-economic service of general interest" which is aimed at exercising the UK's competence to provide, commission and organise health services free from any constraints in the EU Treaties; and declaring the NHS to be "a service supplied in the exercise of governmental authority as a service supplied neither on a commercial basis, nor in competition with one or more suppliers" is aimed at excluding the operation of the World Trade Organization's General Agreement on Trade in Services (Clause 1(4)(b)). This is supplemented by Clause 23, which is aimed at preventing the Transatlantic Trade and Investment Partnership (TTIP) and other international agreements affecting the NHS without the approval of Parliament, the Scottish Parliament, the National Assembly for Wales and the Northern Ireland Assembly.

Clauses 2-5 contain provisions intended to frame restoration of the founding principles. These include particularly the duty of the Secretary of State to provide key services throughout England.

### ***Clause 6: re-integrating public health into the NHS and allowing delegation to local authorities, Health Boards, and to a re-constituted Public Health England and NHS England***

Public health functions were carved out of the NHS by sections 11 and 12 of the Health and Social Care Act, supplemented since by regulations.<sup>1</sup> For example, the Secretary of State's public health functions include vaccination, immunisation and screening, whilst services to promote healthy living, such as sexual health services, are the responsibility of both local authorities and the Secretary of State. A general power to provide services to prevent, diagnose and treat illness - previously only a function of the Secretary of State - was conferred on local authorities; a power that may be exercised as a result of the 'devolution deals' that will be implemented through secondary legislation under the Cities and Local Government Devolution Act 2016. Regulations now require local

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<sup>1</sup> The Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) Regulations 2013 (S.I. 2013/351), amended in 2015 (2015 No. 921).

authorities to provide or make arrangements securing provision of open access sexual health services in their area by exercising the public health functions of the Secretary of State to make arrangements for contraceptive services; and by exercising their functions relating to preventing the spread of and treating sexually transmitted infections.

Clause 6 re-integrates these functions into the NHS by returning them to the Secretary of State. These would then be delegated in accordance with regulations to local authorities and Health Boards in accordance with joint proposals that they would prepare under Clause 9; and to Public Health England and to NHS England reconstituted under Clause 7 as Special Health Authorities. The re-constituted NHS England's functions would be performed via regional committees (Clause 8).

The reason for this 're-integrate, delegate and propose' approach is to acknowledge the view that public health and many community services should be delivered through and by or in conjunction with local authorities, whilst restoring these services as an integral part of the NHS.

The fact that a service was designated as a 'public health service' and provided by a local authority would not be a basis for permitting charges.

***Clause 9: Health Boards would plan and deliver services, and be jointly responsible with local authorities for public health and integration of social care***

Health Boards would plan and deliver health services on behalf of the Secretary of State on the basis of bottom-up proposals prepared by local authorities with NHS England, clinical commissioning groups, NHS trusts and foundation trusts and approved by the Secretary of State. Patients, clinicians and other staff, voluntary organisations, trade unions and academics would be empowered to participate in preparing the proposals which would be finalised over two and a half years and would be required to minimise disruption in accordance with regulations.

Having assisted in developing the proposals for Health Boards, clinical commissioning groups, NHS trusts and NHS foundation trusts would be replaced by the Health Boards (Clauses 13-15), and NHS re-constituted (Clause 7); and the regulator, Monitor, would be abolished (Clause 18).

Health Boards would also be responsible jointly with local authorities for bringing forward proposals in accordance with regulations for the planning and delivering public health services, and integrating health and social care services.

Integration of health and social care requires careful consideration, and ideally its own primary legislation (not only regulations), as in Scotland.<sup>2</sup> The original distinction, which sought to balance the interests of hospitals and local authorities, was created by the NHS Act 1946 and the National Assistance Act 1948, and has been fairly described as "a fudge".<sup>3</sup> The broad formal differentiation was between free nationally-provided health services and means-tested locally-provided social services. Over time this fudge has been exploited in various ways to enable a shift from NHS-funded to means-tested local authority care, using policies such as Care in the Community, closure of NHS long-stay beds and NHS day care provision, and introducing continuing care criteria which enabled the NHS to discontinue NHS care by time limiting care or redefining eligibility.

There is much genuine concern that integration would lead to the provision of means-tested – and reduced - health services. Changes proposed by the Bill in the location of functions through

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<sup>2</sup> Public Bodies (Joint Working) (Scotland) Act 2014.

<sup>3</sup> Bridgen, P and Lewis, J. Elderly people and the boundary between health and social care 1946-91: whose responsibility? Nuffield Trust, 1999.

delegation do not extend to changes in the power to charge, and health services must remain free. We support the principle of free publically provided social care, but this is an issue which ideally requires further primary legislation.

Contracts with and/or grants to voluntary organisations would be permitted.

Administration of medical, dental, ophthalmic and pharmaceutical services would also be the responsibility of the Health Boards (Clause 10).

***Clause 12: the Secretary of State would be given a limited power to give directions***

The Secretary of State would have a general but limited power to give directions to Health Boards and NHS England (and others). He or she would be obliged to have regard to the desirability, so far as consistent with the interests of the health service and relevant to the exercise of the power in all circumstances, of protecting and promoting the health of patients and the public, and of the bodies being free to exercise their functions in the manner that they consider best calculated to promote the NHS. Neither could the power be used to interfere with the professional independence of health service staff. Their professional autonomy and right to participate in scientific and public debate on matters relating to health and the needs of their patients would be guaranteed as happened prior to 1990.

These directions must be contained in regulations, except in a genuine emergency, so that the exercise of executive power would be open to Parliamentary scrutiny and procedure.

This provision is a modified version of the duties of autonomy (the hands - off clauses) introduced by the 2012 Health and Social Care Act and which would be abolished by Clause 2.

***Clause 16: Transferring staff should not result in large redundancy payments for technical job losses***

After consultations with trade unions, the Secretary of State would be required to make regulations to set out the terms and conditions applying to the transfer of staff. These include entitlement to redundancy payments, particularly for senior staff whose job loss is technical rather than real.

The Bill will not affect the vast majority of staff engaged in clinical care, and those skilled in the essential tasks of commissioning will still be required.

However, the inescapable down-side of the Bill is that there will be the unavoidable loss of a number of jobs directly connected with administering the market bureaucracy and promoting competition, such as managing commercial contracting and billing, as well as positions in finance, human resources and the marketing and press departments. This is particularly distressing because most of the jobs that would be lost would be those performed by people with clerical, accounting, media and similar skills, many of whom will not be particularly well paid. Their positions need to be addressed with the greatest sensitivity and flexibility, in close consultation and cooperation with trade unions, in bringing about a just transition. This should involve proactive opportunities for redeployment and re-skilling. Involvement of trade unions in the design of the Health Boards is also intended to help keep job losses to the absolute minimum.

***Clause 17: local accountability would be ensured by Community Health Councils***

Community Health Councils, with the duty of representing the interests of the local public in the health service, would be re-established. Since 1990, there has been a progressive downgrading of the systems and mechanisms for local accountability alongside growing complexity resulting from

the increasing fragmentation of services and the different responsibilities of local authorities, CCGs, trusts, foundation trust boards, Monitor, NHS England and the Care Quality Commission for commissioning and providing NHS funded services. The Bill simplifies those structures and restores area responsibilities. Further consultation will be required to enhance representation of the public, patients, local authorities and trade unions in order to strengthen local accountability.

***Clause 19: preventing NHS foundation trusts from reducing services***

This Clause, whilst not technically necessary within the scheme of the Bill, highlights the need to prevent NHS foundation trusts reducing NHS services and disposing of assets.

Until April 2013, Foundation Trusts were required to provide “mandatory services” listed in their authorisations. From April 2013 until March 2016, these services were listed as “Commissioner Requested Services” (CRS) under their licences. From April 2016, CRS will be re-designated, and Monitor has said that it expects services CRS – i.e., mandatory services until April 2013 - to be reduced.

Buildings and equipment needed to deliver CRS must be identified on an Asset Register, with restrictions on their disposal. Reductions in services designated as CRS will give NHS foundation trusts greater freedom to dispose of them or use them for other purposes such as for private patients. This is particularly worrying in the context of the ability of NHS foundation trusts to obtain 49% of their income from outside the NHS.

It is also very worrying and unacceptable that Monitor has stated that “[i]t is not intended that the [CRS asset] register should be a public document so the licensee can apply appropriate measures to ensure its confidentiality”.<sup>4</sup> These are NHS assets and the public must have the right to know what they are.

***Clause 20: national terms and conditions would apply***

This Clause is intended to ensure that the UK-wide ‘Agenda for Change’ system under the auspices of the non-statutory NHS Staff Council that has been in place since 2004 would apply to all staff employed by those who provide NHS services. Recognising the NHS as a national service and the desirability of staff being able to move freely between its constituent parts without suffering detriment would help ensure fairness, equity and equal value for NHS staff and good patient care. This Clause would not affect those staff not currently covered by the Agenda for Change system such as hospital doctors and dentists and very senior managers.

We are aware that currently junior doctors have been told by the Secretary of State that a national contract will be imposed on them. If they do not agree to this, Foundation Trusts have the ability to and may decide to offer locally negotiated terms and conditions of service thereby introducing local pay bargaining on a foundation trust by foundation trust basis. Under these contracts junior doctors would be required to treat both NHS and private patients regardless of their own moral position on the NHS and its values. Junior doctors must be protected from exploitative employers and not be used to facilitate new inequalities.

***Clause 21 - Centralisation and reduction of PFI obligations***

The Private Finance Initiative (PFI) in the NHS has placed excessive financial burdens on NHS trusts and NHS foundation trusts which detrimentally affect their ability to deliver services to patients.

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<sup>4</sup> The asset register and disposal of assets: guidance for providers of commissioner requested services. Monitor, April 2014.

Clause 21 would transfer financial obligations for the buildings and maintenance under NHS PFI agreements to the Treasury, which would have the duties to assess and publish the obligations, and to explain to Parliament how it proposed to reduce them. This would include publication of detailed information on interest rates, equity returns, refinancing deals and subcontracts, so that all public money would be auditable.

Service contracts linked to PFI for ancillary and other services would not be renewed, as these services would be directly provided and managed in-house by Health Boards. Adjustments would need to be made to the resource allocation formulae as required to reflect differences between Boards, for example, in maintenance, capital charges and other obligations. (In time, the capital charging system should also be abolished.)

Since the Bill was tabled, one potential limitation in the Clause as currently drafted that has been pointed out is whether it would ensure a return to the public sector of any property and other assets that PFI deals may have transferred to or vested in the private sector; this should be covered and can be addressed at the committee stage of the Bill. Concerns have been expressed that taking the debts away from trusts would render them a more attractive privatisation prospect; this cannot occur under the Bill as trusts will no longer exist and will be replaced by Health Boards.

However, one clear limitation of the Clause is its applicability only to NHS PFI deals. We think there is merit in a new Bill to propose ending PFI deals across all sectors.

#### ***Clause 22 - Abolition of new charges for migrants and overseas visitors***

Sections 38 and 39 of the Immigration Act 2014 enable the imposition of new charges on certain categories of persons.

Section 38 empowers the Secretary of State by order to require certain migrants to pay a charge for NHS services, known formally as “an immigration health charge”, payable in advance when applying for leave to enter or remain in the UK or when applying for entry clearance. The Immigration (Health Charge) Order 2015 has now been made under this section, imposing since April 2015 an annual immigration health surcharge on people applying for a visa to enter the UK to work, study or join their family for more than six months, or to extend their visas for a limited time. EEA nationals are excluded. Australians and New Zealanders were also initially excluded, but the government has announced that they will be included from April 2016. Exemptions apply to about a dozen categories of person, such as those who are seeking asylum, are identified as a victim of human trafficking, and have suffered certain domestic violence). This charge is currently £200 per person per year, or £150 for students. Children and other dependants are also charged at these rates.

Section 39 of the Act has the effect of extending the categories of persons who can be regarded as “overseas visitors” and so in the words of the Explanatory Notes to the Act, “ensuring they can potentially be charged for health services throughout the UK.” It provides that people needing leave to enter or remain and not having it, and people who have limited leave to enter or remain, are not to be treated as ordinarily resident. This includes people who have lived in the UK and paid taxes for several years. (These charges are now imposed under The National Health Service (Charges to Overseas Visitors) Regulations 2015.)

These sections offend against the fundamental principles of the NHS. They are also potentially in violation of the United Kingdom’s long - standing international legal obligation under the International Covenant on Economic, Social and Cultural Rights to respect, protect and fulfil the right to health without discrimination, and so would be repealed.

Moreover, the complexity of both sets of the 2015 Regulations makes determining the people who must pay or who do not have to pay a bureaucratic nightmare; and it is highly questionable whether the rules will raise more money than the costs of administration.

***Clause 24: allows flexibility in timing of implementation of the Bill***

The timescale for implementation is flexible over a twelve-month period, save for clause 1 which would come into effect on royal assent. Further flexibility is provided by allowing proposals for Health Boards to be prepared and finalised over two and a half years, and not replacing CCGs, NHS trusts and NHS foundation trusts until after they have assisted local authorities with those proposals.

***Clause 25: further amendments and repeals are necessary***

Many more amendments to and repeals of existing legislation than are mentioned in the Bill would be needed. It was originally proposed that these would be included in a parallel Act of consequential provisions, as was done in 2006. However, as that Act does not exist currently as a Bill, Clause 25 proposes that this would be done via regulations. These amendments would include, for example, abolition of Healthwatch.

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