WILL THE HEALTH SERVICE UNRAVEL?

Despite recent amendments to the English health bill in response to opposition, **Allyson Pollock**, **David Price**, and **Peter Roderick** argue that it will enable charging for health services that are currently free

bmj.com

- News: Raft of public health services is threatened by health bill, say specialists (*BMJ* 2012;344:e1675)
- Feature: After the bill, what next? (*BMJ* 2012;344:e1661)
- *BMJ* blog: Edward Davies: This bill is happening. Doctors will need to make it work
- More about changes to the NHS in England at bmj.com/nhsreforms

Entitlement to free health services in England will be curtailed by the Health and Social Care Bill currently before parliament.[1] The bill sets out a new statutory framework that would abolish the duty of primary care trusts (PCTs) to secure health services for everyone living in a defined geographical area. New clinical commissioning groups (CCGs) will arrange provision of fewer government funded health services and determine the scope of these services independently of the secretary of state for health. They may delegate this decision to commercial companies. The bill also provides for health services to be arranged by local authorities, with provision for new charging powers for services currently provided free through the NHS (clauses 1, 12, 13, 17, and 49), and it will give the secretary of state an extraordinary power to exclude people from the health service. Taken together the measures would facilitate the transition from tax financed healthcare to the mixed financing model of the United States. We provide an analysis of the key legal reforms that will govern policy development and implementation if the bill is enacted.

Repeal of the health secretary's duty to provide health services

Under current law the secretary of state has a duty to "promote" a comprehensive health service and, for that purpose, a duty to provide specific services throughout England to meet all reasonable requirements.[2] Although the secretary of state will continue to have a duty to "promote" a comprehensive health service, clause 12 of the bill changes the duty to provide to a duty to arrange, which it transfers from the health secretary to CCGs. This weakens the health secretary's overarching duty because primary legislation no longer specifies the measures he or she must take to promote a comprehensive health service.

Recent amendments would mean that the secretary of state "retains ministerial responsibility to Parliament for the provision of the health service in England."[3] However, this would not restore the link between the duties to promote and to provide and would continue to allow deregulation of provision under the measures we describe below.

Abolition of area based responsibilities

Clause 33 of the bill would abolish primary care trusts, and clause 12 in effect abolishes their area based responsibilities. Unlike PCTs, CCGs will not have to provide health services for everyone living within a defined, contiguous, geographical area. Instead, a CCG will be responsible for people on the lists of its constituent primary care providers, which may draw patients from anywhere in the country. Clause 12 of the bill requires CCGs to take responsibility for "persons who usually reside in" their area but are not with another CCG, but they will not necessarily be responsible for anybody else, such as temporary residents, visitors, or workers who have not registered with a member of the group—except for "emergency care."

The bill establishes a legal basis for CCGs to secure fewer government funded health services

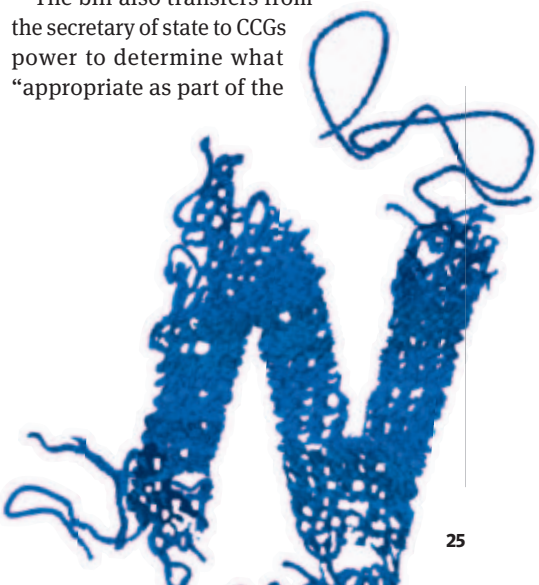
Legal basis for CCGs arranging fewer government funded health services

CCGs would be required to arrange fewer statutory services than PCTs currently provide or arrange for areas. Under current "functions regulations,"[4] PCTs must provide or secure the following services on behalf of everyone in a specified geographical area:

- Accident and emergency services and ambulance services
- Services provided at walk-in centres
- Facilities and services for testing for, and preventing the spread of, genitourinary infections and diseases and for treating and caring for persons with such infections or diseases
- Medical inspection and treatment of pupils
- Services relating to contraception
- Health promotion services
- Services in connection with drug and alcohol misuse
- Any other services that the secretary of state may direct.

These regulations will be repealed, and the bill does not require CCGs to secure the above services. They have to arrange only ambulance services and "emergency care" for everyone living in the area defined in their constitutions. The bill therefore establishes a legal basis for CCGs to secure fewer government funded health services.

The bill also transfers from the secretary of state to CCGs power to determine what "appropriate as part of the



health service" for certain individuals. The services concerned are care of pregnant and breastfeeding women, care of young children, prevention of illness, care of people with illnesses, and aftercare of people who have been ill.

In this way CCGs may decide what is appropriate for government funding. Moreover, decisions about what is appropriate can be delegated to commercial companies and, under rules set out in schedule 2 of the bill, need not be made by general practitioners, other clinicians, or NHS staff.

Two further provisions change substantially the context in which decisions about which services are appropriate for government funding will be taken. Firstly, clause 103 of the bill requires all providers of health services to draw up patient eligibility and selection criteria as a condition of their licence. According to the bill, the criteria must be applied where there is a choice of providers to determine "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." For the first time in the history of the NHS, access to government funded health services will therefore be a function of providers' selection policies as well as of CCGs' determination of what is appropriate as part of government funded health services under clause 12.

Secondly, the bill would abolish the duty of local providers under the Community Care (Delayed Discharges etc) Act 2003 to give notice to local authorities when a patient discharge from hospital is considered "unlikely to be safe [...] unless one or more community care services are made available."[5]

Healthcare functions of local authorities, CCGs, and secretary of state will overlap

Under new public health functions, the bill establishes a parallel health service in the local authority sector. The public health functions give local authorities powers to arrange, among other things, "services or facilities for the prevention, diagnosis or treatment of illness" (box). Similar functions are also conferred on CCGs and on the secretary of state. The government acknowledges that responsibilities will overlap but does not make clear which services must be provided by which body as part of the centrally funded government health service and which may be subject to the new charging powers.[6]

The powers are set out in new sections 2A and 2B, which cover, respectively, public health protection duties of the secretary of state that may be delegated to local authorities (under section 6C(1)) and public health improvement functions of local authorities and the secretary of state (box).

PUBLIC HEALTH FUNCTIONS THAT ARE SUBJECT TO NEW CHARGING POWERS

Section 2A: Secretary of state duty as to protection of public health that may be delegated to local authorities

- Research or such other steps as the secretary of state considers appropriate for advancing knowledge and understanding
- Microbiological or other technical services (whether in laboratories or otherwise)
- Vaccination, immunisation, or screening services
- Other services or facilities for the prevention, diagnosis, or treatment of illness
- Training
- Information and advice
- Services of any person or any facilities

Section 2B: Functions of local authorities and the secretary of state as to improvement of public health

- Information and advice
- Services or facilities designed to promote healthy living (by helping people address behaviour that is detrimental to health or in any other way)
- Services or facilities for the prevention, diagnosis, or treatment of illness
- Financial incentives to encourage people to adopt healthier lifestyles
- Assistance (including financial assistance) to help people minimise any risks to health arising from their accommodation or environment
- Training for people working or seeking to work in health improvement

Local authorities do not have to provide services that are not arranged by CCGs

There is no legal requirement under new section 2A and 2B for any of the services that are not arranged by CCGs to be provided by local authorities. By not imposing on local authorities a duty to provide or arrange the provision of these services—the only stated exception to date being sexual health services—the bill establishes the legal basis for not providing these services.

There have been a number of government statements about what government health budget will fund and assurances that "the public health budget will fund the NHS to commission certain public health services, which will include immunisation programmes, contraceptive services, screening programmes, public healthcare for those in prison or custody, and children's public health services from pregnancy [sic] to age five (including health visiting)."[6] However, virtually none of these services is mandated in the bill and the government has indicated that a wide range of services may not be mandated in the future.[7]

How new charges can apply

The bill would allow charges to be introduced for services provided or commissioned by local authorities under their public health functions

The government does not have a mandate for the legal destruction of the founding principles of the NHS

or under public health functions that the secretary of state has delegated to them (see box). In addition, where services fall out of the functions regulations and where CCGs or their commercial companies decide that certain services are no longer appropriate as part of the government funded health service, commercial providers would be able to offer services privately and to charge for them.

People may be excluded from health services

Current law does not permit anybody to be excluded from the health service.[2] However, the bill includes a measure that would allow restrictions of the people for whom CCGs must arrange provision. Under Clause 12, new section 3(1A) of the 2006 Act would state: "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." New section 3(1D) states: "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."

Explanatory notes to the bill suggest that the power will be used to exclude "people who are resident in Scotland but registered with a practice that is a member of a CCG," and possibly "temporary residents." Residents of Northern Ireland and Wales would also be affected. However, as drafted new section 3(1D) would also allow the secretary of state to make regulations to exclude people receiving primary medical services under particular types of contract, such as those entered into by large corporate providers. Patients receiving care from providers with alternative provider of medical services (APMS) contracts, for example, could cease to be NHS patients, and their care would no longer have to be provided free of charge.

Conclusion

Legal analysis shows that the bill would allow reductions in government funded health services as a consequence of decisions made independently of the secretary of state by a range of bodies. The bill also fails to make clear who is ultimately responsible for people's health services, and it creates new powers for charging. It signals the basis for a shift from a mainly tax financed health service to one in which patients may have to pay for services currently free at point of delivery. The government has been unable to show, as it has argued, that these changes are "vital."[6] It does not have a mandate for the legal destruction of the founding principles of the NHS.

Allyson M Pollock professor, Centre for Primary Care and Public Health

David Price senior research fellow, Centre for Primary Care and Public Health, Queen Mary, University of London, London E1 4NS, UK

Peter Roderick public interest lawyer, London, NW1 0XG, UK

Correspondence to A M Pollock **a.pollock@qmul.ac.uk**

Accepted: 7 March 2012

Contributors and sources: AMP and DP have researched and written extensively on health systems and health policy issues. This article arose out of 15 legal and policy briefings for the House of Lords. PR is a public health lawyer. He has written several legal analyses of the bill since May 2011 and has coauthored many briefings for peers: www.dutytoprovide.net. AMP, DP, and PR contributed equally to the article.

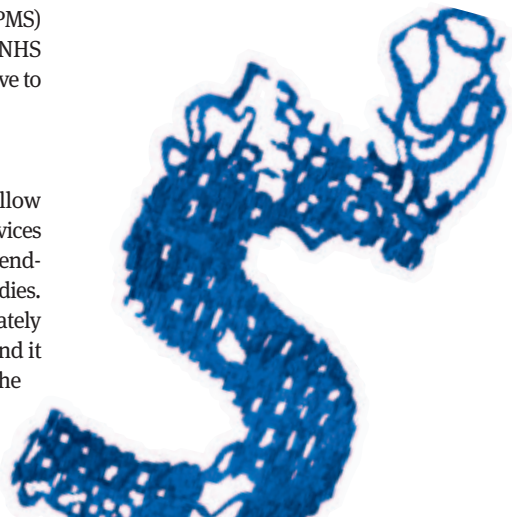
Competing interests: None declared.

Provenance and peer review: Not commissioned; externally peer reviewed.

1 House of Lords. Health and Social Care Bill 2011. HL Bill 92. www.publications.parliament.uk/pa/bills/lbill/2010-2012/0119/2012119.pdf.
2 House of Commons, National Health Service Act 2006, sections 1 and 3. www.legislation.gov.uk/ukpga/2006/41/contents.
3 Health and Social Care Bill briefing note 12: Earl Howe's response to the Constitution Committee's follow-up report and his letter dated Jan 12, 2012. www.allysonpollock.co.uk/administrator/components/com_article/attach/2012-01-17/Pollock_HouseOfLords_HSCB_Briefing12_HoweLetter_17Jan12.pdf .
4 House of Commons. The National Health Service (functions of strategic health authorities and primary care trusts and administration arrangements) (England) Regulations 2002 Statutory Instruments 2002 No 2375. www.legislation.gov.uk/uksi/2002/2375/contents/made.
5 House of Commons. Community Care (Delayed Discharges etc.) Act 2003. www.legislation.gov.uk/ukpga/2003/5/contents.
6 House of Lords Select Committee on the Constitution. Health and Social Care Bill: Follow-up. HL Paper 240, Dec 20, 2011. Appendix 2: correspondence. www.publications.parliament.uk/pa/ld201012/ldselect/ldconst/240/24002.htm.
7 HM Government. Healthy lives, healthy people update and way forward. Cm 8134. 2011. www.official-documents.gov.uk/document/cm81/8134/8134.pdf.

This article appeared on bmj.com under the title: Health and Social Care Bill 2011: a legal basis for charging and providing fewer health services to people in England

Cite this as: *BMJ* 2012;344:e1729



BMJ.COM BLOGS **Martin McShane**

Little things

The reforms grind on. In the stratosphere there is a lot of noise and turbulence—people arguing passionately and polemically. Meanwhile, the architecture of a new system is being constructed around those of us working in the old system. People are wondering where their future lies, or if they have a future. The basic construct is becoming clearer to many of us and we are working to support its creation. This is driven by the desire to ensure that the good work done for the public and the patients in the past does not get lost in the transition between systems, and to try to secure the theoretical benefits of the new system. It is also to try to mitigate the unintended consequences, which might not be so beneficial.

This past week has been illuminating, as I have moved between supporting the development of clinical commissioning groups, commissioning support services, and specialised commissioning.

In the East Midlands, specialised commissioning accounts for about £670m of public money. The Carter review in 2006 proposed new arrangements for specialised commissioning which led to the creation of the 10 specialised commissioning groups (SCGs) based on the strategic health authority areas. The East Midlands SCG is accountable to the primary care trusts that delegate part of their budgets for the low volume, high cost, and complex care that SCGs commission on their behalf. This role will now be taken by the NHS commissioning board. Whereas the SCG budget was inextricably linked to that for the population of each primary care trust, this will no longer be the case for clinical commissioning groups. This is worrying. Patients with conditions needing specialist services will be influenced by the actions and inactions occurring in those services commissioned by clinical commissioning groups. Will these groups be concerned about how this affects a budget for which they are no longer accountable? The types of treatments and interventions that the SCG commission are high profile and often politically charged. As the primary care trust representative on the SCG board, I have worked hard with colleagues to control the incessant pressures on the budget and have supported some difficult decisions because, otherwise, the resources available for those with less headline grabbing problems would be diverted. Will the national commissioning board be worried about increasing the top slice from clinical commissioning groups' budgets to minimise the political flak it could attract?

Martin McShane is director of strategic planning for NHS Lincolnshire

Read this blog in full and other blogs at bmj.com/blogs