



# Briefing Paper

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## The Health and Social Care Bill Second Reading brief

**Royal College of General Practitioners**  
**31 January 2011**

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### **Introduction**

The Royal College of General Practitioners is the largest membership organisation in the United Kingdom solely for GPs. Founded in 1952, it has over 42,000 members who are committed to improving patient care, developing their own skills and promoting general practice as a discipline. We are an independent professional body with enormous expertise in patient-centred generalist clinical care.

This is the largest Health Bill ever published by the Department of Health and RCGP is concerned that legislation of this length and complexity should not be “rushed through” Parliament without proper debate and we would urge Members to ensure that sufficient time is provided for proper scrutiny.

In this Brief we have sought to focus on a number of areas of the Bill which affect patients and general practice.

The RCGP welcomes the over-riding principle of a National Health Service led by clinicians with patients at the centre, striving to deliver the best possible health care and outcomes for all. We support the opportunity to work with our specialist colleagues, other members of the healthcare team, patient groups, social care professionals and managers to provide safe, effective and evidence based solutions to meet patients’ healthcare needs.

The College believes that good commissioning is about being a good GP, it is about understanding the impact of clinical decisions on the public’s health and purse, understanding the need to practice safely, effectively and in a evidence based manner and about understanding how the needs of patients can be best served through the design of services that meet their needs. Good commissioning is about engaging in clinical dialogues with colleagues in health and social care, and establishing effective channels of communication between patients, the public and elected representatives.

We remain concerned, however, about the pace of change, the interaction of structural reform with the required unprecedented financial savings (the ‘QIPP Challenge’), the danger of fragmentation and

unnecessary duplication arising from multiple providers. We recognise the principle of patient choice but feel the Government needs to strike a fairer balance between the rights of the individual and the efficiency and effectiveness of the NHS as a whole within an increasingly constrained budget. We are concerned that the reforms have the potential to destabilise the NHS and cause long-term harm to patient outcomes.

## Summary Issues

The RCGP supports the policy of placing clinicians at the heart of commissioning and that GPs and health professionals more widely will be involved in the planning of services and in the allocation of contracts for these services. We welcome the opportunity for clinicians to better engage with patients and local communities so services better reflect local health needs. However we have some serious concerns (reflected in comments from our members) about the potential impact of the Bill's provisions on the NHS including:

- Pace and scale of reform and the ability to deliver effective behavioural and organisational change at the same time as seeking unprecedented financial savings every year for the next four years
- Potential adverse impact of excessive choice and "any willing provider" both for individuals and for society
- Potential damage to the GP-patient relationship and the role of GPs as the advocate for patients
- Health inequalities may be exacerbated as those with the greatest need have the least ability to exercise choice
- Stripping of NICE's (National Institute for Health and Clinical Excellence) responsibility to provide definitive guidance to the NHS for the use of new drugs or health technologies in favour of a system of value-based pricing for medicines
- Impact of the abolition of practice boundaries on continuity of care as well as potential consequences for the protection of children and vulnerable adults.

A further underlying concern is the lack of evidence in support of the reforms and an absence of any apparent intention to pilot or trial the changes in any meaningful way to identify unintended consequences.

## Key Issues

### **Pace and Scale of the reforms alongside the QIPP Challenge**

The Bill proposals represent a dismantling of current NHS structures in the delivery and management of healthcare, to be replaced by a National Commissioning Board and GP consortia. There are also changes to the Monitor's existing regulatory role and to the administration of public health by local authorities. This radical restructuring is expected to take place at the same time as unprecedented efficiency gains of 4% each year for the next four years, enabling the NHS to save £20 billion by 2015 (it is estimated that GP practice will need to find £2500 in savings per practice, per day for the next three years<sup>1</sup>).

The Health Select Committee, in its Third Report of this Parliamentary Session, on Commissioning<sup>2</sup>, while supporting the need for commissioning reform, points out that such reforms cannot be isolated from the financial context of the unprecedented efficiency gains. We would like to see evidence that these two co-

<sup>1</sup> Durham N. Can every GP practice in England save £2,500 a day? *GP* Jan. 26 2011 Editors' Blog [http://community.healthcarerepublic.com/blogs/editors\\_blog/archive/2011/01/26/can-every-gp-practice-in-england-save-163-2-500-a-day.aspx](http://community.healthcarerepublic.com/blogs/editors_blog/archive/2011/01/26/can-every-gp-practice-in-england-save-163-2-500-a-day.aspx) (Jan 27 2011)

<sup>2</sup> Health Select Committee Third Report of 2010-2011 Session 21 January 2011 Commissioning TSO summary

existing imperatives of the Government will not detract from each other and leave sub-optimal outcomes in respect of both objectives. We suggest evidence is gained by putting in place the reforms in one or two (diverse) regions of England and then assessing the situation before applying more widely. In any event, we urge the Government to put in place a system of support and managerial leadership during the crucial transition stage as this would enhance the chances of the reforms succeeding in the current financially stringent environment.

The proposed structural reforms will also prove disruptive and they may not achieve the stated aims because they will divert effort away from clinical care and quality improvement. The ability of the NHS to provide a high quality service should not be jeopardised by irreversible changes to the infrastructure of the NHS which have not been tested. We recognise that the Government have initiated pathfinders, but it appears to us that these are pilots only insofar as those leading them are heading in a particular direction not that they are being used to test whether the policy works.

### **Potential adverse impact of excessive choice and “any willing provider” for individuals and society**

The RCGP sees the emphasis on “any willing provider” (AWP) as an impediment to the development of effective, co-ordinated, services and believes it will increase transaction costs due to the complex nature of the Health economy. Collaboration and co-operation should be promoted in preference to competition alone as a means of achieving greater efficiency and delivering consistent and long term healthcare.

The principle of AWP for healthcare appears to render the task of commissioning local services very difficult and could make long-term planning in commissioning a major challenge. In this time of financial constraint, it is unlikely the NHS will sustain the surplus choice needed for a market to operate, implying a major opportunity for the private sector to enter the NHS infrastructure in England. Our members have expressed concerns about this, one commenting; “I do not see how private companies taking up substantive commissioning roles will be compatible with patient choice given their bottom-line will have to be to reduce service costs”. The monitoring of multiple provider contracts and care pathways is likely to detract management energies from more innovative service developments. Detailed quality assurance of multiple provider contracts is also seen by RCGP members as extremely challenging and potentially duplicating of effort without due benefit. We continue to believe that Consortia should be able to work collaboratively across primary and secondary care boundaries in order to improve services for patients rather than being forced to promote competition between providers.

The RCGP sees a major contradiction between the proposed right of patients to choose from AWP and the expectation on commissioning consortia to put energy into developing excellent local services which integrate care pathways: integrated care models as practiced by providers, such as Kaiser Permanente from the USA, align, rather than divide, providers<sup>3</sup>.

The RCGP would rather see “enough excellent providers” than “any willing provider” and have the ability to make the decisions about what is needed for local communities (for more on this see our response to the Government consultation ‘Liberating the NHS: Greater Choice and Control’<sup>4</sup>). The extension of patient

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<sup>3</sup> Gleave R. Across the Pond – Lessons from the US on Integrated Healthcare *The Nuffield Trust* 2009 p27-28

<sup>4</sup> Howe A. RCGP response to Department of Health Consultation – Liberating the NHS: Greater Choice and Control Jan. 14 2011 [http://www.rcgp.org.uk/pdf/RCGP\\_Response\\_to\\_Greater\\_Choice\\_and\\_Control.pdf](http://www.rcgp.org.uk/pdf/RCGP_Response_to_Greater_Choice_and_Control.pdf) (Jan 27 2011)

choice needs to be balanced against higher quality standards for all services, so that all patients can experience the best healthcare that the NHS can offer. The over-emphasis on AWP could militate against the provision of an efficient and effective comprehensive, co-ordinated and local primary healthcare system with unfortunate consequences for continuity of care and health inequalities in particular.

### **Potential damage to the GP-patient relationship and the role of GPs as the advocate to patients**

To demonstrate our support for GP-led commissioning, RCGP has developed the RCGP Centre for Commissioning with its funding partner - the NHS Institute for Innovation and Improvement to equip GPs, practices and GP consortia with the skills, competencies and expertise required to deliver effective healthcare commissioning which ensures patient-focused, safe, high quality healthcare and improved local health outcomes. Inevitably, however, moving commissioning and resource decisions from Primary Care Trusts to GP consortia, particularly at this time of financial constraint, will see patients more directly identifying rationing of resources with their GP practice. Patients not receiving the treatment they feel they deserve are likely to blame GPs for budget constraints whether or not the treatment they seek is considered clinically appropriate. They are likely to not consider the wider obligation to society also incumbent on commissioners.

Our members have highlighted the clear ethical conflict between sound financial management and doing what is best for each patient as they present to their GP. GPs will - at times - lose the trust of the patient and/or be seen to fail as managing the health budget. As commissioners, GPs will need to balance doing what is best for their patients and what makes budgetary sense for the wider population within their consortium of practices. Where patients no longer trust their GP they may play the system and 'shop around' (which they will be encouraged to do by the proposed abolition of practice boundaries are abolished) until they find a more pliant GP: this will result in duplication of consultation costs at the very least and slowly see a drift to market fragmentation. This is reason enough for piloting the reforms so that these fears can be substantiated or confounded and addressed accordingly. RCGP continues to believe that the heart of general practice is the clinician-patient relationship and would urge Members to ensure that the legislative changes do not impact on the ability of GPs to provide the treatment they feel is most appropriate.

### **Increase in Health Inequalities**

The RCGP has serious concerns that GP commissioning will create a postcode lottery and greater health inequalities. Some consortia will provide certain services that others will not, or cannot, afford. The poorer, less mobile patients, and those with multiple chronic medical problems such as the elderly and frail, as well as those in remote and rural areas where choice will continue to be relatively limited, can be expected to lose services. The hoped-for progress in reducing health inequalities may be threatened by the emphasis on patient choice which, whilst desirable in principle, in practical terms sees those with the greatest health needs often possessing the least ability to exercise choice (the long understood "inverse care law"<sup>5</sup>) or to have an effective 'voice'. The RCGP would wish to see emerging consortia having official encouragement to work collaboratively with their specialist colleagues and tariffs for integrated care being designed and supported by appropriate contracts.

Our concerns about health inequalities are shared by others – including the Public Accounts Committee -

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<sup>5</sup> Hart JL The inverse care law. *Lancet*. 1971 Feb 27;1(7696):405-12

which in its recent report<sup>6</sup>, “Tackling inequalities in life expectancy in areas with the worst health and deprivation”, concluded in respect of the Government’s White Paper health reforms of July 2010, that “in the transitional period while this change is managed, it is important that tackling health inequalities does not slip down the Department’s agenda. The Department will need to set a clear framework of accountability at all levels of the health service if it is to be successful in addressing health inequalities in future”.

We urge that all outcome measures be piloted before nationwide implementation, to ensure that the consequences are those intended i.e. that they will provide cost-effective and improve health outcomes. As we argued in our response to the Government’s consultation paper ‘Liberating the NHS: Transparency in Outcomes’ we continue to believe the outcomes framework should highlight the reduction of health inequalities as a priority. We argue, in fact, that health inequalities and inclusion issues may warrant a domain of their own.<sup>7</sup>

### **National Institute for Health and Clinical Excellence: loss of responsibility to provide definitive guidance to the NHS for the use of new drugs or technologies in favour of a values-based pricing for medicines**

The RCGP is concerned about the Department of Health’s proposal that the new National Institute for Health and Care Excellence will no longer provide definitive guidance to the NHS for the use of new drugs and health technologies, but that instead the NHS will in future operate on a value-based pricing for medicines. We infer from this change that the step of making the connection between the clinical benefit of a new drug and any economic assessment will become the responsibility of GP consortia. The RCGP would rather see a fair, national and transparent framework for making the difficult decisions about the best use of (limited) resources – and therefore the current role of NICE should be strengthened rather than weakened.

Our concerns are derived from our members’ fears about:

- The inevitable erosion of the crucial relationship between GPs and their patients
- Public doubt about GPs when acting both as commissioners and as prescribers
- Creation of tensions between secondary care professionals (who are likely to be the clinicians who recommend the more expensive new drugs) and GP consortia whose patients will expect them to fund the new drug
- GP consortia will not have the expertise to assess the cost-effectiveness of new drugs and will find it harder to resist the pressures from pharmaceutical companies about prescribing their new drugs if there is not a national body to make these decisions.

### **Impact of the abolition of practice boundaries**

The previous administration in ‘Your Choice of GP’ and this Government in July’s Health White Paper consultation *Liberating the NHS: Greater Choice and Control* raised the possibility of the abolition of practice boundaries for GP practices. This proposal found little support amongst the RCGP membership. The plans for free choice of GP practice will impact adversely on continuity of care, a much valued, trusted and important aspect of patient care. There are also potential consequences for the protection of children and

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<sup>6</sup> Public Accounts Committee – Third Report of 2010-2011 Session 2 November 2010 - Tackling inequalities in life expectancy in areas with the worst health and deprivation HC470 TSO Summary

<sup>7</sup> Howe A. Response to Department of Health Consultation Liberating the NHS: Transparency in Outcomes Oct 11 2010 [http://www.rcgp.org.uk/pdf/RCGP\\_response\\_to\\_Transparency\\_in\\_Outcomes.pdf](http://www.rcgp.org.uk/pdf/RCGP_response_to_Transparency_in_Outcomes.pdf) (Jan 27 2011)

vulnerable adults, where parents/carers are able to register out of the area. Some rural practices may become 'unsustainable' and there are concerns regarding potential for easier abuse of prescribing and other services. Fuller details are contained in our response to this consultation submitted on 14 January<sup>8</sup>. See also our response to 'Your Choice of GP June 2010. The Government claimed overwhelming public support but our members felt that consultation was highly leading.

In more detail, the RCGP's concerns with the potential impact of this proposal if implemented include:

- Undermining of the established concept of general practice as the point of first medical contact within the healthcare system providing open and unlimited access, dealing with all health problems
- Threat to the personalised and continuous care now offered by GPs to patients and their families and the strong bond this can have for patients with their local GP practice
- The geographically defined GP practice area is relevant in relation to working with other specialised health services (such as for mental health, midwifery/health visitor/district nurse) and local authorities (social care and public health) so abolition will undermine interaction with these other services
- As we argued earlier GP practices will be destabilised and suffer varying workloads should some patients – typically the younger and fitter ones and the “worried well” – choose to seek treatments elsewhere, leaving the local practice with the less mobile and those with more long-term and complex problems which will place additional financial burdens on the practice and increasingly unable to cope
- Home visits will not be possible for patients using a GP practice away from where they live (and these are more likely to be needed out of patients' working hours); someone “caught out” at home but registered many miles away may need to use local emergency services - hospital A&E admissions are likely to rise in this situation
- Costs are likely to rise if practice boundaries are removed, e.g. a patient with multiple problems who changes practice often is likely to result in an increased referral rate to secondary care; or e.g. the cost in co-ordinating patients living a great distance from their registered practices
- Continuity of care and medication may also be at risk if patients register and are treated for illnesses close to their work and then need treatment at home for an incapacitating illness.

The proposal to abolish practice boundaries has been suggested before and our concerns have been echoed by others, for example by MPs in a Westminster Hall debate in December 2009<sup>9</sup>.

The RCGP advocates that the best option is to retain practice boundaries but to have more flexibility in the current “temporary doctor system” which allows a limited walk-in service for acute care far from home, and to extend practice opening hours. The emerging opportunities of electronic records will also help the working fit who commute from home to be adequately safeguarded for most acute services.

## **Some Ethical Issues**

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<sup>8</sup> Howe A. RCGP Response to Department of Health Consultation Liberating the NHS: Greater Choice and Control [http://www.rcgp.org.uk/policy/liberating\\_the\\_nhs.aspx](http://www.rcgp.org.uk/policy/liberating_the_nhs.aspx) (Jan 27 2011)

<sup>9</sup> Hansard 16 December 2009 TSO Column 268WH et seq. [http://www.publications.parliament.uk/pa/cm200910/cmhansrd/cm091216/halltext/91216h0004.htm#column\\_268WH](http://www.publications.parliament.uk/pa/cm200910/cmhansrd/cm091216/halltext/91216h0004.htm#column_268WH) (Jan 27 2011)

The RCGP and its members have identified some wider, ethical, issues which it would be valuable for Government to consider. The most crucial one is whether the focus of clinical practice should be on the individual patient or the population. While the General Medical Council's *Good Medical Practice* states that doctors "must make care of the patient your first concern" GPs may find themselves in a dilemma when faced with decisions about resource allocation. Other ethical issues include how GPs will allocate their time between commissioning and caring for patients; whether law makers should have a moral obligation to be more open to research evidence when setting out major reforms; what degree of professional autonomy should GPs expect in the new era – will they be allowed to bring the less measurable strengths of general practice to the fore or still be bound by targets, prescribing incentives, referral sanctions and other performance management approaches?

## Summary

The RCGP supports stronger clinical leadership for commissioning services for patients and for those patients and their communities to enjoy health care which meets the local needs. However, we have concerns about the pace and extent of the reforms against the context of efficiency cuts and the lack of evidence to support many of the reforms and little commitment to pilot or trial the changes. We also believe that the reforms as currently set out will damage GP-patient relations, invite excessive competition in the healthcare market which will be driven by price to the detriment of quality and a fracturing of the comprehensiveness and continuity of care valued and needed by many patients, particularly the frail and elderly and disabled children. Additionally, we can only see the reforms leading to a deterioration in health inequalities and the loss of a national, holistic healthcare service in England.

In summary RCGP wishes to see:

- putting in place the reforms in one or two (diverse) regions of England and then assessing the situation before applying more widely
- the Government to put in place a system of support and managerial leadership during the crucial transition stage as this would enhance the chances of the reforms succeeding in the current financially stringent environment.
- "enough excellent providers" rather than "any willing provider" and the ability to make the decisions about what is needed for local communities
- A commitment that the legislative changes do not impact on the ability of GPs to provide the treatment they feel is most appropriate
- An explicit reference to reducing health inequalities in the outcomes framework
- A continuing ability for NICE to provide definitive guidance to the NHS for the use of new drugs and health technologies
- The retention of practice boundaries with more flexibility in the current "temporary doctor system"

We would again urge Members ensure that sufficient time is provided for full scrutiny of this important legislation

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