

The market in primary care

Changes to primary care have shifted clinical control away from general practitioners and financial control away from government, argue **Allyson Pollock and colleagues**

Since 2003 the government has created a market in primary care and replaced the old general medical services contract governing general practitioners with a range of alternatives. The changes gave primary care trusts in England, health boards in Scotland, and local health boards in Wales new powers to negotiate contracts with commercial companies.^{1 2} Many of the changes to regulation were intended to facilitate the entrance of new providers to the healthcare market.³ General practitioners are no longer contracted directly to the NHS but to the firms or practices that contract with primary care trusts in the market. These bodies are in turn regulated largely through the market mechanism of commercial contracting. We explain how the reforms change the basis of government control and mechanisms for public accountability in primary care and the possible effects on staff and patients.

Breaking the monopoly

The primary care market is premised on the break-up of the general practitioners' monopoly of the provision of primary care. From 1948 until 1997 GPs were contracted to work for the NHS under a general medical services contract between the secretary of state and the individual practitioner, on terms negotiated nationally. The contract was set out in the provisions of the *Red Book*, an extensive set of guidelines and regulations covering range and quality of services, staffing, and premises.

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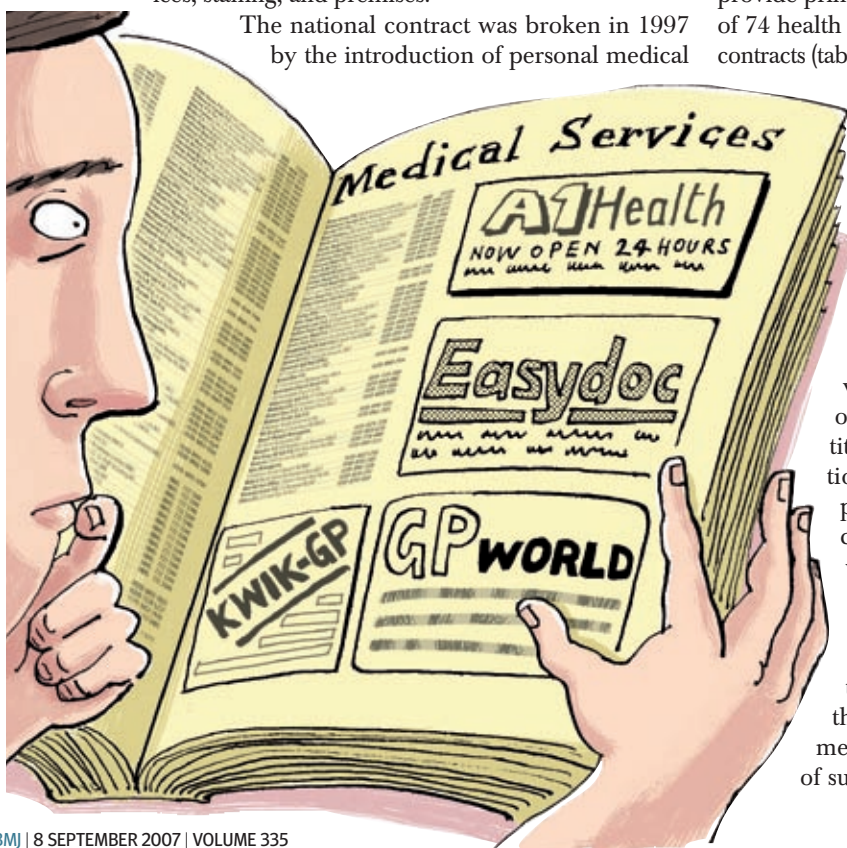
services contracts, which allowed local negotiations between general practitioners and commissioners about service specification.⁴ In 2003 the Health and Social Care (Community Health and Standards) Act ended the general practitioners' monopoly over the provision of primary care to the NHS, allowing primary care trusts to commission care from "anyone capable of securing the delivery of such services."⁵ The national agreement under which general practitioners were contracted directly to the secretary of state for health was replaced by four contracts:

- A new general medical services contract between practices and trusts
- An alternative provider of medical services contract⁵
- A locally negotiated personal medical services contract
- A primary care trust medical services contract enabling trusts to employ general practitioners directly on salary.

General practitioners no longer have a direct contractual relationship with the state because the contract is between the practice or the company and the primary care trust. They may continue as partners in a practice; as employees of practices, trusts, or corporations; as directors or shareholders of commercial companies providing primary care; or as subcontractors to whatever entity holds the primary contract.

In March 2007 about 30 companies held commercial contracts to provide primary care services in England through their ownership of 74 health centres and general practices, excluding out of hours contracts (table). The companies comprise general practitioner owned and operated companies; international healthcare corporations, including drug companies; companies with commercial links to the drug industry and healthcare corporations; companies providing catering, cleaning, and laundry services under private hospital contracts; and some joint ventures between these.

General practitioners' professional control over the range and provision of primary care services has been substantially reduced. Before the reforms doctors were contracted by the government to provide "all necessary and appropriate medical services of the type usually provided by general medical practitioners."⁶ The arrangement specified doctors' conditions of service to the NHS in terms that maximised professional autonomy. Under the new standard contract it is contractors, not general practitioners, who have the duty to provide services "appropriate to meet the reasonable needs of . . . patients."⁷ It is the contractor's duty to manage services required by patients registered with them, "offering a consultation and, where appropriate, physical examination for the purpose of identifying the need, if any, for treatment or further investigation; and the making available of such treatment or further investigation as is necessary



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and appropriate.⁷ Contractors may also determine the way in which services are delivered and determine, “in their reasonable opinion,” when home visits take place, when out of hours services are offered, who is removed from patient lists, and which serious incidents relevant to a contractor’s performance are notified to primary care trusts. Furthermore, the new system allows for contractors to manage specialist services formerly provided in hospitals but moved out into the community.

Change in legal basis for service provision

The introduction of commercial providers changes the legal basis of service provision, moving it from public law under direct government control to private commercial law. Whereas NHS contracts between primary care trusts and providers of primary medical services are non-legal agreements between NHS bodies—that is, trusts and strategic health authorities—commercial providers have commercial contracts that are enforceable in courts under private law.

Contracts with limited liability companies mean that the NHS cannot obtain redress beyond the value of the company’s shareholding if the company fails to deliver on its contracts or becomes bankrupt. The NHS commissioner has no recourse to other assets or income of the shareholders.

Unbundling primary care services

General practitioners are no longer bound to provide their patients with integrated and comprehensive services. The new contract has separated out primary care services into essential services, which are the minimum that must be provided to patients who are ill; additional services, such as screening, child health surveillance, and immunisation; and enhanced services, including such things as management of chronic diseases, minor surgery, and more specialist services currently provided in hospitals, which a practice can choose whether to provide.

An important consequence of this is that these services can be subcontracted to different providers. New entrants to the market are no longer committed to provide a full array of primary services to all patients but may select the services they wish to provide, if the primary care trust agrees.

Regulatory framework and professional control

The change from professional regulation and direct government control to commercial contracting has been introduced in advance of a system to regulate the new market, which was only being consulted on in November 2006.³ The Department of Health proposes that market forces should be the principal regulatory control on contractors. “Effective use of competition” and “healthy competition between different services users,” not “top-down performance management” is the preferred model, according to the consultation document.³ In this model regulation is chiefly through the contracts.

Although the proposals do not provide for a new primary and community services regulatory framework,⁸ several acts of deregulation accompany the reformed contracting system. Firstly, freedoms have been introduced to increase contractors’ ability to manage new financial risks by adjusting their cost base and restructuring their costs. For example, the government allows alternative primary care providers considerable freedom with respect to staff terms and conditions and the

mix of staff employed. The contract prices, although negotiated locally with primary care trusts, are not necessarily bound by national agreements such as the terms of employment for salaried general practitioners⁹ or a requirement to guarantee NHS pensions for their employees, or detailed requirements about the way in which care is provided.

Secondly, the introduction of practice based commissioning gives contractors budgetary control over a wider range of services. Contractors can hold the NHS budget not just for primary care but also for acute hospital care and community services, making them both gatekeepers to and budget holders for services.

Thirdly, quality regulations do not apply to all providers. Service quality is the responsibility of the primary care trust and is regulated through the quality and outcomes framework. Although the quality and outcomes framework is the element of the new contract that has most exercised general practitioners, it does not apply to alternative contractors. These contractors therefore have greater latitude to adopt new models of care, change staffing patterns and skill mix, and allocate funding for services.

Fourthly, rules on the sale of goodwill have been lifted. Goodwill refers to the practice of valuing a business on the basis of profits expected to flow from the contracts it holds, in addition to the value of tangible assets such as buildings and equipment. Sale of goodwill in primary care was banned in the NHS. In April 2004, however, the ban was lifted for all practices providing enhanced and additional services, allowing practices to be bought and sold on the basis of the number of patients they have and the income they represent.

Finally, providers have been given the power to devote part of their NHS budgets to advertising their services. A voluntary code of practice was published in 2006 allowing providers “to make more information about their services available to patients and referring clinicians in order to help them make choices and advise patients.”¹⁰ However, no limits were set on the proportion of NHS spending that can be devoted to advertising.

Implications of the reforms

John Reid’s statement that the new general practitioner contract “signals the most ambitious attempt to reform primary care services since the creation of the NHS” is fully justified.¹¹ The government has moved away from direct government control and systems of professional regulation to a system where commercial contracts awarded to competing providers constitute the government’s preferred model of public service reform.³

The changes raise important questions about government control and public accountability. Although primary care trusts are formally responsible for primary and community services, it is not clear how they will be able to influence the market when commercial contracts are in place.

The Department of Health proposes that management of financial performance will not be extended to privately owned providers but will be the responsibility of “their owners/trustees/shareholders.”¹² This proposal is at odds with an earlier commitment by government to Lord Sharman’s recommendations that public money should remain publicly accountable even when it is channelled through private firms.¹² So how will NHS spending be accounted for in the new primary care market?

Companies with commercial contracts to provide primary and community medical services to the NHS in England (March 2007)

Company	Service, area covered, contract type (where known)
Private healthcare corporations	
BK Health UK	5 medical and health centres (4 practices run under PMS in England and 1 GMS Wales)
Care UK (formerly Anglia Secure Homes)	Out of hours provision across Essex 7000 patient practice in Barking and Dagenham (APMS) HM Prison/Young Offenders Institute, Chelmsford HM Prison Wellingborough
Chilvers McCrea (subsidiary of Mercury)	23 general practices Prison care Out of hours care Variety of contract forms: GMS, PMS, and APMS
Concordia Health	2 general practices
IntraHealth	4 general practices (PMS)
Mercury (subsidiary of Tribal Group)	1 primary care centre, City and Hackney primary care trust (integrated PMS and WIC this one not explained in footnote)
Nestor	Out of hours provider for 44 primary care trusts and 5 Welsh health boards 2 primary care centres Forensic medical services—young offender institutions, police authorities, detention centres
Serco	All out of hours care for Cornwall Out of hours care in Cardiff Cardiff and Leicester prisons
United Healthcare	General practice, Derby
Drug company	
Pfizer Health Solutions	Chronic disease management for North Birmingham and East Birmingham primary care trusts
Joint ventures	
Hillingdon Healthcare/Harmoni	General practice services in Hillingdon (APMS)
Harmoni/WCI Group	Out of hours care for 11 primary care trusts 9 primary care centres
General practitioner providers	
Aston Healthcare	General practice, Mansfield
Central Surrey Health	Community nursing
Devon Doctors Cooperative	Out of hours service, Devon
GatDoc	Out of hours service, Gateshead
Hurley Group	Sternhall Lane, Peckham Riverside Medical Centre Hurley Clinic, Lambeth
Local Care Direct	Out of hours service, West Yorkshire
NEWDOC	Out of hours service, North Warwickshire and District
Northern Doctors Urgent Care	Out of hours service, North Tyneside primary care trust
On Call Care	Out of hours service, Maidstone
Rushcliffe Mutual	Provision of services and practice based commissioning in Nottinghamshire (APMS with primary care trust) 21 general practices
SELDOC	Out of hours service Lambeth, Lewisham, and Southwark
Shropdoc	Out of hours service for Shropshire, Telford and Wrekin, Powys and Wrexham
Thamesdoc	Out of hours service for Surrey primary care trust
Wayside	Surrey Health and Woking local prison (APMS)
Wolverhampton Doctors on Call	Out of hours service for primary care trust
Wsdoc	Out of hours service for West Sussex, 7 out of hours surgeries

GMS= General medical services contract, PMS=personal medical services contract, APMS=alternative provider of medical services contract.

Recent inquiries by the National Audit Office and the public accounts committee into out of hours services¹³ and the consultants' contract¹⁴ suggest that primary care trusts and the Department of Health have insufficient information and knowledge to negotiate clinical care contracts. A National Audit Office survey of primary care trusts and out of hours services found that the majority of contract terms were drawn up by contractors not by commissioners. These findings are consistent with predictions from the economics literature that complex services, and clinical care in particular, cannot be successfully regulated through contracts because commissioners can never specify contract terms in sufficient detail to meet all contingencies.¹⁵

Finally, the introduction of commercial contracts will see the jurisdiction for healthcare policy and law move away from national government to the European Union. However, the EU's mandate is trade and commerce and not public health.¹⁶

The government has allowed more firms to provide NHS funded primary and community care because it believes that competition will improve the public health. But nothing is yet known about the consequences for access, costs, quality, and accountability. It is surely time to evaluate the policy.

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- 1 *Health and Social Care (Community Health and Standards) Act 2003*. London: Stationery Office, 2003.
- 2 *National Health Service (General Medical Services Contracts) Regulations 2004*. London: Stationery Office, 2004.
- 3 Department of Health. *The future of health and adult social care in England*. London: Department of Health, 2006.
- 4 *NHS (Primary Care) Act 1997*. London: Stationery Office, 1997.
- 5 NHS Primary Care Contracting. *Primary medical services contracts—a guide for potential contractors*. London: NHS Primary Care Contracting, 2006.
- 6 *The Red Book. Remuneration for general practitioners*. London: Stationery Office, 2006. <http://redbook.i12.com/rb/Docs/rb0.htm>.
- 7 Department of Health. *Standard general medical services contract*. London: DoH, 2006.
- 8 King's Fund. *Response to the Department of Health consultation on the future of regulation of health and adult social care in England*. London: King's Fund, 2007.
- 9 BMA. *Alternative provider medical services (APMS) in primary care*. 2006. www.bma.org.uk/ap.nsf/Content/Alternativeprovidermedicalservices?OpenDocument&HighLight=2,Alternative,Provider,Medical,Services#National.
- 10 Department of Health. *Code of practice for promotion of NHS services*. London: DoH, 2007.
- 11 Reid J. *Limits of the market, constraints of the state: the public good and the NHS*. London: Social Market Foundation, 2005.
- 12 House of Commons. *Audit and accountability in central government: the government's response to Lord Sharman's report "holding to account"*. London: Stationery Office, 2002. (Cm 5456.)
- 13 National Audit Office. *The provision of out-of-hours care in England*. London: Stationery Office, 2006.
- 14 National Audit Office. *Pay modernisation: a new contract for NHS consultants in England*. London: Stationery Office, 2007.
- 15 Allen P, Croxson B, Roberts JA, Archibald K, Crawshaw S, Taylor L. The use of contracts in the management of infectious disease related risk in the NHS internal market. *Health Policy* 2002;59:257-81.
- 16 Prosser T. *The limits of competition law*. Oxford: Oxford University Press, 2004.