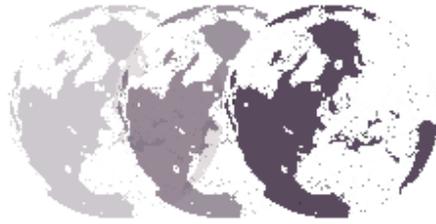


**The Centre for
International
Public Health Policy**



**Response to the Scottish Government consultation on
changes to eligibility criteria for providers of primary
medical services**

17 December 2008

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The Centre for International Public Health Policy makes the following submission under the Scottish Government's consultation on changes to eligibility criteria for providers of primary medical services (hereafter the 'proposed changes to eligibility criteria').

Conclusions and recommendation

The new general medical services (GMS) contract makes extensive provision for participation by companies limited by shares operating under commercial (private law) contracts. The object of the reform is to create a provider market.

- The Scottish Government seeks to strengthen regulation of this market by increasing the controls on market entry. The consultation does not address the legal status of providers' relationship to the health service. However, the legal status of the contract is the main vehicle for NHS commercialisation and the model has already been introduced to long-term care, independent treatment centres, mental health, pharmacy, and dentistry.
- None of the Scottish Government's proposals is sufficient to prevent commercial contracting by shareholder companies.
- Insofar as the Scottish Government's focus is on entry controls, all the proposals run counter to general policy trends and competition law frameworks in the UK and in the EU, and for this reason are unlikely to be successful.
- Contracting policy is under the control of health boards. Health boards can avoid commercial contracting by opting for salaried GPs or for NHS (non-commercial) contracts.

We recommend that the Scottish Government mandate health boards only to contract using non-commercial arrangements. We also recommend that the Scottish Government, with the devolved authorities in Wales and Northern Ireland, make representations to the UK government concerning the removal of commercialisation pressures in the UK-wide GMS contract that conflict with their devolved powers.

Background

1 *The new GMS contract*

In 2004, the national agreement under which GPs were contracted directly to the secretary of state for health was replaced by four different contracts: a new GMS contract between practices and health boards, the Health Board Provider of Medical Services or HBPMS contract (in England the equivalent is the Alternative Provider of Medical Services or APMS contract), a locally negotiated PMS contract first introduced in 1997, and a new contract enabling health boards to employ GPs directly on salary.

The four contracting routes allow for participation by shareholder companies in two main ways. The GMS allows participation by certain companies limited by shares. The HBPMS contract allows contracting with any shareholder company.

2 *The reformed regulatory framework*

The aim of the reform is to introduce commercial contracting methods to primary care in order to create a market in primary care services¹.

The new contractual basis for primary care services abolished the long-standing relationship between the GP and the state, substituting instead a legal contract between health care purchasers and

¹ Pollock AM et al. The market in primary care. *BMJ* 2007; 335: 475-7.

contractors. GPs are no longer contracted directly to the NHS under a nationally negotiated agreement but to the firms or practices that contract in a market with primary care trusts (PCTs) (in England) or Health Boards (in Scotland or Wales). GPs may continue as partners in a practice; as employees of practices, or PCTs, or corporations; or as directors, or shareholders of commercial companies providing primary care; or as sub-contractors to whatever entity holds the primary contract.

Depending on the contracting route chosen, the new contracts can be subject to public law or private commercial law. NHS contracts between health boards and providers of primary medical services are non-legal agreements between 'NHS bodies' such as health boards. Commercial providers have commercial contracts, which are enforceable in courts under private law. The determination of contract status is a policy decision of health boards. Commercial contracting is being rolled out throughout UK health services.

3 *Loss of professional autonomy*

The UK government's representation of the GMS reforms as a continuation of GPs' 'independent contractor status' has obscured the radical nature of the departure from practices established in 1946. A basic effect is loss of professional autonomy and self-regulation.

GPs' professional control over the range and provision of primary care services has been substantially reduced under the new arrangements. Under the old GMS contract doctors were contracted by the government to provide 'all necessary and appropriate medical services of the type usually provided by general medical practitioners'.² The arrangement specified doctors' terms of service to the NHS in terms that maximised professional autonomy. Under the new standard contract it is contractors, not GPs, who have the duty to provide services 'appropriate to meet the reasonable needs of [...] patients'.² It is the contractor's, not the doctor's duty, to manage services required by patients registered with them. Services can also be outsourced to different subcontractors. New entrants to the market are thus no longer committed to provide a full array of primary services to all patients but may select only services which it wishes to provide, if the health board agrees.

4 *The market reforms and the European Union*

The introduction of commercial or market contracts exposes Scottish health care policy to European Union control under the terms of the EC treaty. The EC treaty seeks to ensure a competitive single market by establishing rules of competition that outlaw state intervention in the market. Since 1998, uncertainty surrounds the legal treatment of health services following a series of landmark judgements by the European Court established that national health systems involving private or 'market' providers are not necessarily immune from Community law. The European Union is currently trying to resolve this uncertainty by creating a new legal framework that extends single market rules to aspects of health services through a proposal for a directive on patient mobility.³ According to a recent legal opinion⁴, it is questionable whether the Scottish Parliament has the legal power to change regulations transposed into Scottish domestic law under directives of the European Union. European Union liberalisation rules are designed to remove market barriers such as restrictions on entry.

² The Red Book. Remuneration for General Practitioners. The Red Book Collection. London, HMSO, <http://redbook.i12.com/rb/Docs/rb0.htm> (accessed 1 April 2007).

³ Pollock AM et al. *Response to the Scottish Government's consultation on the European Commission's proposals for a directive on the application of patients' rights in cross-border healthcare* 2008. Edinburgh: CIPHP.

⁴ Opinion of senior counsel for Dr Christopher Johnstone & Prof Allyson Pollock. Available from CIPHP.

The proposals for future arrangements for contracting for GP services

GPs have always had the freedom to form limited companies for the purposes of providing primary care. However, under pre-2004 arrangements all GPs also had an agreement with government to provide services. That agreement has been abolished and GPs relationship to the health service is now based entirely on their relationship with the service provider. The corporate policy of providers depends on their objectives and on the legal status of their contract with the health service.

The Scottish Government is seeking to tighten regulation in this new commercial environment by controlling entry to the new provider market. Below we examine the proposals in turn.

Proposal A – debarring commercial providers

This proposal seeks to control entry to the new provider market by excluding HBPMS contracts for GP services, and therefore the unqualified right to participation by shareholder companies in primary care contracts, but it does not abolish the qualified right of shareholder companies to participate in GMS and PMS contracts and it does not prevent the use of commercial contracts.

Moreover, the attempt to control entry in this way runs counter to general policy trends and competition law frameworks in the UK and in the EU, and for this reason is unlikely to be successful.

Proposal B – Simplification of eligibility criteria for persons providing GP services (under contract to the NHS)

This proposal, like proposal A, seeks to control entry to the new provider market but it does not exclude participation by shareholder companies or prevent the use of commercial contracts.

Moreover, it depends for success on an assumption that shareholder companies owned by health care professionals will adopt different corporate policies from shareholder companies not run by health care professionals. This assumption is not supported by evidence.

Proposal C – Commitment to patient care of GPs in the traditional model

This proposal, like proposals A and B, seeks to control entry to the new provider market but it does not prevent the use of commercial contracts.

Moreover, it is based on an assumption that companies involving practising GPs will, in a commercial environment, adopt policies different from companies that do not involve practising GPs. This assumption is not supported by evidence.

Proposal D – Voluntary organisations and related bodies

The same observations apply to this proposal as to proposal B.

Research evidence⁵ does not support the policy of bringing in the not-for-profit sector as a main service provider of NHS health care. On the contrary, the evidence shows that in a market

⁵ Pollock AM et al. *A literature review on the structure and performance of not-for-profit health care organisations*. Report for the National Co-ordinating Centre for NHS Service Delivery and Organisation R & D (NCCSDO) 2007.

environment not-for-profits' corporate policy resembles that of for-profits.⁶ These findings do not support a policy of a larger role for the not-for-profit sector.

Conclusions and recommendations

The new GMS contract makes extensive provision for participation by companies limited by shares operating under commercial (private law) contracts. The object of the reform is to create a provider market.

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⁶ Rathgeb Smith S, Lipsky M. *Nonprofits for hire: The welfare state in the age of contracting*. Cambridge MA: Harvard University Press 1993.