The Centre for International Public Health Policy

THE UNIVERSITY OF EDINBURGH

Response to the Scottish Government's consultation on the Tobacco and Primary Medical Services (Scotland) Bill, 26 February 2009

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The Centre for International Public Health Policy makes the following submission under the Scottish Government's consultation on the Tobacco and Primary Medical Services (Scotland) Bill, 26 February 2009.

Conclusion and recommendations

We argued in our first submission[1] under this consultation that none of the Government's original proposals for amending legislation were sufficient to prevent commercial contracting by shareholder companies. We pointed out that the focus on entry controls run counter to general policy trends and competition law frameworks in the UK and in the EU. We also pointed out that in Scotland, health boards can avoid commercial contracting by opting for salaried GPs or for NHS (non-commercial) contracts.

Our view is unchanged. The Tobacco and Primary Medical Services (Scotland) Bill fails to prevent commercial contracting by shareholder companies, and we reiterate our recommendation that the Scottish Government enact legislation that mandates health boards only to contract for primary care services on a non-commercial basis. This requires a new bill different from the one proposed.

We also recommend that the Scottish Government, with the devolved authorities in Wales and Northern Ireland, make representations to the UK Government and English Department of Health concerning the removal of commercialisation pressures in the UK-wide general medical services (GMS) contract that conflict with their devolved powers, and furthermore that arrangements should be put in place to ensure that changes in patient entitlements consequent on local contracting should be adequately monitored.

Finally we recommend that the Scottish Government improve and review the data required to monitor the impact of current changes to out-of-hours provision on access, use and outcomes of care.

Introduction

We welcome the changes to eligibility criteria for bodies contracting with health boards contained in part 2 of the Tobacco and Primary Medical Services (Scotland) Bill. However, we note that the amendment does not meet the commitment of the Cabinet Secretary for Health and Wellbeing in 2008 to "ensure that NHS Scotland remains firmly in the public sector – a public service delivered in partnership with the public."[2] This is because the bill adopts and perpetuates the English market system introduced by the new GMS and related contracts. These new contracts overturn the consensual approach to primary care entitlements in two ways. First, they allow health service funds to flow to shareholders and second, they facilitate commercially inspired changes in service entitlements and workforce standards. If the bill were to be passed in its present form, the Scottish NHS would retain key characteristics of the English commissioning system at odds with the non-commercial views expressed by the Scottish Government.

Background

The UK 2004 GMS contract reforms fundamentally changed the relationship between GPs and the state by allowing locally negotiated commercial contracts between GP practices and health boards in Scotland.

The reforms involved the following deregulation

- separation of control over services from the GPs who actually provide them
- introduction of private commercial contracts to replace NHS agreements
- additional freedom from the national regulatory framework for services normally provided by GPs (the Red Book)

- Additional freedom for local negotiation of services and staff terms and conditions
- Freedom for commercial companies to provide primary care services.

Taken together, the reforms established a primary care market by changing the contractual basis from public law to private commercial law. Commercial contracting has been substituted for professional self-regulation within a nationally negotiated agreement[3].

In England, companies under private law can now compete for locally negotiated, cash-limited, commercial contracts. These companies control primary care services, staff mix, terms and conditions of service, doctor-patient ratios, and access for patients. Since 2004, PCTs in England have been able to subcontract services to "anyone capable of securing the delivery of such health services"[4]. These different providers include American managed care companies such as UnitedHealth Europe[5], and also retail companies such as Boots, Tesco, and Sainsbury's, some of which now offer GP services in addition to pharmacy services. At the same time the general pharmaceutical contract introduced in England allows for other GP services to be provided by high street pharmacists and pharmaceutical companies.

The UK government has claimed that GPs have always been and will remain independent contractors under the reforms. But for the last forty years independent contractor status has been discussed in terms of clinical autonomy in the context of developing state controls for ensuring universal access, quality of care, and core services[6]. The transfer in 2004 of the contract to practices, including commercial undertakings, introduces a commercial impetus to the development of primary medical services (PMS) and represents a radical break with the earlier tradition.

The Tobacco and Primary Medical Services (Scotland) Bill

Section 30 of the Tobacco and Primary Medical Services (Scotland) Bill retains the health board freedom to contract with commercial companies. As things stand, any company can take on a locally negotiated contract. The amendment introduces new eligibility criteria that will restrict contracts to companies which satisfy all of the following conditions:

a at least one share in the company is legally and beneficially owned by a medical practitioner or other health care professional;
b any share which is not so owned is legally and beneficially owned by an individual (s.30(2c)); and
c the shareholder has "sufficient involvement in patient care" (s.30(4)).

The bill is apparently intended to honour a 2008 commitment by the Cabinet Secretary of Health and Wellbeing to an NHS with a "mutual ethos", that is, one "designed to serve its members" and publicly delivered[7]. This goal has been interpreted as a pledge to eradicate competition from NHS provision. For example, Lothian Health Board says it rules out service provision through "a commercial competitive environment subject to the risks and rewards inherent in commercial and financial markets"[8].

Response

Section 30 of the Tobacco and Primary Medical Services (Scotland) Bill does not conform to the minister's 2008 assurance that NHS Scotland will remain a "mutual" organisation "firmly in the public sector – a public service delivered in partnership with the public." On the contrary, the bill adopts the English model and retains the 2004 market reforms that create a primary care market open to competition with commercial companies

The bill will retain the health board freedom to negotiate primary care services locally with commercial undertakings on the basis of commercial contracts. Such contracts, enforceable in private law courts, are designed to introduce a commercial, competitive environment that will influence models of care.

In England entrepreneurially minded GPs have exploited these provisions to undermine traditional entitlements to GP services. ChilversMcCrea is a company set up by a doctor and a nurse in Chelmsford in 2003, and is now the largest alternative provider of NHS primary care services in the UK, managing 40 GP practices in England and Wales from its base in Essex.[9]

The company is associated with the policy of 'lower cost general practice' involving the replacement of GP out-of-hours cover with nurses and emergency care practitioners[10]; with a dramatic expansion of private sector involvement in primary care at the expense of traditional GP-led practices[11]; and with joint ventures with multinational companies such as Boots for the provision of 'in-store' surgeries.[12] This undertaking would remain eligible to contract in Scotland were the bill to be approved in its present form.

Other GP-led companies are avoiding adoption of the BMA model contract, a key part of the 2004 reforms, with only 52% of salaried GPs in PMS (s.17C) practices on the model contract and a growing number employed as 'fixed share partners' with no employment rights and few voting rights[13]. Meanwhile, another GP-led company, IntraHealth, is credited with being the first to open a GP surgery in England staffed entirely with privately employed doctors.

No data are collected centrally by the English Department of Health on the involvement and services of companies of this type so it is not possible to monitor changes in service entitlements, access for patients, or staffing.

Meanwhile in Scotland, Tayside Health Board is using a similar contracting route to revolutionise out-of-hours cover in Kinloch Rannoch by proposing the substitution of a roster of locally-recruited volunteers for GP cover. The scheme, known as 'First Responders', will make Rannoch the first community in the UK to lose 24-hour GP cover.

Restriction of eligibility for s.17C practices will therefore not prevent the entry into the Scottish NHS of commercially-driven, private health care organisations. On the contrary, it will perpetuate the practice of putting health service delivery in the hands of private law bodies that are not publicly accountable.

Conclusion and recommendations

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Our view is unchanged. The Tobacco and Primary Medical Services (Scotland) Bill fails to prevent commercial contracting by shareholder companies and we reiterate our recommendation that the Scottish Government enact legislation that mandates health boards only to for primary care services contract on a non-commercial basis. This requires a new Bill different from the one proposed.

We also recommend that the Scottish Government, with the devolved authorities in Wales and Northern Ireland, make representations to the UK Government and English Department of Health concerning the removal of commercialisation pressures in the UK-wide GMS contract that conflict with their devolved powers; and furthermore that arrangements should be put in place to ensure that changes in patient entitlements consequent on local contracting should be adequately monitored.

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[1] Pollock AM, Viebrock E, Price D. *Response to the Scottish Government's consultation on changes to eligibility criteria for providers of primary medical services*. Edinburgh: CIPHP 2008.
[2] Scottish Government. *Better health, better care: action plan*. Scottish Government: Edinburgh 2007, p3.
[3] Pollock AM, Price D, Viebrock E, Miller E, Watt G. The market in primary care. *BMJ* 2007;335:475-7.
[4] Department of Health. *NHS Primary Care Contracting* 2006.
[5] Salisbury C. The involvement of private companies in NHS general practice. *BMJ* 2008;336:400-401.
[6] Lewis J. The medical profession and the state: GPs and the GP contract in the 1960s and the 1990s. *Social Policy & Administration* 1998;32(2):132–150.
[7] Scottish Government. *Better health, better care: action plan*. Scottish Government: Edinburgh 2007, p5.
[8] Lothian Health Board, board minutes, 11 December 2008, p2
[9] http://www.chilversmccrea.co.uk/map/CM%20Practices%2008_11_woname.pdf.
[10] *Pulse* 17 September 2008.
[11] *Pulse*, 3 December 2008.
[12] *Pulse*, 29 April, 2008.
[13] *Pulse*, 5 November 2008.
[14] Pollock AM, Viebrock E, Price D. *Response to the Scottish Government's consultation on changes to eligibility criteria for providers of primary medical services*. Edinburgh: CIPHP 2008.