To market, to market: what future for primary care?
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Executive summary

In this paper, we explore the reasons for the current discussion in the NHS about the potential to develop a primary care market. Consideration is given to the wider policy context, the state of primary care, and the appropriateness or otherwise of using a market model to bring about change in this sector. We assert that primary care needs to change in order to respond to two main factors:

- a need for greater responsiveness to the needs and wants of patients and the public
- a need for services to be able to develop new models of care that can address the rising prevalence of chronic diseases

Case studies of primary care developments are used as a basis for examining the extent to which a market in primary care is already being put in place in the NHS. This is then followed by a consideration of the implications of such a market for patients, providers and commissioners. We conclude by making the following recommendations:

That the use of contestability in primary care has significant potential in relation to developing more responsive and integrated services for patients.

That as a minimum, the primary care market should be used as a way of extending practice opening hours, developing greater choice of practice location, offering consultations via email and phone, and instigating new models of care for people with long-term conditions and for those who traditionally do not access general practice.

That in order to bring about a more responsive primary care service, commissioners need to engage in more creative and assertive contracting with primary care providers.

That the policy framework for such contracting activity is largely in place, but commissioners need to be bolder in their approach, and ready to challenge existing standards of provision by using the contracting process in a more robust manner.

That additional incentives must be developed as a way of engaging primary care providers in the development of more responsive and integrated services, and this will require a blend of different contracting and payment approaches.

Commissioning capacity and expertise in the NHS is currently inadequate for the challenges ahead, and needs to be less focused on the purchasing of secondary care – as commissioning is strengthened in coming months, it is vital that primary care contracting is given proper attention.

New entrants to the primary care market should be welcomed as a means of increasing capacity and developing new models of care, and should be subject to a level playing field in terms of operation within the market.

Clear workforce policies need to be developed in order to ensure that scarce staff resources are appropriately deployed and that all staff, in whatever organisation, can be part of wider primary care training and development activity.

All primary care providers of whatever form need to be accredited and regulated by strong PCTs that see market regulation and management as a core function.

Market failure is a very real possibility for some existing and new providers and PCTs need to develop ways of managing this whilst assuring continuity of service provision for patients.

A culture change in relation to the provision of information to patients about primary care services and choices is required, with people having access to much more detailed data about all aspects of local services.

Patient registration is a vital element of NHS primary care, and should be retained, but it requires some rethinking and clarification, in particular in relation to what rights and responsibilities it confers on patients and providers.

As more providers enter the primary care market, they need to be linked into the wider NHS information system in order that patient data can be safely communicated, and continuity of care supported.

Commissioners have a duty to protect and enhance continuity and co-ordination of care as they contract for primary care services, ensuring that their activity enhances partnership working and service integration, and avoids service fragmentation and duplication.

Acknowledgement

This paper draws upon a programme of policy analysis and development at HSMC that focuses on the potential impact of a primary care market. This programme has included a learning network over 2004-2005 for clinicians and managers in Birmingham and the Black Country on commissioning, a conference on ‘Opening up the Primary Care Market’ in July 2005 and an HSMC seminar on the same topic in September with West Midlands NHS colleagues. We would like to acknowledge the ideas, discussion and contributions of the colleagues involved in these events – their analysis of the current and possible future scenarios for English primary care has been invaluable.
Introduction

The Labour government has signalled its commitment to using market mechanisms as a means of bringing about changes to health services. To date, market-based approaches such as extending the use of private sector providers of diagnostic and care services in the NHS, offering patients the choice of a private as well as NHS provider for elective care, and operating a payment system underpinned by legal/commercial contracts have been largely confined to acute sector care. Recent policy announcements have however indicated that the government wishes to extend its reliance on greater plurality and contestability of health care provision (albeit still funded by the NHS) to primary care.

In this paper, we explore the origins of the policy of opening up the primary care market, the early experience of developing a primary care market in England, and the possible implications of such a development in respect of the impact on patients, providers, commissioners, and the wider health system.

Why a market?

In its NHS White Paper of 1997 (Department of Health, 1997), the incoming Labour Government indicated that it was to retain the purchaser-provider split, the central tenet of the NHS internal market of the preceding Conservative governments. Similarly, Labour ‘went with the grain’ of primary care-led purchasing, the principle of placing the responsibility for planning and funding health services in the hands of GPs and other professionals working in primary care.

Over time, the Blair administration has demonstrated an ongoing faith in the market model of health care, with primary care-based commissioners (primary care trusts) who fund and purchase health care, and providers (NHS trusts and other bodies) who deliver health services. The value of commissioning care is seen to be the fact that it enables ‘contestability’ within the health system, the ability on the part of funders (PCTs) to move contracts and associated resource away to alternative providers if the service provided by a trust does not meet the commissioner’s quality standards and other requirements.

Towards the end of Labour’s second term in office, a range of ‘system reforms’ were put in place in the NHS, with the aim of enabling the health system to deliver on an ambitious programme of ‘modernisation’, or service improvement, required of the health service by politicians in return for the significant additional resource being put into the NHS over the period 2002-2007. These system reforms have further strengthened the market-based approach to running the NHS, and have five main elements:

- A policy of ‘patient choice’, whereby patients are offered a choice of provider of elective care (including one private sector option), choice of time of treatment, and with an intention to extend such choices to other areas of care.
- The development of independent sector treatment centres as a means of creating additional elective care capacity.
- A new activity-based payment system for the NHS, ‘payment by results’, whereby hospital activity is paid for according to a fixed national tariff, and commissioners can move activity (and associated resource) from providers at full cost.
- The introduction of new more autonomous hospital providers, foundation trusts. These trusts operate as public-interest corporations, and account to a new national regulator Monitor for their performance, rather than through traditional NHS management hierarchies.
- The reintroduction of micro-level purchasing in the NHS in the guise of practice-based commissioning, a policy that enables practices, or groups of practices, to assume a partial or total budget for the commissioning of care for their registered population, within the overall accountability of their host PCT.

The importance of these system reforms in bringing about the government’s desired changes to the NHS was emphasized in a speech by Lord Warner, Minister of State for NHS Delivery in July 2005:

‘What we need to do now is move to a more sustainable and sophisticated approach. Instead of a top-down command and control approach, we need to implement reforms that create powerful mechanisms to drive continuous improvement…There will be greater contestability for providers and commissioners and this will help make choice a reality and drive up quality.’ (Department of Health, 2005a).

And why in primary care?

It can be argued that NHS primary care has always operated as a quasi-market, with independent providers (GPs, dentists, pharmacists and optometrists) providing services to the NHS under contracts with PCTs. Some of these providers have been more closely aligned with and managed by the NHS than others. GPs are dependent on NHS funding and have seen their practices and services become increasingly managed by the wider health system (Smith and Walshe, 2004), whereas optometrists have remained very much as private retail providers with some resource coming to them via NHS contracts.

Primary care is however under pressure to improve because of increasing demands from patients and the changing needs of the population. Increasing demands derive from rising incomes and higher educational standards, leading patients to have raised expectations of the NHS in general and primary care in particular. Patients today expect the NHS to be responsive and flexible and are less willing to wait for an appointment and to accept services that may appear to be organised more for the benefit of providers than service users.

Changing needs derive from the rising prevalence of chronic diseases in the population. The Department of Health has estimated that 17.5 million adults in Great Britain may be living with a chronic disease (Department of Health, 2005b). Around 80% of consultations with GPs relate to chronic disease and patients with a chronic disease or complications use over 60% of hospital bed days (Department of Health, 2004). The WHO has reported that risk factors like tobacco use, physical inactivity and unhealthy diets lie behind the increase in chronic diseases (World Health Organisation, 2005).

Meeting the needs of people with chronic diseases depends first and foremost on the provision of high quality primary care. Increasingly, however, primary care needs to be integrated with the specialist expertise available within hospitals, and it requires rapid access to diagnostic facilities. The current model of general practice, typically based on three or four doctors supported by a small team of other staff, does not always facilitate the provision of specialist support and diagnostic facilities in a primary care setting.

In recognition of this, there is growing interest in new approaches to primary care provision. NHS general practice has traditionally offered relatively little choice to patients about which provider to use, when they can access services, and by what means (e.g internet, phone, personal consultation). Although patients have a theoretical right to choose and change their GP, many practices operate a ‘catchment area’ approach similar to that used by many schools, others have ‘closed lists’ whereby they declare themselves to be ‘full’, and the population lacks comprehensive information about the range of local practices and the services they offer.

The opening hours of general practices have, if anything, become more restricted since the introduction of a new general medical services contract for primary care in 2004. Few practices open beyond early evening, and almost no practice is open routinely at weekends. Out of office hours, patients rely on services put in place by the wider NHS including out-of-hours/ emergency primary care centres, the NHS...
The government has recently initiated a "listening" exercise related to primary care, a move which is aimed at finding out people's views about how they use the service. Such a move would be in line with the policy of making the health service more 'consumer-focused', an approach which is increasingly managed by the patient. It could, however, be argued that in a more consumer-focused service, patients may want to make the choice of going directly to another professional, for example a physiotherapist, or a nurse, without seeing a GP first. Such a move would be in line with the encouragement for people to increasingly manage their own care, becoming more 'expert patients'.

A further dimension to patient choice in primary care is that of which professional people choose to consult. The traditional GP role as gatekeeper of NHS services has meant that patients almost always view their GP as their first port of call. It could however be argued that in a more consumer-focused service, patients may want to make the choice to go directly to another professional, for example a physiotherapist, or a nurse, without seeing a GP first. Such a move would be in line with the encouragement for people to increasingly manage their own care, becoming more 'expert patients'.

The government has recently initiated a 'listening' exercise related to primary care, a national consultation entitled 'Your health, your care, your say'. This consultation is aimed at finding out people's views about community and social care services (including primary care and general practice), and to try and elicit the opinions of those whose voices are not often heard, including teenagers, the homeless, and people with learning difficulties. A white paper on 'out of hospital care' is planned for the winter of 2005-2006, and will set out the government's plans for the next phase of development of primary care, community services and social care.

What is clear is that the government is intent on drawing primary care and community services into its overall programme of reform based on the use of market-based incentives, and the "Your health, your care, your say" consultation would appear to be the consumer perspective of this. The implication is that despite a strong primary care system with good levels of user satisfaction, more needs to be done in relation to making the system work in a responsive and flexible manner that ensures that people's needs are met and choices fulfilled.

But where do we start from?

Primary care is the part of the NHS that is most envied by many international researchers and policy makers. Barbara Starfield has cited UK primary care as being foremost among the world's primary care systems, offering efficient care that produces good health outcomes, and with the benefits of a registered list of patients, capitalisation funding, and gatekeeping of secondary care and diagnostic services by GPs (Starfield, 1998). Fry and Horder (1994) similarly rated UK primary care as number one in relation to offering comprehensive care on a universal basis and at a reasonable cost.

The central question being addressed in this paper is the extent to which opening up more of a market for primary care offers opportunities to develop more responsive and appropriate care for patients with ever more complex needs, or whether it fundamentally compromises what is acknowledged to be a leading primary care service. From our analysis of the current state of NHS primary care, it would seem that the appetite for change is more at the margins (more choice, greater flexibility of locations and opening times, faster access to diagnostics, improved co-ordination of multiple services for people with long-term conditions) rather than being about a wholesale change to the wider primary care system.

How is the market opening up?

The opening up of a market in primary care, that is the encouragement of a wider range of providers of primary care services, is something that is perfectly possible and legitimate within existing legislation and policy. PCTs have the ability, as commissioners of primary care for their local population, to use the Personal Medical Services (PMS) contract or the Alternative Provider of Medical Services (APMS) contract to purchase care from new providers of primary care including NHS trusts, foundation trusts, voluntary or third sector bodies, or private sector companies. Indeed, in some areas, PCTs have used these contract options as a way of filling gaps in current primary care provision, or securing innovative models of care that were not being provided by existing NHS practices. Two examples of this are set out in boxes one and two.

Box one – Vale of Aylesbury PCT: commissioning a primary care service for a new housing development

In the Vale of Aylesbury, the PCT decided to tender for the provision of a new primary care service, delivered from two sites, for a predicted population increase of 9,000 by 2016 due to new housing development on the outskirts of Swindon. The PCT received two applications; one from a local practice and one from BK Health, a private company led by three GPs and a business manager. Following a rigorous procurement process the PCT selected BK Health due to its innovative approach to service provision and value for money. Their proposal included a ‘core service based on the GMS quality framework, as well as locally agreed PMS targets, but with a far smaller reliance on the ‘traditional role of GPs, and a far greater reliance on the developed nursing team, and other clinicians’. One example of this was their intention to use a nurse triage model to manage demand and resources effectively. It also included integrating dental, dispensing and clinical pharmacy, minor injuries, specialised sexual health and provision of ‘immediate and first response care’. In addition, BK Health included in their bid plans for a multi-use training centre and proposals for facilitating a high level of community involvement in service development. The PCT used an APMS contract for the service, and is now working through issues such as the performance management framework for the contract, and the integration of APMS clinicians into the PCT and wider health economy. The building of the new development will start in 2006.
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Box two – commissioning for quality primary care services in Brent PCT

The PCT serves a diverse population with high health needs and recognises that primary care has poor levels of skill mix to meet the varying needs. The PCT is also succession planning for the retirement of almost half of their GPs in the next few years and is directly managing seven practices with a total population of 10,000. Using APMS contract provisions to tender for primary care services the PCT is testing the market for delivery of services to this population. The decision challenges the ‘automatic right to provide’ of traditional general practice and seeks a degree of contestability as an appropriate way of securing high quality services for local people. The PCT also believes it has a responsibility to ‘grow the market’ and work in partnership with new providers. Following a process similar to that used in private finance initiative (PFI) developments and the Local Improvement Finance Trust (LIFT) programme, the PCT is currently developing a shortlist of preferred providers. This will then proceed to an invitation to negotiate stage with a view to securing a chosen provider by April 2006.

Box three – ChilversMcCrea Healthcare: a GP and nurse-led private primary care company

ChilversMcCrea is a commercial primary care provider established by a GP and a nurse, and providing primary care services to a range of PCTs across England under APMS contracts and using locally franchised providers. The company seeks to change provision ‘to fit the culture of the land’ and in a way that supports all patients including the disempowered such as the homeless. As a profit-making organisation ChilversMcCrea sees itself as a source of investment within a health care economy and a route for service development and innovation, especially in relation to new models of primary care that use different skill-mix and approaches to care delivery. Providing strong ‘back-office’ functions is a feature of Chilvers McCrea, including practice management, training and development, and other administrative and business support. The company feels that there would have been a more rapid take-up by private companies of primary care contracts if non-NHS bodies were able to access mainstream NHS development and support funding in the way that NHS GPs are able to do. Whilst recruitment of doctors has not been a problem for Chilvers McCrea, the company has expressed concern at the fact that staff transferring from the NHS are unable to remain in the NHS Pension Scheme.

Box four – Care UK: moving from home care into primary care

Care UK is a large private sector company that has previously operated in the residential and home care market and more recently in the development of independent sector treatment centres for elective and diagnostic care. The company is working with NHS commissioners to develop public/private partnerships in primary care with a focus on long-term conditions, prevention of disease and provision of primary care services. By using new NHS primary care contract options, the company seeks to find economies of scale by developing new forms of primary care based in larger surgeries and networks that in turn can create strong commissioning and performance management systems and processes. The company asserts that they have a true customer focus supported by a culture of innovation and strong commercial acumen. Care UK considers that a contestable primary care market and plurality of service providers can add capacity into the system, whilst recognizing the risks of a competitive market potentially leading to fragmentation of services and therefore a loss of continuity of care.

These two examples (boxes one and two) of opening up the primary care market demonstrate in a powerful manner the importance of PCTs being able to exercise their role as commissioners of primary care, feeling able ‘to boldly go’ and contest their primary care provision in the same way that they have (sometimes) done with secondary care and diagnostic services.

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This begs the question as to why relatively few PCTs have to date used the flexibilities presented by PMS and APMS contracts to tender for new forms of primary care. For some PCTs, there may be a lack of commissioning capacity to undertake such an exercise, with managers and commissioning specialists overwhelmed by the secondary care commissioning and existing primary care contracting workload. For others, relationships with general practice and their professional executive committee (PEC) may be deemed to be at risk if the PCT is seen to challenge standards of local provision and to suggest that other providers might be needed in order to deliver an improved service.

However, if NHS commissioning is to take place in the transparent, accountable and robust manner that is suggested in ‘Commissioning a patient-led NHS’ (Department of Health, 2005c), PCTs, and practice-based commissioners, will need to have the capacity to collect, analyse and compare data about existing and potential providers of local primary care (as well as secondary care) services. It will also fall to PCTs to retain responsibility for ensuring the commissioning of an overarching and integrated patient pathway, specifically for those with long-term conditions. Similarly, there may be a need for specific training and development for commissioning and primary care development managers, for example, in the areas of service specification, commercial procurement, contract negotiation with the private or independent sector, and contract management and review.

The primary care market is not only opening up from the perspective of PCTs being prepared to offer services for competitive challenge and tender. There is also evidence of a growing provider market in primary care, and of new forms of primary care organization emerging that are in a position to take on contracts to deliver care traditionally seen as the preserve of general practice and NHS community health services. Some of these organizations are new or existing private sector health care providers, as indicated in boxes three and four below. Others are non-governmental organizations or social enterprises including GP-run and nurse-run organizations and community-owned bodies focusing on the health needs of specific localities or client groups.
What would be the implications of opening up the primary care market?

The opening up of a market in primary care provision poses some important challenges for all stakeholders concerned with using, providing, funding, and quality assuring primary care. In examining the potential impact of a primary care market, we explore the implications for:

- Patients
- Providers
- Commissioners

Patients
For patients, the opening up of the primary care market has the potential to offer greater choice of services, particularly for those people whose practices currently offered a limited range of provision, or where their work and other commitments make it very difficult to access services when their GP practice is open. Practices may open for longer hours to suit the needs of their particular patients, for example, having evening and weekend surgeries that enable people to see the doctor or nurse without having to take time off work and perhaps lose pay. Similarly, for working parents, there could be a wider range of choice of timings and locations of child health and baby clinics, whilst for teenagers, services may be provided in non-practice locations and led by specialist nurses and other health workers.

In order to make choices about the primary care they receive, patients will have to receive improved information about services provided in primary care, perhaps in the form of a directory of local services provided by the PCT or through NHS Direct and on-line, setting out what each practice (NHS or otherwise) offers, both in terms of standard primary care and also specialized services such as maternity care, young people’s health, diagnostic services, extended diabetic services, and complex care for older people.

There is a need for patients to continue to be able to be registered with a main provider of primary care (likely to be a GP practice, but this could perhaps be another new form of primary care provider organization), in order that continuity and co-ordination of care can be assured, and a basis for public health monitoring and management be in place. Registration should offer patients primary care services that are responsive and flexible and should allow (as it does now) patients to attend walk-in centres or commuter clinics when they are unable to access their main primary care facility. Registration does however need to be underpinned by a comprehensive, single patient record (in computerized form and able to be safely shared across providers and with patients), for only then will proper continuity of care and information be possible as patients access multiple primary care providers.

New entrants to the market, particularly those from the private sector, will bring with them an increased awareness of customer expectation and delivery, and will be keen to tap into areas of patient demand and expectation that the NHS has been slow to address. For some patients, this may be a welcome introduction to what a health service can potentially offer ‘up the ante’ in terms of patient demand.

One example of this is the use of email for patient/clinician consultation. For many patients, the ability to email their practice or other care provider would reduce the need for face to face appointments, saving both patient and clinician time. Whilst there is some concern that electronic consultations may sometimes be clinically inappropriate, there is growing evidence to support the fact that patients would welcome an alternative means of cancelling or changing appointments, obtaining test results or ordering repeat prescriptions (Carr and Sheikh, 2004).

For patients with long-term conditions, more contestability in primary care should mean a greater range of more appropriate and integrated models of care. PCTs and practice-based commissioners will be able to use their influence to funnel some of their funds to purchase services that draw together services across the traditional primary/secondary care interface. In this way, approaches to care will be developed that are well-co-ordinated by the appointed case manager and use health care assistants, social care assistants, allied health professionals, carers, patients (as self-carers) and doctors in new and creative ways.

Such models of care are already being developed in some parts of the NHS, often drawing on international experience such as that of Kaiser Permanente and United Healthcare in the USA among others. The allocation of personal budgets to patients with which to purchase elements of their care from family, friends, statutory providers, or independent sector organisations through direct payments would add further ‘bite’ to the development of more appropriate and acceptable care for people living with long-term conditions.

Opening up the primary care market will not necessarily be good news for all patients, and there are particular risks for some of the most vulnerable in society. Research evidence suggests that higher income groups tend to capitalize on service choice to a greater extent than people in lower income groups, thus reinforcing or worsening health inequalities (Fotaki, 1999;
Voluntary sector primary care providers, or possibility of joint ventures with private or enhanced practice services, and a lack of bidding to assume some or all of this proposed new activity, finding ways of doing things differently. This lack of new capacity and alternative provision when there is a perceived lack of current general practice and other primary care services (as in the Aylesbury case study) or of practice that is of an unduly low standard (as in the Brent case study), including restricted opening hours of practices, few additional or enhanced practice services, and a lack of community-based diagnostic provision. Providers will want to explore the possibility of bidding to assume some or all of this proposed new activity, finding ways of expanding their practices, forming new practice networks, and developing facilities akin to ‘super-surgeries’ (Ham, 2005).

Competiton may be the lever to encourage primary care to use its existing skills and resources in a more efficient manner by means of changes to clinical roles and responsibilities. Not only will this be of interest to nurses and therapists frustrated with the dominance of the medical model for gatekeeping and care management but also to commissioners looking to reduce their funding of over-doctored services.

New primary care providers will seek parity with NHS services as a basis for entering the market. They will want their staff to be able to remain on NHS pensions and they will see no good reason for being excluded from accessing the funding opportunities open to NHS practices in relation to premises and facilities. Similarly, they will wish to use the clinical governance support offered by pharmaceutical and audit advisers, take advantage of the training and development provision put in place by PCTs, and participate in local planning and development activity within PECs and other forums. This will present a challenge to existing providers who are used to operating very much within the ‘ NHS family’, but given that NHS GPs are, strictly speaking, currently operating as contractors to rather than within the NHS, why should they have preferential support and protection within a primary care market?

Providers will only commit to involvement in new PCT contracts if they are offered contracts of adequate length and value, and if they feel the overall investment is going to be worth it in terms of financial gain. It is easy to jump to the conclusion that new providers will be private companies or organizations formed by GPs. There is however a strong possibility that we will see many new forms of primary care provider, including social enterprise or public interest companies, client group-focused organizations from the voluntary sector, and professional groups operating on a ‘chambers’ basis. This lack of certainty of provision points to the need for powerful commissioning and planning, effective quality assurance and sophisticated market regulation, roles that will be in the remit of newly reconfigured PCTs.

Commissioners

An effective market in primary care is dependent on a strong and sophisticated commissioning function. Commissioners have the role of assessing health needs in the population, making decisions about the allocation of funding, specifying the contracts that underpin such funding, and ensuring that service delivery is reviewed and performance data used in the next cycle of planning and commissioning. In a more developed primary care market, the commissioner (PCT) also has to govern the local health system, setting and monitoring the rules of engagement for providers and other commissioners (such as practice-based commissioners), ensuring that conflicts of interest are avoided and/or managed, and acting as steward of the public resource that has been entrusted to it.

PCTs need to have the confidence to get on and use the market mechanisms already available to them, for as we have seen, many have not, to date, capitalized on the new primary care contracting arrangements available to them. Reasons for this include lack of management capacity, the predominance of acute services within the commissioning function’s activity, and perhaps a reluctance to make direct challenges to practices within the PCT.

PCTs are currently in the process of being tested for their ‘fitness for purpose’ (Department of Health, 2005c) and this will lead to new reconfigured commissioning PCTs in 2006. If these organizations are comprised mainly of staff from the previous PCTs, there will be significant development needs in order to bring about a different approach to contracting for primary care.
A further challenge to PCTs will be how to find ways to assure appropriate contestability and market management whilst also enabling and incentivising effective partnership working between providers. The development of strong partnership working is of particular importance in relation to the management of long-term conditions, but is an area potentially at risk within a more open market where levels of trust may be lower (Fotaki and Boyd, 2005) and service fragmentation more likely to occur (Hunter, 2005).

There are also challenges in relation to the PCT’s role as manager and steward of the local health economy. The PCT will need to be alive to the possibility of provider cartels (for example, the domination of the local market by a GP-run company, or the buying up of practices by a single corporate entity), and of the possible adverse consequences of situations where local hospitals seek to become providers of primary care (using primary care as a way of assuring referrals to the hospital). Likewise, the commissioner will have to have a plan for how to deal with market failure – the withdrawal from the local health economy of a provider no longer to continue in business, or the lack of viability of a general practice (or hospital service) that remains very popular with its residual patients.

As a steward of public money with the responsibility for assuring care provision and health improvement for a local population, the PCT will have to have a robust approach to assuring continuity and comprehensiveness of service provision. One aspect of this will be their ability to influence and facilitate appropriate models of clinical leadership that protect and develop robust clinical governance arrangements across the whole patient pathway. This will require some overarching mechanism for bringing providers together and may be one useful role of ‘new’ professional executive committees (PECs). It may also require a change in the composition of PCT boards to reflect their new roles. It can be argued that a divestment of provider services will negate the need for a lead nurse at board level and that the clinical roles on the board should be open to any clinician demonstrating the appropriate set of skills.

What is clear is that in an NHS required to operate as a market, the task of the commissioner is ever more challenging, calling for additional capacity and new skills often not widely used in the NHS to date. If the public and patients are to receive the promised benefits of a market in primary care, they will need to be assured that their PCT, and its practice-based commissioners, are effective planners and purchasers of care, and sound guardians of their interests.

Summary and recommendations

NHS primary care is in many respects the envy of the world. The wider English health system is therefore responsible for ensuring that primary care remains in pole position, and that the move to a market addresses the known weaknesses of the system (lack of choice, lack of patient responsiveness, medical model that is less amenable to long-term conditions) and does not undermine the acknowledged strengths (patient registration, capititation funding, strong gatekeeping). In short, there is a real imperative to avoid throwing the baby out with the bathwater.

Based on our analysis of the emergence of a market in primary care, and the potential implications of extending it further, we make the following recommendations:

- The use of contestability in primary care has significant potential in relation to developing more responsive and integrated services for patients.
- That as a minimum, the primary care market should be used as a way of extending practice opening hours, developing greater choice of practice location, offering consultations via email and phone, and instigating new models of care for people with long-term conditions and for those who traditionally do not access general practice.
- That in order to bring about a more responsive primary care service, commissioners need to engage in more creative and assertive contracting with primary care providers.
- That the policy framework for such contracting activity is largely in place, but commissioners need to be braver in their approach, and ready to challenge existing standards of provision by using the contracting process in a more robust manner.
- That additional incentives must be developed as a way of engaging primary care providers in the development of more responsive and integrated services, and this will require a blend of different contracting and payment approaches.
- Commissioning capacity and expertise in the NHS is currently inadequate for the challenges ahead, and needs to be less focused on the purchasing of secondary care – as commissioning is strengthened in coming months, it is vital that primary care contracting is given proper attention and capacity.
- New entrants to the primary care market should be welcomed as a means of increasing capacity and developing new models of care, and should be subject to a level playing field in terms of operation within the market.
Clear workforce policies need to be developed in order to ensure that scarce staff resources are appropriately deployed and that all staff, in whatever organization, can be part of wider primary care training and development activity.

All primary care providers of whatever form need to be accredited and regulated by strong PCTs that see market regulation and management as a core function.

Market failure is a very real possibility for some existing and new providers and PCTs need to develop ways of managing this whilst assuring continuity of service provision for patients.

A culture change in relation to the provision of information to patients about primary care services and choices is required, with people having access to much more detailed data about all aspects of local services.

Patient registration is a vital element of NHS primary care, and should be retained, but it requires some rethinking and clarification, in particular in relation to what rights and responsibilities it confers on patients and providers.

As more providers enter the primary care market, they need to be linked into the wider NHS information system in order that patient data can be safely communicated, and continuity of care supported.

Commissioners have a duty to protect and enhance continuity and co-ordination of care as they contract for primary care services, ensuring that their activity enhances partnership working and service integration, and avoids service fragmentation and duplication.

The health policy of the current government has been described as being one of trying to bring about 'creative discomfort' (Stevens, 2004) in an NHS in need of 'modernisation' if it is to deliver the degree of choice and access required by national plans (Department of Health, 2000, 2004). The extension of market principles into the provision of primary care is clearly designed to bring such discomfort into traditional general practice and other primary care services. NHS primary care may not be very broken but it does require a degree of fixing if it is to be properly responsive to patients and able to deliver services needed by people living with long-term conditions.

Providers face some challenge to existing ways of working, and a need to explore ways in which they can better respond to patients’ desire for greater responsiveness and choice. For patients, there is the prospect of NHS primary care that builds on the best of what has gone before, yet offers more accessible and better integrated services in local settings. This does however depend on strong and effective commissioning of primary care and other services, perhaps the biggest challenge facing the NHS today.

References


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