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Choice and Competition in Primary Care: Much Ado About Nothing?

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Executive Summary

- Market development has been driven largely by the need to increase capacity and access to primary medical care services in under-doctored areas. Other reasons given by PCTs for commissioning services include creating new capacity in areas of population growth; divesting themselves of directly managed practices; and stimulating innovation in service delivery.
 - There is no evidence to suggest that any one type of provider organisation is dominating the primary care market. GP-led companies have been most successful in terms of winning contracts, and this may reflect their ability to combine a corporate infrastructure with NHS experience. Corporate providers have begun to establish a presence but they currently have a limited role in running practices.
 - PCTs were generally positive about the performance of new providers and gave many examples of improvements in the quality and accessibility of services under their management. However, it is too early to assess whether greater competition and the entrance of new providers will raise the overall standard of primary care services.
 - While there is growing awareness within PCTs of the benefits of using the APMS contracting route, experience of procurement has exposed gaps in commissioning capacity and expertise. Moves to develop regional procurement hubs are an important step towards filling this gap, but more attention will need to be paid to developing the necessary skills for effective commissioning.
 - Various factors need to be addressed to create a level playing field between different providers. These include the current exemption of corporate providers from offering staff NHS pensions, and means of supporting local GP practices and third sector providers to compete in the bidding process.
 - Tendering for primary medical care contracts has proved to be a time and resource intensive process for both commissioners and providers. Substantial transaction costs are being incurred, and only time will tell whether the benefits will outweigh the costs.
 - The Equitable Access programme has required all PCTs to procure a GP-led health centre whether or not there is a need for additional capacity.
- There is a risk that new providers entering the market may unintentionally destabilise existing providers that are delivering a high standard of care to patients.
- Far more attention has been paid to competition in primary medical care, than to patient choice. There is low awareness among patients and the public of their right to choose a GP, and a dearth of information to support that choice. At both a local and national level, the issue of facilitating patient choice needs prioritising otherwise there is a danger that new services will be under-utilised.
 - This report provides a snapshot in time of a rapidly changing primary care market. As PCTs conclude their procurement of new GP practices and GP-led health centres, there is a need for more systematic evaluation of the impact of choice and competition on the delivery and outcomes of primary medical care.

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Introduction

Since 2004, government policies have encouraged new providers to enter the primary medical care market to compete for patients and deliver innovative services. These policies have been underpinned by the introduction of alternative provider medical services contracts (APMS) alongside other forms of primary medical care contracts (see Box 1) and by the national Equitable Access to Primary Medical Care Services programme.

This paper examines the development of the primary medical care market in the NHS in England, with a specific focus on general practice. It is based on a series of interviews that were conducted with strategic health authorities, PCTs and provider organisations. Our aims were to document where and how the primary care market has opened up, as well as exploring the experiences of commissioners and providers in this process. In so doing, we were able to identify a number of emerging themes in an area of health policy that has attracted increasing attention.

While the main focus of the paper is the practical experience of commissioners and providers in developing choice and competition in primary care, the research reported here speaks to the wider debate about the impact of extending market principles to general practice. Government policies to extend opening hours, bring in new providers and develop polyclinics have

attracted trenchant criticism from the British Medical Association, leading critics to warn of the dangers of 'the aggressive commercial takeover of general practice and other NHS clinical services' and to suggest that:

'GPs can take the easy and the greedy route or they can mobilise through the British Medical Association and the colleges, and use all the avenues open to them to force the PCT to protect NHS services for all NHS patients rich and poor, healthy and sick alike'
(Pollock and Price, 2006).

Alongside these siren voices, academic commentators have offered a more balanced view, noting that government policies:

'have potential benefits of increasing the pace of innovation but also (create) serious risks of damaging doctor-patient relationships, increasing inequities in provision, and weakening the professional autonomy of general practitioners'
(Salisbury, 2008).

Our findings show that reports of the death of general practice in England are not only premature but also simply wrong. Corporate providers have not taken over general practice and GPs have been remarkably successful in organising themselves to respond to the challenge of new entrants to the market and winning the lion's share of the contracts awarded to date.

The major unknown is whether choice and competition will on balance offer benefits that outweigh the not inconsiderable costs of opening up the market through the procurement processes that have been used. The work we have done suggests that more effort needs to be put into evaluating the impact of the policies that have been put in place to enable a considered judgement to be made. This includes assessing the impact of new entrants on established providers and the extent to which the GP-led health centres being procured by the NHS are effectively utilised and offer value for money.

Where is the primary care market opening up?

Until December 2007, when the Department of Health launched a nationwide procurement of primary care services, there was significant variation across England in the extent of competitive tendering and the emergence of a provider market. Most of the activity was concentrated in London and the northern regions (North East, North West, Yorkshire and Humber). By contrast, but with the exception of London, few PCTs in the south of England had undergone local procurements and the pattern of primary medical care provision remained largely unchanged. These differences reflected the low priority attached by most PCTs to bringing new providers into the primary care market.

To understand regional variations in the procurement of primary medical care provision, HSMC approached individuals in senior commissioning or primary care development roles at all ten SHAs for a telephone interview. These interviews were conducted between January and February 2008, with additional information being provided afterwards in some cases. Table 1 summarises the views of SHAs on the emerging primary care market in their region at the beginning of 2008 and in advance of the national Equitable Access programme.

Box 1. Primary care contracting routes

General medical services (GMS): UK-wide contract containing nationally agreed terms, service requirements and funding allocations. The contract is negotiated centrally by the Department of Health and British Medical Association, and managed locally by PCTs.

Personal medical services (PMS): locally negotiated contract, with flexibility to tailor services to meet local population needs. PMS contractors must provide the full range of essential primary care services.

Specialist provider medical services (SPMS): allows for flexibility within a PMS agreement for non-essential primary care services to be provided to non-registered patients. Contract can only be awarded to those qualified to hold a PMS contract.

Alternative provider medical services (APMS): allows PCTs to contract with a wide range of providers including corporate, third sector and other public sector (e.g. Foundation Trusts) organisations. A locally negotiated contract, which can be used to commission essential services and/or specific elements of service provision.

Primary care trust medical services (PCTMS): under PCTMS, PCTs can provide services themselves by directly employing staff.

Table 1. Summary of responses from SHAs on experience of local procurements of primary medical care capacity in advance of the national Equitable Access programme

| SHA | To what extent is the primary care market opening up in their area? | Who are the new entrants in the primary care market? | Are GPs competing for contracts? |
|-----------------|---|---|--|
| East Midlands | Five APMS contracts have been awarded in the region to a variety of organisations including corporate providers, local general practices and social enterprises. All the tenders were for practices where single handed GPs had retired or which were located in under-doctored areas. | United Health Primary Care, ChilversMcCrea, Central Nottinghamshire Clinical Services | An APMS contract to run a new primary care centre in Kirkby-in-Ashfield was awarded to Central Nottinghamshire Clinical Services, a social enterprise made up of local GPs who were already providing out-of-hours services in the Nottinghamshire area. |
| East of England | The SHA felt the generally good level of primary care provision in the region meant that there wasn't a strong driver to open up the primary care market. Three PCTs have gone out to tender for general practice services including Luton, which is the only under-doctored area in East of England. | ChilversMcCrea | |
| London | General practice services have been put out to tender by a number of PCTs in the London region. Barking and Dagenham and City and Hackney PCTs were involved in the first wave of the Fairness in Primary Care procurement programme. More recently APMS contracts have been awarded by Tower Hamlets, Camden and Hounslow. The SHA expects that the Darzi Report will create a further opportunity to open up the primary care market in the region. | United Health Primary Care, ATOS Healthcare, Care UK, Greenbrook Healthcare | A contract to run six practices in Hounslow was awarded to Greenbrook Healthcare, an organisation co-founded by partners at the Brook Green Medical Centre in Hammersmith. |
| North East | County Durham and Hartlepool PCTs were involved in the Fairness in Primary Care procurement programme. PCTs are working on market development strategies, including establishing a procurement policy to operate across the region. NHS North East is working collaboratively with all PCTs to undertake market analysis in order to open the market further. | IntraHealth, Blackhall Medical Group, Encompass Healthcare | |
| North West | A number of PCTs in the region are either encouraging local GPs to extend their services or commissioning additional capacity through competitive tenders (e.g. Knowsley and Liverpool). The market has mainly opened up where there are GP shortages and high pockets of deprivation. Half of the PCTs involved in the Fairness in Primary Care procurement programme were in the North West. | Aston Healthcare, ChilversMcCrea, IntraHealth, Integral Health, SSP Health | SSP Health, a GP partnership led by two local doctors, manages eleven practices across the region. |
| South Central | A number of PCTs in the South Central region have sought to open the primary care market, including Hampshire, Buckinghamshire and Berkshire West. For example, Hampshire PCT offered a small former single handed practice for competitive tender and received bids from 14 organisations including corporate providers and local practices. ChilversMcCrea entered into partnership with a single handed GP who subsequently retired. | ATOS Healthcare, BK Health, The Practice plc, Cedar Medical, ChilversMcCrea | The Practice plc, founded by two Buckinghamshire GPs, manages three practices in the area. GP-led company Cedar Medical manages PMS contracts for two new practices in its local area in Basingstoke and a further local practice won the contract for a PCTMS practice. IOW Lighthouse Medical, a consortium of local GPs, has entered the market to bid for GP services including the Equitable Access procurement and local enhanced services on the Isle of Wight. |

| SHA | To what extent is the primary care market opening up in their area? | Who are the new entrants in the primary care market? | Are GPs competing for contracts? |
|--------------------------|--|--|---|
| South East Coast | Only Medway PCT – an under-doctored area – has put general practice services out to competitive tender. For the Equitable Access procurements, the SHA has organised a workshop to encourage providers (in particular local GP practices) to bid by giving them a better understanding of the bidding process and the documentation which needs to be completed. | | The APMS contract tendered by Medway PCT was awarded to a group of GPs from neighbouring West Malling. A number of practices are forming a consortium in order to bid for contracts under the Equitable Access programme. |
| South West | To the SHA's knowledge, no PCTs have competitively tendered for general practice services. This might be explained by the generally good levels of general practice provision in the region, and by the willingness of many local GPs to provide additional services. | | |
| West Midlands | Most of the procurements that have taken place in primary care have been for out-of-hours services. There has been relatively little activity around the procurement of core GP services and only a small number of new market entrants. External contracting has been largely focused on areas where needs for services are not being met. | Willow Bank Community Interest Company, Apnee Sehat, ChilversMcCrea, Pathfinder Healthcare Development | Pathfinder Healthcare Development (PHD) is a community interest company set up by GPs in the Smethwick area of Birmingham. PHD has bid for a number of contracts locally, and currently manages five practices. |
| Yorkshire and The Humber | Local procurements have taken place in some PCT areas, including Leeds and Kirklees. While most of the activity has been in under-doctored areas or in response to GP retirement, a number of PCTs in the region are going out to tender on their directly managed (PCTMS) practices. | ChilversMcCrea, One Medicare | One Medicare – founded by partners and the practice manager of Ferrybridge Medical Centre in Wakefield – manages five practices in West Yorkshire and has been awarded the contract for a GP-led health centre in Derby City. |

Increasing capacity and access

The most common reason given by SHAs and PCTs for competitively tendering primary care services was to fill gaps in provision. This may explain why there was far more procurement activity in the north of England and London, where the majority of the country's most under-doctored areas are located (Department of Health, 2006). It might also account for the pattern emerging in the south, where market development was limited to a relatively small number of PCTs where there were shortages of primary care services. Indeed, the view expressed by some SHAs in the south was that the drivers to open up the primary care market were not as strong in their regions because levels of provision were already good.

Improving access has also been the stated goal of the government's national procurement of primary care services. For example, the Department of Health's Fairness in Primary Care (FPC) programme was introduced in early 2007 to deliver the commitment made in *Our Health, Our Care, Our Say* to 'increase [general practice] provision in areas that are not well served...to increase the equity of provision and to ensure that everyone has a real choice' (Department of Health, 2006). Now reaching its concluding stages, FPC has supported the procurement of additional capacity in nine of the most under-doctored PCTs in England. This includes Hartlepool PCT, which tendered for the re-provision of a directly-managed (PCTMS) practice and the development of community based substance misuse services (see Box 2).

Divestment of directly managed practices

While increasing capacity and access were the main reasons given for commissioning services, they were not the only ones. The drive for PCTs to divest themselves of their provider responsibilities and establish themselves as commissioning organisations has been influential. A number of PCTs that we spoke to had gone out to tender on practices that they had brought under direct management as PCTMS practices – usually following the retirement of a single handed GP or in response to poor performance – and more were planning to do so soon. Some were in the process of setting up rolling procurement programmes for the re-provision of PCTMS practices over the coming months.

Box 2. Hartlepool PCT and the Fairness in Primary Care national procurement

Hartlepool was one of four PCTs to participate in the first wave of the Fairness in Primary Care national procurement programme. This provided an opportunity for the PCT to enhance access to essential primary care services by increasing GP numbers, as well as developing more flexible services to meet the demands of their local population. The process was managed by the Department of Health Commercial Directorate, but the PCT was able to take a lead on activities such as local public and stakeholder consultation. This consultation was carried out between December 2006 and May 2007, and informed the development of a service specification for a community-based specialist substance misuse service and the re-commissioning of an existing PCTMS practice.

The PCT received 30 expressions of interest; these included four local GP practices: two submitted as a joint bid and the other two submitted bids in partnership with national corporate providers. After a pre-qualification questionnaire, formal bids were received from three providers. In June 2008, the contract was awarded to GP-led company IntraHealth Limited, based in neighbouring Peterlee. IntraHealth will provide extended opening hours from 8am-6.30pm and offer a full range of enhanced services including minor operations, mental health, pathology tests and management of long term conditions.

The APMS contract that was awarded by Hartlepool PCT includes clear performance management arrangements and identifies specific targets focusing on access, quality, service delivery and value for money. This requires the provider to continually improve its performance. The contract is monitored on a quarterly basis but the PCT meets with the provider every month to discuss potential issues that may have an impact on performance. The contract also includes financial penalties, allowing the PCT to claw back funding if there is non-delivery of these targets.

New practices in areas of population growth

Three PCTs had tendered for the provision of new primary care services to provide coverage in areas of major population growth. For example, one PCT had situated a new practice in a commercial complex with a co-located walk in centre, in order to serve the growing number of city centre residents. The contract specified extended opening hours (7am-7pm and Saturday morning) as well as the provision of local enhanced services for mental and sexual health. In the other two PCTs, new practices were linked to housing developments to support predicted population increases of 9,000 and 12,000 people respectively.

Stimulating innovation

While contestability has been identified as a key vehicle for stimulating innovation in primary care, few of the PCTs that we spoke to were explicitly using competitive tendering for this purpose. Service specifications had generally focused on the provision of core GP services, although in many cases across extended opening hours including evenings and weekends.

The view that new models of community based care would be delivered through practice based commissioning (PBC) rather than by bringing in new providers was expressed by some. Where this was the local view, PCTs may be steering away from the use of commissioning to secure innovation to avoid conflict or duplication with GP commissioners.

PCTs were increasingly aware of the opportunities presented by the emerging provider market for developing a broader range of primary care services. Most had received applications to run practices from provider organisations that were offering different skill mix or nurse-led models and recognised the potential of these approaches for tailoring services to priority groups, notably people with long term conditions. Some indicated that they would be making greater use of the flexibilities offered by the APMS contracting route in future to commission new types and models of service. Unlike the nationally set terms and conditions of the GMS contract, service specifications and contract payments for APMS are negotiated locally between PCTs and providers.

Equitable Access to Primary Medical Care Services

Based on interviews with SHAs, by early 2008 only a small minority of PCTs had undergone competitive tendering for primary medical care services, and even fewer had awarded APMS contracts to new market entrants. However, the picture has changed radically since that time, with the launch of the Equitable Access to Primary Medical Care Services programme. Under the programme – which is supported by £250 million of additional funding – the Department of Health has required every PCT to commission a new GP-led health centre which will open seven days a week to registered and non-registered patients. A further 113 new general practices will be procured in the 50 areas in England with the poorest provision. An example advert for the Equitable Access programme can be found on page 15.

While Equitable Access has been principally linked to the delivery of priorities around access and responsiveness in primary care (e.g. Darzi, 2007), it is also serving as a vehicle to open up the primary care market to a wider range of providers. Announcing the initiative, health secretary Alan Johnson commented that:

'[Equitable Access] is not just about building extra primary care capacity but developing high-quality, responsive services with a strong focus on prevention. This is a great opportunity for entrepreneurial GPs as well as social enterprises, voluntary organisations and the independent sector to develop innovative services for patients.'

The NHS Chief Executive, David Nicholson, has stated that the Department of Health launched the Equitable Access programme because PCTs had been slow to use the powers available to them to open up the primary care market.

The Equitable Access approach is described by the Department of Health as a 'national programme of local procurements'. What this means in practice is that the procurements will be managed locally by PCTs or by regional procurement hubs acting on their behalf, but according to a national framework laid out by the Department of Health. This framework includes core requirements and success criteria for each type of service (Table 2) and a timetable for

the procurement process which envisages that contracts will be awarded and signed by December 2008. PCTs are recommended to develop a set of financial and non-financial criteria for evaluating bids, in order to select the one which offers 'the best value for money rather than the lowest price alone' (Department of Health, 2008a). An example of these criteria, which is being used by a cluster of PCTs in one SHA region, is outlined in Box 3.

In October 2008, the Department of Health confirmed that many PCTs had reached the stage of shortlisting providers. Figures published by the Department of Health show that, of those shortlisted for the GP-led health centre contracts, 49% were GP-led bidders, 40% were corporate providers and the remaining 11% included third sector organisations, NHS acute trusts and PCT provider arms.

Responses to Equitable Access

SHAs and PCTs were generally positive about the drive to increase provision in areas of unmet need and acknowledged the contribution this could have to reducing health inequalities. However, opinions on the GP-led health centres were far more mixed. It was widely recognised that the extended services and longer opening hours could increase patient choice, with particular benefits in terms of access for the working population. Many were also hopeful that the health centres would act as local catalysts for change and drive up quality among existing NHS primary care providers.

But the requirement for all PCTs to develop a GP-led health centre was questioned, given that levels of provision were already good in several parts of the country. It was suggested that inequalities of access could have been more effectively addressed by targeting additional capacity into areas of high deprivation and need for services. Rather than creating a productive competitive environment, some respondents felt that the new services might ultimately destabilise local provision. While the health centres are intended to increase the availability of services, they could end up having the opposite effect if they unintentionally lead to the closure of practices that are already providing high standards of care to patients.

One PCT estimated that over 20% of the local population would need to switch GP to ensure the viability of the various new services commissioned under the FPC and Equitable Access programmes. There was uncertainty about how patients would be encouraged to re-register at a new practice, as well as the impact that this might have on existing primary medical care services. The possibility that new services would end up replacing rather than augmenting existing ones, therefore having no overall effect on local primary care capacity, was raised. A further possibility was that patients in some areas might not use the new services in sufficient numbers to make them cost-effective.

Many also queried how the Equitable Access programme linked with national and local priorities, especially those around urgent care and PBC. For example, local commissioning plans in a number of areas were focused on developing community based services to reduce emergency admissions. It was felt that these priorities would have been better served had PCTs been given the flexibility to invest in urgent care services or minor injury units, rather than being required to spend their £1 million allocation on a GP-led health centre. As one SHA put it, 'It is unlikely that this is where PCTs would put their money if they had the choice.' In terms of PBC, it was suggested that PCTs may struggle to build a culture of cooperation with GPs, who are seeing their incomes come under threat in an increasingly competitive environment. The challenge for PCTs, as one SHA saw it, was to develop a 'constructive tension' between collaboration and contestability.

Practical concerns were also raised, above all that nine months was insufficient time for PCTs to manage a procurement process from placing adverts to signing contracts. Many felt that important aspects of the process, such as local consultation, would be jeopardised in an attempt to meet the Department of Health's timescale and complete by December 2008. It is significant that, after we had completed our interviews, the timetable for the Equitable Access procurement was revised with a new deadline for signing contracts of March 2009.

Table 2. Equitable Access procurement framework

| | GP practices | Health centres |
|--------------------------|--|---|
| Core requirements | <ul style="list-style-type: none"> • Core GP services • List size of at least 6,000 patients • Extended opening hours (minimum of 5 hours per week) • Plan to be an accredited training practice • Engaged in practice based commissioning • With extended (and overlapping) practice boundaries | <ul style="list-style-type: none"> • Core GP services • Easily accessible locations (e.g. reflect commuter needs) • Open 8am-8pm, 7 days a week • Bookable GP appointments and walk-in services • Registered and non-registered patients • Maximising opportunities to integrate and co-locate with other community based services |
| Success criteria | <ul style="list-style-type: none"> • Increase in number of primary care clinicians • Increase in extended opening across PCT • Increase in patient choice • Improvements in patient satisfaction • Evidence of focus on promoting health and preventing ill-health • Measurable increase in quality of service • Active engagement and participation in PBC | <ul style="list-style-type: none"> • Availability of bookable appointments and walk-in services for anyone • Evidence that services are located in areas that maximise convenient access • Evidence of maximising opportunities to co-locate and integrate with other services • Increase in extended opening across PCT • Increased public awareness of the range of services available locally and where to make appropriate use of them |

Box 3. Example evaluation criteria for Equitable Access procurements

The PCT will evaluate the bids on the parameters of:

1. Service Delivery and Performance – divided into the following five areas:
 - Clinical
 - Contract Delivery and Management
 - Workforce
 - Premises, Facilities Management and Equipment
 - Information Management and Technology
2. Cost and Affordability
3. Risk – graded as either low, medium or high for each of the following areas:
 - Financial
 - Legal
 - Service Delivery and Performance
 - Marketing Plan (if applicable)

Criteria will be scored according to a grading system:

| Grade Label | Grade | Definition of Grade |
|-----------------------------|-------|--|
| Unacceptable | 0 | Inadequate patient service delivery |
| Compliant with shortcomings | 1 | Satisfactory except for some administrative or process inefficiencies that would impact service management without directly reducing service delivery to patients or that would adversely affect patient service to a small extent |
| Satisfactory | 2 | Provision of the required patient service at satisfactory standards |
| Superior service value | 3 | Additional value in healthcare provision and health outcomes through the reliability and/or effectiveness of service delivery and processes [including support aspects] envisaged |
| Superior patient value | 4 | Significant additional value in healthcare provision and health outcomes through the reliability and/or effectiveness of service delivery and processes [including support aspects] envisaged |

The commissioner experience

HSMC conducted interviews with individuals in senior commissioning or primary care development roles at 13 PCTs situated within eight SHAs. These PCTs were proposed by their SHAs on the basis that they had experience of opening up the primary care market in their area. While all had undergone competitive tendering for primary medical care services, levels of experience varied substantially between organisations with some having placed a number of contracts and others still completing the process for the first time.

Many PCTs discussed their reasons for using open tender, as opposed to other procurement routes. In some cases, usually where a practice had become vacant or

was found to be failing, alternatives such as list dispersal or re-assignment had been preferred and initially explored. However, these options had proved not to be viable – typically because other local practices had been unable or unwilling to take on additional patients – and so an open tender had become necessary.

Other PCTs had set out to use contestability to achieve specific goals. For some, this was seen as a useful opportunity to ‘test the market’ and establish the level of provider interest in their area. This included the explicit purpose of increasing competition in primary care by ‘adding some grit into the system’ through new entrants into the market offering a better quality or range of services, and thereby stimulating improved performance among existing local providers. While few of these PCTs were able to point to concrete evidence of such

an effect, most had only awarded contracts in recent months making it too early to judge outcomes.

The contracting process

The approach taken to procurement was similar across PCTs, broadly following the framework that has been developed by the Department of Health for the national procurement programmes (Box 4). While local commissioning had generally included the opportunity for contract negotiation with providers, this was not permissible under the Equitable Access national procurement framework. Not all PCTs had used the APMS contracting route, and a small number had given bidders the option of specifying a GMS, PMS or APMS contract. Many of those that had used APMS felt that they had not fully exploited the benefits that this offered and were keen to do so in the future.

Compared to the more prescriptive character of the national GMS contract, APMS was felt to offer advantages in terms of the flexibility to tailor service specifications and key performance indicators to local needs. Moreover, it was seen as providing a far more robust basis for performance monitoring given that PCTs could stipulate measurable outcomes and monitoring arrangements for the contractual period. As one PCT noted, the APMS contract requires them only to 'pay for what they want and what they get'. This was one of a number of PCTs indicating that it would like to use APMS more widely for primary care contracting.

A clear message emerged from PCTs about the time and resource intensive nature of the procurement process. This process was typically estimated to have taken about a year to complete, although protracted contract negotiations had substantially increased this timescale in a small number of cases. As well as staff input from within the organisation, costs had also included carrying out local public consultations to inform service specifications and – in some cases – commissioning external procurement or legal support. One SHA suggested that the cost of competitive tendering may mean that it is only a viable option for PCTs in deprived areas where additional funding is available.

Evidence of a provider market

Views on the size and competitiveness of the provider market varied, reflecting the differing levels of interest that PCTs had received in response to their invitations to tender. For example, one PCT in the South Central region received only two applications to manage a new GP service, one from a local practice and the other from a GP-led company. At the other end of the spectrum, a London based PCT put six directly provided practices out to tender – with the option of bidding for only one, all six or any number of practices – and received 170 applications from 42 different providers. There did not appear to be any consistent pattern in terms of market development over time. Indeed, while one PCT noted that applications had steadily grown with each new tender, another found that interest among providers had dropped the second time around.

The responses from PCTs indicated that a number of different types of provider organisations were commonly bidding for contracts, including entrepreneurial local practices, GP-led companies and corporate

Box 4. Department of Health PCT Procurement Framework

1. Build a procurement team
2. Define project specifications
3. Affordability exercise
4. Local consultation
5. Develop procurement plan
6. Issue advert
7. Memorandum of information
8. Bidder information event
9. Pre-qualifying questionnaire (PQQ)
10. Evaluation of PQQ
11. Invitation to tender (ITT)
12. APMS contract
13. Evaluation of ITT
14. Award contract
15. Mobilisation/transition
16. Full service commencement

providers. There was little evidence that third sector organisations were tendering for contracts. One PCT remarked that it had failed not receive a single application from the third sector, even after contacting a number of local organisations to encourage them to bid.

This raises questions about whether third sector organisations are currently in a position to take advantage of opportunities created by contestability, and suggests that support may need to be provided to help them enter the primary care market. Equally, it is possible that the third sector has

chosen to retain its longstanding role as a provider of niche services, rather than expanding into mainstream healthcare provision. Either way, as the Public Administration Select Committee (2008) recently concluded, public sector commissioners would benefit from a better understanding of the capabilities and capacity of their local third sector.

Award of contracts

There has been a great deal of recent discussion about what types of organisation are being awarded primary medical care contracts, driven by concerns about the involvement of the independent sector in primary care. As some PCTs pointed out, this is a difficult issue to resolve given the emergence of a number of hybrid provider organisations – which have been established by GPs and/or other primary care professionals for the purpose of bidding for primary care contracts, but operate as private companies. These include ChilversMcCrea Healthcare, which was established by a GP and nurse in 2001 and now manages 37 general practices across England (see Box 5). By combining GP leadership (or co-leadership) and corporate infrastructure, such organisations call into question the validity of distinguishing providers according to an NHS/non-NHS distinction. Definitions of the three main types of 'new' primary care provider organisation are given in Box 6.

Box 5. ChilversMcCrea Healthcare – a GP and nurse-led primary care company

ChilversMcCrea Healthcare Ltd was established in 2001 by a GP and nurse who saw an opportunity to offer a new model of primary care provision. As clinicians registered within the UK, the company's founders and directors, Sarah Chilvers and Rory McCrea, were able to compete for and hold NHS contracts. While this rule was changed in 2004 to enable other providers to provide primary care in the NHS, ChilversMcCrea had a head start in entering the market and established a firm foothold as an alternative provider of primary medical care services.

The company won its first contract in July 2003 and currently it runs 37 practices in different parts of England. It is also involved in providing other services such as walk in centres, prison health care, and out of hours care. As a GP-led company, ChilversMcCrea is able to access the NHS pension scheme and this is one of the factors that enables it to compete effectively.

Following its rapid growth, ChilversMcCrea formed an alliance with a corporate provider in 2006 to enable it to strengthen its position in the market. In the event, this alliance proved short lived. The company reverted to its previous status and it is now the biggest provider of primary medical care services in the NHS.

ChilversMcCrea has recently formed a telemedicine company in partnership with TBS GB Ltd.

Notwithstanding these problems of categorisation, contracts were being awarded to all types of provider organisation. In terms of new market entrants, we found that GP-led companies were managing significantly more practices than either corporate providers or social enterprises (Table 3). However, concerns were raised by a number of PCTs about the quality of business cases that were being submitted by local practices and their potential to effectively compete in a bidding process that also included well resourced corporate providers and GP-led companies operating on a national basis. This had created a tension between needing to ensure the conditions for open and fair competition, but wanting also to support and encourage local practices to bid.

Box 6. Defining 'new' primary care providers

GP-led companies: companies set up by general practitioners for the purpose of bidding for general practice and other primary care contracts. Have access to the NHS pension scheme.

Corporate providers: investor owned companies, usually operating for-profit. Do not have access to the NHS pension scheme.

Social enterprises: not-for-profit organisations – often set up by groups of healthcare professionals – which reinvest any profits back into the organisation. NHS staff transferring into new social enterprises and delivering NHS care can stay in the NHS pension scheme.

Table 3. Number of practices managed by new market entrants

| Provider | Type | Number of GP practices |
|---|-------------------|--|
| Aston Healthcare | GP-led | 9 practices in the Liverpool/Knowsley area |
| Atos Healthcare | Corporate | 2 practices – 1 in Manchester and 1 in London |
| BK Health | GP-led | 2 practices in the South Central region |
| Care UK | Corporate | 3 practices |
| Cedar Medical | GP-led | 4 practices – 3 in Basingstoke and 1 in Bristol |
| Central Nottinghamshire Clinical Services | Social enterprise | 1 practice in Kirby-in-Ashfield |
| ChilversMcCrea Healthcare | GP-led | 37 practices nationally |
| Concordia Health | GP-led | 2 practices in South East London |
| Greenbrook Healthcare | GP-led | 6 practices in the Hounslow PCT area |
| IntraHealth | GP-led | 8 practices – 5 in County Durham, 2 in Manchester and 1 in Bedfordshire |
| One Medicare | GP-led | 6 practices – 5 in West Yorkshire and a GP-led health centre in Derby City |
| Pathfinder Healthcare Development | GP-led | 5 practices in the West Midlands region |
| SSP Health | GP-led | 11 practices in the north west of England |
| The Hurley Group | GP-led | 5 practices across London |
| The Practice plc | GP-led | 6 practices across Wiltshire and Buckinghamshire |
| UnitedHealth Primary Care | Corporate | 5 practices – 2 in Derby and 3 in Camden |
| Willow Bank | Social enterprise | 1 practice in Stoke |

Underpinning this concern was a lack of clarity about when reasonable support for local practices might spill over into giving them an unfair advantage, and a concern that this could trigger a legal challenge by unsuccessful bidders should a local practice be awarded a contract. One PCT had wanted to hold an Equitable Access bidders day to support local GP practices, but had widened invitations to all types of provider organisation because of these concerns. It is likely that guidance for PCTs on developing their provider market, or even a stronger role for SHAs in this process, would be welcomed.

Performance of new providers

We were keen to seek views on how providers who had taken on primary medical care contracts were performing. Commissioners were foremost concerned that practices were providing a good standard of core general practice and building their capacity to take on a wider range of enhanced services.

Where contracts had been in place for sufficient time for PCTs to comment on performance, they were generally positive about how practices were being run. All were able to give examples of improvements in the quality of patient care, most often in terms of extended opening hours, increased scores in the Quality and Outcomes Framework (QOF) or better patient experience. Derby City PCT, for example, reported a range of improvements at the Normanton Medical Centre since UnitedHealth Primary Care had taken over its management in September 2006, including a 30% increase in the list size (see Box 7).

There was also some evidence that new providers were developing innovative approaches to service delivery. At the Normanton Medical Centre, UnitedHealth Primary Care is using skill mix to develop targeted services for long term conditions management. A further three PCTs were soon to or had recently signed contracts with providers who were offering innovations in long term conditions management, but it was too early for them to comment on the development of those services. Another PCT told us about a mobile ultrasound unit developed by a new provider which manages a number of practices in their area. The service had reduced patient waits for a scan from an average of twelve weeks to just one, and was being rolled out more widely to other practices locally.

Box 7. Management of the Normanton Medical Centre, Derby, by UnitedHealth Primary Care

In September 2006, UnitedHealth Primary Care took over management of the Normanton Medical Centre in Derby. This inner city practice, which serves an area with a large BME population, was put out to tender by Derby City PCT following the retirement of its single handed GP. A total of four bids were received for the contract, which did not include any applications from local GP practices. The practice was advertised nationally and locally.

The PCT worked closely with the new provider to ensure a smooth handover, so that there would be minimum disruption to patient care. Within the first year, United had extended opening hours to 8am-8pm (Monday – Friday), established a permanent workforce of two full time GPs and a nurse practitioner, and improved quality by increasing QOF scores from 81% to 93.7%.

United are now proactively managing patients with long term conditions. Practice staff have validated disease registers, and set up call and recall systems, to enable proactive intervention for patients with chronic diseases. They are planning to use risk stratification tools to assess levels of care required, and are developing services for the South Asian community focused on diet and wellbeing.

In 2007/8 Derby City PCT ran a second competitive tender for a general practice, again following a GP retirement. They were keen to ensure local needs were taken into account, so invited patient representatives to take part in interviewing shortlisted provider organisations. This was felt to be important not only in terms of ensuring that the process served local needs, but also in helping to promote local acceptance of the commissioning decision.

Only one PCT reported that the performance of a new provider had been unsatisfactory because they had not delivered on the innovative practice that had been promised in their tender. Others did raise the question of how long providers should be given to fulfil service commitments before being considered to be underperforming. The need for clear performance monitoring frameworks was recognised.

Only two PCTs described detailed arrangements for performance managing new providers. One had developed a set of key performance indicators which were staged in terms of importance. Their contract specified that the provider put in place an action plan to remedy any underperforming areas, and made provisions for revenue deduction should problems persist. In an earlier survey of PCTs conducted by the Kings Fund, APMS contract monitoring arrangements were found to be the same as those for GMS and PMS: namely an annual review (Walsh *et al*, 2007).

Aside from the negative report described above, only the issue of continuity of care was raised as a concern. Specifically, three PCTs indicated that there had been problems recruiting or retaining staff at practices

being managed by new providers in their area. This was felt to have disrupted continuity of patient care and stalled quality improvement efforts. The possibility that junior GPs were taking on salaried positions at local practices serving deprived communities, as a way of gaining experience before taking on a partnership or senior role, was raised by one of the PCTs in question.

The provider experience

HSMC interviewed seven providers who had experience of bidding for primary care contracts ranging from a small community interest company led by GPs to larger GP-owned and corporate providers. Most had a history of innovative developments and all had won at least one contract, with one managing almost 40 practices. All were currently bidding for more contracts including those within the Equitable Access programme. Two had been involved in earlier national procurement programmes.

Opportunities to increase access, deliver a wider range of community based services and improve the overall quality of service provision were common drivers for entering the primary care market. Not surprisingly, different business models had emerged but

most combined clinical and business expertise, reflecting a common view that clinicians working alone probably lacked the commercial skills necessary to be successful in the market environment.

All were optimistic about the opportunities the market created for providers, with most concerns relating to the procurement process rather than service delivery. However, there was a consensus that to remain financially viable it was necessary to grow the business to more than one or two contracts and there was opportunity to do this with the increasing number of tenders from PCTs for practices, outpatient and more specialist services. Two providers saw a market developing with single handed GPs, offering them infrastructure support and partnership or salaried arrangements which enabled them to focus solely on clinical activity.

Various themes emerged from the interviews demonstrating similar experiences and opinions. Where there was a different experience this tended to reflect the size of organisation and the resource available to respond to tenders.

The contracting process

Providers had experience of bidding for single and multi-practice tenders. Some concern was expressed about how cost effective it was for PCTs to tender for one small practice and that list dispersion was probably more appropriate in these circumstances. Concern was also raised about incumbent GPs bidding for PCTMS practices, that should their bid be unsuccessful this might affect relationships with the new provider.

All commented that the tendering process was bureaucratic, lengthy and 'document intensive' requiring significant financial and time investment. This put smaller organisations with limited resources at a disadvantage and unable to compete against larger and commercially orientated providers. Some felt that the national procurement process – which was also being adopted by PCTs – had been based on the Independent Sector Treatment Centre model which created unnecessary paperwork for primary care contracts.

There was agreement that PCT commissioning capability was weak. Information provided by PCTs to bidders in relation to staff, finance and local population need was reported to be variable and at times inaccurate. Clarity was lacking on the

service model with 'PCTs not understanding what they are procuring' and 'not understanding general practice'. Concern was expressed in some cases about the expertise of PCTs to negotiate property leases and the conflict of interest in having local GPs on the interview panel. Some providers had noticed recent improvement in PCT management of the tendering and interview process and clearer specifications.

Competition for contracts was felt to be increasing with the number of bidders rising significantly in the last few months and a handful of national organisations appearing regularly on the shortlist. However, the providers we interviewed felt most contracts were being awarded to local organisations as PCTs wanted to see a high level of knowledge and understanding of the local community. This potentially created an uneven playing field for national bidders who relied largely on information provided by PCTs. One provider commented that it saw its future competition coming from the provider arms of local PBC clusters as they became more established, but also felt some PCTs wanted to create tension in the system by bringing in external providers.

Contracts that had been won were a mix of GMS, PMS and APMS. One provider delivering under all three arrangements

commented that in practice they did not feel very different. Another stated that GMS felt a stronger contract for the provider but was less financially attractive than APMS. It was also suggested that PCTs had less understanding of how to maximise the benefits of APMS and needed opportunity to create local flexibility outside of a national contract. Additionally, APMS as a fixed length contract could prove unattractive to some providers unless awarded for a reasonable length of time and it was suggested that PMS potentially provided greater financial rewards and 'had a more local feel to it'.

Signing off contracts for some had proved problematic. One provider underwent a lengthy negotiation process due to it being the first APMS contract it and the PCT had worked with. A number of issues had come up that had no local precedent, and it had taken considerable time to reflect these in the PCT/provider agreement. Another felt the PCT had lost interest once the contract had been awarded. Willow Bank, a new community interest company (CIC), was awarded its contract in October 2007 but delay had been caused by negotiations with the Pension Agency for part-time staff working within a CIC model (see Box 8). Another successful bidder had worked with the PCT to negotiate the agreed service delivery model.

Box 8. Willow Bank Community Interest Company

Willow Bank CIC is a partnership between a former PCTPMS Stoke urban general practice, Gingerbread (a local charity providing hostel accommodation for single parent homeless families) and a local management consultancy, Change through Partnership. Formed in 2006 to respond to the PCT tender for the practice, it has become a Department of Health Social Enterprise Pathfinder site.

The CIC is focusing on developing services that are targeted and sensitive to the more vulnerable populations in the city: urban residents, homeless and lone-parent families, immigrants, people with substance misuse problems and Asian families. These are populations that are not generally served well by a traditional general practice model but are high users of services. Willow Bank is developing the practice based on a social medicine model, delivering a one-stop integrated health and social care service. Their aim is to retain the local, friendly 'corner shop' approach to service delivery whilst building an infrastructure that ensures greater efficiencies and is seen as sufficiently 'professional' to be a realistic provider of APMS services elsewhere.

Operating within a not-for profit philosophy all staff can be members of the company under a membership share agreement. Any staff member can put themselves forward for election to the board and all staff have a vote on board membership whether or not they choose to be shareholders. The practice community stakeholder group also has Board membership. One of the main challenges facing the CIC is establishing a company business model that allows staff to be members or Directors of the organisation whilst retaining their NHS terms and conditions, particularly in relation to pensions.

Service models

All providers were delivering the traditional range of primary medical care services. Some had also extended provision to include enhanced and specialist services – such as prison medical services, chronic disease outpatients activity and sexual health – either through the core contract or as a result of winning additional contracts. Larger providers had taken on a wider scope of work including walk in centres, out of hours and community based ophthalmology services.

There was some evidence that providers were bringing innovation to service delivery. Willow Bank was developing a service model to meet the needs of specific populations and was the only provider that had gone into partnership with the third sector to achieve this. Organisations that had freed up clinical time for GPs by providing support for back office functions were using the additional capacity to develop specialist community services and maximise the use of existing GP premises. In addition, the ownership of a number of local practices had enabled one provider to share patient records across an integrated system enabling patients a choice of care setting with walk-in evening and Saturday appointments. Its vision was to develop ‘a community health care outlet’, building on the GMS contract to deliver services on a community based model.

Most providers stated that their list sizes had grown significantly as a result of delivering locally sensitive services and addressing access issues. Clear business aims to attract new patients and ‘develop the brand’ were expressed. However, some cautioned about growing too quickly to sustain a quality service and had a strategy for growth and numbers of contracts they would bid for to ensure they did not over-commit.

Workforce

All providers cited issues relating to workforce and typically these concerned the transfer of terms and conditions for existing NHS staff and specifically pensions. One provider commented that GPs transferring under TUPE (Transfer of Undertakings) regulations from PCTMS practices to a new provider could result in them being paid more than the average salaried GP. Another national provider had provided a pension scheme equivalent to that offered by the NHS, but its costs were

approximately 16% higher than the NHS scheme due to higher contributions, which made it more of a challenge to make a business case viable. This was cited as another example of an uneven playing field given that GP-led companies have access to the NHS pension scheme.

Recruiting GPs was not identified as a problem with many now wanting to be salaried rather than in a partnership and new GPs not wanting to buy into property or commit to one practice. One provider commented that nurse recruitment was more difficult now that it had used existing capacity and needed to recruit additional personnel. It was intending to develop a ‘pool of staff’ that allowed for greater flexibility in service provision.

Lack of understanding about ‘private’ provision was described as a learning need for some staff and patients who were reluctant to work or register with larger companies. One provider had experienced some resistance from staff in practices that it was taking on, who thought that other GPs were employed by the NHS and didn’t make a profit.

Developing the market

Some providers welcomed the opportunities created by the Equitable Access programme but felt that PCTs needed to be clear about their specifications. The new services were not seen as competition to existing GP practices but creating additional capacity to extend community provision and reduce unnecessary hospital activity. One saw PCTs becoming a ‘regulator of services rather than direct provider’ and this created further potential for business growth as did the potential to collaborate with NHS Foundation Trusts wanting to move into primary care. Additionally, it was suggested that PCTs should have more power to decommission failing practices and open up those practices to fair competition.

Addressing issues to create a level playing field was seen as a priority, such as removing the restrictions on NHS pensions for all those delivering NHS services and a fairer approach to corporate indemnity. One provider suggested that to ensure a ‘fair crack of the whip’, local GPs with limited resources should be supported to bid for contracts by PCTs but on the understanding that they were not sole providers of general practice, though it could be argued that the provision of such support might act against fair competition.

It was felt that the Department of Health tendering process was much too complex and bureaucratic and prohibited smaller companies with limited resources from bidding. PCTs should develop flexible arrangements rather than requiring providers to sign up to APMS before submitting bids, and be more realistic in terms of contract length. At least five years, but ideally ten, was felt to be more attractive to potential providers.

Emerging themes and issues

The procurement process

The success of the primary care market will ultimately depend on PCTs having a strong and effective commissioning function. At a minimum, the skills needed for primary care commissioning include assessment of population health needs; benchmarking and comparison of different types of data (e.g. activity, financial, patient experience) across tender applications; contract negotiation and management; and robust methods of consulting local communities on proposed service changes (Smith *et al*, 2005).

Among those PCTs we interviewed, their early experiences of tendering had exposed significant gaps in their capacity and expertise, particularly with regard to technical procurement and legal skills. The view that commissioning was an under-developed function within PCTs was also expressed by providers, and is reflected more generally in the current policy around ‘world class commissioning’. Similar shortcomings have been reported in relation to out of hours services, where a lack of experience, time and reliable management data have made it difficult for PCTs to write service specifications and commission effectively (National Audit Office, 2006).

Some PCTs may choose to develop the necessary skills in-house, but this is not likely to be a viable option for all. Reflecting on their experiences of competitive tendering, a number of the larger PCTs we spoke to expressed concerns about how smaller, less well resourced equivalents would cope. This issue has come to the fore with the Equitable Access programme, given that all PCTs are required to commission at least one new primary care service by the end of 2008.

Our findings suggest that there are two main options available to PCTs. One is to commission external support, either from approved Framework for Procuring External Support for Commissioners (FESC) suppliers or from local partner agencies. We heard from PCTs who had sought advice from their local acute trust, and from those who were buying in the services of their local authority procurement team. The alternative is for resources to be developed at a regional level, and a number of regional procurement hubs have been established to support Equitable Access. Whichever of these models is used by PCTs, it will be important to ensure that there is clear accountability for the process and agreement about the roles that each contributor will play.

PCTs who have tendered under an APMS contract are recognising the benefits that this has to offer, particularly in terms of tailoring service specifications and performance measures to local conditions. However, it is evident that commissioners have paid more attention to the procurement of services than the management of contracts post-procurement. If commissioners are going to use APMS to specify, enforce and, ideally, improve standards of service provision then they will need to establish early on the outcome measures that are needed and the period of time over which performance will be judged. Given the potential legal implications of terminating a contract, it will be essential for PCTs to have clear and robust agreements with new providers about how underperformance is both measured and dealt with.

A further challenge for commissioners will be to strike a balance between using time restricted contracts and ensuring that new providers are able to operate within a relatively stable environment. If the contract length fails to provide a degree of financial and organisational stability, providers may become risk averse and be discouraged from pursuing longer term developmental goals. Under such conditions, it is likely that ambitious service expansion and innovation plans would be the first casualty. The use of longer (e.g. ten year) contracts, with break clauses for both parties, may be sufficient to overcome this problem. This would also reduce the transaction costs that are incurred through procurement.

Level playing field

One of the most common themes emerging from our interviews was that of fairness and equity in the primary care market. The view that different types of provider are not operating on a level playing field was expressed by commissioners, providers and SHAs alike. While public debate has largely focused on the notion of an imbalance in favour of corporate providers (e.g. Arie, 2006), the experiences shared with us suggest that this issue is not so straightforward.

Many practices – especially smaller ones – will not have the capacity and resources to enter into the bidding process. As an illustration, one London based practice was reported to have devoted half of one GP's time over three months and around £35,000 in putting together their bid for an APMS contract (Cole, 2008). At least in part, resource limitations may explain the comment made by many PCTs about the lower quality of bids being submitted by local practices.

Conversely, however, corporate providers are likely to lack the local knowledge, networks and visibility of local GPs. This may put them at a relative disadvantage in the bidding process, for example in demonstrating how they will establish themselves within the local community and make links with other primary care providers. Ineligibility for the NHS pension scheme creates further challenges for corporate providers, not only when it comes to bidding for primary care contracts but also in attracting staff.

As PCT community health service providers establish themselves as arm's length or fully independent organisations, they are entering the market through single or partnership bids. A level playing field may be even more difficult to establish if NHS provider services compete for contracts and conflicts of interest could arise if such services are part of the commissioning PCT. Competitive tendering will always be liable to accusations of unfairness from the independent sector while PCTs are providing support to local GPs to bid for contracts. Moves to strengthen the role of SHAs in regulation and system management are welcome, and a process for resolving competition-related disputes is being put in place with the establishment of an NHS Cooperation and Competition Panel (Department of Health, 2008b).

Local response to new providers

Since the introduction of the APMS contracting route in 2004, opposition to the opening up of the primary care market has been vocal and ongoing. Alongside concerns about whether local GPs can realistically compete against corporate providers and GP-led companies operating nationally, the possibility that a more commercialised system will damage the quality and continuity of primary care has been raised (e.g. Arie, 2006; Pollock *et al*, 2007). In early 2006, local residents in North Derbyshire mounted a legal challenge to the PCT's decision to award the management of two practices to UnitedHealth on the grounds of insufficient public consultation. Public action has also been mobilised by the British Medical Association (BMA) which, in response to the Equitable Access procurement, launched a national 'Support Your Surgery' campaign. By June 2008, 1.3 million patients had signed the BMA's petition against the involvement of commercial companies in primary care (Nowotny, 2008).

It is against this backdrop that PCTs have been putting primary medical care services out to competitive tender. Both commissioners and providers alike shared their concerns about the acceptance of new provider organisations in their area and the potential for local opposition. In practice, experiences had varied. While some new providers had successfully established themselves, others had encountered resistance, especially from local GPs. As evidence of this, a number of commissioners gave examples of the difficulties faced by new providers in joining Local Medical Committees or PBC boards.

All of this points to the importance of PCTs engaging key groups – including service users and local providers – in the commissioning process. Such engagement will need to be both meaningful and visible if it is going to add legitimacy to the commissioning process and help to build local acceptance. Significantly, better local involvement was one of the most common responses from PCTs when asked how they would do things differently in the future. The Department of Health's guidance on public involvement for Equitable Access procurements advises on when and how local communities should be consulted on commissioning proposals (Department of Health, 2008c). But some PCTs are already going further than this, for example by including public representatives on their bidder interview panels.

Facilitating patient choice in primary care

The notion that contestability and competition will act as a lever for improving standards of primary care services crucially depends on the exercise of patient choice. Arguably, some local providers will only take action to improve their performance when they begin to lose patients (and therefore income) to new providers offering a better quality and/or range of services. In order for this to happen, patients have to both recognise and respond to disparities in the quality of local services by choosing to leave practices with poor standards, and re-registering elsewhere.

As one SHA pointed out, the development of the primary care market has so far taken for granted that essential consumerist elements are in place, and this assumption may be misplaced. Indeed, while patients have been free – at least in principle – to register with a GP of their choice since the NHS was created, there is very little evidence that patients are exercising choice of primary care provider in reality (Corrigan, 2005). There are likely to be various reasons for this and some groups – such as people with long term conditions – may be discouraged from changing practice because of the high value they place on continuity of care and a stable GP relationship. But it is also the case, as some PCTs pointed out, that there is low public awareness of the right to choose a primary care provider and a dearth of reliable consumer information to support the choice process.

The provider organisations that we spoke to all gave examples of where they had increased list sizes, and some were using methods such as leafleting to actively promote their services to local populations. Some PCTs were also exploring options, including a directory of information on local practices and public awareness campaigns. But arguably the extent of switching behaviour falls far short of what is required for an active primary care market. Achieving the Department of Health's target of a 6,000 patient list size at the new Equitable Access practices will be especially challenging. Unless more attention is given to facilitating patient choice, there is a very real possibility that new services will be under-utilised in some areas. If this turns out to be the case, the commissioning of new primary medical care provision will offer poor value for money for taxpayers.

Conclusion

This report provides a snapshot of the primary care market as it has developed in the NHS in England over the course of 2008. This was a period of significant transition in a market that had been – until December 2007 and the announcement of the Equitable Access national procurement – opening up only in pockets of the country, largely concentrated in the regions in the north of England and greater London. Experiences of commissioning primary medical care services varied, and we found differences in perspective not only between SHAs, PCTs and provider organisations, but also within these groups.

It is evident that the claims of some commentators about the takeover of primary medical care by corporate providers are not well founded. Providers of all types possess competitive advantages in some respects, and disadvantages in others. GP-led companies appear to be competing successfully in the market and the degree of independent sector involvement at the time of writing remains very small. As an illustration, three leading corporate providers (UnitedHealth, Care UK and Atos) manage only ten general practices between them. This represents a minuscule proportion of the approximately 8,300 general practices in England. It remains to be seen whether the outcome of the Equitable Access programme will cause this judgement to be altered.

As we were finalising the report, it was announced that another corporate provider – Virgin Healthcare – had put on hold its plans to bid for primary medical care contracts (West, 2008). We also became aware that a number of other corporate providers and GP-led companies were reconsidering their involvement in the Equitable Access programme, based on concerns about the financial viability of the business model underpinning the procurement and the terms of the contracts being offered. The strength of these concerns varies between areas depending on the sharing of risk between commissioners and providers, and the nature of the services that PCTs are commissioning. In areas where providers are assessing their continued involvement in the programme, the scope for competition may be limited and the opportunity to bring in new providers may be missed. The

consequence could be that some PCTs are unable to award contracts if the bidders who remain in the market are unable to deliver the standard of service expected at the right price.

Our interviews with commissioners and providers highlighted a risk within the Equitable Access programme that the innovation resulting from new providers entering the market may unintentionally destabilise existing providers delivering a high standard of care to patients. This is because all PCTs have been required to procure a new GP-led health centre whether or not there is a need for additional capacity. If patients move from well performing providers to the new health centres, then the viability of these providers will come into question.

The other side of the same coin is the risk that the new capacity provided through GP-led health centres will not be effectively utilised and will therefore fail to offer value for money. As we have noted, little effort has been put into informing patients of the choices available within primary care, and how they can change practices. This, together with the loyalty of many patients to the practices they are currently registered with, and the importance for some of continuity of care, may result in the new health centres offering services that are not fully used. As in the Independent Sector Treatment Centre programme, this would represent a poor use of NHS resources.

What this suggests is that the use of a national programme to procure additional primary medical care services may both destabilise existing providers of good quality care in some areas and result in under used new capacity in other areas. Whether this happens will only be clear on completion of the procurements currently underway and experience of how the new health centres work in practice. Instability and spare capacity may be necessary to create the conditions for choice and competition but they could have the effect of undermining the achievements of general practice in the NHS if the consequences are not well managed

As yet, the overall effects of competition are unknown. Reflecting on local procurements that pre-dated Equitable Access, the PCTs we interviewed were satisfied with the performance of new providers in their area. Moreover there was some evidence, such

as the UnitedHealth and Derby City PCT example given above, that new providers were delivering improvements in the quality and accessibility of care. However, in many cases contracts had been in place for too short a time to fully assess what impact this was having. The ability of PCTs to use contracts with new providers to deliver improved care to patients is also uncertain in view of the limited experience of PCTs in commissioning primary medical care services.

It is clear from the work reported here that tendering for primary medical care contracts has proved to be a time and resource

intensive process for both commissioners and providers. Substantial transaction costs are being incurred, and only time will tell whether the benefits will outweigh the costs. There will be a great deal of learning from the Equitable Access experience that can inform further refinement of the procurement framework and documentation to ensure that they are fit for purpose. This includes using regional procurement hubs and developing the skills of PCTs in commissioning primary medical care services. There are also outstanding issues to be addressed in ensuring that there is a level playing field between different providers.

As the primary care market takes shape across England, there is a need to evaluate its progress more systematically and separate myth from reality. Of particular importance will be understanding how patients and primary care providers respond to the introduction of new capacity. Future research needs to address these issues and assess whether choice and competition are effective means of delivering better primary care for patients.



South West

Call for Expressions of Interest for the provision of NHS Primary Medical Care and related services

Primary Care Trusts (PCTs) within NHS South West invite Expressions of Interest from all suitably qualified and experienced healthcare providers (including general practitioners, social enterprise / third sector organisations and other providers) to provide a range of primary care, enhanced primary care, diagnostics and minor surgery services.

The commissioning PCTs are as follows:
Bath and North East Somerset PCT
Bournemouth and Poole Teaching PCT
Bristol Teaching PCT
Cornwall and Isles of Scilly PCT
Devon PCT
Dorset PCT
Gloucestershire PCT
North Somerset PCT
Plymouth Teaching PCT
Somerset PCT
South Gloucestershire PCT
Swindon PCT
Torbay Care Trust
Wiltshire PCT

To be considered for the formal tender process you must be able to demonstrate an effective track record of delivering primary medical care. The proposed schemes are subject to public engagement in accordance with current legal requirements.

For further information on each of the above schemes and the procurement process, interested parties are directed to the relevant scheme's Memorandum of Information, which will appear on the commissioning PCT's website no later than 12th May 2008 and can be accessed via the Equitable Access Programme tab on the NHS South West website available at: www.southwest.nhs.uk.

Those wishing to submit an Expression of Interest in tendering for the contracts are asked to do this in accordance with the instructions set out in the individual schemes' Memoranda of Information.

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This policy paper is a follow up to two previous papers published by HSMC on the emerging primary care market. These are Smith, J., Ham, C. and Parker, H. (2005) *To market, to market: what future for primary care?* and Parker, H. (2005) *Opening up the primary care market*.

About HSMC

HSMC has been one of the leading UK centres for research, personal and organisational development in health care for over thirty years. Commissioning of healthcare and provision of healthcare outside hospitals have become specific areas of expertise in recent years, underpinned by a continuing commitment to issues of quality improvement and public and patient engagement. This reputation has also started to extend to adult social care, with a growing track record in inter-agency commissioning and provision of health and social care services. HSMC has also developed a national reputation for both organisational and leadership development across all health settings. For further information visit: www.hsmc.bham.ac.uk