

SOCIAL MARKET FOUNDATION HEALTH COMMISSION

**CHOICE AND CONTESTABILITY IN PRIMARY CARE**

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## Key points:

- The debate about introducing 'choice' in the NHS is often conducted at a rarefied, ideological level. We ought instead to be carefully investigating what scope there might be for choice to improve the care that patients receive.
- 'Choice' as applied to the NHS is usually taken to mean choices made by individual patients. We argue that, in primary care, there is a case for empowering GP practices to choose the Primary Care Trust (PCT) to which they wish to belong.
- If properly managed, this system could incentivise PCTs to improve their working practices – especially commissioning, which is often taken to be the most powerful lever possessed by PCTs to improve the standard of patient care. Currently, there is a great deal of evidence to suggest that PCTs are not using this lever effectively.
- Individual patient choice is also important in primary care. We argue that allowing patients a freer choice than they have at present to choose GP practice – including practices in other PCTs – could incentivise practices to improve their working practices. In an era where practice based commissioning is likely to lead to practices becoming more and more specialised, choice of GP practice becomes increasingly important.
- The central goal of any reform of the working practices of the NHS should be to improve the care that patients receive. The two forms of choice we set out here – GP practices choosing the PCT to which they wish to belong, and individual patient choice of GP practice – can function in combination as a powerful catalyst for improving the quality of patient care.

## **Introduction**

The debate about extending 'choice' in our public services seems to have been rumbling on for some time now. Initially, the debate seemed to be conducted at a very rarefied, ideological level – between evangelists who saw the extension of choice as a magic-bullet solution to all of the problems in public services, and prophets of doom who foresaw the irrecoverable decline of these services were choice to be extended.

Since then, the debate has taken on a more sober tone (although shrill voices on both sides can still occasionally be heard). Like any other single policy proposal applied to vast and complex systems such as public services, choice is unlikely to be either a universal panacea or a death knell. What is much more likely is that *some kinds* of choice – carefully structured, and introduced at the right time and in the right places – might be able to bring about *some kinds* of benefits (although quite possibly at the expense of introducing some kinds of new costs).

The present paper is a contribution to this more reasoned debate. In it, we shall examine the case for introducing certain kinds of choice into the primary care sector of the NHS. Of course, NHS *secondary* care has for some time now seen the introduction of certain new kinds of patient choices. Choice of provider of elective surgery has been piloted since 2002, and a national rollout in the wake of these pilots is now in motion. Phase one of the rollout, which involves giving all patients who have waited six months or more for elective surgery a choice of provider, began in summer 2004. By December 2005, the number of alternative providers of elective surgery offered to patients at the point of GP referral must be five or more (phase two of the rollout).

The Government clearly believes that these kinds of choices have important beneficial effects for the secondary care sector - it claims that patient choice of hospital can 'drive service improvements transforming the NHS into a more responsive, patient-centred service'.<sup>1</sup> The Government also claims to be

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<sup>1</sup> <http://www.dh.gov.uk/PolicyAndGuidance/PatientChoice/Choice/ChoiceArticle/fs/en?>

committed to a 'primary care led' NHS. As such, there is a clear need to examine the extent to which the extension of choice can bring about improvements in this sector also.

Much of the current debate around choice in the delivery of NHS services focuses on choices made by individual patients – over what they receive, from whom, at what time, and at which location. This is certainly one important dimension of choice, and we shall devote the second half of this paper to examining perhaps the most fundamental patient choice within the primary care setting – the choice of which GP practice to join. Choice of GP practice has of course been a reality for *some* patients since the inception of the NHS – those patients who by happy chance happen to live within the geographical catchment areas of two or more GP practices which also happen to have space on their practice lists. We shall examine the case for extending this choice to *all* patients, and for widening their choices to include practices beyond those located close to their homes.

We shall begin, however, by examining a different kind of choice. Natural though it might be to focus on patients when thinking about choice within the health service, this ought not to blind us to the possibility of other groups in the NHS exercising choice. The primary care sector in the UK is unique in that it serves as the main gatekeeper to secondary care. Moreover, it is important to remember that around 80% of all treatment episodes begin *and end* in primary care. GPs have frequent contact with their patients, and have in-depth knowledge of their needs, both clinical and non-clinical. They are in a good position to exercise certain choices on behalf of their patients, in securing high quality, value for money services that are tailored to their needs. Since all GP practices in England and Wales now operate under the administrative auspices of a Primary Care Trust (PCT), the particular choice we propose to consider in the first half of this paper is this: Ought GP practices to be allowed to choose the PCT to which they wish to belong?

Our argument will proceed through four sections. In the first, we describe the evolution of the current PCT structure of primary care. In the second, we present the reasons for thinking that it is theoretically possible for PCTs to improve the quality and cut the costs of services, focusing on the mechanism frequently cited as being most likely to bring about these benefits – commissioning. In this section, we will also describe the reasons for thinking that, theoretical possibilities notwithstanding, PCTs face significant obstacles standing in the way of their developing effective commissioning practices.

In the third section, we outline the case for allowing GP practices the freedom to choose the PCT to which they wish to belong. We will explain how this system could operate in practice, and will suggest the ways in which this system could overcome some of the obstacles to effective commissioning outlined in section two. We will also consider how this system could provide mechanisms other than commissioning for bringing about improvements in the quality of services.

In the fourth section, we consider the limitations and possible drawbacks of our system.

## **GP Practices Choosing PCT**

### **1) The New Structure of Primary Care: From 'Primary Care Groups' to 'Primary Care Trusts'**

April 1999 saw the beginning of the restructuring of primary care away from the GP fundholding model. All general practices were required to come together into geographically defined groups under the administrative auspices of a 'Primary Care Group' (hereafter 'PCG'). Note 'geographically defined' – the operative logic in constructing primary care groups was that geographically close GP practices would simply be grouped together. The white paper outlining the PCG model (*The New NHS*) estimated that these groups would serve population sizes of around 100,000.<sup>2</sup> This estimate proved to be largely borne out in practice, as the average population served by PCGs in 1999 was indeed around 100,000. The range was wide however, with the smallest (South West Shropshire) serving a population of 43,681 with 29 GPs based in 8 practices, and the largest (Brighton and Hove) serving 277,160 patients with 140 GPs in 53 practices.<sup>3</sup>

Most primary care expenditure within the area covered by a PCG was gradually transferred from the relevant Health Authority to the PCG in the form of a 'unified budget', unlike the previous system where primary, community, and secondary budgets were separated.<sup>4</sup> As under the old internal market, PCGs were allowed to retain budget surpluses, provided these were spent on services that are of benefit to patients. Surpluses were shared between the PCG and its GP members. There was no set rule for allocation, but individual GP's did not simply keep their own surplus. Rather, a system of collective responsibility and collective allocation of surplus applied.

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<sup>2</sup> Secretary of State for Health (1997). *The New NHS: Modern, dependable*. London: Stationary Office.

<sup>3</sup> Bojke C, Gravelle H, and Wilkin D (2001) 'Is bigger better for primary care groups and trusts?' *BMJ*; 322: 599-602.

<sup>4</sup> Azeem M and Lawrence M (1999). Unified Budgets for Primary Care Groups. *BMJ* 318 772-76.

There were, however, some salient differences between the old internal market and the new PCG structure. The short-term contracts that abounded in the internal market were replaced with securer, longer-term funding agreements. It was hoped that these agreements would bring about a change in the working relationships between different sectors of the NHS – away from the ‘competitiveness’ of the internal market, towards a new era of ‘partnership-working’.

From their inception, PCGs were encouraged to apply for the status of ‘Primary Care Trust’ (hereafter PCT). All PCGs have since taken up this option. In April 2000, there were only 17 PCTs; now there are 303, and no PCGs remain. Whereas PCGs were committees of health authorities, PCTs are ‘free-standing, statutory bodies, responsible for the health care budgets of the majority of hospital and community health services.’<sup>5</sup> Typically, a PCT controls a total budget of around £60m (though the figure can be much higher). A Professional Executive Committee (PEC) is responsible for the day-to-day running of the PCT, and is largely composed of professional members. However, the Government hopes that PCTs will be responsive to the needs and wishes of individual patients, and to this end the overall responsibility for the performance of a PCT will lie with a board which has a majority of lay members. Lay members and chairpeople are appointed by the Secretary of State for health. In addition, PCTs usually also operate a sub-committee solely devoted to commissioning, made up of members of the PCT board, the PEC, and health professionals working within the PCT.

Like the PCG structure it has replaced, the new PCT structure shares some similarities and dissimilarities with the pre-1997 model of GP fundholding. Most relevantly for this paper, the purchaser/provider split remains in place. PCTs hold budgets, and are allowed to retain their surpluses. They can choose the provider from whom they will commission services, and they are free to change providers – thus ensuring some measure of contestability in the system. PCTs have the freedom to commission services from a variety of

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<sup>5</sup> Beecham L (1999) ‘Primary care trusts will have wide powers’ *BMJ* (318):555

providers both within the NHS (in primary, community, social, or hospital care, local and non-local) and from the private and voluntary sectors, in order to meet the twin goals of high clinical standards and good value for money.<sup>6</sup> In practice however, PCTs are encouraged to build partnerships with providers, and to view switching contracts as a measure of last resort. In addition, contracts with providers – the new ‘service level agreements’ – are fairly long-term in nature (running for one or three years).

Collectively, PCTs hold around 75% of the total NHS budget. Given this, they have – in theory, at least – the power to lever very significant improvements in the NHS, both within primary care and beyond. The Department of Health hopes that the aforementioned commissioning freedoms will bring about an improvement in the *quality* of services. Specifically, it is hoped they will reduce waiting times, increase responsiveness, and improve clinical outcomes. Less interest is expressed in reducing the *costs* of services. PCTs are expected to focus their commissioning decisions on volume, appropriateness and quality; not price. The price for units of activity will be fixed against a standard tariff, using Health Resource Group benchmarks

## **2) Is the PCT system likely to succeed?**

It is difficult to assess how successful PCTs have been in bringing about improvements in the quality of services, since there is a paucity of published evidence on this question. This is unsurprising – PCTs are, after all, still relatively young organisations.

However, The National Tracker Survey of PCTs for 2000/2001 claimed that these organisations may have begun to support some quality improvements, and to extend the range of available services.<sup>7</sup> The Survey also claims that

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<sup>6</sup> Department of Health, Delivering the NHS Plan: next steps on investment, next steps on reform, April 2002

<sup>7</sup> Wilkin, Gillam, Coleman, The National Tracker Survey of Primary Care Groups and Trusts 2000/2001: Modernising the NHS?, National Primary Care Research and Development Centre, University of Manchester, King's Fund, 2001

PCTs have responded well to national priorities (especially the National Service Framework for coronary heart disease).

More recent research backs up this cautious praise for PCTs. The Commission for Health Improvement's report *What CHI has found in: primary care trusts* (published in March 2004) has found that PCTs are in the main helping GP practices to meet access targets.<sup>8</sup>

Even though there is a lack of published evidence on the success or otherwise of PCTs in bringing about quality improvements, it could be argued that there is at least a theoretical possibility that PCTs will produce these benefits. Commissioning is frequently cited as the mechanism most likely to bring about improvements in the quality of services, as well as reductions in their costs. The PCT structure retains the purchaser/provider split of the previous system of GP fundholding. There is some published evidence to suggest that GP fundholding had some success in levering improvements. Some studies claim to show a rise in productive efficiency as a result of fundholding, from a 1.5% annual increase pre-reform to 2% post-reform.<sup>9</sup> GP fundholders provided more out-reach services, obtained quicker secondary care admission, and generally got more response from providers, than did non-fundholders.<sup>10</sup> It was also claimed that GP fundholders were better at generating surpluses than health authorities.<sup>11</sup>

Other studies claim that GP fundholding was an effective means of cost containment. Rising prescription costs was one of the reasons for introducing GP fundholding. In their study of all GP practices in England, Harris and Scrivener<sup>12</sup> found that prescribing costs were reduced for fundholding practices by around 6% over the period of their study. Successive waves of fundholders showed a similar pattern of changes: a small relative reduction in

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<sup>8</sup> CHI (2004)

<sup>9</sup> Mulligan J (1998) 'Health Authority Pricing', in Le Grand J, Mays N, and Mulligan J (eds.) *Learning From the NHS Internal Market* (London: Kings Fund).

<sup>10</sup> Glenerster et al (*op. cit.*); Goodwin N 'General Practice Fundholding' in Le Grand et al (1998)

<sup>11</sup> Goodwin (*op. cit.*)

<sup>12</sup> Harris C and Scrivener G (1996) 'Fundholder's Prescribing Costs: The First Five Years' *BMJ* 313:1531-34.

the pre-fundholding year; a maximum relative reduction in the first year of fundholding; and a decline in relative reductions in the second and third years of fundholding. After this, increases in costs were largely similar to non-fundholders, but the absolute difference in levels between fundholding and non-fundholding practices remained. Interestingly, these cost reductions were secured by lowering the cost per item rather than lowering the number of items prescribed. Thus, the evidence would seem to suggest that GP fundholding reduced prescription costs without creating a false economy or reductions in the standard of care.

Any improvements in cost-containment wrought by GP fundholding must be weighed against the increased administration costs of the system. These increases were largely put down to the introduction of new accounting procedures. It is claimed that the proportion of NHS expenditure spent on administration rose from 8% to 11% as a result of these changes.<sup>13</sup>

Since the PCT structure retains the purchaser/provider split of the old GP fundholding system, and since there is some evidence to suggest that GP fundholding had some success in bringing about improvements in services, this might give some grounds for thinking that it is at least theoretically possible for the PCT structure to have similar success. However, this argument ought to be treated with a certain amount of caution, for three reasons.

Firstly, as Julian Le Grand urges, we must be wary about the quality of much of the published evidence on GP fundholding.<sup>14</sup> The literature on whether GP

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<sup>13</sup> King's Fund (1997) *Management Costs*. London: King's Fund.

<sup>14</sup> Le Grand puts this lack of evidence down to three factors. Firstly, the Conservative government was sceptical about conducting an evaluation, suspecting that those calling for an evaluation were actively engaged in an attempt to derail the policy. Secondly, he claims that, unlike the US, the UK lacked the kind of independent research associations sufficiently equipped to undertake a full evaluation of such a large-scale reform. Thirdly, the evaluative process itself was likely to face significant methodological difficulties, due to the difficulty of controlling for confounding factors, the occurrence of time lags, and problems with measuring specific variables.

fundholding was successful at keeping down the costs of prescriptions and referrals is especially controversial.<sup>15</sup>

Secondly, although the purchaser/provider split remains in the new PCT structure of primary care, its form has altered. As we described above, the onus now is on co-operative rather than competitive relationships. While purchasers are still empowered to switch from their current providers, it is recommended that this be used only as a measure of last resort. Contracts are now larger in scale, and run for longer terms.

Thirdly, and perhaps most importantly, there is a fair sized body of evidence to suggest that, theoretical possibilities notwithstanding, certain aspects of the PCT structure will frustrate in practice the development of the effective commissioning practices that might bring about the kinds of benefits for patients in which we are interested. We have divided these obstacles into eight types:

- i) **Lack of appetite:** The National Tracker Survey revealed that commissioning figures low on the list of priorities espoused by senior members of PCTs. Another study has reported that some PCTs lack the kinds of commissioning subgroups we described above. Where such groups do exist, it is unclear how representative they are.<sup>16</sup>

Birmingham University's Health Services Management Centre recently completed a three-year national evaluation of PCTs, and reports similar findings on commissioning. The Birmingham study found that PCTs have been slow to get started on commissioning

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<sup>15</sup> Gosden and Torgeson D (1997) The effect of fundholding on prescribing and referral costs: a review of the evidence.' *Health Policy* (40) 2 pp103-114, and 'Purchasing in Practice' (1995) summarize the evidence.

<sup>16</sup> Bond, Nurture not nature, *Health Service Journal*, 21 February 2002, pp30-31

acute care, with one of the reasons being a perceived 'lack of financial clout'.<sup>17</sup>

Perhaps the clearest indication of lack of appetite is that many PCTs have delegated their commissioning powers to other bodies. A survey of PCTs in the South West region of England found that they often didn't keep all of the funds devolved to them to commission care. Only 8 out of 26 PCTs kept all of the funds themselves, the rest simply gave some or all of these funds back to the health authority.<sup>18</sup>

- ii) **Poor levels of partnership working between PCTs and providers:** The National Tracker Survey revealed that almost half of the PCTs they surveyed were not routinely consulting with social services when commissioning community health services. More recently (in July 2003), the Commission for Health Improvement's report on the outcomes of its clinical governance reviews of eight PCTs highlighted a need for greater efforts to engage stakeholders. For example, there was little evidence of work undertaken to engage primary care contractors, particularly dentists, pharmacists and optometrists, at North Manchester PCT. South Peterborough PCT and South Manchester PCT were also found to be in need of a commissioning strategy, and Central Manchester PCT was told it needed to review arrangements to ensure a more balanced approach to commissioning.<sup>19</sup>

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<sup>17</sup> E Regen, J Smith, N Goodwin, H McLeod, J Shapiro (2001). *Passing on the Baton: Final report of a national evaluation of primary care groups and trusts*. University of Birmingham, Health Service Management Centre.

<sup>18</sup> Baxter, Shepherd, Weiss & Le Grand, 'Ready, steady, stop', *Health Service Journal*, 14 March 2002, pp28-29

<sup>19</sup> [www.chi.nhs.uk](http://www.chi.nhs.uk)

- iii) **Financial restrictions facing PCTs:** The National Tracker Survey reveals that many PCTs came into existence with historic local NHS debts. Half of the PCTs surveyed by the NHS Alliance said they had little or no flexibility in using their allocation to commission services. Three-quarters of PCTs said they had not been able to change the way patients received diagnoses and treatments or had only been able to do so in a limited way. Overspends by hospitals were considered the main reason for preventing PCTs from using their allocation as they would wish.
- iv) **PCTs are hidebound by predetermined clinical and performance management frameworks:** PCTs must comply with a great many national targets and priorities and there are fears that their doing so could divert attention away from the task of developing effective commissioning arrangements. The King's Fund have recently argued that 'there are limitations to the number of central priorities that PCTs can accommodate without seriously impairing their capacity for local action.'<sup>20</sup> The final Wanless report, published in February 2004, also claims that central targets are adversely affecting the behaviour of PCTs.<sup>21</sup>
- v) **PCTs do not allow for sufficient clinical involvement:** When PCGs were introduced in 1999, it was hoped that this new structure of primary care would allow clinicians a greater say in the planning and delivery of health services. The shift towards PCT status was seen by some as further facilitating this shift towards a clinically-led

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<sup>20</sup> Banks-Smith, Shipman, and Gillam. What Influence have national service frameworks had on the priorities of primary care groups and trusts? *The Journal of Clinical Governance* (2002) 10:7-11

<sup>21</sup> Wanless, D (2004) *Securing Good Health for the Whole Population* (London: HM Treasury)

primary care sector.<sup>22</sup> The mechanism often cited as allowing clinician involvement is the PCT Professional Executive Committee (PEC). Some commentators have high hopes that PECs will allow for substantive clinical leadership of PCTs. PECs have been described as the 'engine rooms' of PCTs that can 'ensure that service re-design engages those that matter most with the professional knowledge to make a difference.'<sup>23</sup>

However, many other commentators are much more sceptical about the scope for clinical involvement within the working practices of PCTs. Certainly, the shift away from GP Fundholding to PCGs and then to PCTs has seen a centralisation of commissioning powers away from frontline GPs. Commissioning budgets are now held at PCT level without any devolution of control. Few devolve budgetary control to locality groups or introduce indicative budgets at the level of practice. Individual GP practices seem to have little voice in commissioning decisions. In its most recent report (March 2004), CHI claims that there is still a 'lack of clinician involvement in the commissioning process', and a 'lack of public and patient consultation in the commissioning process'.<sup>24</sup> This situation is beginning to change, however – we shall come to discuss 'practice based commissioning' in section five below.

- vi) **Lack of suitable staff:** The National Tracker Survey uncovered wide variations in the numbers and types of staff available to PCTs – one in seven had no finance staff at the end of 2000, and most Chief Officers regarded staffing levels as inadequate. Managerial staff and information management and technology support staff were frequently listed as high priorities for investment. Similarly,

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<sup>22</sup> 'The formation of PCTs in the last two years has given clinicians great opportunities to influence the delivery of primary care.' *Clinicians: Managing to Lead* ([http://www.natpact.nhs.uk/news/index.php?article\\_request=307](http://www.natpact.nhs.uk/news/index.php?article_request=307))

<sup>23</sup> Ibid.

<sup>24</sup> CHI (2004)

researchers at the Centre for Healthcare Management at Manchester University have suggested that many PCTs have insufficient staff to cover basic administrative functions, let alone the major modernisation tasks they are expected to take on. The NHS Confederation describes the move to trust status as a 'significant and time-consuming leadership challenge' and maintains that tasks such as engaging clinicians and frontline staff (particularly in the commissioning process), defining the organisation's vision and strategy, and agreeing corporate priorities, represent a 'heavy leadership agenda'.<sup>25</sup>

More recent studies would seem to suggest that the situation is not improving. In 2004, CHI remarked that it remains 'concerned about management capacity in PCTs'. It claims that, in one in four of the PCTs it surveyed, senior managers had overly extensive roles. It also found that many PCTs still had not appointed a full senior management team or had only done so very recently. The net result of this situation, CHI argues, is that 'it may leave senior managers exposed to unacceptably high workloads with associated risks'.<sup>26</sup>

CHI also found that most PCTs did not adequately appraise the performance of their staff. Not only is this likely to reduce staff morale, it means that valuable information from those working at the sharp end – information that ought to feed into commissioning decisions – is being lost.<sup>27</sup>

Also in 2004, an NOP poll of 50 PCTs found that one third of financial directors were not full time, and that three quarters had no private sector experience (and deemed such experience unnecessary). The poll also uncovered that almost half of PCTs

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<sup>25</sup> NHS Confederation. PCT Management Capacity, December 2001

<sup>26</sup> CHI (2004)

<sup>27</sup> Ibid.

have no IT director. Only one of the PCTs polled by NOP had a full-time IT director.<sup>28</sup>

**vii) Striking the balance between partnership and contestability:**

The main difference between the PCT format and the old GP Fundholding system is the former system's emphasis on partnership working and relationship building with other organisations in the health economy. Yet at the same time, PCTs are expected to inject elements of contestability and competition into their commissioning arrangements. Michael Sobanja from the NHS Alliance points out that while, in theory, PCTs have the opportunity to shift provider, 'this doesn't marry with the cosy relationship they are expected to have with providers.'<sup>29</sup> It is unclear how PCTs are expected to inject contestability into the system whilst at the same time preserving partnerships with local provides.

**viii) Shortfall in information required for informed commissioning decisions:**

The National Tracker Survey concluded that this was 'a serious obstacle to progress' and found little signs that the situation was improving. The Survey also highlighted a shortage of skilled staff and resources to meet information management and technology targets.

More recent reports suggest that the situation has not improved. CHI's 2004 report suggests PCTs are still not commissioning effectively because they are not yet using information fully. In particular, CHI expressed concern over the apparent confusion that often exists over respective roles and risk management when PCTs

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<sup>28</sup> NOP World Health (2004) *PCT Polling*

<sup>29</sup> Conversation between Sally Williams and Michael Sobanja, Chief Officer of NHS Alliance, 21 October 2002

commission on behalf of each other or in conjunction with local authorities.

The CHI report also claims that there is limited access to IT systems within PCTs. Staff in community health services have limited access to computers, and unequal IT training opportunities. Perhaps the starkest figure from CHI is that 91% of optometrists working within PCTs currently report no online access to information.<sup>30</sup>

The findings of the CHI report are backed up by a recent report from the Audit Commission, which claims that PCTs must seek to improve their understanding of the different kinds of resources available to GP practices and the various ways in which these resources are used. The Audit Commission argue that this information, coupled with information about the health needs of the community and patients' views, ought to feed directly into commissioning decisions. Only then, it claims, will PCTs 'develop strategies for commissioning and supporting primary care that will raise standards and deliver equity.'<sup>31</sup>

The Audit Commission have also recently found that a particularly important form of information required to commission effectively – information on cost effectiveness – was only measured in two out of the ten PCTs they investigated.<sup>32</sup>

- ix) The optimal size of PCTs:** Finally, there is a lack of consensus regarding the optimal size for PCTs to become effective commissioners. Back in 2001, The National Tracker Survey reported that three-quarters of PCTs were planning mergers that

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<sup>30</sup> CHI (2004)

<sup>31</sup> Audit Commission (2004a) *Transforming primary care: The role of primary care trusts in shaping and supporting general practice*

<sup>32</sup> Audit Commission (2004b) *Quicker treatment closer to home: Primary care trusts' success in redesigning care pathways*

would double their average size. Many mergers have now taken place, and there is a fear that such mergers will mean recreating health authorities under a different name. The NHS Alliance has warned: 'If we are not very careful, we shall find ourselves going back to square one with large, bureaucratic organisations that cannot respond flexibly to the needs of local communities. We are already seeing this happen in some areas.'<sup>33</sup>

In terms of commissioning, it could be argued that larger PCTs have greater purchasing power and are more likely to exert a powerful influence on providers. Against this, it could be countered that larger PCTs are also less likely to achieve the kind of localism that they have been set up to deliver. The larger the PCT, the larger the communities it represents and the greater the number of practices and GPs with which to engage. Consequently, it is likely to be harder to engage local frontline professionals and the public, and therefore harder to remain sensitive to local needs and circumstances. PCTs could be seen as remote, out of touch organisations, frontline clinicians may feel disenchanting and disempowered, and commissioning arrangements will appear distant. There is some evidence to suggest that this is already happening. A King's Fund study showed that PCTs have struggled to implement public involvement work and are in danger of becoming distant, corporate bodies. It urged PCTs to maintain the community focus that characterised PCGs, to ensure that the commissioning process is properly owned by clinicians and local communities.<sup>34</sup> More recently, a report from the Audit Commission found that only 27% of general practitioners felt they had any kind of influence over commissioning.<sup>35</sup>

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<sup>33</sup> NHS Alliance. 'Big isn't better, says NHS Alliance' (5 July 2001)

<sup>34</sup> Anderson, Florin, Gillam, and Mountford. Every Voice Counts: Primary Care Organisations and Public Involvement. King's Fund (2002)

<sup>35</sup> Audit Commission (2004a) *Quicker treatment closer to home: Primary care trusts' success in redesigning care pathways*

### 3) Allowing GP practices to choose PCT

So far, we have argued that there is little evidence at the moment to suggest that PCTs have been successful in bringing about the sorts of benefits in which we are interested. We have also argued that, while there are some grounds for thinking that it is theoretically possible for PCTs to bring about these benefits through the mechanism of commissioning, there is a great deal of evidence to suggest that PCTs confront very significant obstacles standing in the way of their developing effective commissioning practices. As the CHI report from March of this year concludes: '[O]n the basis of the evidence collated so far, CHI has concerns about the current capacity of PCTs to use commissioning as a lever for improvement.'<sup>36</sup>

As we described in the first section, the operative logic in constructing PCGs was geographical – all GP practices within specific areas were grouped together to form PCGs, with average populations of around 100,000. It has been claimed that this method of construction, and the population size of 100,000, was not based on a review of evidence.<sup>37</sup> Rather, it was probably based on previous experience with other commissioning models and on the views of primary care professionals.<sup>38</sup>

As such, the current composition of PCTs should not be viewed as being set in stone. Rather than GP practices being assigned to a particular PCT, a case could be made for allowing practices to *choose* the PCT to which they wish to belong. Allowing them this choice could act as a powerful incentive for PCTs to improve their working practices, including their commissioning practices. Currently, PCTs are funded according to a complex formula that includes as one of its key variables 'weighted capitation targets'. In essence, this means that the amount of funding a PCT receives depends in large measure on the number patients it serves, weighted for the projected health needs of those patients.<sup>39</sup> If GP practices were allowed to choose PCT, taking their patients (and, therefore, funding) with them, this would provide an incentive to PCTs to

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<sup>36</sup> CHI (2004)

<sup>37</sup> Bojke et al (2001)

<sup>38</sup> Secretary of State for Health (1996) *Primary care: the future*. Leeds: NHS Executive

<sup>39</sup> Department of Health (1999) *Primary Care Trusts: Financial Frameworks* (Annex B)

become as attractive as possible to GP practices. The NHS Confederation has remarked that the pressure that would be put on commissioners as a result of there being an effective choice of commissioner 'could be the incentive needed to improve commissioning and promote closer engagement between commissioners and those they serve'.<sup>40</sup> The Confederation does not specify who ought, or could, be the choosing agents. Our system can supply the answer – the choosers ought to be individual GP practices and groups thereof.

In making their decisions about which PCT to join, GP practices will be motivated to seek out the best all round deal for their patients – increasing the quality of services, while containing costs. As such, in becoming attractive to GP practices, PCTs will be incentivised to show GP practices that they are capable of securing high quality services at reasonable costs. Since effective commissioning is an important way to do this, this could conceivably help overcome the first two obstacles we outlined in the preceding section – a lack of appetite within PCTs to develop effective commissioning practices, and a lack of partnership working between PCTs and providers. PCTs would now be powerfully incentivised to develop such practices and partnerships.

They would also be incentivised to develop the kind of IT systems that are required in order to commission effectively. Doing so might require quite innovative working practices. PCTs ought perhaps to look outside their own boundaries to meet their IT needs – either to other PCTs, or to organisations outside the NHS. PCTs are already entering into close working arrangements with nearby PCTs and other organisations (e.g. hospital trusts and social services) in order to provide better coordinated care. PCTs share staff, second staff to one another, and employ staff from other organisations.<sup>41</sup> Given this precedent, PCTs ought perhaps to be equally flexible over the sourcing of IT services. Our system would certainly provide them with the incentive to do so.

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<sup>40</sup> The NHS Confederation (2003) *Fair for all, personal to you: the NHS Confederation response to the choice consultation*.

<sup>41</sup> CHI (2004). Our emphasis.

Doubts might be raised, however, about the ability of PCTs to engage in these flexible IT practices in an era when the self-proclaimed 'core' of the NHS National Strategic Programme for IT 'is to take greater central control of the specification, procurement, resource management, performance management and delivery of the information and IT agenda'. However, even within this avowedly centralist strategy, there is still some scope for decisions to be made at local level – including at PCT level.<sup>42</sup> The Programme explicitly allows for 'local (PCT level) selection and implementation of IT'. The only stated restrictions are that any systems procured by PCTs must comply with national data standards, system specifications, and infrastructure requirements. No restrictions are placed on *where* PCTs may procure IT. It would seem that PCTs retain a reasonable degree of control over their IT policy, even under the National Strategic Programme for IT. The system of allowing GP practices to choose PCT will incentivise PCTs to use this power wisely.

The system we describe here could also help to offset the problem of PCTs not allowing sufficient clinical involvement. By choosing the PCT they feel would commission best for their particular patient population, GPs would have a powerful indirect say in commissioning. CHI have recently claimed that many professional groups working within PCTs – including GPs - are more likely to feel less involved in the workings of the organisation, and to experience it as 'remote'. CHI argues 'this is not surprising considering general practices (and subsequently pharmacy, optometry and dental practices) were not given any *choice* about their allocation to their primary care organisation.'<sup>43</sup> Under our system, this is precisely the kind of choice that would be allowed to GP practices. If the absence of this choice was one of the causes of GPs experiencing the PCT as remote, its provision might increase the extent to which GPs feel involved in the workings of the PCT – including its commissioning practices.

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<sup>42</sup> Department of Health (2002) *Delivering 21<sup>st</sup> Century IT Support for the NHS*.

<sup>43</sup> CHI (2004)

Moreover, allowing GP practices to select PCT could conceivably incentivise PCTs to improve aspects of their working practices other than commissioning. Not all services provided by a PCT will be externally commissioned. Many (especially health promotion and health education) will be provided within a PCT. If GP practices (and therefore patients, and therefore funds) can move around the primary care system, PCTs could be incentivised to improve the quality of services that are not externally commissioned. They might also be incentivised to bring about important changes to fundamental working practices, such as ensuring the effective integration of health and social care, and the development of more effective partnerships with Strategic Health Authorities, NHS Trusts, and local authorities. Moreover, they might also be incentivised to copy examples of good working practices in other PCTs. CHI has recently argued that, while there are examples of effective and innovative working practices in some PCTs, 'too often this occurs in isolated pockets within the organisation'. The CHI report also laments the fact that '[m]any PCTs have not yet developed ways of sharing innovative or effective practice across the organisation.' Our system of allowing GP practices to choose PCT could conceivably put in place the right kind of incentive structure to encourage the spread of best practice.

How might the system work in practice? Certainly, there would have to be a good deal more information available than there is at the moment regarding the relative merits of different PCTs. This information is essential if GP practices are to make a *fully informed* choice regarding which PCT to join.

Secondly, some restrictions will have to be placed on the choices of GP practices regarding which PCT they wish to join. It will not be practical for a GP practice in the south west of England to join a PCT in the north east, since the services commissioned by that PCT will simply be too far away for the patients of the GP practice to make effective use of them. For practical purposes, GP practices would have to be restricted to a choice between geographically proximate PCTs. This will mean that some practices - those close to a number of different PCTs (practices in urban areas, most likely) -

will have a greater range of choices than those that are not close to a number of different PCTs (practices in rural areas, most likely).

Thirdly, it ought to be stressed that the system might not actually result in many GP practices moving from the PCT to which they currently belong. If many did decide to switch, this would be both administratively complex and costly, and could count as an argument against the idea. Rather than actually switching PCT, the simple fact that GP practices *can* switch if they so choose – that is, the mere *threat* of switching - could be enough to incentivise PCTs into making important improvements in their working practices. Seeing these improvements being made will encourage many GP practices to stay put.

#### **4) Limitations and possible drawbacks of allowing GP practices to choose PCT**

It is certainly conceivable that the system of allowing GP practices to choose PCT could incentivise PCTs to improve their working practices (including their commissioning arrangements) in such a way as to improve the quality of the services patients receive.

This system has limitations, however. We ought not, for example, to expect it to remove *all* the obstacles stopping PCTs from developing effective commissioning practices. As we described in the previous section, the system could conceivably remove at least some of these obstacles – it could instil a greater appetite to commission effectively, it could incentivise PCTs to develop better working relationships with providers, and it could give GPs a powerful indirect say in the commissioning decisions made by PCTs. However, the system will not help overcome certain other obstacles standing in the way of PCTs becoming effective commissioners. It will not help PCTs overcome the problem of their being hidebound by too many centrally imposed clinical and performance management frameworks, their being saddled with historic debts, and their lacking the necessary administrative staff (especially skilled managers and information technology staff). The

system of allowing GPs to choose the PCT to which they wish to belong seems best able to overcome obstacles that stem from a lack of drive and innovation on the part of PCTs (e.g. their lacking the appetite to develop effective commissioning practices). However, not all of the obstacles facing PCTs can be linked to a lack of drive and innovation on their part, and the system we describe will make little headway with these obstacles.

So much for limitations. The problems of the current PCT structure are manifold, and it is unrealistic to expect any single change (such as the change to allowing GP practices to choose the PCT to which they wish to belong) to resolve all these problems. The system we describe does at least seem capable of helping to offset some of these problems. A more serious concern is that the system might actually have certain negative consequences in practice. If GP practices can move PCT, we can expect disparities in the size of PCTs that are even wider than those we described in the first section. We can expect well-performing PCTs to increase in size (as GP practices are attracted to join them), and poorly performing ones to contract (as GP practices leave). There is evidence to suggest that PCTs that are larger than the current average size (patient population of 100,000) struggle to maintain good working practices. Bojke *et al* cite evidence suggesting that the per capita cost of providing care is minimised with patient population sizes that are certainly no larger (and possibly smaller) than 100,000, and that managerial economies of scale are exhausted at levels considerably smaller than 100,000.<sup>44</sup>

Specifically on commissioning, the evidence on size of PCT is more complex. The minimum patient population required to effectively commission a service varies markedly according to the nature of the service – from a minimum of 50,000 for community nursing, to over 1 million for organ transplants. If the system we describe does create some PCTs that are considerably larger than the average size now seen, we can at least expect such organizations to be

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<sup>44</sup> Bojke *et al* (2001). There is some evidence from the US, however, suggesting that mergers between health maintenance organisations (which take the combined served populations to well above the 100,000 figure mentioned by Bojke *et al*) can allow the merging firms to achieve economies of scale that produce cost reductions (Town, Robert J. [2001] 'The Welfare Impact of HMO Mergers' *Journal of Health Economics* (20) 967-990.)

more effective commissioners of certain services.<sup>45</sup> However, it is also conceivable that when very large PCTs that purchase large volumes of services decide to switch provider, the financial blow to the provider might be very great (thus inviting the problem of ‘provider collapse’). In addition, many in the NHS are already concerned at the increase in the size of PCTs brought about as a result of mergers, since larger PCTs are less likely to be sensitive commissioners for local populations.

In response to this potential downside, we would make two points. Firstly, it is unlikely that the operation of our system would, in practice, bring about a significant inflation in the average size of PCTs. An inflation of this magnitude would only occur if large numbers of GP practices did actually move PCT. As we described in the previous section, the simple threat of GP practices leaving is likely to be sufficient for PCTs to take steps to improve their working practices. If PCTs did take these steps, GP practices would be unlikely to act on the threat and actually leave. As such, there is reason to think that a system that allowed GP practices the chance to switch PCT would not contribute to a significant inflation in the size of PCTs.

Secondly, even if *some* PCTs increased in size as a result of the system we propose, the main danger of this – PCTs becoming unresponsive to local needs – is offset by the fact that our system provides a powerful incentive for PCTs to continually strive to be responsive in this way. Unresponsive PCTs would rapidly alienate the GP practices they serve, and run the risk of losing those practices and the funds that they provide. The very same mechanism that allows PCTs to grow in size – allowing GP practices to switch PCT – also serves as a check on unresponsiveness.

Another possible downside of our system is that it might seem to constrain PCTs ability to engage in strategic planning, and to operate an effective public health programme (e.g. tackling health inequalities). If the patient groups covered by a PCT are continually changing due the movement of GP practices to and from the PCT, it might become much more difficult to perform

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<sup>45</sup> Ibid.

both these roles. In response to these points, we can again point out that both these problems are only likely to arise if significant numbers of GP practices do actually decide to switch PCT – as we described above, the simple threat of their being able to do so will make it unnecessary for many practices to actually make the switch. We might also point out that, under the existing PCT system, we are already seeing failings in strategic planning and public health measures. Both the Audit Commission<sup>46</sup> and CHI<sup>47</sup> have recently argued that both these tasks are not being carried out satisfactorily in many PCTs, since many are not routinely collecting the kind of data that would allow them to plan effectively or put in place appropriate public health initiatives. The reason for this might well be that PCTs were constructed over quite a short period of time, and provision for public health planning was not adequately planned for.

It would seem that the way forward here is adequate data collection, and the appropriate use of this data. Our system could incentivise these improvements in data collection and use, since GP practices will place great value on effective strategic planning and public health programmes when choosing a PCT. PCTs who fall behind in these areas might, under our system, lose practices to other PCTs.

It may well be the case, however, that even with these changes to data collection and use, PCTs might not be the appropriate agencies to conduct certain kinds of public health tasks. With these tasks, it might make better sense to shift responsibility to Strategic Health Authorities. A recent report by the Faculty of Public Health of the Royal College of Physicians has made a case for certain public health functions (especially those relating to managing equitable access to health and social care) to be conducted at SHA level. This report also claims that ‘public health practice at this level is strong, if under-resourced, and needs to be formally recognised as relevant and growing in importance.’<sup>48</sup>

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<sup>46</sup> Audit Commission (2004) *Information and data quality in the NHS*. London: Audit Commission

<sup>47</sup> CHI (2004)

<sup>48</sup> Gray S, Griffiths S, Jewell T *Public Health at Strategic Health Authorities: Implications of regional changes*. London: Faculty of Public Health

There is of course now yet another upheaval in primary care in the offing – the move towards practice based commissioning. From April 2005, GP practices that express an interest will be given ‘indicative budgets’ to engage in ‘commissioning services for their patients and local populations.’ Over time, we might reasonably expect that a lot of the commissioning decisions that are currently the province of PCTs will be taken on by GP practices within a PCT.

This might seem to diminish the need for our system, which is partly about incentivising PCTs to commission effectively. However, the shift towards practice based commissioning will not happen overnight. In the interim period, commissioning decisions will still be made by PCTs, and it is important that they are incentivised to this well. Our system provides such an incentive.

Moreover, as the Department of Health admits, even when practice based commissioning *is* up and running, PCTs will still play an important role in commissioning. They will be responsible for all contracts with secondary care providers. GP practices will be able to ask PCTs to ‘commission particular services on their behalf (“block back”)<sup>49</sup> There will also be a set of commissioning decisions – for specialist services that can only be effectively commissioned for large patient populations – that will be exclusively the preserve of PCTs. In summary, the Department of Health ‘anticipate[s] that some services will be commissioned by individual practices (even quite small ones), some by groups of practices, and some may still be commissioned by the PCT’.<sup>50</sup> Given that PCTs will continue to have a commissioning role even when practice based commissioning is in full swing (assuming that it will be taken up), there is still a need to incentivise effective commissioning from PCTs.

Finally, while highly important, commissioning is just one aspect of the work of PCTs. The system we set out above promises to encourage PCTs to improve *all* their working practices.

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<sup>49</sup> Department of Health (2004) *Practice Based Commissioning: Engaging Practices in Commissioning*

<sup>50</sup> *Ibid.*

In sum, practice based commissioning does not diminish the importance of allowing GP practices to choose PCT. We would argue that both systems could usefully augment one another. Practice based commissioning is an attempt to make PCTs more clinically led and driven, with the overall aim of improving the quality of the services that reach the patient. Our system has precisely the same aim. Even when practice based commissioning is fully operational – which will be quite some time – our system will continue to leverage improvements in the working practices of PCTs. While either system in isolation might not result in the substantive clinical leadership of PCTs that many deem to be desirable, both in combination would seem to constitute a fairly significant step towards this goal.

## **5) Conclusions**

Primary care has undergone several major upheavals in recent years – the GP fundholding system was superseded by the PCG structure put in place in 1999; in their turn, PCGs have now been entirely replaced by PCTs.

We welcome the new PCT structure – as we argue above, PCTs have very considerable powers to be a force in leveraging quality improvements across the NHS. However, there is evidence to suggest that PCTs are not using their powers optimally. This is especially true of the potentially most effective weapon in their arsenal – their commissioning powers.

It would be regrettable if the PCT structure was not given the best possible chance to succeed. The change we moot above – allowing GP practices to choose the PCT to which they wish to belong – could act as an important incentive to needle PCTs into developing effective and innovative commissioning practices. It can also, we argue, incentivise improvements in PCT working practices other than commissioning. This is a significant and substantial change to the existing primary care framework; but, crucially, it is

not yet another upheaval in a sector that has been the target for several major reforms in recent years.

The system we have described in this half of the paper allows GP practices to exercise a specific choice on *behalf* of their patients, in securing access to high quality, cost-effective services. When GP practices choose to join a particular PCT, they in effect ‘take their patients with them’ – all the patients on that practice list will now be receiving services commissioned and organised by that PCT. While GP practices are well placed to exercise this choice on behalf of their patients in a responsible manner, it nevertheless seems important to allow patients some say, rather than treating them as passive ‘lists’ of individuals who can be shunted from one PCT to another. One very powerful way in which patients could have this say is if they are free to choose which GP practice to join – freer than they are at present. We shall focus on this form of choice in the second half of the paper.

### **Patient Choice of GP Practice**

The current Government has declared a firm commitment to increase the range and type of choices open to individual patients throughout the NHS. Specifically in primary care, the Government seeks to retain the benefits of continuity of care manifested by the GP system, while at the same time opening up the range of choices allowed to patients at the primary care level. There are four main elements to the Government’s choice agenda for primary care:

- i) a commitment to increase capacity in primary care, focusing initially on those areas where patients have the greatest difficulty in accessing GP care;
- ii) a commitment to ‘develop a wider range of primary care providers, offering a wider range of services’;<sup>51</sup>

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<sup>51</sup> Department of Health (2003) *Building on the Best: Choice, Responsiveness and Equity in the NHS*, p28

- iii) a commitment to make it easier for patients to access primary care when away from home, including the scope to relax some practice registration requirements;
- iv) a commitment to promote easier access to diagnostic services, and provide better support to patients with chronic conditions, in the primary care setting.

In terms of capacity, the Government claims they are on track to deliver the NHS Plan target of 2000 more GPs, and also claim that spending on primary care will rise by 33% from 2002-3 to 2005-6. In terms of developing 'a wider range of primary care providers and services', the government claims PCTs are to be encouraged to develop new services: 'polyclinics' offering the full range of general practice and specialist services; nurse-led clinics; and even 'private providers treating NHS patients within a framework that ensures value for money and safeguards the interests of the NHS.'<sup>52</sup>

As well as expansions in 'traditional general practice', the Government claims a willingness to extend the remit of less 'traditional' providers of primary care, e.g. NHS Direct, Walk-In centres (of which there are now 42, attracting some 4 million attendees since 2000), telephone and email consultations and other virtual techniques, a wider range of complementary services (physiotherapy, psychotherapy, etc.), and pharmacy-based chronic disease monitoring (e.g. for asthma, high blood pressure, etc).<sup>53</sup>

Perhaps the most salient changes in terms of extending meaningful choice at the primary care level concern two mooted (not definite) changes to GP registration rules. It has been suggested that there might be benefits in allowing working patients to register with two practices – one close to their workplace, which serves them during working hours, and another close to

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<sup>52</sup> Ibid. p29

<sup>53</sup> Ibid. p30

home (which serves at all other times). Even more intriguing is this suggestion:

‘[I]t has sometimes been felt that practices choose which patients register with them, rather than the other way round. We will consult on amending the regulations. We want to ensure that patients can register with their preferred surgery unless, of course, the practice has agreed with its primary care trust that its patient list is already full.’<sup>54</sup>

Of course, patients have always had, in theory at least, a limited choice of which GP practice to join – if they were lucky enough to live in the overlap between the catchment areas of two or more practices which also happen to have space on their practice lists, they could choose the practice with which they wished to register.

Clearly, this is a fairly limited form of choice – for many patients, choice of GP practice is currently not possible. Many patients will not live in the overlap between two or more practices’ catchment areas, especially those patients who do not live in densely populated areas. Moreover, many of those patients who *do* live in such overlaps will encounter closed lists at many of the GP practices with which they are formally able to register. A recent IPPR report has found that many people still find it difficult to enrol with a practice in their area.<sup>55</sup>

Why should we allow this to be the case? The GP practice catchment area dates back to a time when it was assumed that most patients would need to be able to walk to the surgery, and when it was assumed that doctors would be making a lot of home visits. Both these assumptions no longer apply. Most patients can use public or private transport in accessing a GP surgery. Doctors make nowhere near the number of home visits they did at the inception of the NHS, though they do still routinely make such visits in the case of terminal illness. (It must be remembered, however, that primary care

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<sup>54</sup> Ibid. p31

<sup>55</sup> Deborah Roche (2004) *PCTs: An unfinished agenda* (London: IPPR)

clinicians other than GPs – such as district nurses – also routinely make home visits.) If much of the rationale behind the creation of the GP practice catchment area no longer applies, we ought not to feel obliged to maintain this system.

Leaving aside the possible redundancy of the reasoning behind the catchment area system of GP registration, we want in this half of the paper to consider what *positive* reasons there might be for allowing individual patients a much freer choice than they have at the moment over which GP practice to join. In section one, we will set out these reasons. In the second section, we consider the kinds of preconditions that must be in place in order to facilitate this kind of patient choice.

In section three, we consider the ways in which patient choice of GP practice ought to be managed to offset certain potential problems. In the fourth section, we turn to the crucial question of the *scope* of patient choice of GP practice – should patients be allowed to choose a practice from any PCT, or only from the PCT within whose boundaries they currently reside?

In section five, we outline some possible changes to the way in which GPs are remunerated, and we will link these alternative forms of remuneration to some of the ideas on patient choice of GP practice described in the previous sections.

In the sixth and final section, we will discuss gatekeeping in the primary care context, and question the accepted wisdom that only GPs are fit to act as gatekeepers. Again, we will link our ideas to the overarching theme of patient choice.

### **1) What are the benefits of allowing patients to choose GP practice?**

One powerful reason for allowing patients this kind of choice is that, if properly managed, it could function as a lever to improve the quality of care provided

by GPs. In the first half of this paper, we argued that allowing GP practices to choose PCT can incentivise PCTs to improve their working practices. The incentive is financial in nature – since PCTs are funded according to how many patients they serve, they have a financial interest in making themselves as attractive as possible to GP practices. The same financial incentive could apply to GP practices if patients were allowed to choose the practice with which they wish to register. Although the new General Medical Services Contract offers rewards to GP practices for ‘delivering clinical and organisational quality’, funding for GP practices will still largely be done under a system of capitation.<sup>56</sup> So, even under the new GMS contract the amount of funding a GP practice receives is still largely a function of the number of patients (adjusted for projected medical needs) on its register. Allowing patients a free choice of which GP practice to join could, given the current capitation-based model of practice funding, provide GP practices with a considerable financial incentive to make themselves as attractive as possible to patients.

Moreover, patient choice of GP practice could usefully *augment* the system of allowing GP practices to choose PCT we set out above. We concluded the first half of this paper by pointing out that giving patients a freer choice of GP practice could be an important way of empowering patients who could otherwise be passively shunted from PCT to PCT as a result of decisions made by their GP practice. There is, however, an additional way in which giving patients a freer choice over which GP practice to join could augment the system of allowing GP practices to choose PCT. While this latter system could incentivise PCTs to improve their working practices, it could be argued that it also functions as a *disincentive* for GP practices to improve *their* working practices. If sanctions levied by the PCT are one of the main ways of ensuring the quality of GP care, allowing GP practices to move around

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<sup>56</sup> ‘The new Carr-Hill allocation formula will provide equity, recognise casemix and practice circumstances, and ensure money will flow according to patient need. The particular needs of patients will be taken into account when calculating the amount each practice receives in its global sum allocation to provide a range of essential and additional services.’ Department of Health (2003) *Investing in General Practice: The New General Medical Services Contract* (section 1.22).

different PCTs could potentially serve to weaken this form of accountability.<sup>57</sup> However, if individual patients were allowed to choose the GP practice to which they wished to belong, a powerful incentive 'from below' would be exerted on GP practices. Thus, we could preserve the advantages of the system whereby GP practices choose PCT (i.e. PCTs are incentivised to improve their working practices), while offsetting the potential weakening in accountability caused by that system, by giving individual patients choice of GP practice.

As a final positive reason for allowing patients to choose GP practice, it is surely undeniable that this choice would be welcomed by patients. Earlier this year, the Audit Commission reported that many patients still experience difficulties in accessing their GP (due to difficulty in getting through on the telephone to make an appointment, or long waits to see a GP, or difficulties with practices' opening times).<sup>58</sup> Many patients find it inconvenient to register with a GP close to their place of residence - because they spend much of the week at their workplace, for example. Allowing patients to register with a practice that has efficient appointment booking systems, short waits to see a GP, convenient opening hours, or which is considered geographically convenient by the patient (perhaps one close to work, or one that is equidistant between work and home) would come as a considerable boon to many.

Moreover, ease of access to primary care is not only good for the patient – it is good for the health care system as a whole. If we made it easier for those patients currently facing access problems to register with a GP, it seems reasonable to assume they will be more likely to seek prompt treatment for medical conditions as and when they arise. This could conceivably reduce the higher 'downstream' costs that often accrue when patients put off visiting their

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<sup>57</sup> Of course, PCTs might refuse to take on very poorly performing GP practices – we do not argue that PCTs are *obliged* to accept all applications for membership. Nevertheless, it seems reasonable to assume that the financial gain that would be made from taking on a new GP practice will motivate at least some PCTs to accept application requests from even poorly performing practices.

<sup>58</sup> Audit Commission (2004a) *Transforming primary care: The role of primary care trusts in shaping and supporting general practice*.

GP, and simple conditions that are cheap to treat become complex ones demanding more expensive treatment.

Ease of access is not, of course, the only reason why patients might select a particular GP practice. Another reason is if that practice has an expertise in dealing with specific medical conditions. Under a system of free movement of patients around the primary care system, we could reasonably expect certain GP practices to specialise in the management of certain conditions, especially common chronic conditions that can be well managed in a primary care setting (such as diabetes and high blood pressure).<sup>59</sup> The recent NHS Improvement Plan recognises the benefits of providing chronic care ‘in a community setting’.<sup>60</sup> Patient choice of GP practice could provide the incentive for practices to become responsive in this way.

We can expect the shift towards practice based commissioning to further facilitate this kind of practice specialisation. The Department of Health hopes that via practice based commissioning ‘practices will be able to secure a wider range of services, more responsive to patient needs and from which patients can choose.’<sup>61</sup> Practice based commissioning gives individual GP practices the financial resources to tailor their services. The plurality of different kinds of GP practice will make choice of GP practice a meaningful experience. Moreover, to *not* allow patients choice of GP practice in an era when practices now have the financial wherewithal to tailor their services in various ways is to condemn certain patients to practices that might not best meet their needs. Patient choice of GP practice is not only rendered meaningful by practice based commissioning; it is a necessary counterpoint to the latter initiative.

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<sup>59</sup> Given that many chronic medical conditions are relatively expensive to treat, the way in which GPs are remunerated requires careful attention. Under a simple capitation system (or one that was only crudely adjusted for casemix and projected needs), the free movement of patients around the system might *not* incentivise GP practices to specialise in treating these chronic conditions – why make yourself attractive to expensive patients, when you could make yourself attractive to young, fit, healthy ones? We will have more to say about the way in which GPs are remunerated in section two below.

<sup>60</sup> Department of Health (2004) *The NHS Improvement Plan: Putting People at the Heart of Public Services*.

<sup>61</sup> Department of Health (2004) *Practice Based Commissioning: Engaging Practices in Commissioning*.

Another reason patients might have for choosing a particular practice could be that the doctors in that practice are especially skilled at communicating with specific patient groups (e.g. minority ethnic groups). A recent European wide survey suggested that patients placed communication skills high up the list of desirable traits in a family doctor.<sup>62</sup> Allowing patients to choose the GP practice to which they wish to belong makes it more likely they will establish a relationship with a GP with whom they can interact well. Not only will this be of value to the patient, it could again be argued that this would also prove valuable to the health system as a whole. Good communication between doctor and patient is important in allowing patients to accurately convey their symptoms (which is important for accurate diagnosis), and in ensuring patients understand medical advice (thus aiding compliance with treatment).

Furthermore, good communication at the primary care level would seem to be essential if the Government's choice agenda for secondary care is to succeed. Patients will only be able to make informed choices about secondary care providers if they are armed with the appropriate information, and GPs have been identified as key players in providing this information. The better the communicative relationship between GP and patient, the better this information will be conveyed.

## **2) Facilitating patient choice of GP practice**

For patient choice of GP practice to be meaningful, certain changes would have to take place. Most importantly, patients would require access to accurate information regarding the quality of the services offered by GP practices. Currently, such detailed information is not readily available to patients. Moreover, given the managerial and IT constraints facing PCTs we described in the first half of this paper, it is doubtful whether detailed information about the quality of individual GP practices is even routinely collected. The CHI report of 2004 into the working practices of PCTs found that as many as 75% of patients in some PCTs did not receive adequate

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<sup>62</sup> The study is cited in Richards T (1999) Patient's Priorities. *BMJ* 318: p257

information regarding local health services.<sup>63</sup> This report also found that people from minority ethnic backgrounds were especially poorly served – in some PCTs, staff were not aware of translation facilities, in others these services were simply not available at practice level, and in still others demand greatly outstrips supply. Moreover, problems of information provision are not new – they seem to be ongoing. A *Which?* study from 1996 suggests that the sort of information about GPs and GP practices formally guaranteed to patients under the Patient’s Charter is not always easily obtainable in practice.<sup>64</sup>

Given this rather bleak picture, we would seem to be some way off a situation where individual patients, armed with the relevant information, could make an informed decision between several different GP practices. The newly established patient and public involvement forums (which can inspect NHS premises and seek patients’ views) might be a useful place to start in collating the kind of information required to support meaningful patient choice of GP practice.

### **3) Managing the system**

Clearly, the system of allowing patients to choose their GP practice ought to be carefully managed. One possible danger to be guarded against is the phenomenon of ‘doctor hopping’ – where patients who are determined to receive a particular treatment, or who would like second opinions (or third or fourth...) on a particular problem, can simply hop from one practice to another until satisfied. As well as inflating costs, ‘doctor hopping’ could also undermine one of the supposed key virtues of the NHS primary care system – continuity of care. GPs will find it much more difficult to build up the kind of intimate knowledge of patients that can only come over a period of time, and will find it harder to organise packages of integrated care for patients.

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<sup>63</sup> CHI (2004)

<sup>64</sup> The good GP guide. *Which Magazine* September 1996, pp8-13.

However, it could be countered that the phenomenon of ‘doctor hopping’ is unlikely to be widespread. Most individuals know the value of sticking with a particular GP. Moreover, when individuals find a GP they like and trust, they are usually reluctant to change (many patients in multi-partner practices will wait longer for an appointment with the particular GP with whom they usually consult). The virtue of allowing patients a free choice of GP practice is that they are more likely to *find* a GP with whom they interact well – when they have done so, they are likely to stay put.

A potentially more grave problem is that allowing patients the freedom to switch GP practice could cause a shift away from clinical priorities – if, for example, patients with less serious medical conditions demand immediate and possibly costly treatment on threat of moving to another practice. Many GPs might relent in the face of this financial threat, to the detriment of those patients with more serious conditions. The way to manage this problem is not, however, to simply give up on the idea of allowing patients choice of GP practice. This system is, of course, partly premised on the idea of GPs responding to the threat of patient exit by changing their working practices in various ways. A *well-managed* system will ensure that they change their working practices in ways that broadly reflect clinical priorities. Thus, no GP practice should be *allowed* to acquiesce to patient demands that are deemed unreasonable. Careful usage of National Service Frameworks, which specify the appropriate treatment pathways for various diseases, should ensure that unreasonable requests will not be met by any GP practice. As such, patients will have little incentive to switch practice in search of treatment that is not mandated by a National Service Framework. In addition, it might be possible to put in place a system of financial penalties for those GP practices who do breach National Service Frameworks. More sensitive forms of fee-for-service might be one way of doing so. We shall return to the issue of fee-for-service in section five below.

Finally, it is imperative to manage carefully any system of patient choice of GP practice to avoid the problem of inequitable access. Under a poorly managed system of this form, it might be possible for the best informed, most confident,

best connected patients, who have the best access to transport, to monopolise the highest quality GP practices. This would leave comparably less well informed, less confident patients, who have less access to transport, with the lower quality practices. Not only is this inequitable, it is irrational – many of the patients in the latter group will be the sickest and most in need of high quality medical care.

To avoid these problems, certain steps must be taken. The information we described in the previous section, which allows patients to make an informed choice of GP practice, must be made available to all patients – not merely the most confident and articulate. For less confident and articulate groups, forms of information provision that are sensitive to their needs (e.g. patient advisers) might well be more appropriate). Transport facilities must be provided to all patients who need them, to enable easy travel to the practice of their choice. We have more to say about transport in the following section.

It might also be possible to avoid inequities in access by adopting more sensitive forms of capitation to remunerate GPs appropriately for accepting specific kinds of patients on their lists. As we have claimed, it is reasonable to think that the patients who would be left behind in a poorly managed system of patient choice of GP practice will be among the sickest and the most vulnerable (the elderly, the homeless, those in long-term residential care, etc.). It is possible to attach greater financial value to these patients under a sensitive capitation system. Were this to be done, GP practices would be incentivised to attract these patients, and positive steps would be taken to ensure they were not left behind. We shall have more to say about the way GP practices are remunerated in section five below.

Finally, it should be pointed out that the existing system – where patients have only the limited kind of choice of GP practice we describe above – has not, historically, served patients from vulnerable groups particularly well. The two changes we moot in this paper – giving GP practices choice of PCT, and patients choice of GP practice – are designed to turn around a historical culture of unresponsiveness. If the changes are managed appropriately in the

ways we suggest, it is conceivable that all patients – including those in the most vulnerable groups – could benefit from higher quality, more responsive services.

#### **4) The scope of patient choice of GP practice**

We might wonder about the scope of patient choice of GP practice – should patients be restricted to choosing GP practices from within a particular PCT (say, for example, the PCT within which their current GP practice is located), or ought they to be able to choose any GP practice from any PCT? The latter option would, in effect, give patients a choice over which PCT to join. There may well be benefits in allowing the latter kind of choice. The decisions of a PCT affect the quality of care that is provided by GP practices throughout the PCT. Patients are subject to these PCT decisions – a particular PCT might have a poor track record in commissioning the specific kinds of medical services required by particular patient groups, for example. In situations such as these, choice of GP practice within a specific PCT might be worth very little to patients. Allowing patients to, in effect, choose a PCT – by allowing patients to register with a GP practice in any PCT – would clearly be valued by many patients.

Of course, we have already intimated a reason why it might seem important to allow patients to in effect choose PCT by being able to choose a GP practice in whichever PCT they choose. In the system we outline in the first half of this paper, GP practices are empowered to choose the PCT to which they wish to belong. A choice by a GP practice to switch PCT is, in effect, to impose the choice upon all the patients on that practice's list - the incentive structure in this system only works if patients, and therefore funds, follow the choices of GP practices. However, some patients on that practice's list may not be happy with the switch of PCT – perhaps the new PCT is not effective at commissioning the specific kinds of medical services they require. It seems important that, notwithstanding the advantages of the system of allowing GP practices to choose PCT, patients should not be completely beholden to the choices made by their GP practice. As well as being able to make their views

heard regarding any potential switch of PCT by their GP practice, patients must reserve the right to veto decisions made by their practice to join a different PCT. Giving patients the freedom to choose GP practices in any PCT would be an effective way to ensure they are not beholden to relocation decisions made by the practice with which they are currently registered.

Just as in the case of patients choosing GP practices, patients will only be able to make an informed choice between PCTs if they can access information about the relative merits of different PCTs. Unlike with individual GP practices, data *is* routinely collected on the working practices of PCTs. There is, however, a challenge in rendering this data into a form that is accessible to the public (the rather crude 'star' system may not be the best format), but this is surely not an insurmountable problem.

Geography might well limit patient choice of PCT. A patient may want to choose a GP practice in a PCT that has a good track record in commissioning the particular kinds of services he requires, but that PCT (and the hospitals from which it commissions secondary care) might be many miles from the patient's home. We can expect the NHS to pay reasonable travel expenses – just as it currently does for many patients. Furthermore, it is important that relevant transport is made available to all in society who need it – especially the vulnerable groups we discussed in the previous section. However, there may have to be a cap on the amount paid to each individual under a system of individual patient choice of PCT. In the absence of such a cap, costs could spiral alarmingly.

Similarly, a patient registering with a GP practice far from his or her home poses certain challenges as regards the provision of care *in* the patient's home – home visits from GPs (both in and out of hours), visits from district nurses, etc. PCTs and GP practices might be unwilling to bear the burden of the extra costs that would be levied by making home visits to patients who live far away. In practice, however, this may not be as serious a problem as it seems. Most patients are unlikely to register with practices that are prohibitively far from their own homes, especially if (as we moot above) there

is a ceiling above which the NHS will not reimburse travel expenses. It is reasonable to expect, therefore, that the bulk of the patients on a GP's practice list will still live within a reasonable distance. Moreover, the current shift towards practice based commissioning will allow GP practices to be flexible and imaginative in how they provide home visits. Instead of providing these from the practice itself, it might be possible for practices to commission home visits from a practice that is geographically closer to the homes of patients who live far away. The recent Department of Health guidance on quality requirements in the delivery of out-of-hours services gives GP practices and PCTs a measure of flexibility in how they commission these services, providing only that basic quality standards are met.<sup>65</sup> Given this precedent, it would seem there is nothing to stop GP practices being equally flexible in how they commission other types of home care.

## **5) Patient choice and GP remuneration**

Increasingly, PCTs are switching to a 'payment by results' format. In 2003/4, PCTs began to introduce cost and volume service agreements, which reflect actual work done (with increases or reductions in activity charged at full, not marginal, cost). These agreements are expected to spread in 2004/5 to include all work commissioned from Foundation Trusts.

GPs however, as we described above, are still mainly remunerated according to a capitation system – albeit, a newly modified and increasingly sensitive one. The new General Medical Services contract states that GP practices will be funded according to a modified version of the Carr-Hill resource allocation formula. This formula takes into account the age and gender of the population (including patients in nursing and residential homes). It also adjusts for additional morbidity and mortality related needs, list turnover, and certain unavoidable costs of delivering services to certain populations (e.g. in rural locations).<sup>66</sup>

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<sup>65</sup> Department of Health (2004). *National Quality Requirements in the Delivery of Out-of-Hours Services*.

<sup>66</sup> [http://www.nhsconfed.webhoster.co.uk/docs/Annex\\_D\\_Car\\_Hill.doc](http://www.nhsconfed.webhoster.co.uk/docs/Annex_D_Car_Hill.doc)

It might be thought that, in order for the financial incentives in the system of patient choice of GP practice to operate, we will need to stick to capitation forms of remuneration. In other words, in order for the free movement of patients around different GP practices to function as a financial incentive to those practices, an amount of money must follow the patient. This is certainly true, and it might seem that some kind of capitation system is the simplest way to ensure that funds follow patients around the system. However, as we intimated above, under a system whereby patients can choose GP practice it is even more crucial that any kind of capitation system is appropriately sensitive to the relative costliness of individual patients (i.e. the amount of health care they are likely to consume). If the system is not sufficiently sensitive in this way, we might find that GP practices – who are now, in effect, competing for patients - will be unwilling to make themselves attractive to those patients with complex medical conditions who are likely to consume the most health care, including patients in the vulnerable groups we identify above.

Conversely, if we take care to make the capitation system sensitive, it might be possible under a system of patient choice of GP practice to lever an improvement in primary care services for these patients with complex and costly medical conditions (who are usually chronically ill). If a way were to be found to pay GPs fairly and sensitively for providing treatments to these patients, they might be positively incentivised to provide the relevant care. If GPs know they would be properly remunerated for providing the costly care required by those patients with complex conditions, then, under a system where patients choose GP practice, we could expect a certain proportion of practices to expend effort on perfecting systems for the efficient provision of the relevant care. These GP practices would actively be seeking to make themselves attractive to patients with complex conditions, knowing that they would be properly remunerated for providing the costly care these patients require. Of course, even under such a sensitive system of remuneration it might still be the case that no practices in a given PCT will choose to specialize in providing care to these patients. This is a further reason why

patient choice of GP practice should not be restricted to the practices in one PCT - they should be allowed to choose any practice in any PCT.

It *might* be possible to formulate a sufficiently sensitive capitation system. Certainly, the aforementioned newly modified Carr-Hill formula shows a willingness on behalf of the Department of Health to move towards increasingly sensitive forms of capitation. Nevertheless, the complexity involved in developing more and more sensitive forms of capitation has been well documented.<sup>67</sup> It might be simpler to move to a mixed system of GP remuneration, which retains aspects of capitation, but also has elements of payment-for-service. Thus, we might adopt a sophisticated capitation system (like the modified Carr-Hill system), which ensures GP practices are appropriately remunerated for accepting patients with complex and costly medical conditions, and also allow payments to be made to GP practices according to how many 'units' of a given treatment they prescribe. In this way, some of the inevitable crudities and simplifications of the capitation system (no such system will ever be perfectly sensitive) can be compensated for. In addition, by choosing the particular services for which we wish to remunerate on a payment-for-service basis, it might be possible to bring about efficiencies in the way these services are provided. Of course, the tightrope that has to be walked in any system of payment-by-service is to ensure that GP practices are not thereby encouraged to *over-supply* the service in question.<sup>68</sup>

Payment-for-service systems must include robust post-payment checks and audit, to ensure that demand for services is genuine and not artificially stimulated by providers. However, with effective checks and auditing procedures, it is possible to encourage GPs to efficiently provide certain treatments without thereby encouraging them to over-provide. A good general rule of thumb might be to restrict fee-for-service to those areas currently marked by under-provision, and to use a sensitive capitation system to

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<sup>67</sup> See for example Van Barneveld, E.M., L.M. Lamers, RCJA van Vliet, WPMM van de Ven "Risk sharing as a supplement to imperfect capitation: a tradeoff between selection and efficiency." *Journal of Health Economics* 2001, 20(2): 147-168.

<sup>68</sup> Graham Rich, chief executive of West Hull PCT, told me in a personal communication that in 1991 when GPs in his area were paid per night visit performed, they artificially stimulated demand for these services by actively encouraging patients they saw during the day to call during the night if they had any further problems.

remunerate for providing services for which there is a high risk of over-provision.

There will never be a perfect system of GP remuneration – but there are degrees of imperfection. The mixed system we propose here, which has elements of sensitive capitation and payment-for-service, would seem to avoid some of the major pitfalls of other systems. Moreover, there may well be a political will at the moment to switch to something like this mixed system. The new GMS contract suggests a willingness on the part of the Department of Health to shift to a mixed remuneration system. Certainly, capitation (under the Carr-Hill formula) is at the heart of the new system. However, the contract states that practices will also

*'have the opportunity to receive additional funding to support aspiration and achievement of a range of quality standards. The new quality framework will reward practices for delivering quality care with extra incentives to encourage even higher standards.'*<sup>69</sup>

The types of standards in question are both clinical and organisational. The clinical standards pertain to many common conditions, including coronary heart disease, stroke, high blood pressure, diabetes, asthma, and mental health. The organisational standards pertain to patient records, information provision to patients, education and training, practice management, and medicines management.

Moreover, the new GMS contract states that while all practices will be expected to provide what are deemed to be 'essential services', practices 'will also provide a range of additional services and have the opportunity to increase their income further through opting in to the provision of a wider range of services.'<sup>70</sup> We welcome these incentives to encourage diversity in the range of services provided by GP practices, since it would make the range

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<sup>69</sup> Department of Health (2003) *Investing in General Practice: The New General Medical Services Contract* (section 1.8).

<sup>70</sup> Department of Health (2003) *Investing in General Practice: The New General Medical Services Contract* (section 1.3).

of choices open to patients under a system where they could choose their GP practice all the richer.

## **6) Patient choice and the GP 'gatekeeping role'**

All patients seeking non-emergency NHS care are expected in the first instance to contact the general practitioner with whom they are registered. Access to secondary care is largely controlled by GP 'gatekeepers' – more than 90% of NHS treatment episodes begin in primary care.

This system of GP gatekeeping is often admired by other countries for its apparent efficacy in containing costs. Gatekeeping seems to be an effective way of dealing with the fundamental asymmetry of information in health care distribution. Individual patients are often uncertain about the causes and nature of their medical problems, about the types of treatment they might require, and about how best to access these treatments. By functioning as 'patient navigators', GPs help overcome this asymmetry and produce a more efficient allocation of health care resources.

Under a system of expanded patient choice, the GP gatekeeping role takes on even more importance. Not only are GPs expected to be an important source of information for patients regarding what *sort* of care (either primary or secondary) is most appropriate for them, they are also now expected to be an important source of information regarding *where* to be treated. In the recent Choice Pilots, specially appointed patient care advisers (PCAs) were on hand to help patients choose an alternative provider of the secondary care on which they had been waiting.<sup>71</sup> These PCAs were generally considered to be a success, with many patients lauding the help they had received in making a choice of provider. As the choice initiative unfolds, and more and more patients are to be offered an increasing range of choices, we can expect the numbers of PCAs (or similar advisers) to grow. However, it would be foolish to not use GPs as an important source of information for patients

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<sup>71</sup> <http://www.nhs.uk/nhsmagazine/primarycare/archives/nov2002/feature5.asp>

facing an expanded range of choices. GPs not only have a wealth of accumulated knowledge about treatment options (and the relative strengths and weaknesses of different local providers of these treatments), but are also uniquely placed to use their knowledge of a patient's particular health profile and medical history to provide exactly the right kinds of tailored information needed to make informed choices. For the specific kind of choice we recommend in this half of the paper – patient choice of GP practice – GPs could clearly be of use in providing information about other GP practices and (since we moot giving patients the choice of any practice in any PCT) information about other PCTs.

There might be some question about the objectivity of the information provided by GPs (if they have an interest either in keeping a particular patient on their practice list, or an interest in having that patient move on). However, most GPs will invariably place central importance on their patient's best interests, and will advise patients accordingly. GPs are too rich a source of information for them not to be used in this way. Most crucially, this is what patients *want* – in a recent BUPA/MORI survey, more than 80% of respondents claimed that they would prefer to make choices in close collaboration with a GP.<sup>72</sup>

However, in asking GPs to take on this expanded role of information provider, we must recognise that we are asking them to take on extra work that might prove fairly time consuming. A recent CHI report found that many GP practices report difficulties in developing appropriate ways to get patients and the public involved in managing their own health, and many practices expressed a desire for their PCT to provide the extra time, support, and funding that might be required to make this possible.<sup>73</sup> Given this, it is unlikely that many GPs would have the time to aid patients in making the kinds of choices we moot in this paper. Furthermore, given that we are allowing patients the chance to choose a GP practice that meets their particular needs (e.g. one that is conveniently located, or that specialises in the management

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<sup>72</sup> [www.mori.com](http://www.mori.com)

<sup>73</sup> CHI (2004)

of their particular medical conditions) we might reasonably expect attendance rates at GP surgeries to rise. This will make it even less likely that GPs will be able to find the extra time in the working day required for them to take on this expanded role of information provider.

One possible solution to this problem is to encourage primary care clinicians other than GPs – practice nurses, for example – to perform a gatekeeping role. The recent CHI report into the workings of PCTs argues that an NHS committed to reform and modernisation should be willing to look at novel ways to utilise available skills and resources more effectively ‘by allowing nurses and therapists, highly skilled professionals, to prescribe medicines.’ If these highly skilled professionals are to be encouraged to prescribe medicines (which involves making decisions about the nature and severity of a patient’s symptoms), they could also perform a gatekeeping role (which also involves making these kinds of decisions about symptoms). This gatekeeping role can take several forms. Firstly, it could take the form of gatekeeping access to GPs. Thus, instead of GPs – the most highly trained and expensive members of GP practice – being used right at the front of the organisation, practice nurses could be used to gatekeep access to GPs. Some GP practices already operate this system, and it has generally been well received by both patients and staff. A recent Audit Commission report found that GP practices that used nurses in this way halved the time that patients waited to see a GP.<sup>74</sup> Clearly, efficiencies can be wrought by using non-GP staff to gatekeep access to GPs. The saved GP time could be used in a number of ways – including the provision of information to those patients thinking of making various kinds of choices.

Of course, not all patients will be happy to consult with primary care clinicians other than GPs. The Audit Commission report suggests that this is especially likely for patients who are experiencing an ongoing medical problem – these patients generally want to see the GP with whom they usually consult. Nevertheless, the report suggests that patients reporting with a one-off

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<sup>74</sup> Audit Commission (2002) *A Focus on General Practice in England: July 2002*

problem are quite likely to accept a consultation in the first instance with a clinician other than a GP, even if this means they do not subsequently get 'referred' to see a GP. The success of NHS Direct – a nurse-led telephone advice service that has seen a growth in annual calls from 1.7 million in 2000 to 6.4 million in 2004 – gives a clear indication that many patients are comfortable making first contact with clinicians other than GPs.<sup>75</sup>

The second kind of gatekeeping role that could be played by primary care clinicians other than GPs is more controversial. As we described above, GPs have traditionally acted as gatekeepers to most forms of secondary care. However, if 'highly skilled professionals' other than GPs are to be allowed to do some prescribing, and are currently being used in some practices to gatekeep access to GPs, why not allow these professionals to gatekeep access to secondary care? There would seem to be more drawbacks here, however. Although many non-GP gatekeepers would make appropriate referral decisions, and would only refer those patients who genuinely do need to see a specialist, there is a danger that over-cautiousness would be more common amongst these professionals than in GPs – they would, in other words, be more likely to err on the side of caution and refer more patients to specialists than would GPs. This would result in an increase in the workloads of many secondary care providers. Obviously, the problem of over-cautiousness does not apply to the first kind of gatekeeping – it would be impossible for this form of gatekeeping to result in an *increase* in GPs' workload, since all the patients seen initially by non-GP clinicians would have accessed the GP directly under the old system. It might be best if, rather than giving non-GP gatekeepers the power to refer patients directly to secondary care providers, they could 'fast-track' patients whom they suspect ought to see a specialist to receive an urgent GP consultation. The GPs could then double-check the suspicions of the non-GP gatekeeper, and we could expect a more appropriate usage of secondary care resources.

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<sup>75</sup> Department of Health (2004) *The NHS Improvement Plan: Putting People at the Heart of Public Services*. HMOs in the US have a relatively long history of using nurse practitioners to triage care. The Massachusetts based 'Health Dialog' organisation even provides patients with 24-hour access to 'health coaches', who are clinically trained (but are not doctors). Patients report high levels of satisfaction with this system. (<http://www.healthdialog.com>)

## **7) Conclusions**

In this second half of the paper, we hope to have achieved several things. We hope to have shown that individual patient choice of GP practice can, if managed correctly, act as an incentive to improve the quality of primary care services (as well as improving the experience of primary care for many patients). We also hope to have shown how allowing patients this kind of choice can usefully augment the system of GP choice of PCT we set out in the first half of the paper.

Allowing patients choices of any kinds within the NHS demands certain preconditions. Provision of information is often cited as one such precondition, with good reason. We set out the specific kinds of information patients will need to make a meaningful choice of GP practice, but we also draw attention to certain other preconditions that must be in place – most importantly, we suggest certain changes to the way in which GPs are remunerated. We hope to have shown that an appropriately sensitive remuneration system (which may have to encapsulate elements of both capitation and payment-for-service) is essential in ensuring that patient choice of GP practice results in a diversity of services rather than a truncation of those services which are most complex and costly to provide.

Finally, we hope to have constructively cast some doubt on the accepted wisdom that only GPs are fit to perform a gatekeeping role. We suggest that other primary care clinicians (such as practice nurses) can gatekeep access to GPs, which could usefully serve to free up GP time for other purposes – including the purpose of providing tailored information to patients newly empowered to make a range of choices.

## Overall Conclusions:

### The importance of choice in primary care

The central objective of any kind of reform of the working practices of the NHS should be to improve the care received by patients. The topic of introducing 'choice' into the NHS has provoked such heated and often ideological exchanges that it is often forgotten that the debate ought to be structured around one simple question: What effects will the introduction of greater choice have on the quality of care that patients receive? With this guiding question, the costs and benefits of different forms of choice ought to be calmly evaluated. Not only is ideology unwelcome, it is not even *required* - we all ought to agree that the guiding evaluative principle is the improvement of patient care.

This kind of appraisal has been our aim in the present paper. Primary care has undergone some fairly significant changes over the past 15 years or so. GP Fundholding has come and went. PCGs were created. Finally, PCTs have emerged across the country. In this paper, we moot two further fairly substantial changes. Some feel that NHS primary care has been 'over-reformed' in recent years, and if further reform is to be undertaken there had better be a good reason for doing so.

We have argued that we ought to give serious consideration to the two forms of choice set out here not because 'choice' is somehow intrinsically good, or for any rarefied ideological reasons. Rather, these forms of choice can function in combination as a powerful catalyst for driving up the quality of the care received by patients. There will undoubtedly be work involved in implementing these choices – in providing the preconditions we describe above, and in managing the systems in the way we have taken pains to specify. In a sector already burdened with a heavy reform agenda, we face a challenge to instil the appetite to undertake this further work. But the changes we propose here – which are substantial, to be sure – are not major upheavals. However primary care develops in the future, the benefits that can be wrought by allowing the sorts of choices we moot in this paper – chiefly,

the benefit of incentivising providers to strive continually to improve their working practices – will never cease to be relevant.