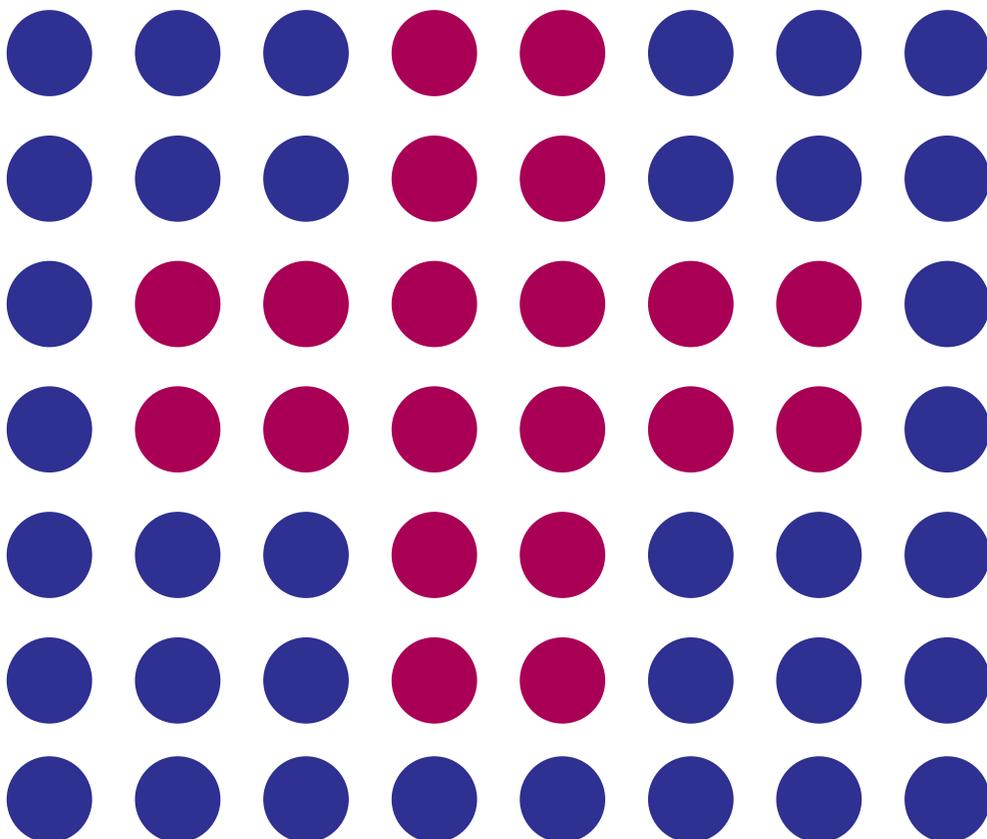


Registering choice: how primary care should change to meet patient needs

Professor Paul Corrigan



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Foreword

No one would argue how important primary care is in informing our experience of the NHS. Around 90% of our health care treatment takes place outside hospitals - making our GP both the "gatekeeper" to the NHS and also, for the majority of us, the only contact we have with the health service. Being able to choose our GP, therefore, is a crucial element of the Government's NHS reform, which is driven by the twin goals of improving patient choice and equity of access.

It is hardly surprising, then, that the Social Market Foundation has placed the improvement of choice in primary care at the heart of its choice research project alongside choice in secondary education. Its recent publication *Making choice a reality in secondary education* acted as a useful benchmark for the Government's own ideas for school reform, published as it was just before the Education White Paper in October. Similarly, this report creates a unique backdrop for the Government forthcoming health White Paper, *Healthcare Outside Hospitals*, which is due to be launched in January 2006.

The Government claims that the White Paper will usher in an era of greater patient choice and increased diversity of primary care providers. In this report, Professor Paul Corrigan, the former Special Adviser to the Secretary of State for Health, describes how this could be achieved in three steps: increasing capacity and diversity in primary care; reforming the performance management regime; and creating an information strategy which allows all sections of society the ability to know what primary care services are on offer and how to choose a provider accordingly.

Professor Corrigan reminds us that we have had the right to choose a GP since 1948 but unfortunately, increasing constraints on the system makes this right a hypothetical one

for many. The reality of closed lists, restrictions on where we can register and GP surgeries which offer almost identical services means that even patients lucky enough to have a choice of GP have no real alternatives to choose between. Professor Corrigan explains how we have reached such a terrible state of unequal and limited access to our GPs, and what can be done to turn this situation around, offering crucial advice to government policy makers in the run up to the latest choice-based NHS reforms.

These reforms, encapsulated in *Healthcare Outside Hospitals*, should be seen as an opportunity to reconnect the public with the very heart of the NHS - making *Registering choice: how primary care should change to meet patient needs* a vital addition to the policy debate surrounding their design and implementation.

Mike Kerr,
Industry Leader, Public Sector
Deloitte

1 There are two public and two private sector delivery models outlined in Corrigan, P: *Size Matters: Making GP services fit for purpose New Health Network*, November 2005

Executive Summary

After several years in which improving patients' access to NHS hospitals has been the major focus for health care reforms, recent months have seen a strengthening of the debate around the delivery of primary care. 2006 will see a Government White Paper on health and social care outside of hospitals, which will potentially lead to the most radical changes for 50 years.

For many years the Government has claimed to want to shift significant activity from secondary care to primary care, but this has not been achieved. If within the next few years this significant shift to primary care does not take place, the NHS will be in trouble. Therefore, ensuring that the primary care system is fit for purpose and can take on a greater proportion of the nations' health service needs not only to be a policy intention, but needs to be a significant part of policy implementation.

This pamphlet concentrates on one part of these changes. It explores what would happen if members of the public genuinely owned their right to register with a GP. It tries to understand what would happen if there were real choices for people to place their registration with an organisation that genuinely offered convenient and specific services that those individuals wanted.

The first chapter of this report discusses how the primary care system would have to be changed if members of the public actually had that right. We point out that patient demand for specific sorts of GP services would be much more effective than it is at the moment. As a result, a much more effective means of organising and expressing that demand is required and, to meet that effective and differentiated demand, we will need a differentiated and better organised supply. At the moment, you can have any GP service you like – as long as it is very like any other

GP service on offer. Alternative models of public and private supply are already being constructed by the public and private sectors to address this.¹

The second chapter of this report explores the different ways in which the existing NHS works with primary care services that fail, and how this might be improved. At the moment, the public sector model is to maintain almost under any circumstances all existing services. Closing a service is generally a bureaucratic act rather than as a result of patient choice. Under the new primary care provision that we envisage in the first part of this report, this will change and customer preference will play a bigger role in identifying those services that succeed and those that do not. However, this would take place within a regulatory framework which upholds public safety and ensures providers are given adequate support to respond to and meet the needs of their patients.

The third chapter discusses the different forms of information that the public will need to make informed choices, given the expansion and differentiation of the primary care sector that we are likely to see. It poses these questions against the very considerable inequalities in the availability of information that exist at the moment, and it recognises that there are very different cultural approaches to how information is used. An official policy on information development needs to take these existing inequalities into account and not only ensure that information 'reaches' everybody, but that the information can actually be used culturally by the different people who need to use it. Given the freer market that will develop in a world of choice, primary care providers will have an interest in providing this information themselves in such a way that people will be able to use and understand it.

For 50 years the NHS has offered its services to a public that has had to accept what is on offer. Increasingly the public, through their preferences, will have greater input to how their services develop. It is through this public pressure that a patient led NHS primary care service will evolve.

Introduction

Reasons for reform

The case for any reform of the primary care sector needs to demonstrate how it will improve access to higher quality health services, and must begin with a strong critique of the current system. If we fail to do this, some will feel that all we are offering is a possible better future, but that since there is not much wrong with the present, why should we risk the change? It is very easy for people to demonstrate that reform will generate too many problems and costs to justify change.

We can illustrate this point with an example. There have been some strong arguments against the introduction of electronic patient records into the NHS: some argue that it is going to be very difficult to transfer doctors' writing into an electronic form – what happens if some gets transcribed wrongly and what happens if all the computers in the country crash? They argue that people may die as a result.

But let us be clear about the status quo and its dangers to life. The current patient record system is far from perfect, and people die every day because of it. If someone has a road accident in a different town which renders them unconscious, all anyone at A and E knows about the victim is in his wallet. As for confidentiality, very private and personal records are kept in beige envelopes in public just behind reception desks.

Those of us who argue for reform have to be clearer about our critique of the current system. Using the example above, it can seem somehow wrong to point out that the existing state of medical records leads to patient deaths. But if we fail to do this, it leaves those of us arguing for change with two hands tied behind our back. So within this example one of the reasons the NHS needs digital medical records is that the present system is unsafe. The problem is we feel loyal to the status quo and it

somehow seems morally wrong to criticise it.

To critique the current state of the primary care sector, we should start with the first principle of the NHS: healthcare should be equally available for all, and free at the point of need. And although 80% of healthcare episodes begin and end in primary care – making our GP both the “gatekeeper” to the NHS and also, for the majority of us, the only contact we have with the health service – primary care does not provide equal access. We have, in theory, been able to choose our GP since 1948. Yet the reality of closed lists, restrictions on where we can register and GP surgeries which offer almost identical services means that even patients lucky enough to have a choice of GP have no real alternatives to choose between.

Furthermore, this restricted ability to choose is spread unequally: the 10 PCTs that cover the poorest areas of the country are also those with the fewest GPs per head of population. Given the shortage of GPs across the country, all of the problems associated with this shortage will be worse in poorer areas: more people will be without a GP at all, and for those with a GP, choice will be a lot more restricted.

The importance of choice in the wider policy context.

Despite the fact that, in terms of political rhetoric, the Government's choice agenda is gaining momentum, there are still very few people actually making real choices within the NHS. The culture of the policy argument may be about choice, but the culture of the reality of health care is still about doing what you are told. This pamphlet aims to move the debate of choice from what is the periphery of health service experiences, the hospital, to the core of the NHS – primary care.

One of the hallmarks of NHS reform is the way in which many of the drivers for improvement and change are being moved from the very top of the system into the hands of the patients themselves. This is not just a change in the way in which the system is run, but a change in the way in which the system will develop in future. The new NHS is evolving into a system that will need less and less instruction from Whitehall and more and more organic change from below.

There is already some evidence for the efficacy of this approach in developing elective secondary care. In June 2003

The Kings Fund analysed the very early pilots in the NHS that offered choice to those patients who had been waiting for a heart operation for more than 6 months.² They recognised that choice could have benefits which went beyond the experience of the patients who were offered that choice, and could have an impact upon providers in the hospital system.

They concluded

“The Government’s recently introduced choice schemes for elective care will shorten the waiting time for people who would otherwise have to wait for six months or more. This will mean that others will have to wait longer but even so the scheme may be worthwhile. However its main effect will be to put pressure on providers rather than to extend choice”³

Their recognition that choice was a method of “putting pressure on providers” demonstrates that choice could improve healthcare services by increasing the motivation for providers to attract and keep patients.

Some argue that this pressure cannot be created because choice is insufficiently powerful unless the patients’ personal money is also engaged in this process. Effective choice only takes place when you have a personal financial stake in it. This argument is flawed, however: choice can be effective and empowering when individuals are distributing a public good and the resources that flow from it. The power of public preference can have an impact without them having to use their own money.

All of the proposals within this pamphlet support the prime value of the NHS – that care should be provided equitably and free at the point of need. Indeed, my argument for reform is based on the assertion that the existing method of delivering primary care, where there has been little or no choice, has failed to provide equitable access to primary care. We can only put this basic value of equity of provision into practice through implementing choice-based reforms in primary care provision.

2 Appleby Harrison and Devlin: *What is the real cost of more patient choice*. The Kings Fund, June 2003

3 Op cit page 50

4 Tony Blair *The Courage of our Convictions* Fabian Society, 2002

5 Alan Milburn *Redefining the NHS* Speech to the New Health Network, 2002

6 HMSO *Choosing Health* November 2004

The policy outcomes of choice

Reflecting this dual role of choice as a benefit to patients and as a driver of change in providers, this report will discuss two policy outcomes of choice: first, the empowerment of the patients/members of the public, and second, the improvement of the system that comes from the application of patient preference.

Empowerment

The Government welfare reform programme has been based upon a characterisation of welfare institutions as ones that create dependency amongst the public. Welfare benefit reform, changes in tenure on council housing, and the development of choice in schools and hospitals have all been aimed at increasing the power of the citizen over the welfare institution.⁴ The development of patient choice was a significant part of this policy, starting with a choice of hospital after a patient had been waiting for 6 months for an operation.⁵

Yet the Government is introducing policies not just about health service improvement, but also about health improvement. The policies outlined in the White Paper *Choosing Health*, for example, argued that health improvement depended upon individuals taking more control of their own health choices.⁶ It is difficult to see how people can be expected to take more control over their own health improvement if they are not also taking more control over their own health services. If they are making choices to meet their needs then the service will have much greater impact on health improvement.

So greater patient empowerment would help ensure services were delivered at the convenience of the patient, and consequently improve the capability of the service to deliver health improvement.

However, one of the main debates about choice on the left is the issue that middle class people are in some way intrinsically better at choosing than working class people, and will automatically gain from the introduction of choice. Yet the middle classes are *already* at an advantage, and *can already* exercise more choice than others, and this stems in part from the very limitation of choices on offer. Improving choice, and ensuring it can be exercised by the many rather than the few, will be a major theme in this pamphlet.

Improvement in system performance

To have an impact on providers' activity, the choices that patients make must have consequences. When individuals make a choice between two different providers, the resources for that treatment must go to the provider they have chosen. The impact of these choices can then be felt very quickly. Second, for the power of preference to drive improvements in anything but a random way, patients must make informed choices about the GPs available. This is why the provision of clear, understandable information is an essential part of this process – as our proposals in chapter three explain further.

The importance of choice in primary care

As we explain above, primary care is the main experience that the public has of the National Health Service. If we want to change the overall public experience of the NHS to one which centres much more firmly on the patient, then it will be no good constructing a reform programme which only works in hospitals and ignores primary care. Since one of the main aims of reform is to systematically empower the patient, a failure to approach patient centred reform in primary care would lead to a failure of reform as a whole.

The second point is that primary care in all its manifestations will continue to act not just as the main provider of health services, but as the gatekeeper to all other services. If patients do not feel that they are central to their health services at this gate-keeping stage, it is unlikely they will feel empowered as they move on through the system.

Third, the primary care relationship is much more constant over time than that of secondary care, which is mainly episodic in nature. Thus, the argument for patient empowerment in a continuing relationship with a GP is a much more effective means of developing individual patients' ability to become engaged in their own health improvement.

In fact, we have had the right to choose our GP since 1948. However, for most, this has been a very limited choice. Too many people are unaware of this choice, and for many there has been insufficient capacity to make it a realistic one. Moreover, if all GP practices offer the same services, choice is limited by definition. Insufficient differentiation and insuffi-

cient information about what differentiation exists has also limited the choice of GP.

Increasing capacity in primary care would not only make choice of GP a reality for a larger number of people, but would also provide the possibility of offering very clear alternatives to choose between. That means not only having different organisational models of supply, but also different forms of delivery, to suit the needs of wider sections of society.

Of course, many people would choose to have a consistent relationship with a single GP if they were given a more choice about the type of primary care on offer. However, this is not the only criteria by which people will choose their primary care provider. There are those who may live different lives and want different choices. For example, where convenience of location, or convenience of time combines with a belief that information technology can shift personal health information between GPs, some patients may not choose above all else the personal service of a particular doctor.

If these different criteria were allowed to play a role in determining different types of provision, there would be very different models of primary care which we could choose between. For choice to really work, different models need to be on offer. In this way, the public should have the opportunity to differentiate primary care to construct different types of provision around different needs.

An important caveat should be noted at this point, one that will be referred to throughout the paper: the introduction of greater choice in primary care does not make choice the only driver for improvement in the NHS. There will still be central inspection, there will still be a locally based organisations such as the PCTs, the system will not 'become a market based system': it will be a National Health Service where choice has been introduced as a part of the system of improvement.

Chapter one: the role of choice in developing quality and capacity

The existing system of primary care provision

It is the task of existing PCTs to ensure that there is sufficient capacity of primary care to cover the whole of their population. This allows us to quantify the worse part of the problem. 14% of the population live in areas where there are closed lists, with one in three London GP surgeries closed to new patients.⁷ Clearly PCTs are not as efficient as they should be in ensuring there is sufficient supply of primary care to meet patient need.

For PCTs to solve this problem, they must use existing contractual arrangements to offer new GP practices to fill capacity gaps. There are four routes by which this can occur:

1. With the new 2003 General Medical Service (GMS) contract, PCTs have greater scope for encouraging collaborative working between practices. Under this contract, GPs can now offer a wider range of services and their pay will be tailored to the services they offer.
2. Through a Personal Medical Contract (PMS) PCTs can offer salaried appointments to GPs. Almost half of GPs are now on these salaried contracts. This was intended to provide the PCT with an opportunity to fill gaps where the GMS contract had not worked, as the salaried GP would be able to move into and out of locations in an easier way than those on the more traditional GMS contract.

⁸ NHS Alliance *The future shape of primary care and general practice* October 2004

⁷ See survey carried out by Paul Burstow MP, <http://www.paulburstow.libdems.org.uk/news/196.html>

3. Under the “alternative provider medical services contract” PCTs may award contracts to be provided by organisations outside of the NHS.
4. PCTs can provide services themselves, running community health services and employing the necessary staff. This latter scheme raises tensions between the PCT as a commissioner and as a direct provider.

Prima facie this looks a fairly complete range of different models of contract, ranging from the traditional small business partnership approach, through letting contracts to outside organisations, to directly employing GPs. Given this range it is difficult to see why there should need to be a case for new forms of alternative provider. However, the only uniting factor of these four different methods of providing primary care is the fact that it is the PCT that organises them. If, for any reason, the PCT is lacking in skills or capacity to deliver, then it is unlikely to be able to deliver through methods three and four when it could not deliver through methods one and two. Having the alternatives as a measure of policy is one thing, using them is another.

The PCT reflects the interests of many stakeholders, including those of existing providers. The analysis of capacity, and any plans to increase capacity are carried out on many occasions in conjunction with existing primary care providers. They at the very least have an interest in maintaining their market share, and at the most have an interest in severely limiting any market entry. It would take a strong PCT to disagree with all existing providers and increase provision. It is clear we can no longer allow something as important as access to primary care to depend on whether a PCT is strong enough to carry out this role.

It would be wrong to say that all existing providers are arguing against new market entry. Indeed, one of the clearest arguments for new and alternative provision comes from an NHS Alliance discussion document. This demonstrates that one of the major groups of primary care practitioners and organisers want change.⁸ However, the organisational framework persists in allowing providers to play a role in opening or closing the lock on the creation of new provision.

Furthermore, there is not a large pool of spare GPs and primary care staff that can be simply called down into any area which needs extra capacity. This makes capacity building in primary care a difficult exercise, which needs formidable abilities by a PCT to carry out. Therefore, if there is any hesitancy by the PCT in increasing local primary care capacity, they are unlikely to accomplish this task.

This description of improving capacity in primary care reflects the classic ‘1948’ planning model that has in the past characterised much of public service planning in the UK: an organisational body interprets need and demand, and then plans from above to distribute capacity to meet that demand. The assumption is that the organisation can understand demand, provide supply and has the capacity to both organise demand and supply.

Another question to raise is whether the main organisational form that has been chosen since 1948 to provide primary care – that of the partnership or small business model – is in fact the only form that it is right to provide primary care in 2005. Such organisations can be quite conservative in welcoming innovative new forms of provision and are often reluctant to encourage them.⁹

This conservative small business model of provision, combined with a top down approach to planning of capacity, is not conducive to innovation.

Why this is an issue of capacity as well as quality

The historic problem for the NHS at both secondary and primary care level has been one of insufficient capacity. In England, the numbers of doctors, the amount of primary care, and the number of beds per head of the population are all at the bottom end of any Western European league table of statistics.

With good reason, the NHS blames this lack of capacity on the lack of past investment: insufficient financial resources, doctors and capital expenditure on primary care are common. However, whilst the financial resources required can be judged purely in a quantitative way, the services these finances must produce in different communities vary considerably. It is symptomatic of the institutional problems of the NHS that we see

9 Corrigan, P: *Size Matters: Making GP services fit for purpose* New Health Network November 2005

primary care in East London offering the same services as in Northumberland or Surrey. Both may need primary care, but do both need the same model of primary care?

So filling the gaps left by decades of under-investment is not simply a process of rolling out more of the same. Two things at once need to happen: more financial resources need to be put into the system, and these need to produce differentiated primary care services to meet different needs in different communities.

It is therefore not correct to see the issue of quantity of capacity as distinct from the issue of differentiated capacity. Much more of the same sort of primary care would still see those who had different needs left un-catered for. That is why the process of delivering more must coincide with the process of delivering *differently*.

It would also be wrong to assume that the problem of a lack of capacity in primary care will be solved by a top-down process of capacity building from the centre. Such a process would assume that once the quantum of capacity has been solved by old style planning, improved quality would be driven by patient choice. This is not the case. We need reforms to ensure the patient is both the driver of increases in capacity, as well as – with the help of central intervention – one of the drivers of improvements in quality.

In private markets, the issue of market entry and exit is simply the extreme end of the overall theme of performance improvement. If you successfully enter a new market you must be doing so because, either in quantity or quality terms, you are successfully filling a gap in the needs expressed by customers.

In England, the numbers of doctors, the amount of primary care, and the number of beds per head of the population are all at the bottom end of any Western European league table of statistics.

Markets bring into being capacity where there is excess specific demand for quantity or for quality improvement. The organisation delivering the capacity then thrives only if it continues to meet the quality demanded by customers. So what starts as a quantity issue of capacity very quickly becomes a quality issue of how that capacity thrives and survives.

Transferring this to primary care, the latter process of quality improvement driven by patient empowerment will only succeed as a mechanism if there are alternative places for patients to choose to go. So we need extra and differentiated capacity to be available. If there is insufficient capacity to help develop patient choice, there will be very little exit by members of the public following failure in terms of quality. At the moment, people attend existing primary care providers often because there is no alternative on offer. This essentially prevents bad primary care providers from being driven from the market. Therefore, the mechanisms for failure and improvement depend upon an increase in capacity and diversity.

Solutions to the problems of capacity and quality

There are two forms of improvement that have to be implemented simultaneously if this problem is to be solved as a whole.

First, we need to help people organise their demand for new primary care. We must initially identify and then help to fill those localities where there is the clear demand for new capacity in primary care. Continuing and chronic problems in this area demonstrate that we must not leave the whole process in the hands of PCTs, since the very nature of the existing gaps in provision means that they do not have the capacity to tackle them with the challenge of alternatives.

We need to develop ways in which demand for new primary care – as yet inchoate and experienced by people individually – can be brought together and expressed effectively so that it can bring forth the specific supply that individuals demand.

At the moment, there is no way in which local people who need extra primary care services can trigger market entry. They cannot express their own need and they cannot act for their own needs. This can only be achieved via the PCT, who is charged with identifying need on behalf of people – acting as a

¹⁰ The SMF held a seminar on an earlier version of this paper and one of the speakers, a GP, Dr Tim Wilson helped to develop this crucial part of the argument.

proxy for real demand. This has proved inefficient and we need to create methods by which local demand can be translated rapidly and directly into new provision.

Second, we need to help primary care providers organise new forms of supply. At the moment this is an incredibly sticky and difficult market for either new entrants or entrepreneurial GPs to work in. To enter the market, they either have to be asked to enter by an organisation – the PCT – which also represents the interests of existing providers in the market – or they have to argue for market entry directly against their professional colleagues. We need to construct a system where they can offer alternative supply much more freely to meet patient demand.

The only way we can increase capacity is by creating new markets and facilitating providers to enter them. This needs the expression of both demand and supply. Thus, we need to improve both the bottom-up vocalisation of demand from patients, and the top-down response of supply from entrepreneurial providers.

New ways of identifying demand for extra capacity

This argument is based on a simple truth which is an important part of the existing NHS, but which is often hidden. The member of the public owns their right to register for the provision of primary care.¹⁰ It is they who own that registration and they can place it where they want. This is not a new principle for the NHS, however for most people at the moment that registration is usually expressed in a passive tense, as if it owned by the primary care provider. An individual ‘is registered’ at surgery a, b or c.

One of the first aims of our proposals is to make the choice to register with a GP service an active process. There is little point in understanding this as an active process at the moment, as there are only very small experiences of activity – when someone chooses between very similar providers in a limited way – surrounded by decades of passivity.

The aim of these reforms is to develop the activity inherent in the ownership of our right to register with a primary care provider, and to use that registration to demonstrate our preferences for one form of primary care over another.

As we each develop an understanding of our own needs for specific primary care services, then we will better understand how to use our right to register to develop that need into a demand. Within this model we really own our registration with a GP, and together with this right goes the resources from the local PCT that follows our registration. These resources go beyond the limited resource of an average person registering with any GP and may, for example, carry with it the resources that a long-term condition implies. Under practice based commissioning and the Quality and Outcomes Framework for remunerating GPs, a practice that ‘takes on’ and improves the efficiency of the care for a number diabetics, for example, will improve its resource base. If I as a diabetic choose to register with a, b or c, then the resource follows my choice. The resources that move to a primary care provider as a result of the choice to register with them is an example of how a better understanding of our primary care needs can be turned into effective demand for primary care and a resource for the primary care provider that attracts registrations.

To put personal registration actively into effect as a part of the development of primary care services, we need a series of mechanisms which recognises that local people, with needs and demands for different primary care, are in a better position to identify those needs and place their registration than a bureaucratic organisation.

Let us start with the extreme case of those people who have no access to GPs at all. For them their power to register is useless. At the moment, there are some formal ways in which excess demand can be identified, for example through the instances of closed lists. Yet under such circumstances, by that time, the situation is dire. If the NHS took its values seriously, it would very quickly do something about this. For those people with no GP there is virtually no NHS, let alone any equal access to the NHS. This not just represents a series of very serious individual crises, but it also represents a collective crisis in the community, and is in fact a crisis for the NHS. Whilst the PCT is meant to deal with this, in some (mainly poor) areas of the country, it is failing to address this problem.

There needs to be a much easier and popular mechanism which would allow local people in areas facing such an impor-

tant crisis to trigger this excess demand into supply. They need to be able to demonstrate to suppliers a gap in the provision which they have identified through their needs – irrespective of how the PCT sees their situation. How do members of the public signal to potential suppliers their desire to attract new primary care providers into their area?

This could be developed in a range of different ways. For example, one method might be to involve local democratic representatives. A local councillor could, if approached by sufficient numbers of constituents, trigger a local petition which bypasses the PCT and demonstrates to the emerging market for primary care services that there is a demand in a location. If a set number of signatures were recorded on the petition, then primary care providers interested in setting up in this location would be able to do so without having to be invited by the PCT – the invitation by the local councillor backed by the petition would be sufficient to trigger a request for new provision.

Such a process would have the advantage of linking a healthcare need with elected representatives – in terms of the reform agenda, it would clearly link a choice mechanism – patient demand, with a voice mechanism – the elected representative. Such an innovation would also ensure that the active part of this mechanism was independent of the providers of health service.

Alternatively, we may wish to bypass all forms of intermediary and allow groups of patients to self-organise and petition their PCT directly, with the PCT obliged to respond to a petition

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reaching a certain number of signatures by having to invite more primary care providers to come to the location.

The benefit of such triggers is that they can be used both over issues of quantity and quality and diversity to meet the needs of the local community. However, given the acute crisis in primary care shortages in some locations we could also create an *automatic trigger*, specifically to increase the capacity of primary care provision in those areas where there are closed lists. For example, if there were more than a fixed benchmark of GP surgeries in a PCT with closed lists, this would automatically lead to a call for a new primary care provider in the area. Under these circumstances, since the PCT had failed to carry out one of its main responsibilities, we would remove the role of market gatekeeper from the PCT.

A crucial factor, if we are to implement any of these trigger mechanisms, is that the type of primary care provider able to respond to this demand must be as diverse as possible. If local people, dissatisfied with the range of primary care services that do not meet their needs, petition their councillor or PCT for more providers, they may not want to see more of the same. Their petition might be a call for a simple boost in capacity; however it is more likely to be a call for *alternatives*. This is developed more fully in the next section.

Such mechanisms would ensure excess demand called forth supply, regardless of PCT performance. However, they would also serve as an effective performance indicator of PCTs. Any PCT where such petitions or triggers occurred would have failed to identify the needs of its patients – a clear failing on the part of the PCT. If a PCT was carrying out its commissioning role effectively and translating the needs of its community into adequate primary care provision, then in theory, its authority as “market gatekeeper” would not be challenged by petitions or by closed lists. However, if they do occur, it is vital that such instances – petitions made by dissatisfied local people, the instances of closed lists leading to the PCT being bypassed and new primary care providers being introduced into the system – are recorded and are transparently public. This would ensure that the Healthcare Commission was aware of these failings and reflect that in subsequent performance management ratings.

11. In *Size Matters: Making GP services fit for purpose*, I describe four different organisational forms that are practically being developed – two public and two private.

Different types of provider entering the market

Once we have made demand effective, meeting that demand with supply is currently very difficult. It must be made easier for providers to enter the market.

There are some very odd political minefields in this discussion. There are claims that any extension of primary care services to new independent sector providers would in some way mean a privatisation of primary care. The argument that primary care services should not be run by private companies is odd since, from 1948 to the present day, primary care has been developed through a small business, private sector model. Organisationally, GP surgeries are most like partnerships of solicitors, but because they obtain their remuneration directly from the public purse we in some way neglect to enquire about how they are employed and in which sector.

In this sense, primary care is already privatised, and so it is politically very sloppy to see the entry of another form of private enterprise into the primary care market as privatisation. In fact, given the proportion of GP practices owned through private sector models, it is likely that some of the reforms taking place may well involve the public sector taking over something that has been privatised. This period of reform may see the development of co-operatives or public benefit corporations taking over private sector provision – although it is unlikely that these facts will not stop the process being called privatisation.¹¹

First, having clarified that we are making market entry much easier for new providers, the very first step should be an approach to existing entrepreneurial GPs. It is clear that most GP practices are businesses, and as businesses, the people who run them want to succeed. As in any business sector there are different motivations here. Some people who run primary care businesses are content for them to tick along, while others are more entrepreneurial and are looking for new opportunities to develop services. I would label these people as entrepreneurs, not simply to make money, but entrepreneurial to provide extended and better services. This drive can be blocked by bureaucratic mechanisms.

Given the existence of entrepreneurialism, we already have a considerable latent force for new capacity and innovation, which only needs some assistance to develop into the active

supply of primary care services in different locations from where they work at the moment. The NHS Alliance makes the point:

“Practices could bid for contracts from more than one PCT for enhanced services or even sub contract them. Well organised GP co-ops seeking such business could evolve into new not for profit organizations; some are already taking on new services such as day time visiting; mental health, support to nursing homes, prison medical services and the police.”¹²

The very nature of the list of possible services in the last sentence demonstrates the entrepreneurial nature of some GPs. They recognise opportunities and want to provide services to meet those opportunities. This list illustrates the existing markets on offer – all of which are being approached. This paragraph also argues for the development of new organisational forms as well as demonstrating the energy to enter new markets wherever they are opened up.

Alongside the traditional partnership model, some GPs want to develop the co-operative tradition for the organisation of primary care. This approach has dominated the development of out of hours’ service, being able to organise very considerable sets of resources. It is also the case that in a small number of locations, co-ops have a longer history providing straightforward primary care services. The co-operative think tank Mutuo has identified a clear and compelling business model which would provide a co-operative for the development of extensive primary care services.¹³ If we were to free up the organisation of demand from the control of the PCT, there would be many people who would actively choose to have their primary care services provided co-operatively.

Following the Wanless report, health policy and practice is seeking to engender a closer engagement between people, their health and the health service. The co-operative model is made for this and co-operatives could have a powerful impact upon health improvement and democratic involvement.

Third, there are NHS providers from outside of the existing private sector of primary care services.¹⁴ For example, there is some evidence that NHS Foundation Trusts are interested in

12 NHS Alliance *The future shape of primary care and general practice* October 2004

13 Mutuo is the think tank of the co-operative movement. Its Chief Executive, Peter Hunt, is developing practical models for the further development of primary care co-operatives

14 See *Top hospitals may run GP centres*, BBC, 19 June 2005

developing their own primary care services. This will be a new and important departure, and whilst it would genuinely increase capacity, we would have to ensure that such primary care owned by foundation trusts would have to operate in such a way as to be a fair gatekeeper to the whole of secondary care, and not to funnel business into their own organisation.

There has also been some interest from pharmacists who already provide an important primary care function. They could develop a much wider set of primary care services in some localities, most notably in the High Street. This would have a potentially dramatic impact on capacity in locations where it is at the moment often absent.

Fifth, there is also the possibility of using the model that has already successfully increased capacity for secondary care: that is, independent sector treatment centres. This could be developed by the Department of Health through constructing contracts with a range of approved international and national privately funded providers of primary care services, which people could then call into their local area through the trigger mechanisms we suggest above.

All of these different sources could provide very different models of provision to meet the different types of demands for primary care.

Maintaining the N in the National Health Service

Whilst this paper aims to increase the efficacy of choice and preference as a model in primary care development, it does not commend or expect there to develop a pure market model of primary care. There are increased elements of a market here, but there will be such restrictions on the market form that it cannot simply be called a free market.

Most obviously, all of the care outlined above will be free at the point of need and will involve no private financial involvement from the patient. We must also recognise that the knowledge asymmetries in primary care services are at least as large as the knowledge asymmetries in a range of other services, where there needs to be strong regulation. There are many such examples, but perhaps the most obvious is utility industries. When we buy electricity, we know as little of the different suppliers and of that product as we do when we choose a doctor.

That is why utilities are so powerfully regulated, and why the NHS should be the same.

Up until now this has not been the case. The regulation of primary care services has been based upon a very weak form of intervention, much weaker than almost any other service industry, public or private. It has almost all depended upon a personal professional regulation. If the professional has a licence to practice, then they can practice with very little interference.

Although this has begun to change, any system of primary care choice would need to look to the stronger development of a national system of regulation and inspection, which at the moment is being developed by the Healthcare commission. Under such a system, market entry and market exit are not purely determined by patient choice. In fact the development of new capacity, the improvement of existing capacity and especially market exit will also depend upon a central system of inspection; regulation and governance which will in its own right make decisions about quality and address failure.

Whilst I can imagine patient choice triggering entry, improvement and exit, these will have to be complimented and backed up by clinical governance and the quality control of the Healthcare commission. This will both act as a tool to bring about improvement and exit in response to patient opinion, and will also be continually looking at outcomes that go beyond an individual patient's experience.

We will deal with the issue of failure and performance management in primary care in more detail in the following chapter.

How choice can improve PCTs

As I have alluded to throughout this chapter, a failure in either the capacity or the quality of primary care service is not *just* a failure in delivery of the service itself, but is a failure in the mechanism that is meant to ensure that delivery – the Primary Care Trust.

The Social Market Foundation's Health Commission recently argued that PCTs need an improvement mechanism which would be best developed through contestability, that would allow GPs or patients to 'choose' which PCT to act for them.¹³ The friction caused by preferences of, for example, a

13 *Choice and Contestability in Primary Care*, Third Report of the Social Market Foundation Healthcare Commission, London, April 2005.

whole group of GPs choosing to move PCT, would have a dramatic impact upon improvement of the working of the PCT. Unfortunately, in practice, there are severe problems with the contestability between PCTs as whole organisations. This is because their basic function is developed through the boundary of a locality.

However, there are other forms of contestability and improvement for PCTs to be developed. For example a group of patients, or even more clearly a group of GPs, again in conjunction with their democratic representatives at local or national level, could argue that a PCT has failed to carry out its duty of performance management and improvement. This could trigger a referral of the PCT to the Healthcare Commission and a subsequent investigation. The trigger could also demonstrate a lack of confidence in the management and governance of the PCT.

Action for improvement of unelected state institutions has to be in the hands of superior agencies, but the trigger for those improvements can also happen from below. We therefore need much clearer and easier mechanisms for people in localities to demonstrate dissatisfaction with the quality of performance of a PCT or GP, but this popular trigger works best if it triggers action by others.

It is much more likely, however, that local people will be dissatisfied not in abstract terms with a PCT, but with the concrete services that the PCT was meant to deliver. Intervention mechanisms are much more likely to be triggered by local people responding to a specific failure of quality or capacity of a GP, than an abstract organisational failure of the PCT. That is why we must link mechanisms to address service failure at GP level with the recognition that the PCT is implicated in this service failure, and be reflected in the performance management of the PCTs.

There remains however the problem of ensuring new capabilities for running a failing PCT. At the moment, the only mechanism for this is the traditional one of sacking the chief executive and some senior staff and employing new people. In some places this has been more sophisticated and has been used in conjunction with the creation of combined local PCTs, with the management of one taking over the running of two. In

other services this would be called an amalgamation, or at its boldest, a takeover. This amalgamation mechanism is only possible when the management of a neighbouring PCT has the capability of taking over the organisation of its failing neighbour. This is likely to be rare.

We need to develop an alternative method of new management which does not depend upon proximity. PCTs with an expertise in, for example, organising inner city of rural services could form an association, which could then bid for the running of the management of a failing inner city of rural PCT. The trigger here would be the designation by the Healthcare Commission that the management of this PCT had failed and was now open to offers to be run by others.

Conclusions and exemplar

I start from the assertion that the inverse care law – i.e. people who live in poor areas and have greater needs actually get poorer services – still applies to primary care services. Despite the central values of the NHS, the status quo does not meet the needs of everyone and the recognition of this failure is the main case for reform. I have outlined the way in which easy and popular methods of organising demand will provide people with a method of expressing their needs in a way that PCTs do not. This demand can then articulate with alternative methods of provision to create a more precise service to meet specific needs.

It may be best to select an exemplar of how this process will work. At the moment, once young people have left home, they tend to ‘fall out of’ primary care services. Family planning for some, sexual health for a few and issues of pregnancy and young children for more women than men, may bring them sporadically back into primary care, but our equitable system of providing primary care for all free at the point of need seems to miss out on most 18-30 year olds. The NHS as presently provided is not ‘for them’. For many in this age group their registration stays with their parental home. For some it stays with their university or college. But come their second or third move of home, to all intents and purposes, they are outside of the NHS primary care system. GPs were something that they had as children.

For the 18-21 years olds at college or university, some important services have been developed. Now most higher education institutions have developed a specific service for their students within their college. The students recognise this service because it is there – on campus, in their buildings open at the time they are there and providing an emergency service when they need it. The services provided in a college will be totally different from the ‘normal’ primary care services aimed at older people.

However, the organisation of these very different primary care services only takes place because there is an institution – the university or college – that organises it for both young people and the NHS. Once young people leave college they are thrown back on a service form organised for the settled lives and health needs of their parents and grandparents.

Looked at in terms of health services, for some this may not be a problem. Millions of people are not costing NHS primary care services anything. But in terms of health, this is not the case. We cannot seriously be arguing for a model where the NHS is more engaged with people in their health development and at the same time not worry that for over a decade we lose touch with young people.

Over that decade young people can engage in a wide range of deeply unhealthy activities. For some their bad activities will disappear with age, their bodies will fully recover and nothing long term will happen. For too many others, health behaviours at this time construct a set of long term habits or may just have a long term impact upon their mind or body. They – when they grow older, and we – when we have to pay for the health care of earlier bad behaviours – cannot afford to have primary care absent from their lives. We need young people to demand health services even though they do not know they need them – something which the Government is trying to do through its health awareness campaigns aimed at young people.

Given the central importance of primary care to people’s experience of the NHS, if this service fails to provide clear access to primary care for a section of the population, then the NHS will have been seen to fail. So creating that access is vital. But this is not just any access; it has to be access that meets the specific needs of very different people. In a diverse society, this

has to be a differentiated service. My argument is that the clearest way to ensure a differentiation of services to meet different needs is to empower the person with those needs, and not to have a bureaucracy try and proxy that understanding. This is why choice within a differentiated primary care system will provide services that deliver to the individual and not to an abstract member of the public.

The plan is that by the end of 2008, the public resources spent on the NHS will be treble what it was in 1996. If there are places where people still, 60 years and with all those resources later, cannot have access to a choice of GP that we were all promised in 1948, this will be a real blow to the political left.

Primary care has for nearly 60 years developed this public service ethos by working through the small business sector of GP partnerships. The public service ethos in primary care has been robust enough to survive coming into contact with GPs working in such a context as small businesses. Extending the provision of primary care to co-ops, Foundation Trusts, and pharmacists who share that ethos already does not seem to add greatly to that danger.

Chapter two: dealing with failure in an environment of patient choice

Why choice-driven failure is important

Those of us interested in reform – and indeed those of us against public service reform – all seem fixated on what would happen when services fail. It seems that the full story about collapse and failure must therefore be tied down before any reform can occur.

Whilst this is important, I do want to start by saying that in a new era of the patient-led NHS, most primary care services will thrive and succeed. This is more likely to be the case because they will need to be much more attuned to the wants and needs of the people and patients that they serve. When the public have a real choice and have consequently chosen to go to a particular practice in an active way, people are much more likely to give a fuller allegiance to that practice precisely because they have chosen it rather than have been chosen by it. Therefore, whilst this chapter explores failure in the future in some detail, it does so in the context that failure will be the exception.

The issue of failure is so important because the nature of failure, when there is a real possibility of choice, will be wholly different from what we witness now. At the moment, on the few occasions that it happens, failure occurs because doctors are suspended from practicing by the GMC for malpractice or being unfit to work. Given a lack of real choice, many other forms of poor service can continue without the public having the ability to move away from it. This very lack of choice allows

the continuance of poor services – for example inefficient, impolite staff, a lack of alternative services on offer, and so on – under circumstances where choice would otherwise turn these faults into failure.

If patients did have the power to choose between different primary care services, failure would occur in a different context. If patients had the right to choose between different primary care practices and one of those practices fails to provide what they want, then it is possible that that practice will have few or no patients. Under the existing regime, the very idea of a GP practice without patients is odd. But giving patients the right to choose means that if no one chooses a particular primary care practice in the first place it simply cannot establish itself.

This change will only come about if there is an increase in capacity to help develop patient choice. If, as is currently the case, there is very little opportunity for patient exit from a provider, then failure due to a lack of patients will never occur. At the moment, people attend existing primary care providers often because there is no alternative on offer. Therefore, the mechanisms for failure and improvement outlined in this and the first chapter depend upon the development of new and different capacity.¹⁶

This chapter therefore asks, if there is more capacity in primary care, and that capacity is organised in very different ways to meet different patient needs, so that patients could really choose their primary care service, what would happen when primary care services fail?

Why choice-driven failure is not sufficient

In the future, patients not choosing a particular primary care provider may not be the only reason for failure. In health care, as in a range of other services, patients cannot be the only arbiter of success and failure. It is important to have a national body to assess whether a primary care provider is fit to provide services when they are established. The same body needs to ensure that they have maintained themselves as capable of providing those services.

Some argue that given the asymmetry of knowledge about healthcare provision, it is impossible for a patient to know what is and what is not good for them. Others need to decide for

16 Something we address in the first chapter of this report

17 These standards include requirements relating to the range of services which must be provided, the existence of clinical governance mechanisms, the duty to carry out all obligations with “reasonable skill and care”, the possession of professional indemnity insurance, the qualifications of practice staff, the upkeep of premises, and the quality of record keeping at practices. See Department of Health, *Delivering Investment in General Practice*, 2003

18 A particularly important example of this kind of discretion is negotiations with practices to encourage them to sign up to aspects of the “Quality and Outcomes Framework” (QOF). This is a system of voluntary commitment to additional quality targets, the achievement of which earns a practice financial rewards. Practices have a free choice over whether to sign up to such targets and it is intended that decisions over the QOF should be taken consensually.

patients because they cannot know all the scientific details of medical training, and so it would also be dangerous for patients to be the only people who can decide entry and exit for primary care providers.

This point is valid, but central regulation needs to coexist with, and not replace, patient choice. There needs to be a transparent and publicly accountable system of deciding whether individuals and organisations should be allowed to offer primary care services in the first instance, and a procedure to ensure their ongoing suitability to continue to offer those services. This needs to be organised by government, through independent institutions, on a national basis.

The existing system of failure for GPs

The role of the PCT

Up until now, the regulation of primary care services has been based upon a very weak form of intervention, much weaker than most other service industries, public or private. It has almost always depended upon the regulation of professionals. If the professional has a licence to practice, then historically they can practice with very little interference.

At the moment, the failure of individual GPs to meet the standards of their professional practice is determined, as we shall see below, through the General Medical Council. However the performance of GP *practices* is measured against standards that apply to the components of care they are expected to provide. We can divide these standards into two types: basic standards, which are centrally set and are included in the content of new General Medical Services (GMS) contracts for GPs,¹⁷ and local standards, which are set by PCTs, and which flesh out and add to national requirements after taking into account the particularities of the practices they serve (such as the key demographic characteristics of the overall area within which these practices are located).¹⁸

PCTs play a key role in monitoring these standards. Across a full range of standards, the PCTs collect data and they may also refer individual practices to the National Clinical Assessment Authority (NCAA), an authority charged with assisting PCTs with investigations into individual practices which are giving cause for concern. The NCAA may suggest

that PCTs should take a particular course of action to rectify a problem. However, all advice given by the NCAA is non-binding.

Success of this system therefore depends almost totally upon the PCT. This leaves the system vulnerable to situations, for example, where PCTs are likely to be tougher on their GP practices if they know they can bring in extra capacity to fill the hole left by a failure. If there are no alternative replacements available, however, PCTs are unlikely to close a GP service, even if it is of a very poor standard.

The role of the Healthcare Commission

Much then depends upon the capacity of PCTs to play a quality assurance role with their GPs. It is consequently important to understand how PCTs themselves are assessed.

Primary responsibility for assessing the performance of PCTs falls to the Healthcare Commission, an independent statutory body tasked with reviewing the performance of local NHS organisations. The Commission awards an annual rating to NHS organisations and the rating concentrates on:

- access to health care;
- the quality of care;
- the cost-effectiveness of care;
- access to, and the quality of, information on health care provided to the public.¹⁹

The Commission has very recently developed a new assessment approach which will become operational in 2005-06. This shifts assessment away from the old method of subjecting all NHS trusts to inspection every three years, and emphasises shorter, sharper, and more targeted inspections. These will be focused on those NHS trusts where there is existing evidence of a problem. Each year, Trusts will be expected to publish a

One important standard for PCTs is to ensure that all patients can be seen by a GP within 48 hours.

19 Healthcare Commission: *Assessment for Improvement: The Annual Health Check* 2005

20 Department of Health *Achieving and sustaining improved access to primary care*. 2002

21 Home page, GMC website: <http://www.gmc-uk.org/>

declaration on whether or not they have met certain centrally determined standards. Standards have been divided into 'core' and 'developmental' standards. One important standard for PCTs is to ensure that all patients can be seen by a GP within 48 hours.²⁰

These standards will be tailored to recognise the particular kinds of work undertaken by Primary Care Trusts. The Commission has stated that the standards will apply to *all* the activities of the PCT, whether these are provided directly by the PCT or are commissioned from external providers.

The Healthcare Commission will verify the accuracy of the declarations submitted by Trusts regarding their performance against these standards in several ways. First, patients, staff, and the public will be asked for their views on whether or not standards are being met. Second, corroboration will be sought from other relevant statutory bodies, such as Strategic Health Authorities (SHAs) and local councils. Third, the declarations will be checked against the data collected by non-statutory regulators. Fourth, the Healthcare Commission will carry out unannounced random spot-checks.

The existing system of improvement therefore depends upon PCTs to improve GP practices and the Healthcare Commission to improve PCTs. But whilst, inter alia, patients' views about PCTs may be taken into account, unless in their local area they have the right to choose a different GP, they can have no direct input into their GP's success or failure as a practice.

The role of the General Medical Council

Although there is no experience of failure through patient choice in the current system, there is an existing system of protection concerning the standards the public have a right to expect of doctors: the General Medical Council, established under the Medical Act of 1858. At the moment, the General Medical Council has 35 members of which a clear majority (19) are doctors.²¹

They can take action against hospital doctors and general practitioners, whether in the NHS or private practice, but they are not a general complaints body and can only act where there is evidence that a doctor may not be fit to practice. Their legal powers are meant to maintain the standards the public have a

right to expect of individual doctors, though they are based upon the belief that within a profession, doctors will monitor their own professional standards. Where any doctor fails to meet those standards, the GMC is meant to act to protect patients from harm.

The GMC has powers to prevent a doctor from practicing; suspend a doctor from the register; or place conditions on their registration, if the doctor in question has behaved badly/inappropriately; not done their job properly; received a criminal conviction; is suffering from a mental health condition, and so on.

This is the main way, within the present system, that primary care practices ‘fail’: at an individual level and concerning the narrow concept of fitness to practice. The withdrawal of a GP’s right to practice is a radical measure, obviously requiring judicial safeguards and involvement of their peers. But for some, these safeguards for the profession are too great, leaving patients at risk.

Patients and the public need to know and be communicated with about an open and transparent system of regulation. This needs to cover both the individual and the organisation’s right to practice. I explore these issues below when I look at the reform to regulation that needs to take place alongside the introduction of choice.

Towards an improved failure strategy for primary care providers

When patients have choice, it is through gaining patients that some primary care providers will thrive. It is also the case that some providers may not provide services that sufficient numbers of patients choose, and therefore they may not be able to practice.

It is understandable that people will want to know what will happen to primary care providers in such circumstances, and what will happen to those patients who have chosen those providers with insufficient numbers of patients to stay afloat.

First, it is important to stress that exit for some providers of primary care is the end of a process. The process begins with the provider not being chosen by a sufficient numbers of patients. There are very few systems of choice where overnight

the public decide en masse to reject a service.

Most situations where the public start to move away from their previous choice in favour of an alternative happen with some warning, and happen incrementally. Thus, the first thing for the GP practice to do in such circumstances is to try and find out why. Patients may choose to go to another primary care practice for a wide variety of reasons: they may move because of a particular service that is being offered elsewhere, or they may move because of a reputational issue. A practice could decide to try and counter these movements, by setting up a clinic, for example, to meet the unmet needs of their patients and match their rivals’ offer; or perhaps confront the reputational issue. Organisations can change to align themselves better with what the public want faced with a decline in patient numbers. However, this is a matter of choice. Some practices may feel that the changes required to bring back patients would be inappropriate to the way in which they work. For example, if a GP practice specialising in services for young children is based in a location where for demographic reasons the number of young children is falling, the practice could decide that it wants to continue its specialism, and therefore may choose to move to a location where the demographics are more favourable, rather than modify its working practices.

If providers learn to adapt, and find it possible to change the way the practice offers services to attract patients back and secure the future of the services they offer, the prospect of exit from the market does not apply. The power of patient preference has done its job: the provider has learnt more clearly what people want, and the renewal of primary care services has occurred with that provider.

However, a provider may be unable or unwilling to make such an adjustment. Unless the message from patients is listened to and changes are made, more and more people may move away from the practice, and it is possible to imagine that the business becomes untenable.

However, it is important to note that choice and the power of preference within primary care would not occur within an entirely unregulated market. This pamphlet and few others ever argue for a market in primary care that is totally unregulated, simply because it is social outcomes which are

important – not the adoption of a “pure model” of market forces which permits providers to be driven from the market with no safety net should they not meet patients’ needs. It is better both for the patient, and for primary care providers, that a safety net (in the form of the PCT) exists to resolve problems rather than allow large scale turnover of providers opening and closing throughout the country. PCTs still have a duty to ensure the adequate provision of primary care in their location. Thus, it will be their responsibility to address failure by assisting providers to improve their service offer, and thereby ensuring that a service that is losing patients will have some assistance in bringing about improvement.

For example, a practice that starts to lose patients could be doing so because they have failed to notice a demographic or social change in the locality. Parents with toddlers may have decided to leave the area, and if a provider had specialised in services for toddlers, through no fault of their own, they could start to lose registered patients and therefore income. They may need assistance from the PCT in developing a new specialism more in tune with the population.

Another provider who had, for example, specialised in diabetes, may lose registered patients to a new chain of clinics that had opened nearby. They will need assistance to develop a new approach to local patients. The PCT would know better and be able to offer advice on what would fit in best with the range of patients’ needs with long term conditions in their area. Another practice may have not noticed that it is the reputation of one of their staff that is leading to patients drifting away to other providers. Once they know this they may face a difficult personnel situation, which a small practice may find difficult to face on its own.

As the PCT must retain the duty to ensure that there is sufficient primary care in the location, it will have to understand and monitor the successes and problems of its GP practices. It will – as now – still have an interest in assisting GPs to improve their services. However, in addition to its present understanding of GPs, PCTs would also have to monitor the numbers of patients moving from one GP practice to another, and offer assistance to a GP practice who suffers a noticeable decline in registration numbers. Of course, a GP practice need

not accept this offer of help, though it would strongly be in its interest to do so. If, however, a practice becomes unviable or unsafe, the PCT must of course intervene with or without invitation from the practice in question.

But let us continue down the slope of losing patients. If patients continue to leave, and the PCT’s assistance is rejected, and against all the evidence from both patients and their trust the provider thinks they know best, but as a result their business becomes unviable, what should happen?

Most GP practices can be defined as small businesses. In almost every other service sector, there is assistance provided for struggling small businesses from local and regional small business services. For example, if the small business was an IT company, the local small business service would assist with ideas about growth with possible acquisition and mergers. Yet at the moment, GP practices have all the difficulties of being a small business, with very little of the help and assistance that exists for them. So the development of acquisitions and mergers, one of the main ways in which other small businesses develop, seems much harder in primary care than in, for example, the IT sector.

This is where public sector thinking around the problems of failure is generally so static. There is a simple bifurcation: an organisation succeeds and provides services; or it fails and disappears from the market. In fact, the situation is much more dynamic than this. This dynamism arises from the very root cause of the failing service: the only way in which patient choice will precipitate exit is if there is a dynamic set of alternative providers for patients to choose from.

If there is a dynamic set of alternative providers, then it is also they who have the opportunity to approach a failing provider and suggest a number of alternative organisational outcomes. That is to say, successful organisations are also in a position to assist failing providers through a variety of organisational relationships. Within the private sector, this is called an acquisitions and mergers policy, and there are many different organisational forms that this can take.

The most obvious of these, and the furthest away from the maintenance of the existing organisational structure, is what is colloquially known as a takeover. Under these circumstances, a

provider who is running a successful practice can acquire a failing practice and make an offer to that practice's patients to provide their service. If an existing provider is safely providing services within NHS general practice, they should be able to take over a failing counterpart. If there was more than one provider wanting to take over such a practice, it should essentially be the task of the failing practice to decide who they were to be taken over by.²²

Whilst it is acceptable for a failing organisation to be acquired by another, the patients of the former need to have the choice of different providers that all other patients will have under this system. The aim is to provide the reality of choice for all members of the public, including those who are registered with providers who fail. Such people have the right to register elsewhere and cannot be simply taken over by another provider without choice.

It is the task of the PCT to ensure that there is choice for patients in the first place – a theme we explore in the first chapter of this report – and we propose that it will be the task of the PCT to ensure that there is choice for patients if their primary care provider fails. The new 'owner' of the taken-over practice, together with the PCT, would have to write to the registered patients and offer them the choices of primary care provider that exist within their locality. The new owner will only have the right to own the registration of the patients of the practice it has just acquired if those patient decide to re-register, instead of one of the local alternatives.

The takeover of a failing organisation is just one organisational form through which a provider can leave the market. Given a range of different providers it is much more likely that a practice that is starting to lose patients would be noticed before it reached a terminal phase. Under these circumstances a particular provider, who still has a viable set of patients, is likely to be approached by another provider with a view to merging. In this case, the organisation that is losing patients is likely to gain expertise in developing a more successful organisation.

In the first chapter we explained not only that there needed to be a range of choices for the public, but that there needed to be different types of organisations providing those services in order to meet the variety of patient needs. In such a system, primary care providers will succeed because they have a dynamic

22 This decision might be made in consultation with the existing patients, or might be at the discretion of the practice to decide which of the interested parties were most suited to offer primary care in that location.

23 Harold Shipman was convicted in January 2000 of the murder of 15 patients while he was a GP in Hyde. It is now estimated that he killed many more of his patients. The Inquiry was set up to investigate how someone could have continued to work as a doctor whilst killing so many patients. Whilst he was practising several people expressed anxieties about him, but he was allowed to continue working until we have the awful juxtaposition that a GP is also the most prolific serial killer in British history.

approach to giving patients what they want. This dynamism will also ensure that primary care organisations that are struggling or failing have a set of alternatives around them.

The importance of regulation

As I have explained above, patient preference cannot be the sole mechanism by which a provider leaves the market. Given the information asymmetries at work in the healthcare system, the GMC and the Healthcare Commission play a crucial part in upholding the quality of primary care. Yet neither of these bodies carry out these roles adequately at present.

Even though the GMC is the only real means by which a provider (that is, a single GP) can be made to leave the market, it needs significant reform. Criticisms about the way that it has been working peaked and were focused by the Shipman Inquiry carried out by a high court judge, Dame Janet Smith.²³

The Smith Inquiry issued several reports over four years culminating in the fifth report in 2005. This report contained both detailed and general criticisms of the way in which the GMC had carried out its duty to protect. Many of those criticisms mention the GMC's lack of independence from the profession.

Shipman was an extreme and a unique case. However, the Smith Inquiry outlines root and branch problems which demonstrate that the GMC does not at present constitute an organisation that can provide straightforward and transparent protection for the public.

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Given these criticisms, a reformed primary care system based upon choice will also need a reformed and transparent system for deciding on the ‘exit’ of individuals from the profession. It is vital that a renewed GMC provide a better service in protecting the public.

First, the GMC needs to be more accessible. Transparency in its operation should start by making it much clearer to patients how they can raise their concerns. If they are to be encouraged to go through a local PCT NHS complaints procedure, this must have the capability to clearly take a case to the GMC and to represent the concerns of the patient. Patients must know how to do this, and must have assistance from PCTs in seeing this through.

Second, the GMC needs to be more independent. Whilst self-regulation of a profession by a profession is obviously good for that profession, it is less clear whether or not this is of service to the public. The majority of people in any one GMC judgement, and the majority of people on the Council, need to be lay. As the GMC themselves say on their web site, this is not about protecting doctors, but protecting the public. If that is the case then it is the public that need to help carry out that protection.

So the processes for exit for individual practitioners need to be more accessible, more transparent and more independent. But alongside a reformed GMC we need a powerful Healthcare Commission, making judgements not about individual practitioners, but about the efficacy and safety of the services they are providing. How good are the different outputs and outcomes of different primary care providers in different locations?

In recent months, we have become used to the Healthcare Commission raising concerns about safety and efficacy in secondary care. They need to do the same for primary care. Both locally and nationally, it is the task of the Commission to make a judgment on the efficacy and safety of the organisations that provide primary care. At the moment they only regulate the capacity of PCTs, rather than individual practices.

Legally it is interesting to note that at the moment the Healthcare Commission is only allowed to inspect NHS organisations – and that GP practices do not come into that remit. They are defined by the Healthcare Commission as outside the

definition of an NHS organisation. Whilst this is legally correct, it is nonsense that secondary care can be inspected but primary care cannot. Future changes in the law must rectify this.

Conclusions

The first chapter of this report outlined the importance of organising individual and community demand for primary care in a way which encouraged individuals and communities to be much more hands on in demanding a primary care service that fits their particular needs. It also outlined the importance of a new and dynamic set of alternative providers, whether they are from existing GPs, the co-operative movement or new providers from other parts of the private sector moving into this field. The reorganisation of demand and supply of primary care would put the registered member of the public in the lead in developing a primary care service which worked for them.

This chapter explores the different ways in which this reformed primary care system would deal with the failure of specific providers – whether that failure comes through patients choosing not to go to that provider, or from one of the regulating bodies transparently withdrawing an organisation’s right to practice.

Patient-led NHS reforms are not just change because change is a good idea: if we are interested in patients being in charge of their health improvement, if we want to expand the role that people can take in improving their own health, then we need people to be active in their own health service. We cannot expect, in Derek Wanless’ words, to have citizens that are fully engaged in developing their own health, if they are not fully engaged in developing their own health service.

Chapter three: informing choice

Why is information provision so important?

This report so far has discussed the ways in which the primary care sector could be reformed in order to provide patients with more and better choices of primary care provider. However, increasing the opportunities to exercise choice will be meaningless if patients are not given guidance about how best to take advantage of such opportunities or given information with which they can make the best choices to meet their health needs.

The NHS must provide information to patients to help them make choices in order to take forward the founding principle of *equal access for all*. As we shall see, in terms of information provision, the NHS has failed to address this value for over 50 years, but now, within the current reform programme, is the right time to start taking the principle seriously.

This undertaking will not be easy – mainly because the inequality that has to be tackled is only partly caused by past inequalities of information provided by the NHS itself. These NHS-generated inequalities are part of a wider set of inequalities concerning the provision and use of information within our society, which have become so much a part of how British society works that we fail to notice them: official information has generally been developed and published aiming towards a specific part of our society that presupposes a particular educational and cultural use of information.²⁴

This standardised approach has helped to maintain inequality. Thus, the argument for diversity in the provision of primary care, which we put forward in the first chapter of this report, must also be developed in the sphere of information

25 *Choosing Health* HMSO
November 2004

24 The groundbreaking hospital league tables provided by Dr Foster, for example, were initially published through broadsheet newspapers and needed a high degree of both motivation and numeracy to understand.

provision. Because people have different relationships to information, it will be essential to develop an information policy that recognises these differences.

However, the NHS cannot reduce health inequalities on its own. The Government White Paper on health improvement,²⁵ which emphasised the importance of reducing the inequalities of health outcomes in England, recognised the important role that the NHS would play in this, but also underlined that without a wider set of interventions, for example in the way in which food was advertised, the NHS on its own would be inadequate in reducing health inequalities.

The same is true of inequalities in the provision of information to make better choices about primary care. The NHS must play its part in overcoming such inequalities, but so must the rest of society and the rest of government. In the long term, the drive towards raising numeracy standards in primary schools will play a significant role, but the promotion of better numeracy education as part of the corporate social responsibility of large companies would also be very useful. Similarly, if the tabloids started to develop, as they have in their supplements about diet, giving up smoking and fitness, a responsibility towards developing numeracy amongst their readers, the task of the NHS in providing equal access to information for all would be much easier.

In short, there are two issues here: first, we must develop the argument for an information policy that helps the public to make the best choices in primary care in the context of the NHS value of *equal access for all free at the point of need*. Second, we need to recognise that, on its own, the NHS cannot overcome the inequalities of information use in our society. It can play a role, but it needs others to achieve this goal.

Official information in context

It will be of no use to simply churn out masses of data, however statistically correct, if that data cannot be turned into useful information. This transformation of dead numbers into really useful information cannot be simply left to the public, but needs to be an active part of the official policy on information.

This is why we need to recognise that the knowledge we need to make decisions about our health and health care goes

beyond the realms of official information. Whilst this chapter develops, primarily, an argument concerning the provision of official information, we must place that official information in the context of all the other sources of information that we use to make choices about our health.

The publication of data to assist in health choices is relatively new. Organisations such as Dr Foster, and to some extent of the Department of Health itself, have in the last four years begun to provide the public in general, and some patients in particular, with much more information about the health service than was previously available. Over this period there have been considerable improvements in the extent and the form of the data produced, but it is important to remember that we are still in the very early years of this policy and this experience: at the time of writing, only a small proportion of patients in secondary care have had a real choice of either hospital or doctor, so only that small proportion has the active need for such data.

For the vast majority of us, the data being provided has been interesting as a set of hypothetical ‘what ifs’ rather than real choices: it will only be when millions of people are routinely making choices about the particular health services that they need that people will actively and routinely question the quality and usefulness of the information they are provided with. It is the mass use of information that will improve its provision more than any other factor.

We can be sure that the first decade of this century will see a gigantic stride forward in publicly available information about the NHS. However, when the mass use of information does occur, we must bear in mind that there is a much wider context within which this formal information will exist, and this will inevitably have an impact on whether it is of any use to the public. This context consists of the variety of sources of informal information people use to make choices. It is embedded in the way in which we live our individual lives, how we use different forms of knowledge and how we use that knowledge with our family, friends and communities.

Some people in our society already have experience of using official information to make important judgments. Their cultural and educational experiences make this a normal part of their lives. They look at Ofsted reports of schools and they read

‘Which’ before they buy a plasma TV. But even these well informed citizens use such information in addition to a very different form of knowledge, specific to their cultural place in society. For example, a head teacher making judgments about health care is likely to use the official information provided, and will see that information as important. However, he will use this official information in a way and augmented by other things specific to his culture. This cultural knowledge will be different, for example, from that used by some parents of the children in his school.

Everyone engages in this process. We sift ideas and information that derive from entirely different knowledge bases, and we trade off the results of this different knowledge. Nothing the Government does in providing official information will stop the development of other very different sources of information.

Thus, if we want the provision of official information to be a success, we must recognise that it needs to operate within a cultural milieu of very different sets of knowledge. In addition, we need to acknowledge that some people will find official information compatible with their informal sources of knowledge, others will not. Some will rely more on official information than others, some will have higher quality information sources of information than others, and some will find that their cultural sources of knowledge make it easier to understand official information.

Understanding this difference is not a new phenomenon. In the 1970s the sociologist, Basil Bernstein, discussed the two

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major language codes that he felt existed within the class structure of Britain.²⁶ He argued that for the working class there was a restricted code of language and for the middle-class an elaborated code. On its own, in its own context, he stated that we could not claim that the working-class code was ‘worse’ than the middle-class code, but there was a very important disadvantage: the middle-class code was capable of working together with the language of official Britain in a much clearer way than the working-class code. This meant that for the working-class individual, there was a constant need for translation between their day to day cultural language and that of official Britain. For the middle-class individual, there was a snug fit between their language and that of official Britain.

The point is that the same is likely to be the case with official information to help people make choices about primary care services. If we provide this information without understanding these cultural differences, we will not live up to the NHS value of equal access for all.

The existing system of information provision

The case for a developed information strategy could be criticised because official information about health services is likely to benefit the middle-classes more than the disadvantaged. Some therefore claim that reforms will create inequality in the use of information: middle class people will find it easier to use than working class people.

This argument works very well as a critique of reform, but seems completely unconcerned about the extreme inequalities of access to information that already exist in the current system: because a national strategy of providing information to all about primary care cannot guarantee total equality of information at reception and use, there appears to be no recognition of the considerable inequalities that exist at the moment.

This is why the argument presented in this report is based upon a thorough critique of the status quo. Up until the NHS Plan in 2000, the way in which the NHS has provided information to the public about health services has been a disgrace. For a variety of reasons, some wrapped up in professional defensiveness, others in bureaucratic carelessness, it has been almost impossible until very recently for an ordinary patient to

26 Bernstein, B. *Class, Codes and Control* (Volume 1). London: Routledge & Kegan Paul, 1971.

find out almost anything about the NHS in general, or specifically about doctors, practices or hospitals.

This 50 year history of benign neglect of a duty to inform the public has played a considerable part in constructing the extreme inequalities of knowledge and information that exist in our society. The policy of telling the public very little has not meant that nobody knows anything. As with any large system, a few members of the public knew some people on the inside and through those relationships could gain and develop a close understanding of the way in which the health service worked. For these people, who had a cultural way in to the secret information about the NHS, there was a richly textured knowledge of some aspects of their health service. For the rest of the public there was very little indeed.

So we should not fool ourselves. Not providing information for the many and not having choice for the many has played a role in developing inequalities in the NHS of inputs, outputs and outcomes. Any policy of providing information to assist patients in making choices will not instantly overcome these inequalities, but at least it will be a start. Furthermore, the policies outlined in this chapter will not create perfect equality, but we do need to state clearly that continuing the past policy of neglect, allowing a few people a few peeks into the secret garden of private knowledge about public health services, while the rest know nothing, will only create further inequality.

Of course most people will depend upon their local informal knowledge from family, friends and neighbours for how they make sense of their local health services. No official knowledge can do away with this, nor should it try. But if we leave that as the only form of knowledge then the people whose friends, family and neighbours include doctors and the friends of doctors will have better informal information than the rest of us. If we do nothing, informal information sources simply reproduce existing inequalities. To take another example, if we were to allow information about labour markets to operate this way, people who heard about good jobs were likely to be those who move in circles where such jobs are already carried out, with the same being true for those people who work in unskilled jobs. This is why we have insisted on formalising information

about labour markets.

If we take the basic value of the NHS seriously and we believe that equality of access is possible, then we have to reform the way in which information flows at the moment.

What information do people need?

The importance of convenience and access

In writing this chapter on information, I am assuming that the reforms suggested in the first chapter of this pamphlet will be undertaken: not only will there be more capacity of primary care producers, but that provision will be differentiated towards the different needs of different parts of the population. We start by assuming that some primary care providers will be different from each other and that they will want to appeal to different people to register with them in order for their practice to survive and thrive. Thus, unlike at the present time, there will be value in knowing things about primary care practices, because a) they will be different from each other and b) because patients will be able to exercise choice between them.

The first set of information that a member of the public will need concerns the convenience of access: where and when I can see a doctor, who I can see, and how quickly. These are very basic sets of information that we would expect of any service, and indeed some of it is already provided by primary care practices. At the moment, in terms of convenience and access, a practice will usually provide an address, a phone number and a set of times of clinics. You can find these on leaflets provided by the PCT and their web sites.

However, most existing practices have very similar opening times, and therefore this information is not a lever for making choices. The main differentiation provided at the moment is one that we all use all the time – the address. However even this information is of limited use at the moment, because a patient will only be allowed to register within a range of distance from his own address, and some surgeries may already have closed lists.

Given the lives we lead, different sections of the public will want different sorts of access. Some might want to register with a clinic near their workplace and do not mind seeing different doctors, as long as they can see them quickly. Others

might want to see the same doctor all the time and will be prepared to wait, and so on.

A differentiated set of providers, offering different services and types of access, will want to attract these patients with different needs. Providing good information about the services you provide will become one of the main ways in which you can attract new registrations for your practice. They will be able to do so by providing that information about different access as clearly as possible and would need to state whether they had the space on their list for a new person to register.

But information and its provision should go beyond this static form of written information to the role of the receptionist in primary care practices. If members of the public had a choice about where to go for their primary care registration, the role of the receptionist in welcoming new or returning people to a service would be vital. All services, public or private, that want to attract people to come to them for their services recognise that the role of the receptionist is crucial to that attraction. In a world of choice, the same will be true for primary care. As the front-line of information provision, the practice receptionist can attract or drive away registrars by being not only welcoming but answering questions with real information. Under the circumstances of choice, good receptionists will volunteer good information, and people will choose to come to a practice that does that. This will of course go far beyond the formal provision of access information – it may involve a parent calling to find whether a double buggy can get into the waiting room and whether there are nappy changing facilities in the toilets. A good provider will want to advertise a specific convenience and the receptionist will be a part of that.

The services on offer

Once a patient knows how to access the service being offered, they will want to know more about the nature of those services. For example, can some tests be provided on-site rather than being referred to a hospital? Do they have a diet clinic or a relationship with a preferred provider of slimming advice and assistance? Do they have health trainers, as laid out in the Government White Paper *Choosing Health*?

Given that there are 17.5 million people with long term

conditions in the country, many patients would like to know if a primary care provider has a clinic that specialises in a condition, which is likely to be one of the determining factors in making a choice of GP surgery. An increasing number of people will want to know what a practice's attitude is to complementary medicine. Before choosing a primary care practice, a patient might want to know if the GPs will allow them a choice of treatments for their condition.

All of this information simply describes the services on offer and the ease or difficulty of access. It does not seem much to ask and something which is provided in other private services, like gyms. At the moment however, it is rare that we can easily access this information and then have a choice in using the service. If we do not have the information, we cannot make any judgements about signing up for any services.

Fortunately, increasing patient choice in primary care will give providers a strong incentive to offer more services closer to home rather than depend upon hospitals to provide them – and crucially to provide information on those services to ensure prospective patients are better informed on what is on offer. This is how a GP practice will attract patients. However, we must ensure this basic information is provided systematically across the board, easily accessible, reliable and comparable in order for patients to make informed choices.

Quality, safety and reassurance

The information needed about primary care services goes beyond this simple consumer description of a range of services and ease of access. Patients will also want to know the quality of the services on offer that directly relate to their healthcare needs.

A diabetic, for example, might like to know the proportion of diabetic patients from a practice that have been admitted to hospital as medical emergencies in the last year. Of course, this data will be affected not just by the quality of the primary care practice, but also the ethnic origin and age of the people registered there. However, if there are twice as many diabetic patients from one practice who have been admitted in an emergency than the neighbouring practice, then at least this will raise important questions for the patient to ask of the practice.

So patients will be interested in data about health outputs

and outcomes of people registered at a practice. At the moment the amount of public data that exists about the outputs of primary care service is extremely limited and needs to be expanded. This is partly because the system of performance management for primary care providers is far less transparent than, say, for hospitals, and so generates far less public information. As we noted in chapter two of this report, the Healthcare Commission cannot within law inspect most GP practices because they are not “NHS organisations”. This is an odd exception to the role of the Healthcare Commission and needs changing.

The importance of qualitative information

As we explain above, it is very likely that middle class people will find it is easier to assimilate much of the information on outcomes, since it will probably be more compatible with their informal, cultural sources of knowledge. It is not the case that working class people cannot assimilate official information, but given the way in which information is developed in their culture, they might find hard data more difficult to use. Not only do we need to make data such as statistics easier to understand, but if we take the issue of equality seriously, then ‘official’ information needs to take different forms which are more compatible with other cultural forms of knowledge – not just pure data and statistics.

For example, sometimes it is much easier to read about people who have experienced something that we are about to experience than to read a set of statistics about that experience. It is even better if we can talk about and discuss those experiences. More than anything else, this experience-based information will lead the way in allowing patients to make informed choice in primary care.

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Within the NHS, this is not a new reform but has become a useful policy extension within the development of treatment for long term conditions.

“Using trained non medical leaders as educators, people with arthritis and other long term conditions have been equipped with the skills to manage their own conditions. Compared with other patients “expert” patients report that their health is better, that they cope better with fatigue, feel less limited in what they can do and are less dependent on hospital care. The programme....has supported 10,000 patients in this way. By 2008, it will have been rolled out throughout the NHS, enabling thousands more patients to take greater control over their own lives.”²⁷

The NHS Expert Patients programme is based upon the idea that someone suffering from asthma is much more likely to learn the detail of how to manage that condition from a patient than they are from a doctor.

It is not surprising that the Expert Patients programme has proved a success and is being expanded. Expert Patients have the ability to give a person who is thinking of registering with a primary care provider exactly the sort of qualitative information and discussion that they want and need. Such information can also be provided in a form which is much easier to assimilate in the widest variety of cultures, for example a young boy who has contracted asthma is much more likely to have a useful conversation with another young asthma sufferer.

A primary care provider that wants to attract registration would be very wise to place their expert patients at the forefront of their information strategy. To have a discussion about what it is like to be treated there if a patient chose that provider would be a good advert and will welcome more people than any set of official statistics.

However, qualitative experiential information can be provided in other ways that may not need personal contact. Perhaps, as with books on Amazon, someone could write a review of how a practice dealt with their pregnancy and so on, and it can be put in a regular newsletter or on a web site. It could, but would not have to, be a signed testament, and for

27 NHS Improvement Plan
HMSO June 2004 para 3.9

many it would mean much more than the bare statistical data. Indeed, this niche for anecdotal and experience-based information has been recently acknowledged by the launch of “Patient Opinion”. This website allows patients to send in comments and experiences about particular healthcare providers, particular treatments and operations, and acts as a bank of information which can be referred to by those looking to choose a provider of health services as well as those seeking advance information about an operation or treatment.

Who will provide this information?

Taken as a whole, there is a lot of information required to ensure patients can make an informed choice of primary care provider. Who is going to provide it all? Who will make sure that it is correct and accessible? At the moment PCTs have a duty to provide information about primary care services in their area. They do so within the very limited information market that exists, where there is no competition or differentiation between providers. So the information, whilst important because that is all that exists, is very limited.

Within primary care, there is at the moment no competition for the provision of information – not from the Healthcare Commission, from primary care providers or even from Dr Foster. Competition and differentiation between providers will change this and create a complimentary market for information – as information will be more important for providers in attracting patients and more important for patients to help them choose. The PCTs will not be able to ‘regulate’ this new market, since some of it will be provided informally and privately through the internet. But they could extract a range of information from these other sources which they agree with and give their approval to.

Primary care organisations

The organisations that will provide most information will be the primary care organisations themselves. It will be in their direct interests to do so. This is because most of what has been discussed as valuable in this chapter is not high level medical informatics, but rather basic information about where a provider is, when it is open, what it offers, and how it will treat

patients. This is something the provider is best placed to provide and, given the additional incentives of greater patient choice and diversity of providers that we assume will come about (as explained in the first chapter), something which primary care providers will be eager to provide.

Therefore, once there is some form of choice between primary care providers, the wise ones will attract registrations with good information. Those that fail will find that many of the public will move towards those providers that do give better information.

Some GPs may feel that this is a waste of time. “What I should be doing is treating patients, not trying to give them all this information”. But that attitude demonstrates that they believe that it is at all possible for them to provide primary care to people who are not informed about their health service. The Expert Patients programme has shown that the more the patient is involved in their own treatment and become an expert on it, the more likely they are to be satisfied with their treatment and become a better patient. This is, after all, part of what Derek Wanless meant when he used the phrase “fully engaged” about the relationship between the public and its health.

The provision of information will become one of the ways good primary care providers become differentiated from bad providers. Providers that fail to improve their provision of information will fail to attract patients.

Joint working in the private and public sector

We need to blend two very different approaches to answering the question of who is going to provide healthcare information. The public sector approach to providing information would be to set up a public organisation as a source of reliable information, and state that if information comes from this source it can be trusted – but if it comes from anywhere else, you are on your own. Such a strategy does provide a core of trusted information, but the other types of information that exist organically out in the community remain untouched.

The alternative private sector model would be to turn this information into a commodity. Recognising that this commodity has a price for consumers, and believing that somewhere

somebody will buy the commodity, will make the generation of information financially viable. Quality will be controlled by competition between providers and by the consumers who will decide that company x produces good quality data whilst company y does not.

It would be useful of course to blend these drivers for information and improvement. The Government and the NHS do have a strong responsibility for providing this information, because they hold dear the value of equal access for all free at the point of need, and use this as a framework within which to develop policy. But at the same time, information is a commodity and the internet cannot be decommodified even if we wanted to. Health information is the second most searched for category of information on the web and is likely to expand, whatever the Government thinks. In addition, over the last few years health informatics providers such as Dr Foster have successfully developed a market in providing health information and that market itself has now become differentiated so that some of their information is published through broadsheet newspapers and some through supermarkets.

So both drivers for providing information – the public and the private sector – will continue and a partnership between the two is likely to establish greater strength than competition. The NHS needs the entrepreneurial activity of private enterprises that ensure that their product is timely and of relevance to the people that need it. And the entrepreneur needs the NHS and government to ensure that the information is collected and generated correctly and reliably.

This is the field that could be best served by a joint venture, requiring greater coordination between these two sectors. Dr Foster has proved an excellent source of user-friendly information for secondary care. However, its strength lies in drawing together available data and presenting it in a way in which patients can use. It is the responsibility of the Healthcare Commission and the Department of Health to collect, collate and provide such data in the first instance. It is clear Dr Foster and other such innovative bodies will find it very difficult to offer this same service for primary care information unless the Healthcare Commission, the GMC and the Department of Health collect and make available reliable and appropriate data.

Although the Healthcare Commission is now assessing primary care, this is at PCT rather than at practice level. There is still a real need for the generation and systematic collection of reliable and accurate practice-specific information to allow the private providers of information to thrive.

The Government must acknowledge the value of private sector informatics providers as an effective means of disseminating information to a wider audience than any single state provider will be able to reach. Consequently, it is the responsibility of Government to ensure the same transparent and efficient performance monitoring is carried out in primary care as in secondary care and that this information is held in the public realm to allow the market for information to grow and new providers to establish themselves. Once the Government has committed itself to the systematic collection of information on primary care, it is important that commercial organisations are allowed to develop a user friendly way of publishing the information.

Consumer organisations and community groups

In the health service, given that the treatment of long term conditions is the largest responsibility of primary care,²⁸ the organisations that represent these different conditions have the opportunity to provide assistance to the patients that suffer from these conditions in a way that acute care cannot. For example, Diabetes UK has long provided detailed information about self diagnosis and treatment to its members. It is worthwhile for those suffering from such a condition to give their allegiance to an organisation that will help them gain expertise.

Such organisations are trusted and already provide some information about available sources of treatment. If their members had the opportunity to choose between different primary care providers, such organisations would no doubt be motivated to provide clear information about what is provided and what to look for in different providers. They could advertise new clinics and new approaches and could give advice to their members.

Local voluntary and community groups have a long tradition of helping disadvantaged groups with information. The welfare rights and citizens advice movements have successfully provided information to generations of people in a wide variety

²⁸ 80% of GP consultations are with people with long term conditions: *NHS Improvement Plan* HMSO June 2004 para 3.3

of ways. For some this is a matter of receiving leaflets and advice from a local trusted source. The fact that the Citizens Advice Bureau or a trusted local community group gives out the information means that it is trusted as correct and useful. But other groups help people use that information through support and advocacy, representing disadvantaged people to state agencies. It is clear that information about primary care will be much better used if it can become a part of the work of such trusted agencies and advocates.

Some would feel safer if there was just one provider of information. For them, epistemologically, there is only one piece of true information, so different sources of that one piece of true information are unnecessary. Whether this is a good idea or not, in the age of the internet it is simply not possible to control the flow of information. However, plurality of sources can be extremely beneficial. As we explain above, there are multiple cultural ways of making sense of information and of using it in our different lives. Different people look for different sorts of information and can assimilate information more or less easily depending on the format. A plurality of sources of information, and a plurality of forms it takes, will help reduce the risk that a certain cultural, ethnic or socio-economic group will be left without access to easily understandable and culturally relevant information to guide them in making an informed choice.

Additional support

As we explain above, the multiplicity of potential providers of information in the era of greater patient choice – where information becomes a commodity and sought out by empowered patients – will allow for different forms of information to take shape. This is important to ensure different types of patients can use a form of information they can best understand. But how will these various forms of information reach the patients? Dr Foster and various informatics services, for example, may require access to the internet and awareness of their existence. PCTs and surgeries may provide information more directly via leaflets and expert patients, but can we be sure this will be sufficient to reach the hardest to reach and more needy patients?

This is crucial if we are to resolve the problem of inequity of information of access as described at the beginning of this

paper. It may be that the availability of a range of source and forms of information compatible with different cultures, backgrounds etc., is not sufficient for some patients – they may require additional support and guidance to raise awareness of the sources of information available and the choice open to them.

For some patients who are suffering from long term conditions, the local expert patients will provide important assistance. Such people could not only act as a conduit for information and the different primary care providers but will be able to link that closely to the experience of the particular long term condition that the patient receiving information advice is suffering from. This is the most useful way to receive information where it is linked to learning about a concrete condition.

Alongside the expert patient, sufferers from long term conditions can obtain information from the organisations that represent them – again the advice will provide not just ‘information’ but will be linked to the material experience of a particular condition. We must remember that 80% of GP consultations involve people with long term conditions so a proportion of primary care registrars could receive their advice that way.

But there are other primary care patients who do not build a knowledge base of information based on a long term condition who may well need help and advice. Recent choice pilots of secondary care – such as the London Patient Choice Pilot – employed Patient Care Advisers (PCAs), who explained the available choices to patients and offered them advice as well as assistance in making a choice of secondary care provider. The PCAs proved extremely popular amongst patients and improved the uptake of choice.²⁹

There is a case to be made for PCAs or an equivalent to be used to assist choice in primary care. As the vast majority of our contact with the NHS begins and ends with our GP practice, and as we assume in this paper that the choice and diversity offered by different types of primary care provider will increase in years to come, giving the most vulnerable and hard to reach patients extra help and advice in navigating a more complex system of primary care choices is certainly worth considering.

Patient advice could be offered to new residents moving to the area, for example, as an outreach service by PCTs, with PCT staff acting as advisers to direct patients to appropriate

29 See Rossiter and Williams, *Choice: The Evidence* SMF December 2004

sources of information and also to help them choose between a variety of options in the area. There is, however, a wider need here for information for new residents of an area that goes beyond the health service and involves all local public services. Consumers of all public services, when they move to a new location, need assistance with the broad range of choices they face. Rather than construct three or four different information advisers for education etc., a joint approach would be helpful. Given the emerging strength of Local Strategic Partnerships in creating joint outputs of different services, this may be the place to locate a joint advice service to include patients. Such a scheme would limit the cost implications of a series of single services providing advice separately.

Conclusions

50 years of no choice between primary care providers has not created equality of health access, outputs or outcomes. Nor has the policy of benign neglect in not providing the public with information about their primary health service achieved an equal distribution of information between different groups of people in our society.

As we move to introduce greater choice in primary care, and as providers respond by differentiating their offer, patients will come to value the information available to guide their choices. This will stimulate a market of supply for this information which will rely on the generation of accurate and reliable information from the Government, the Healthcare Commission, PCTs and primary care providers themselves.

When we start to provide much more information about primary care services we must recognise that this information will, if poorly constructed, do little to reduce these existing inequalities. We need to recognise the way in which different cultures generate different knowledge about primary care. If it is to reach different cultures, our policy of information provision needs to fit in with this existing cultural use of information. Qualitative information and experience needs to be placed alongside formal data statistics.

The Expert Patients programme, to be rolled out through the whole of primary care by 2008 and covering the long term conditions that reflect 80% of the consultations that take place

with GPs will provide primary care providers with the opportunity to spread information about their practice to such patients. The primary care providers that learn to provide information well will thrive.

The need to provide information advice for citizens to make choices in local public services is going to increase, particularly for the hardest to reach residents. It would be inefficient for each service to provide their own advisers on local information, so a joint service would no doubt cut the costs of such a potential resource intensive undertaking. However some additional support will be absolutely vital if we are to reduce the existing inequality of information in primary care.

30 *NHS Improvement Plan*
HMSO June 2004

31 *Choosing Health* HMSO
November 2004

32 Statements leading up to
primary care White Paper in
January 2005

33 *NHS Improvement Plan*
HMSO June 2004

34 *Choosing Health* HMSO
November 2004

Conclusion

The future of the NHS depends upon developing a patient led primary care system. Policy document after policy document outline the new tasks that primary care will have to take on board if the NHS is going to thrive. In the next few years, according to existing plans, primary care is going to have to:

- Create a clear framework for the treatment and management of the eighteen million people with long term conditions to keep them out of emergency admissions to hospital;³⁰
- Develop more effective health improvement strategies for individuals and communities;³¹
- Deliver primary care in a closer relationship with social care;³²
- Providing much of the diagnostic and outpatient services currently carried out in secondary care and provide most minor surgery in primary care; and³³
- Play a strong role in diminishing health inequalities.³⁴

These are daunting tasks for any organisation to take on board. Taken together, they are a formidable expectation of a growth in responsibility.

Change and reform are crucial for the primary care sector if it is to fulfil this new role effectively. In order for this to occur, there will need to be a series of spurs to change and improvement. The particular spur outlined in this pamphlet is patient choice.

Given the choice, patients are very likely to choose to have the treatment and management of their long term conditions closer to home. Most patients expect and will demand a closer relationship between primary and social care, and if they had a choice between providers that offered a seamless service and those which did not, they would chose the former. Patients also want to see primary care services that cater to their own health-care needs and lifestyle preferences – so that the services they receive are convenient and appropriate for them as individuals.

If individual patients felt they owned their registration, and had a right to place it with the provider of their choice, where they chose to place this registration would prove a significant driver to the development of a patient-centred approach.

However, the public's choice cannot act as a driver for change if there is no choice available. As the first chapter of this pamphlet makes clear, there is no simple way at the moment for people to express any need for a different primary care service more attuned to their own particular needs. Indeed for some people, mainly in poorer areas, getting access to primary care at all is a problem. For many others, in areas where there are closed lists, their right to choose between different GPs is a theoretical not a practical one. And for those people that do have a choice between GP practices, the services on offer are not very different from each other.

The first chapter argues for a clearer expression of people's specific needs into demand for a different set of services, and argues that these demands need to be met by a more differentiated supply of primary care. At the moment, both demand and supply are organised through a bureaucracy that gives influence to existing providers – a situation which is not likely to lead to much innovation or differentiation.

I then discuss how, within a system of choice, services might fail. At the moment few primary care services fail, good or bad. This is generally seen as a good thing for continuity and stability – but not so good for the patients being provided with a bad service which has no chance of failure. Public preference, within a national system of professional and organisational regulation, will drive improvement, and its corollary will diminish services that people do not want to choose. This does not mean that hundreds of GP practices will close, but it does mean there will be an incentive to learn from patient choices that in most cases will lead to improvement. For a few, the lessons of diminishing numbers of patients will not be heeded and services that would otherwise fail will be taken over by the successful GPs that patients are choosing. For a very few patients, their GP service will fail due to a lack of registrations and it will be important that the local PCT can offer alternative providers to these patients. They too must have choices.

Third, I outline the importance of public information.

For too long the assumption that the public cannot handle information about their doctors and their health service has led to an inequality by default: if you are part of a cultural circle that can gain access to the workings of the primary care system, you will have a lot of information about health services. If you are not you, will know very little. An NHS that takes equality of access to health care seriously should work very hard to equalise the inequality in access to information that has developed through these years of benign neglect. It is true that systematically providing official information about primary care will have difficulty in overcoming the decades of existing inequality, but that does not mean that we should not try.

In particular the Government needs to understand the importance of using anecdotal information drawn from individuals' experience, and not base its whole information strategy on numbers. It must ensure at a national and local level that local communities are empowered to use information about public services, whether it is in healthcare, education or policing. To achieve this, there needs to be a set of advisers that can assist people to make sense of this jumble of information.

Choice in primary care will not be the only driver for change, but it will play a major role in reform and improvement. The idea fits snugly within the aspiration of 1948 that people should have a real choice of GP, but – nearly 60 years on – it takes that aspiration seriously enough to want to turn it into a reality.

SMF Publications

Reinventing Government Again

Liam Byrne and Philip Collins (eds.)

2004 marked ten years since the publication of Osborne and Gaebler's landmark book *Reinventing Government*. In *Reinventing Government Again* a number of authors assess the extent to which the ten principles for entrepreneurial government enunciated in the original are reflected in the UK today.

December 2004, £15.00

Too Much, Too Late: Life chances and spending on education and training

Vidhya Alakeson

This report argues that the link between educational attainment and family background will not be broken as long as the pattern of spending on education and training continues to offer a far greater public subsidy to tertiary rather than preschool education. The report proposes a reallocation of spending in the medium term in favour of children under five.

March 2005, £15.00

The Incapacity Trap

Moussa Haddad (ed.)

This report considers a range of complex and often overlapping problems faced by those on incapacity benefit. Its proposals include a new Rehabilitation Benefit with active personalised support to prepare its claimants for work; subsidies for employers to encourage them to take on employees with health conditions; and an expansion of the Access to work scheme to help companies meet the additional costs of taking on those with a disability.

June 2005, £15.00

No More School Run: Proposal for a national yellow bus scheme in the UK

The Sutton Trust

This report argues that a national system of school buses would have a number of benefits: lowering greenhouse gas emissions; improving safety for children; reducing truancy; and enabling the wider community to take advantage of a reliable source of

transport. It also argues that if choice of school is to become a reality for everyone, an effective school transport system is required. June 2005, £10.00

To the Point: A Blueprint for Good Targets

Report of the Social Market Foundation Commission on the use of targets

This report is a thorough examination of the Government's use of targets in four public services: education, health, housing and the criminal justice system. The report sets out the design flaws in the current targets regime but concludes that these flaws are the result of specific design problems. This report presents a range of practical proposals to improve the way in which targets are designed in the future. These are illustrated with a definition with a definition of a "good target", encapsulating the principles of how, and when, targets should be set. September 2005, £15.00

Making Choice a Reality in Secondary Education

Claudia Wood

In this publication the Social Market Foundation argues that the government's proposals on school choice need to be bold and integrated if they are to succeed - or else they risk making an already unfair education system even less equitable when it comes to underprivileged families. The report emphasises the extent to which the English school system has been blighted by inequity of access and outcome and argues that extending choice to all parents could be the key to levelling this playing field.

October 2005, £10.00

A New British Energy Policy

Dr Dieter Helm

Recognising the emergence of a new energy paradigm, this report argues that energy policy should adapt to reflect the new priorities of security of supply and climate change. It contends that a new policy framework would help the UK balance the increasing demand-supply tensions in world energy markets while directly addressing the new priorities of energy policy. Ultimately, only an investment-focused energy policy can credibly advance the transition to a low-carbon economy.

November 2005, £15.00

Patients have had the right to choose a GP since 1948. Yet for most of us, this right is little more than hypothetical: GP surgeries with closed lists, restrictions regarding where we can register and GP surgeries offering almost identical services means even those of us lucky enough to have a choice of GP find we have very little to choose between.

In this report, Professor Paul Corrigan, former Special Adviser to the Secretary of State for Health, explains why our primary care sector has reached this point and what reforms the Government should implement to address the problem.

In the first chapter, Professor Corrigan explains why patient demand must be organised more effectively to trigger new and different forms of primary care, and how supply must be better organised to meet this demand. He discusses what implications this will have for the future role of the PCT. The second chapter goes on to explore how, in a system of patient choice, primary care providers might fail and what the Government should do to deal with them. Finally, the third chapter discusses the need for more information to help patients make informed choices in primary care; who will provide this information and whether additional guidance, perhaps in the form of Patient Care Advisers, is a justifiable cost to help the hardest to reach groups in society exercise their right to choice.

Coming as it does ahead of the Government's White Paper, Healthcare Outside Hospitals, this report offers a unique perspective on what reforms the Government should be considering in order to usher in an era of user-centred primary care fit for today's more diverse healthcare needs and lifestyle choices.

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