Plural provision of primary care: The case of the English NHS

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From secondary to primary care

- Provider plurality began in secondary care
  - Salient in media
  - Costly
- But that leads to primary care changes
  - Demand - hence cost – management requires substitution of primary for secondary
  - Gate-keeping makes choice of hospital depend on choice of GP
- 'Conviction politics' – general practice 'less public'

Research questions

- How plural has English NHS primary care become?
- What are the implications for the construction of clinical commissioning groups?
- The role and power of the medical profession?

'Primary care' = GPs + community health services + dentists + pharmacists + opticians (+ A&E?) (+ ambulances?)

'Become' means since 1998 – Primary Care Act.

Methods

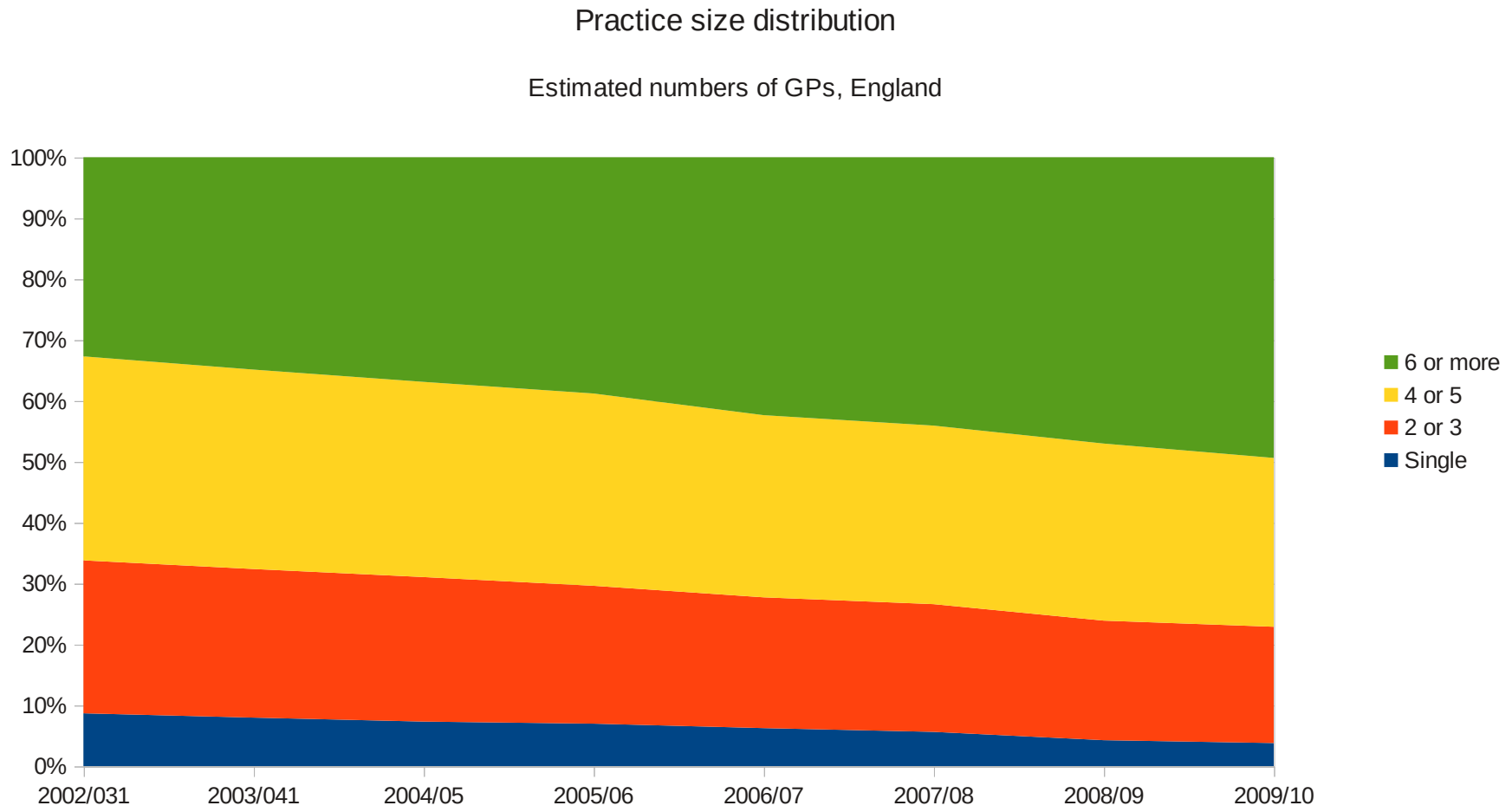
Construct a narrative of pluralisation of primary care, using:

- Systematic review of research on professional partnerships and democratic organisations (co-operatives, mutuals etc,).
- Comparative case studies: 3 different health partnerships + 3 health cooperatives (UK, USA): 6 non-health comparators.
- Re-use of published administrative data.

General practice – old pluralities

- Nearly all professional partnerships
- Trend towards larger group practices
- 9% of GP income from private work (2008); mostly medico-administrative
- Option of 'alternative' health care
- Parallel companies – a legal work-around
- Out-of-hours
  - deputisers
  - cooperatives (see below)

GP distribution by practice size



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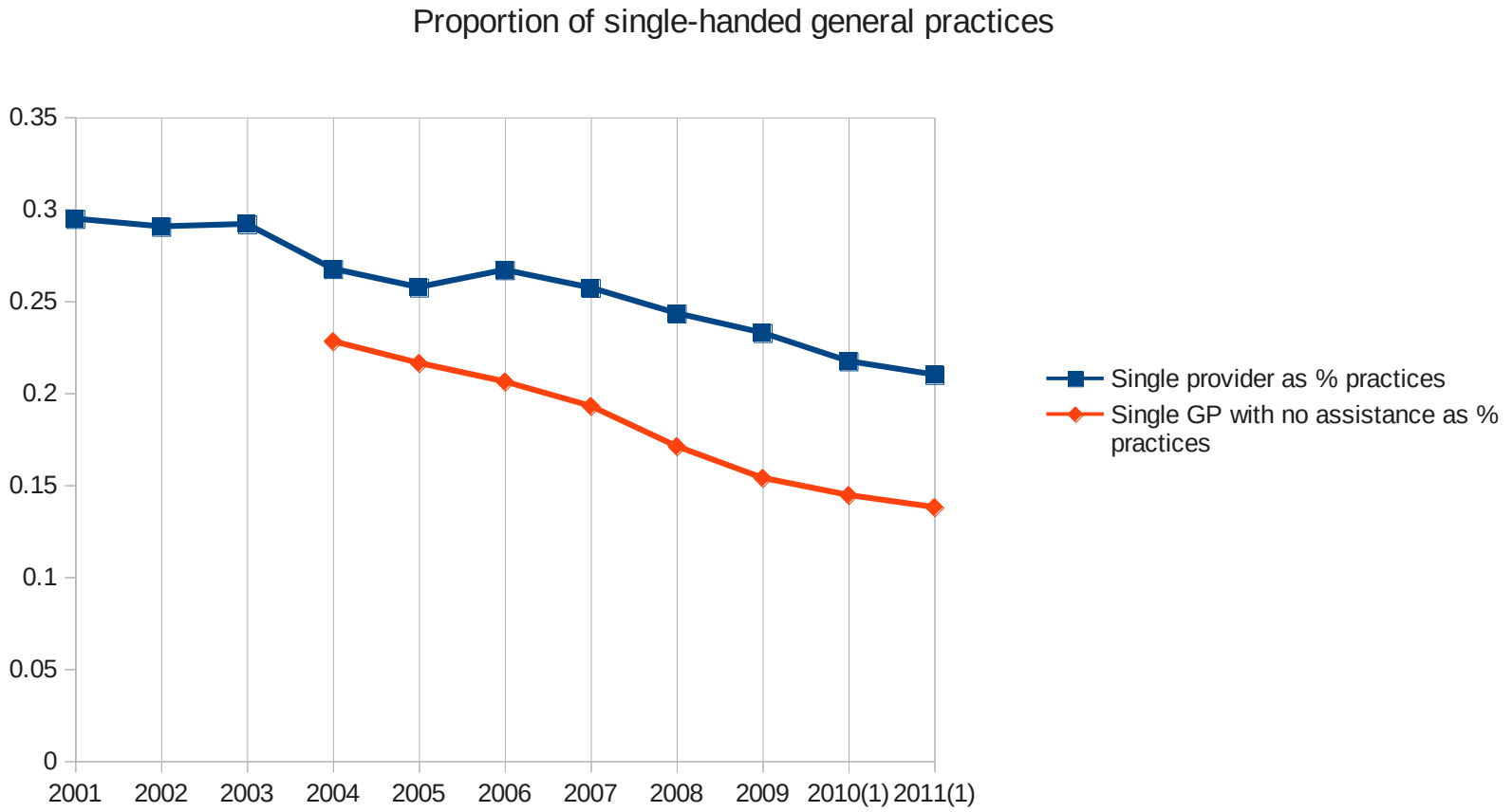
Proportion of single-handed general practices



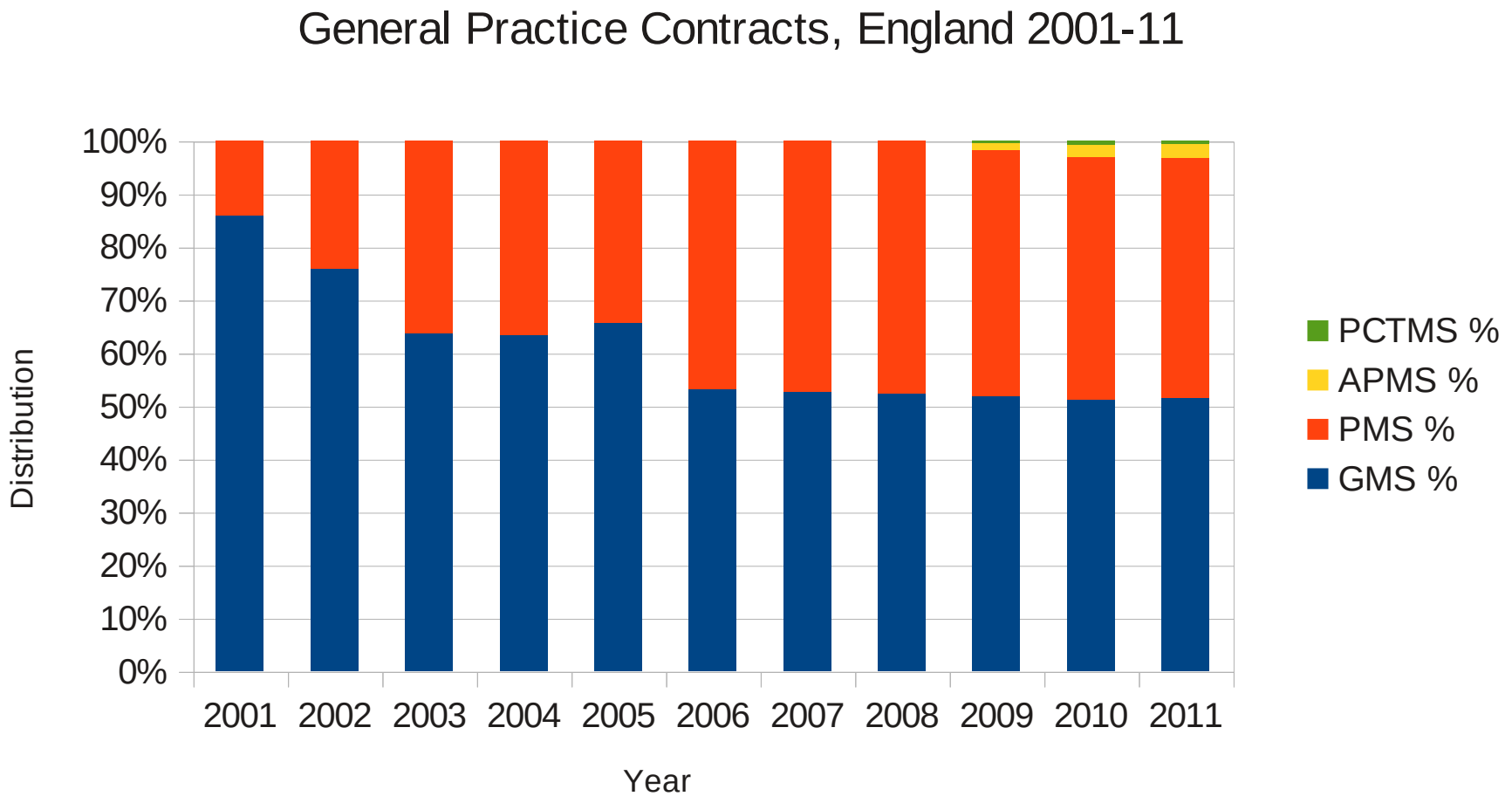
General practice – new pluralities (post 1998)

- GPs with special interests
  - Another try at moving hospital clinics out.
- 'Enhanced Service' payments
- New Contracts → new kinds of general practice (see below)
- Limited Liability Partnerships (2010)
- 'Choice' pilot scheme (April 2012)

Personal Medical Services – a watershed

- 'Salaried general practice'. Possible employers:
  - Partnerships (of GPs)
  - Primary Care Trusts
  - Others …
- Contract is with the practice not the doctor
- Primary medical care can be provided by
  - Non-medical partnerships ('Nurse-led')
  - PCTs
  - Cooperatives, social enterprises, corporations

Distribution of contract types



PMS and its relicts

- New GMS contract – 2004.
  - Quality & Outcomes Framework (QoF) the big addition
  - PMS-like features added to GMS
- PCT Medical Services – nationalised general practice
- Specialist PMS – specialised, supplementary services (non-'core')
- Alternative Provider Medical Services (APMS)
  - Cooperatives
  - Social Enterprises
  - Corporations

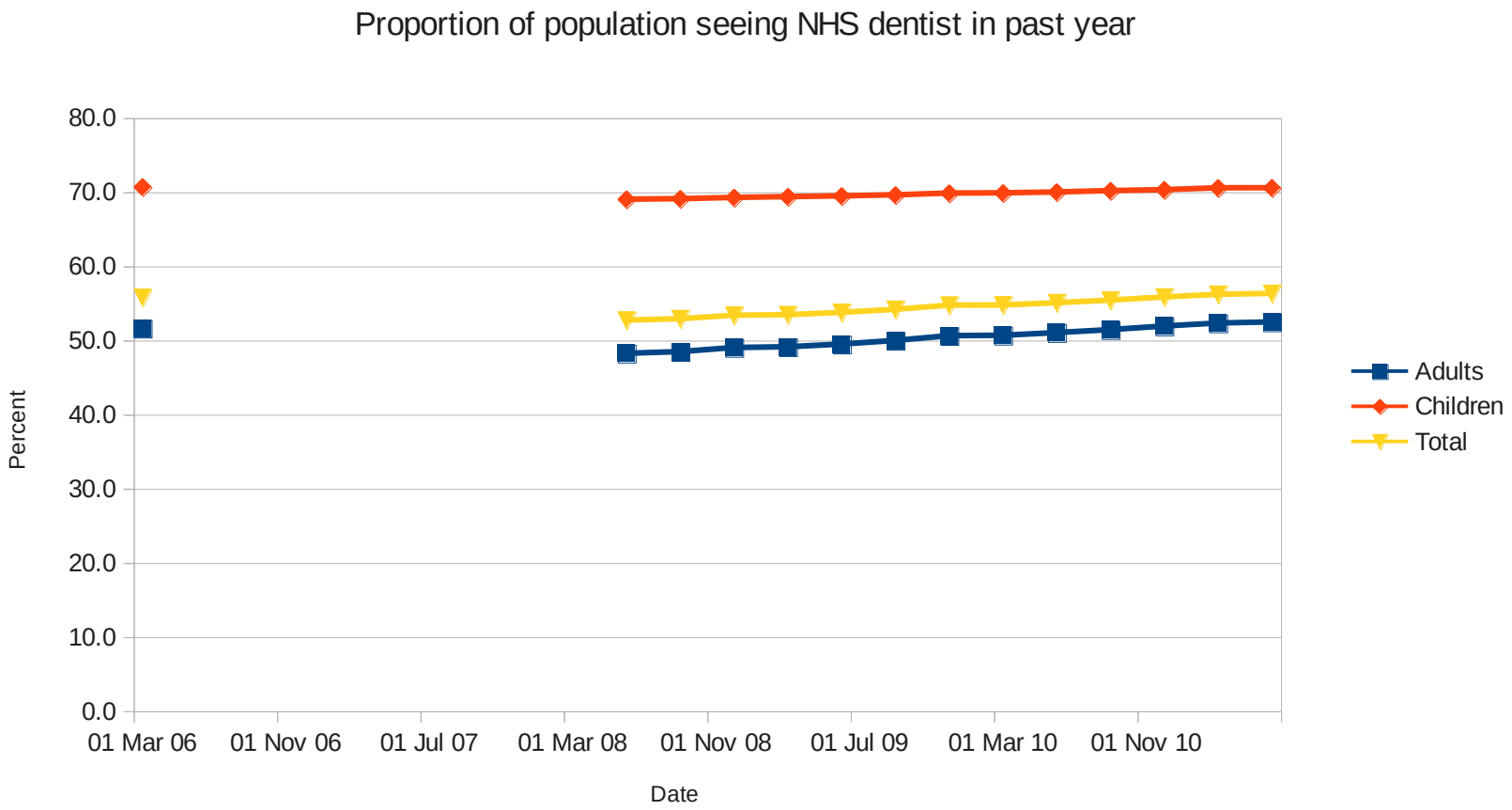
Out-of-Hours Cooperatives

- Paradoxical history
- GP funded and controlled – general practice writ large
- New GMS damaging to co-ops
- Survivors face APMS:
  - Erratic PCT tendering processes
  - Co-ops lack resources for complex competitive bidding
- Corporate competitors. Allegations of:
  - predatory pricing
  - 'Trojan horse' collaborations

Retracting NHS coverage

- English NHS withdrawal from long-term residential care provision (older people, mental health) in 1980s
  - Social security benefit rules
- Fall and rise of NHS dentistry
  - GP dentists gradually withdrawing from NHS work since 1990s
  - 2004: GDS contracts (like PMS)
    - 'Performer' dentists
  - 2006: another new contract
  - Adverse press → Dental Access Programme (2009)
  - 2012: another new contract announced

NHS dental coverage



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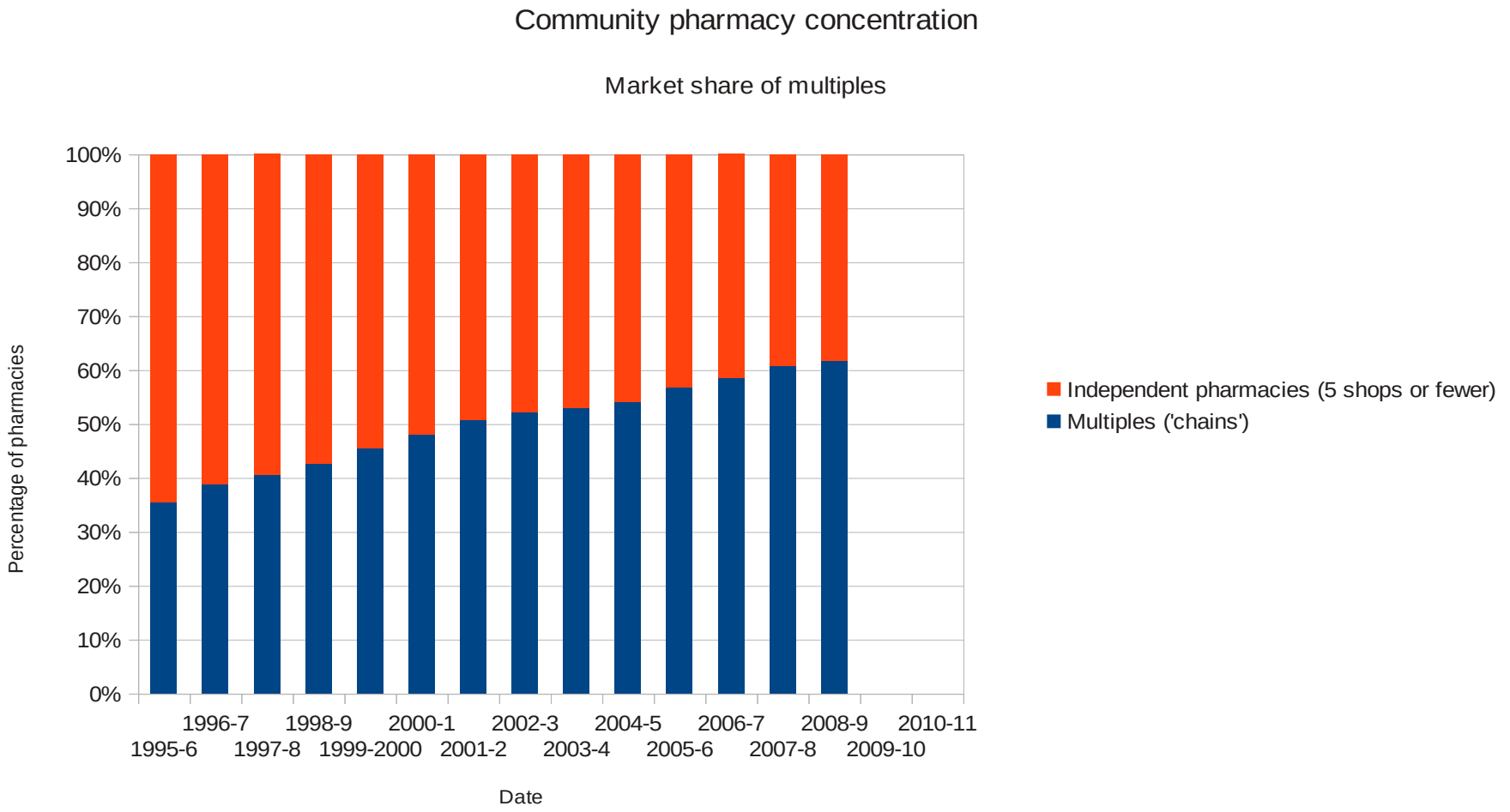
Retail primary care

- Opticians
  - Free NHS sight testing mostly withdrawn (1989)
  - Deregulation of market
  - By 2008, four corporations share 70% of market
- Pharmacies
  - Pharmacy-based consultations – mixed success
  - Prescription charges make OTC cheaper for small items
  - Growth of large pharmacies
  - 'Multiples' gain market share

Community pharmacies - market concentration



Non-medical primary care

- Nurse prescribers, nurse practitioners
- Nurse-led practices – nurse practitioners are owners / partners, employ salaried GP(s).
- Walk-in Clinics
- NHS Direct / NHS 111
- Community matrons
- Improving Access to Psychological Therapies (IAPT)

Corporate community health services?

- GP fundholding and Practice-Based Commissioning allow private provision of CHS – but limited take-up
- Mandatory shift from block contracts to competitive tendering on APMS model
- PCT tactics
  - Move CHS into NHS Trust / Foundation Trust
  - 'spin off' CHS into social enterprise
  - Tendering + corporate provision
- Fluid situation – watch this space …

Re-integrating primary care

- By hardware:
  - Local Improvement Finance Trusts (LIFT) - PPI for primary care
  - Darzi-clinics ('polyclinics', 'polysystems', 'federations')
- By software:
  - GP-led commissioning
  - Local government + NHS collaboration
  - Personal health budgets

Some provisional answers

- How diverse has English NHS primary care become?
  - Qualitatively, much more diverse since 1998
  - Quantitative changes are less dramatic
- Implications for clinical commissioning groups?
  - An uphill struggle for non-corporate providers.
- Role and power of the medical profession?
  - Stratification of general practice
  - Seeds of corporate medicine?

End material

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Questions? Comments? Better ideas?

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