

Which doctor?



Putting patients in control
of primary care

Henry Featherstone and Carol Storey
Foreword by Julian Le Grand



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Foreword

By Julian Le Grand

I have long advocated the virtues of increased choice in public services, both because it seems desirable in and of itself, and because of the incentives it provides for providers to improve the quality of the services that they provide. The present government, to which I have acted as an adviser, has gone a long way down that route for secondary care in the English National Health Service, with positive results both for patients' access to care and for the outcomes of that care. But extending patient choice in primary care has always been problematic – despite, as this report points out, the choice of GP being enshrined in the advertisements that accompanied the creation of the NHS. The difficulties stem from a number of factors, including the catchment area system of allocating patients to GP practices, and rigidities in the funding formulae that give GPs little incentive to take on out-of-area patients, especially those from more deprived backgrounds.

Hence this report is especially welcome. It has many good ideas for developing choice in primary care, including the provision of independent sources of information on the quality of services, the use of Health Trainers to advise on patient choices, and the encouragement of patients actively to re-register with GP practices every few years. I also strongly support the idea of giving GPs a hard budget for commissioning secondary care, thus rectifying some of the problems with the existing system of practice-based commissioning.

But I have a particular, indeed proprietary, interest, in the proposal for a 'patient premium', whereby GPs who accept patients from areas with the worst health and deprivation scores receive an extra payment for each one they take. At a Policy Exchange seminar a few months ago, we discussed this as an extension of the idea of the pupil premium, a proposal for enhancing the progressive impact of school choice that I had put forward many years ago, and that was developed in a recent Policy Exchange publication^[1]. The pupil premium – a premium payment to a school for every child accepted from a deprived area – is designed to give schools an incentive to take on such children and the resources to help with their education. The patient premium should work in a similar fashion, providing GP practices with a direct incentive to take on patients from poor areas, and at the same time giving them resources to deal with any extra calls on their services that such patients might make. Both efficiency and equity would be served.

Overall, the ideas in the report, if properly implemented, could lead to significant improvements in the effectiveness of NHS primary care. They could even contribute to a reduction in that most stubborn of social ills: health inequality. They need to be taken seriously by whatever government emerges after the next election.

London School of Economics, December 2009

^[1] Sam Freedman and Simon Horner, *School Funding and Social Justice: A Guide to the Pupil Premium* London: Policy Exchange, 2008

Executive summary

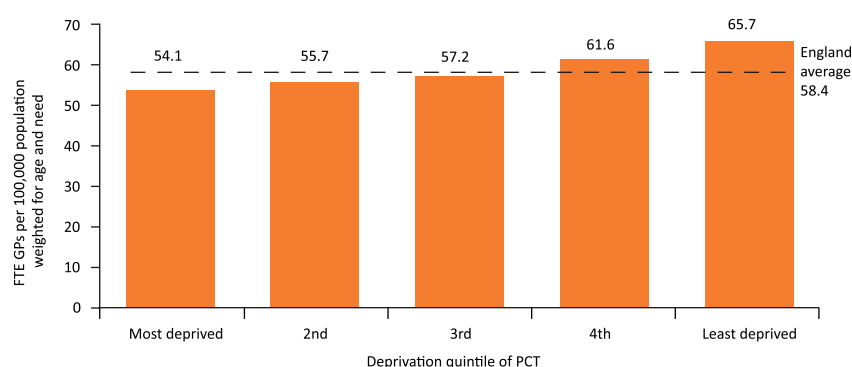
In the last decade choice has become entrenched in the nation's relationship with public services; it is core to the new NHS offering. But, choice of GP was the original NHS offering: "Don't forget, choose your doctor now" said the leaflets and advertisements when the NHS was created.¹ However, we calculate that only 8% of patients each year are offered a choice in the NHS. In an era when NHS spending is going to be under intense pressure, we believe that the choice agenda should be embraced as a way to generate value in the relationship between the patient and the NHS.

Currently, in primary care there is no real choice for patients. Financial disincentives, arbitrary practice boundaries and undifferentiated services have not delivered enough doctors where they are needed. Practice boundaries are geographical catchment areas determined by GPs with the agreement of their PCT - only patients living inside a particular practice's catchment area can register at that practice. In this report we show how, through the mechanism of choice, primary care can be used to help reduce inequalities in health and better engage patients in their own healthcare.

Complex yet ineffective NHS resource allocation

In the last twelve years, spending on healthcare in the UK has risen from £36.4 billion in 1998 to £102.8 billion in 2010.^{2,3} The NHS now employs more doctors, nurses and other healthcare professionals than ever before. There are over 100 new hospitals and waiting lists have all but disappeared. There have been new pay settlements across the board including a series of new General Practice (GP) contracts, implemented in 2004. However, despite these times of plenty for the NHS, there are less GPs where they are needed most: the fifth most deprived Primary Care

Figure 1: Number of GPs per 100,000 weighted population by area deprivation



Source: Department of Health. Tackling health Inequalities. 10 years on. 2009.

1 British Pathe. Trailer film about choosing a doctor under the National Health Service. <http://www.britishpathe.com/record.php?id=51176> Accessed 14 October 2009.

2 The government's expenditure plans 1998-9: Departmental report 1998. Department of Health April 1998.

3 Department of Health: Departmental Report 2009. Annexes. Department of Health 2009.

Trusts (PCTs) in England have an average of 54 GPs per 100,000 population on a needs-weighted basis compared to the fifth least deprived PCTs which have 65 GPs per 100,000 population.⁴

The Department of Health allocates 80% of NHS resources to PCTs on the basis of the relative health needs of their populations. There are 152 PCTs in England with populations ranging from 92,000 to over 1.2 million. Each of these PCTs is given a single total allocation based on a capitated resource allocation formula, the results of which vary considerably between regions. In 2009-10 the highest level of funding was £2,143 per head of population and the lowest £1,253. The England average was £1,540.⁵

This system of resource allocation in the NHS is ineffective because some PCTs receive more funding than they should while others do not receive enough. For example, Department of Health tables show that Richmond & Twickenham PCT is over funded by 23.8% according to the needs of its population, yet it is one of the fifth least deprived PCTs; while Leicester City, one of the fifth most deprived PCTs receives 7.5% too little funding.⁶

PCTs most underfunded (2009-10)	%	PCT Deprivation rank (out of 152)	PCTs most overfunded (2009-10)	%	PCT Deprivation rank (out of 152)
Bassetlaw PCT	-10.6%	72nd	Richmond & Twickenham PCT	23.8%	150th
Barnsley PCT	-9.3%	34th	Westminster PCT	22.7%	46th
South Staffordshire PCT	-7.9%	117th	Kensington & Chelsea PCT	22.1%	70th
Lincolnshire Teaching PCT	-7.5%	103rd	Hammersmith & Fulham PCT	16.4%	33rd
Leicester City PCT	-7.5%	21st	Lambeth PCT	14.1%	9th

Sources: Department for Communities and Local Government. Indices of Deprivation 2007. Department of Health. 2009-10 and 2010-11 PCT recurrent revenue allocations exposition book.

It is the responsibility of each PCT to determine how best to use their resources to meet their local needs and priorities and PCTs use a different formula from the Department of Health to allocate funds to GP practices in their area. But any benefit and equality achieved from capitating funds according to need is undermined by a number of additional fixed payments to GPs and GP practices which distort the market in primary care: the Minimum Practice Income Guarantee (MPIG) and Seniority Payments account for £405 million per year which is 5% of the total expenditure on GP services in England. This process of resource allocation tends to entrench existing provision rather than encourage GP practices or primary care providers to develop services where they are needed most.

The overwhelming majority of GPs are independent contractors to the NHS. They operate on a small business partnership model, employing other staff such as practice nurses, receptionists and even other GPs while retaining a proportion of the practice profits for themselves. However, a prohibition on the sale of GP goodwill doesn't allow well-managed practices to buy out poorer performers, just as currently happens with accountants, solicitors and dentists. Furthermore, the introduction of the new GP contracts has seen an uplift in the salary for all GPs, but

4 Weighted for age and to reflect need for GP consultations, based on the method used for the 2006/2007 revenue allocations for primary medical services. Measured by the Index of Multiple Deprivation 2004.

5 Department of Health. 2009-10 and 2010-11 PCT recurrent revenue allocations exposition book. December 2008.

6 Department of Health. 2009-10 and 2010-11 PCT recurrent revenue allocations exposition book. December 2008.

also widening pay gap between GP partners and salaried GPs. The average income for GP partner in England is £107,667 while that for a salaried GP is £53,940.⁷

Since 1999, one of the key objectives of resource allocation in the NHS has been to contribute to the reduction in avoidable health inequalities. Of course, inequalities in health arise not just because of inequalities in healthcare, but because of

“ Despite these times of plenty for the NHS, there are less GPs where they are needed most ”

inequalities in society such as poor housing. But in the short to medium term, NHS interventions such as the prevention and effective management of risk factors in primary care (e.g. obesity and diabetes) are most likely to deliver reductions in health inequalities, particularly life expectancy.⁸ A Department of Health review of progress in tackling health

inequalities in England has found significant improvements in the health of the nation, but nevertheless, considerable variation in health outcomes still persist, and in some areas the inequalities have actually increased.⁹ This matters because not only do health inequalities persist throughout life, they cross generations.

We believe primary care holds many answers for the NHS: 76% of all activity takes place in primary care, but for just 11% of total NHS costs. Evidence suggests that health systems that are oriented towards primary health care are more likely to deliver better health outcomes and greater public satisfaction at lower costs.¹⁰ International studies show that an increased number of GPs are associated with improved health outcomes for cancer, heart disease and stroke, with increases in life expectancy; and self-rated health.¹¹ Increasing the number of GPs by 10 per 100,000 population reduces all-cause mortality by 5.3%.¹² Achieving this in the fifth most deprived PCTs in England could prevent over 1,300 deaths per year.

We propose that resource allocation in the NHS should be distributed by the Department of Health, or by any new independent NHS board, to a much more granular level - down to individual postcode level of just 15 households - and that the second resource allocation process performed by Primary Care Trusts should be abolished. The NHS resource allocation formula should be weighted on a capitation basis with just three elements: age, postcode and an additional 'patient premium' to act as an incentive to GPs to provide healthcare to patients in areas with the worst health and deprivation indicators.

Unlocking the paradox of choice

However, the choice agenda is not without its critics, and there are many who argue that choice is only wanted by the better off and better educated and that letting patients choose will drive up health inequalities and damage the NHS. But the evidence on choice in healthcare, indeed in the NHS, is that choice is wanted by the people who need it most: 67% of routine and semi-routine want choice compared to 59% of the managerial and professional class; 70% of those earning less than £10,000 per annum want choice, compared to 59% of those earning more than £50,000 per annum, and 69% of those with no educational qualification want choice, compared with 56% of those with a higher educational qualification.¹³ So by designing appropriate incentives the market in primary care can be made to work for those that will benefit from choice the most: those that currently have the greatest inequalities in health.

7 NHS Information Centre. GP Earnings and Expenses Enquiry 2006/07. May 2009.

8 HM Treasury/Department of Health (2002) Tackling Health Inequalities: A Summary of the Cross Cutting Review.

9 Tackling Health Inequalities: 10 Years On - A review of developments in tackling health inequalities in England over the last 10 years. Department of Health. May 2009

10 Macinko J, Starfield B, Shi L. The contribution of primary care systems to health outcomes within organization for economic cooperation and development (OECD) countries, 1970-1998. Health Serv Res 2003;38:831-65.

11 Macinko J, Starfield B, Shi L. Is primary care effective? Quantifying the health benefits of primary care physician supply in the United States International Journal of Health Services 2007; 37(1): 111-26.

12 *ibid.*

13 Appleby J, Alvarez-Rosete A. Public response to NHS reform. The British Social Attitudes Survey 22nd report. 2005

So understanding why patients select one GP practice over another is key. In secondary care – treatment in hospital - access is the most important factor, more so than avoiding long waiting lists. Our research confirms this to be the case in primary care: patients want convenient access to GP practices. But our research highlights the finding that patients value convenience and access more than relationships with a doctor. The implications of this are profound.

Determining factors for choosing a new primary care provider	Most important to you for a new health centre. % selecting *	Most important factors in choosing a GP. % selecting **
Access		
Option to receive treatment there and then	94 %	
Ability to see GP in 24 hours	94 %	
Emergency walk-in appointments	94 %	
Friendly and welcoming receptionist	93 %	
Closeness to home		55 %
Waiting time to be seen and treated		44 %
Doctor-patient relationship		
Ability to choose GP	79 %	
Ability to see same GP on each visit	77 %	25 %

* Data courtesy of Virgin. A nationally representative sample of 1,500 adults conducted in February 2006. Base: 1,215 adults surveyed who are quite or very interested in the new surgery.

** Quality in Healthcare Omnibus survey (Consumers Association 2004). A nationally representative survey of almost 2,000 adults conducted in March 2004.

In the table above, two nationally representative surveys show that the public view primary care services as a homogenous consumer product, with access and convenience rated more important than personal relationships with a doctor. This analysis is supported by a small survey of patients, conducted by the Medical Technology Group, for this report which found 63% of patients said the most important choice in primary care was being able to choose a practice where they could nominate one or more professionals to provide their care, whereas only 35% of patients said that choice of individual GP was the most important factor.¹⁴

Consumer information is poor

There is a lack of high-quality comparable information in primary care. It is extremely difficult for patients to find out how one GP practice is different or better than another - 30% of patients say they don't know where to look for any information that might be available. But in the absence of meaningful data in primary care, simple performance measures can provide a good proxy for clinical performance because high patient satisfaction correlates positively with good quality clinical care.¹⁵

Patients can rate and review hospitals through the NHS Choices website which has just been extended to include GP practices. However, we believe that there should be a clear divide between official and informal sources of information. The NHS should focus on producing standardised, meaningful and accurate information on quality of care and outcomes, whereas personal experience and informal information should be independent and free from the appearance or threat of manipulation or bias. We believe that the NHS Choices website should be run by an independent organisation such as the Consumers Association or I Want Great Care, which already offers a way to rate doctors in the UK.

¹⁴ A survey of 272 patients on behalf of the Medical Technology Group.

¹⁵ Jha, AK., Orav, EJ., Zheng, J., and Epstein, AM. Patient's perception of Hospital Care in the United States. *N Engl J Med*; 359: 1921 - 31

But real healthcare reform as we are proposing can only be driven by putting patients in control of their NHS. Currently, the default position in primary care is no choice at all; patients are just not used to it. As a result the primary care market is largely unresponsive to patient needs. Therefore, we propose that registration with a GP should become an active process repeated every 2-5 years. However, so that this mechanism does not entrench inequalities we suggest that Health Trainers should be used to support patient choice. Health Trainers are already being successfully used to encourage people in disadvantaged communities to adopt healthy lifestyles.

The benefits of fundholding

A fundamental weakness in the way that services are currently commissioned for patients is that GPs do not hold real budgets. GP practices receive funding for core services from PCTs, but the majority of funds to commission other services such as those in acute hospitals or in the community like district nursing are controlled by PCTs. Practice Based Commissioning (PBC) has been developed in an attempt to engage GPs in the commissioning process and to try to shift more services into the community where costs are reduced. But in PBC the budgets are indicative, not real, and as a result it has yet to deliver benefits for patient care and a significant proportion of GPs have not engaged in the process.¹⁶

This is in contrast to the system of GP fundholding and the internal market that operated in the NHS between 1991 and 1997, where increased competition resulted in lower costs.¹⁷ GPs became better at allocating resources as they responded to fundholding incentives and referral rates amongst fundholding practices fell. Admissions for elective procedures amongst fundholding practices were 3.3% lower than they would have otherwise been.¹⁸ And in attracting on-site services from hospital specialists, GP fundholders began to move services from secondary care to cheaper and more convenient primary care settings.¹⁹ Fundholding saw hospital efficiency increase by an average of 1.7% per annum, but after it was abolished in 1997; efficiency fell by an average of 1.6% per annum.²⁰

However, for all the gains in quality, efficiency and system responsiveness, these improvements applied only to patients of fundholders, with negative implications for patient equity.²¹ This raises important questions in terms of how to implement a national policy of fundholding, since by the time it was abolished only 50% of GP practices were fundholders. We briefly discuss two possible options for implementation in Chapter 4.

The commissioning landscape

By shifting budgetary and commissioning responsibility from weak PCT commissioners to those who have most contact with patients - GPs or primary care providers - services will be more directly focused on the needs of patients. Commissioning is a complex process with responsibilities ranging from assessing population needs, prioritising health outcomes, procuring products and services, and managing service providers. If patients are given real choice and GPs hold the funds, the key activities in the commissioning cycle will be split between patients, GP practices and new Primary Care Commissioning Clusters (PCCCs). The existing PCT structures will adopt a more strategic role in managing the commercial and contractual arrangements with

16 Audit Commission. Healthcare Commission. Is the treatment working? Progress with the NHS system reform programme. June 2008

17 Propper C, Wilson D and Söderlund N, (1998), 'The effects of regulation and competition in the NHS internal market: the case of general practice fundholder prices', *Journal of Health Economics*, 17 (6): 645-73. Propper C, (1996), 'Market structure and prices: the responses of hospitals in the UK National Health Service to competition', *Journal of Public Economics*, 61 (3): 307-335.

18 Dushiesko M, Gravelle H, Jacobs R, Smith P (2003). The Effect of Budgets on Doctor Behaviour: Evidence from a natural experiment. Discussion Papers in Economics no 2003/04. York: Department of Economics and Related Studies, University of York. Available at: www.york.ac.uk/depts/econ/documents/dp/0304.pdf

19 Harris A. Specialist outreach clinics. *BMJ* 1977;308:1053

20 Le Grand, J (2002). 'The Labour Government and the NHS'. *Oxford Review of Economic Policy*, vol 18.

21 Mannion R. Practice based budgeting: lessons from the past; prospects for the future. Report to the Department of Health. York Centre for Health Economics. 2005

provider organizations on behalf of the Primary Care Commissioning Clusters. The structures will remain, but the accountability will be reversed.

However, we should be clear that GP practices or Primary Care Commissioning Clusters should not commission all services for all patients. The evidence is that specialised services for complex conditions cannot be sensibly planned, procured and delivered at a local level.²² Specialised services include rare conditions, kidney transplants, secure forensic mental health services and services for very rare cancers which tend to be found in larger hospitals and are commissioned on a regional or national basis.

Currently, the very rarest of these services are commissioned nationally by the National Commissioning Group and this system works well for patients, and feedback is good. Another 35 specialised services are commissioned regionally by 10 Specialised Commissioning Groups, but the £4.6 billion of funds for these services are controlled by PCTs. The result is that none of the 35 specialised services are being commissioned by all 10 Specialized Commissioning Groups and no one Specialized Commissioning Group commissions all 35 services. As a result, care for patients with rare conditions such as Muscular Dystrophy in many parts of the country currently fall well below a minimum acceptable level.²³ In a time when commissioning arrangements and responsibilities are going through a period of change, we believe that these specialised services should be commissioned nationally, until the strategic commissioning landscape stabilises.

We therefore propose the following measures will put patients in control of primary care:

A new transparent model of NHS resource allocation including a ‘patient premium’

1. Resource allocation in the NHS should be distributed directly from the Department of Health, or any new independent board, to GP practices or primary care providers. The method for allocating funds should be based on age, postcode and a ‘patient premium’. The premium element should be funded by a re-allocation from the Hospital and Community Services (HCHS) budget and would act as an incentive to providers to deliver healthcare where it is needed most.
2. Resource allocation budgets should continue to be broken down by speciality area such as acute, mental health, maternity, etc so that they can easily be passed on from GP practices to Primary Care Commissioning Clusters or other providers or commissioners, if required. A separate amount for out-of-hours cover should be added to the allocation. Those primary care providers that want to provide out-of-hours cover themselves might find it offers a competitive advantage to attract patients to their service.
3. Fixed payments which currently distort the market in primary care should be removed, including the Minimum Practice Income Guarantee and Seniority Payments. As part of the process of introducing fundholding to GP practices, restrictions on the sale of goodwill in GP practices should be lifted. This will enable high performing GP practices to take over poorly performing practices.
4. Funding for national specialised commissioning and specialised services, such as Muscular Dystrophy should not be included in the resource allocation to GP practices or primary care providers. It should instead be given to the National

22 Sir David Carter. Review of Commissioning Arrangements for Specialised Services. Report to the Department of Health. June 2006.

23 All Party Parliamentary Group for Muscular Dystrophy. Access to Specialist Neuromuscular Care: The Walton Report. 2009

Commissioning Group and delivered centrally until the landscape for strategic commissioning bodies stabilises. There would be significant cost savings from centralizing these services as well as considerable improvements in the care for patients with the rarest conditions.

Registration with a GP should become an active process

5. Registration with a GP should become an active process that needs to be repeated every two to five years. This would drive competition and contestability into the primary care market. The process of decision making would better engage patients in their own healthcare as well as give a longer budgetary cycle to GP practices, which would also help reduce unavoidable variation in healthcare spending.

Improving information in primary care

6. Improving information is fundamental to unlocking the potential health gain from a market in primary care. It should be a priority for the Department of Health to focus on developing meaningful measurements of performance in primary care. In the meantime, and since patient satisfaction is the best available measure of high quality clinical care, independent sources of rating and patient feedback should be promoted and encouraged. We believe that the NHS Choices website should be run by an independent organisation such as the Consumers Association.
7. Health Trainers should be used as the mechanism for supporting patient choice in primary care in the most disadvantaged areas. They should be equipped with the means to deliver meaningful information to those households where they are supporting choice of primary care provider. Developing a knowledge base of health literacy in the UK will ensure that the most deprived patients are supplied with relevant information.

Introduction:

What is primary care?

Primary care is the place where most serious illnesses first present, but also where the majority of long-term conditions are managed. The National Health Service describes primary care as the term for the health services that play a central role in the local community: GPs, pharmacists, dentists and midwives. However, the primary care team tends to focus around general practitioners (GPs), since they are usually the first point of contact for patients, and provide a co-ordinating role should the patient need the input of more than one healthcare professional. Continuity of care is an important characteristic of primary care in the UK which is considered among the best in the world.²⁴ Another key function of GPs is to serve as a gate-keeper to more advanced and more costly types of care from hospital-based specialists. The NHS requires that patients first register with a GP before they can be referred to access specialist services in non-emergency secondary care. The only other way in which an NHS patient can get referred to further services is through an Accident and Emergency Department.

Since GPs are generalists by training, primary care can provide healthcare for all conditions ranging from routine screenings and immunisations through maternity services to management of chronic diseases and even minor surgery. However, a primary care service appropriate for the needs of future populations will have to be capable of delivering more services than are currently provided in hospitals, such as physiotherapy, X-rays, CT scans and blood tests, as well as effectively manage the increasing incidence of chronic diseases like diabetes. These requirements will become all the more acute as many commentators believe the NHS will, because of an inability of resource growth to keep up with rising demand, need to find cost savings of up to £20 billion over the next 3-5 years.

The establishment of the NHS in 1948 saw GPs arranged as self-employed contractors. They were contracted to work for the NHS under a General Medical Services (GMS) contract between the Secretary of State and the individual practitioner, on terms which were negotiated nationally. Ever since, GPs have operated on a small business partnership model, employing other staff such as practice nurses and receptionists and retaining a proportion of the practice profits for themselves. This national monopoly position continued unchecked until 1997, although the general medical services contract had major revisions in 1948, 1966 and 1990.

Real change came in 1997 when the national GMS contract was supplemented by the introduction of personal medical services contracts, which allowed local negotiations between general practitioners and commissioners about service specification. These personal medical services (PMS) arrangements were taken up by significant numbers of existing practices, approximately 40%.²⁵ However,

24 C. Schoen, R. Osborn, M. M. Doty, D. Squires, J. Peugh, and S. Applebaum, A Survey of Primary Care Physicians in 11 Countries, 2009: Perspectives on Care, Costs, and Experiences, Health Affairs Web Exclusive, Nov. 5, 2009, w1171-w1183.

25 NHS Primary Care Contracting. Primary Medical Services Contracts - A guide for potential contractors. November 2006.

despite these changes, there continued to be persistent and particular problems in ensuring enough GPs were located in deprived areas. GPs monopoly on the provision of primary care underwent major reform with the new GMS contract in April 2004. This dramatically changed the contractual environment for primary care, although at the time the Government promised a stronger role for primary care with more GPs and investment.

The General Medical Services contract was replaced with four separate alternative contracts which allowed Primary Care Trusts (PCTs) to contract with commercial organisations that were capable of delivering primary care services in their area:

1. A new General Medical Services (GMS) contract between GP practices and PCTs. This is the predominant form of contract for GPs and GMS contractors must always provide the full range of essential services and maintain a registered list of patients. The contract must be with at least one GP as a provider of essential medical services.
2. A locally negotiated Personal Medical Services (PMS) agreement. PMS arrangements are an alternative to GMS, in which the contract (the “agreement”) is agreed locally between the contractor and the PCT and is designed to encourage local flexibility and innovation and a focus on local population needs. Importantly, however, there is no requirement to follow the nationally agreed pay structure for GMS and there is no requirement for the contract to be with a GP provider.
3. An Alternative Providers Medical Services (APMS) contract. This is aimed at commercial companies employing salaried doctors and is intended to help reduce areas of historic GP under-provision and improve access in areas with problems with GP recruitment and retention. Again, there is no requirement to follow the nationally agreed pay structure for GMS and, in addition, the APMS contract can be with “any person”, thereby allowing contracts with commercial organizations.
4. A PCT Medical Services (PCTMS) contract where doctors are employed directly on a salaried basis by their PCT.

As a result of the above changes GPs no longer have a direct contractual relationship with the Secretary of State because all contracts are between a GP practice or a company and the PCT. GPs may continue their work as partners in a practice; as employees of practices, PCTs, or corporations; as directors or shareholders of commercial companies providing primary care; or as subcontractors to whatever entity holds the contract with the PCT. At the same time as these new contracts were introduced, and in order to derive greater market flexibility, GPs or primary care providers no-longer had to provide comprehensive services to all their patients. Primary care was separated into three different elements with discretion on which services should be provided by each contractor resting with the local Primary Care Trust:

Essential services: These are the core level of service that patients would expect their GP to provide when they are ill. It has legal basis and includes conditions from which recovery is generally expected or a referral to secondary care might be required, and the management of patients with terminal illness and chronic disease. While GPs are the only professionals qualified to deliver the full range of

essential services to patients, the use of skill-mix by other healthcare professionals such as nurses will play an important part in effective service delivery.

Additional services: There are a number of further services that general practice usually provides to patients, such as cervical screening, contraceptive services, maternity services, child health surveillance, immunisation and minor surgery.

Enhanced services: These are services which a GP practice or primary care provider can choose to provide, although they must be made available within the local area by the Primary Care Trust. They include such things as more specialist services currently provided in hospitals and out of hours care, which is the GP service delivered between 6:30 pm and 8:00 am on weekdays and at all times during weekends and public holidays.

Previously, quality rewards for GPs were small, but the new GMS contract has introduced larger financial incentives for delivering measurable levels of quality in patient care through the evidence-based Quality and Outcomes Framework (QOF).

All these changes to the GMS contract have been criticised as a significant shift away from government control of public services to public service reform and control exercised through commercial contracts.²⁶ The principal argument is that there is a lack of public accountability and that patients have a limited voice in service delivery. While these arguments might sound ideological; they are also pragmatic. Services such as out of hours care are key elements of the primary care model and should not be determined by the closed relationship between PCTs and GP practices or primary care providers, rather the availability of these services should be decided by the patient in selecting which GP practice or primary care provider is best for them. Indeed, a key driver for shifting responsibility for providing out of hours care during the GMS negotiations was the fact that 84% of doctors said that they should be able to choose whether or not to provide out of hours care.²⁷

Furthermore, one of the fundamental aims of the new GMS contract was to recruit doctors into more deprived areas. However, in 2008, four years after its introduction the National Audit Office has found that the new contract has not yet led to a measurable improvement in shifting primary care services into deprived or under-doctored areas.²⁸ We will show how patients can be given a real choice in primary care; how they can be better engaged in their own healthcare and how direct accountability in the NHS can be established.

26 Pollock A, Price D, Viebrock E, Miller E, Watt G, et al. The market in primary care. *BMJ* 2007;335:475-7

27 National Survey of GP Opinion. British Medical Association, 2001.

28 National Audit Office. *NHS Pay Modernisation: New Contracts for General Practice Services in England*. February 2008.

1

There is no choice in primary care

The ability to choose a GP has existed, in theory, since 1948.²⁹ From the outset, the new National Health Service encouraged patients to fill out an application form and hand it into their preferred doctor. The message to all households was clear, “Don’t forget, choose your doctor now” said the leaflets and advertisements.³⁰

But even with the recent NHS emphasis on patient choice only a few patients actually have real options. The focus of choice in the NHS has been on patients being referred to secondary care. We calculate that only 4 million patients were actively offered a choice in the NHS in 2007-08.³¹ There are approximately 51 million people in England and Wales registered with a GP, and at this crucial part of the NHS – the choice of GP - they are being excluded from making choices in the NHS.³²

Because patient choice in primary care hasn’t been a practical option there is no nationally available information on how patients might choose a GP. National Patient Choice Surveys slavishly validate the current direction of policy focus which is for choice of secondary care provider. A recent patient survey in the West Midlands, however, gives an interesting insight into how some patients compare GP surgeries.³³ Patients were asked about sources of information they would use if they wanted to make a comparison between GP surgeries. The most common answer given was ‘media’ which included the internet and local press. Most concerning, however, was the fact that the second most common answer was ‘don’t know’.

29 The New National Health Service. Prepared by the central office of information for the ministry of health

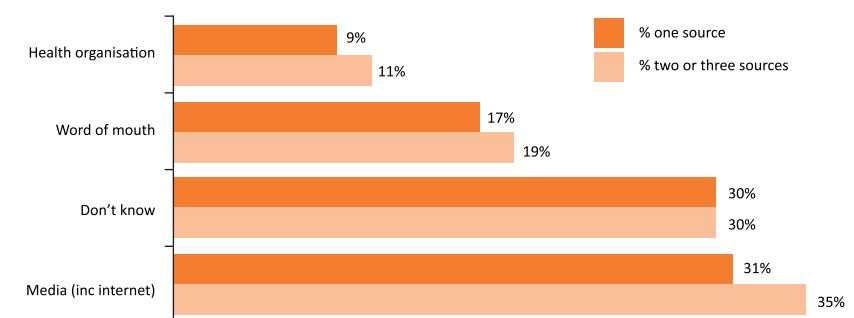
30 British Pathe. Trailer film about choosing a doctor under the National Health Service. <http://www.britishpathe.com/record.php?id=51176> Accessed 14 October 2009.

31 In 2007-08 there were around 16.5 million first outpatient attendances. Of these 8.9 million resulted from GP referral (<http://www.ic.nhs.uk/statistics-and-data-collections/hospital-care/outpatients/hospital-outpatient-activity-2007-08>) to an outpatient clinic. The latest Report on the National Patient Choice Survey - December 2008 England 46% of patients were offered a choice of hospital for their first hospital appointment (DH. Report on the National Patient Choice Survey - December 2008 England. 2009). Therefore: $8.9 \times 0.46 = 4,094,000$ patients offered a choice in the NHS in 2007-08.

32 <http://www.ic.nhs.uk/statistics-and-data-collections/population-and-geography/population/attribution-dataset-gp-registered-populations-2008>

33 NHS West Midlands. Annual Telephone Survey 2008. Ipsos MORI. September 2008.

Figure 2: Patients’ source of information to compare GP surgeries



Source: NHS West Midlands. Annual Telephone Survey 2008. Ipsos MORI. September 2008.

Not only is there is a lack of high-quality comparable information on different primary care providers, patients do not even know where to look for what information might be available. Providing detailed information solely via the internet may ex-

clude marginalised groups from making informed choices, since 35% of households do not have access to the internet.³⁴ The West Midlands survey confirms the potential for unequal access to information: 39% of residents aged 16 to 24 would be most likely to use the internet as an information source, compared with 5% of those aged 65 and over.³⁵ And only 23% of those aged between 16 and 24 say they don't know where to look for information on primary care providers compared with 40% of those aged 65 and over. Many households without internet access are those that have a greater need for medical services such as the elderly, or people without formal qualifications. Of those aged over 65, 70% have never used the internet and there is an educational split between households with internet access: 93% of individuals with a degree have access to the internet at home compared to 56% of people with no formal qualification.

Today therefore, patients have to accept what primary care services are provided in their area. All GP practices have practice boundaries, which are determined by GPs with the agreement of their Primary Care Trust (PCT). Practice boundaries are geographical catchment areas – only patients living inside a particular practice's catchment area can register at that practice. Patients living within walking distance or a short car journey away from a particular practice cannot register as a new patient if they live outside the practice boundary, even if it is more convenient for the patient or the GP.

These practice boundaries restrict choice for patients. Since most GP consultations take place during working hours – between 8am and 6.30pm, and since many people work some distance from their home, accessing a GP can be difficult for many people who work. In one study of utilization of GP services by patients with diabetes and asthma, 37% of patients found work commitments hindered their access to GP services.³⁶ And poor work-time access disproportionately affects manual groups, who are more likely to lose wages from a visit to the doctor than salaried employees.³⁷ Indeed, there is much lower utilisation of GP services in general by manual groups – 18% visited their GP once a month compared to 26% of non-manual groups, and this usage is contrary to where the burden of disease lies.³⁸ New walk-in centres have been introduced to give patients an alternative to their registered GP. There are 90 of these centres which tend to be concentrated in urban areas; however, they tend to be used by young white property-owning adults, with tertiary education.³⁹ Since this pattern of usage is contrary to where the burden of disease lies, the failure to deal properly with access for people at work actually increases inequality. Whilst the goal of equality can be seen as an ideological argument in its own right, it is at the core of the foundation and the development of the NHS as an institution. The principle of 'equal access to all free at the point of need' is a crucial value for the NHS. Anything that detracts from this detracts from the key values of the NHS and needs tackling.⁴⁰

Around 3.5 million patients change GP practice each year and may do so for a variety of reasons, but the most common is because they move house.^{42,43} There are undoubtedly a few, although no official information exists, who change GP without moving house because they are unhappy with the quality or range of services on offer.

“ Not only is there is a lack of high-quality comparable information on different primary care providers, patients do not even know where to look for what information might be available ”

34 ONS. Internet Access 2008. August 2008

35 NHS West Midlands. Annual Telephone Survey 2008. Ipsos MORI. September 2008.

36 Ken S. Field and David J. Briggs. Socio-economic and locational determinants of accessibility and utilization of primary health-care. *Health and Social Care in the Community* 9(5), 294–308 294

37 Anna Dixon, Julian Le Grand. Is greater patient choice consistent with equity? *J Health Serv Res Policy* Vol 11 No 3 July 2006

38 Ken S. Field and David J. Briggs. Socio-economic and locational determinants of accessibility and utilization of primary health-care. *Health and Social Care in the Community* 9(5), 294–308 294

39 Salisbury C, Munro J. Walk-in centres in primary care: a review of the international literature. *British Journal of General Practice*. 2003;53:53-9.

40 Ken S. Field and David J. Briggs. Socio-economic and locational determinants of accessibility and utilization of primary health-care. *Health and Social Care in the Community* 9(5), 294–308 294

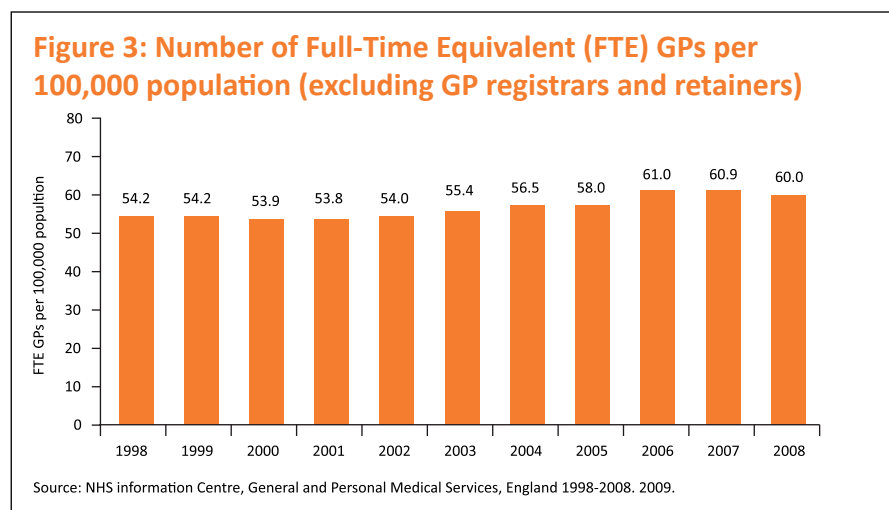
42 NHS Connecting For Health Weekly Digest July 2009. <http://www.connectingforhealth.nhs.uk/newsroom/statistics/digest/080709.pdf?searchterm=gp>

But simply removing practice boundaries – as the Secretary of State has recently proposed to do⁴⁴ – will not be enough to generate a responsive and equitable market in primary care for two reasons. First, because any competitive effect from the 3.5 million people who switch GP when they move house will be removed; and second, because making patients move GP practice will favour those that are more mobile and affluent; it will entrench inequality. Removing practice boundaries solves the middle class commuter problem; it will not do anything to encourage GPs to move into areas with the greatest need for their services.

Under-doctoredness restricts patient choice

The Government’s financial commitment to the NHS has seen the number of GPs rise by 20% over the last 10 years.⁴⁵ However, a growing proportion of GPs tend to work part-time, with 27% of all GPs now working on a part time basis compared to 18% in 1998.⁴⁶ As a result, the rise in full-time equivalent (FTE) GPs per 100,000 population has been much lower at 11%. Indeed, as the graph below shows the number of full-time equivalent GPs per 100, 000 population is now falling.

Improving access to GP services was a key aim of government policy, but gaps in GP provision persist in many areas. Across England around 2%⁴⁷ of practices are closed to new patients. A further 10% operate an ‘open-but-full’ basis,⁴⁸ which means that they are not registering new patients, but by technically remaining ‘open’ they are avoiding the financial consequence of operating a ‘closed list’. Closed and ‘open-but-full’ lists restrict patient choice.



A breakdown of the national figures shows that there is considerable geographic variation in the numbers of practices closed to new patients. In some areas, the proportion of closed lists is as high as 28%. Closed lists are a particular problem in areas where there are insufficient doctors, the so-called ‘under-doctored’ areas.⁴⁹ As seen in the table below, ‘open-but-full’ lists and closed lists⁵⁰ are found mostly in the 10% of PCTs with fewest GPs.^{51,52}

43 Salisbury CJ. How do people choose their doctor? BMJ 1989; 299:608-10

44 Speech by the Secretary of State to the King’s Fund. 18 September 2009. http://www.kingsfund.org.uk/learn/conferences_and_seminars/past_events_catch_up/breakfast_debate.html Accessed 14 October 2009.

45 NHS Information Centre. NHS Staff 1998 - 2008 (General Practice). March 2009.

46 Department of Health. Statistics for General Medical Practitioners in England 1994–2004. NHS Information Centre. NHS Staff 1998 - 2008 (General Practice). March 2009.

47 Source: House of Commons Hansard Written Answers for 28 Apr 2008 (pt 0037); Department of Health. Our Health, Our Care, Our Say. 2006

48 NAO. NHS Pay Modernisation New Contracts for General Practice Services in England. 2008

49 Source: House of Commons Hansard Written Answers for 28 Apr 2008 (pt 0037); Department of Health. Our Health, Our Care, Our Say. 2006

50 Source: House of Commons Hansard Written Answers for 28 Apr 2008 (pt 0037); Department of Health. Our Health, Our Care, Our Say. 2006

51 Identified in Department of Health. Our Health, Our Care, Our Say. 2006

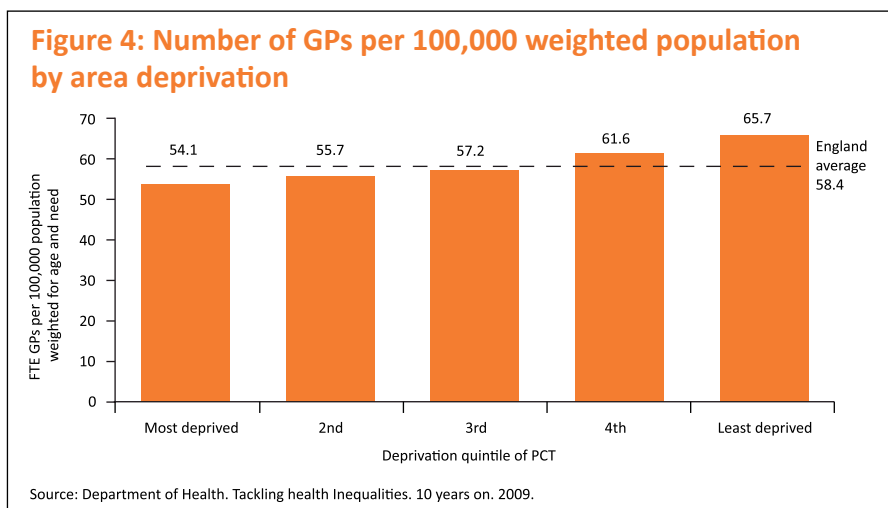
52 Based on WTE GPs per 100,000 population weighted for age and to reflect need for GP consultations.

Rank (1 = worst)	10 PCTs with highest % of (all) practices whose list is closed for new patients to register	% of (all) practices whose list is closed for new patients to register	Bottom 10 % of PCTs with the fewest GPs*
1	Trafford PCT	27.7%	✓
2	Newham PCT	18.6%	
3	Warrington PCT	17.2%	
4	South Tyneside PCT	13.8%	✓
5	Peterborough PCT	12.9%	
6	Salford PCT	12.7%	
7	Great Yarmouth and Waveney PCT	12.5%	
8	Eastern and Coastal Kent PCT	11.9%	✓
9	Blackburn with Darwen PCT	9.7%	✓
10	Hull PCT	8.3%	✓
	England Average	1.7%	

Source: House of Commons Hansard Written Answers for 28 Apr 2008 (pt 0037); Department of Health. Our Health, *Based on GPs (WTE) per 100,000 weighted population Note: PCT boundaries have changed since the 2006 White Paper. PCTs in bottom 10% with fewest GPs are those whose boundaries now cover the previous PCTs identified in the White Paper.

Moreover, the areas that are under-doctored are those with the greatest need for healthcare services. On a needs-weighted basis, the most deprived areas have fewer doctors per head than PCTs in the least deprived areas as shown in the graph below.⁵³ Primary Care Trusts in the least deprived areas have around 11 extra GPs per 100,000 weighted population, which is equivalent over 1,000 additional consultations per week.^{54,55} But not only do deprived areas have insufficient doctors the Care Quality Commission has confirmed that the most deprived areas receive the poorest care from GPs.⁵⁶ Its recent report which looked at progress on tackling cardiovascular disease and health inequalities found that GPs in deprived areas are less likely to refer smokers to stop-smoking services and to prescribe them nicotine-replacement products. Smoking is the largest preventable cause of ill health and premature mortality, so huge opportunities are being missed to tackle the burden of disease in deprived areas.

The Government has belatedly established a program to address inequalities in GP access. Since 2008, the Equitable Access to Primary Medical Care services (EAPMC) has committed new investment of £250 million to support PCTs in



53 Weighted for age and to reflect need for GP consultations, based on the method used for the 2006/2007 revenue allocations for primary medical services. Measured by the Index of Multiple Deprivation 2004.

54 For number of consultations see NHS Information Centre. 2006/07 UK General Practice Workload Survey. 2007; for GPs per 100 000 weighted population see Department of Health. Tackling Health Inequalities: 10 Years On. 2009

55 Average number of consultations per 'full-time' GP partner multiplied by difference in number of GP per 100 000 weighted population.

56 Care Quality Commission. Closing the gap: Tackling cardiovascular disease and health inequalities by prescribing statins and stop smoking services. September 2009.

establishing 100 new general practices in the 25% of PCTs with the poorest provision and one new GP-led health centre in each PCT in easily accessible locations. However, since these are allocations to PCTs, there is no market based incentives to ensure that practices are established in the most deprived areas, simply that the most deprived PCTs are given funds to establish new GP practices.

Undifferentiated services further restrict choice

Primary care services and the way they are delivered are decided and are controlled centrally by the State. The line of command from the Department of Health through Strategic Health Authorities (SHAs) and PCT to GPs is rigidly enforced. However, different communities have different needs – the population living in a young, cosmopolitan conurbation will have very different needs from a rural village. Added to this, different people in the same community can have very different needs – a mother with two young children will need access to services distinct to those required by a middle-aged male commuter. The way these services are delivered matters too. The mother may prefer to be able to walk to a surgery close to her house whereas the commuter may prefer to see a doctor close to his work or before or after the working day.

Although GPs as generalists can advise, treat and manage the majority of medical conditions in a primary care setting, most primary care services are, in fact, delivered in a very similar way.⁵⁷ Investment in the NHS, and primary care in particular, has tended to roll out more of the same which means those who have different needs are not being catered for. Yet, differentiated capacity is as important as quantity of capacity. As Professor Paul Corrigan notes, “the process of delivering more must coincide with the process of delivering differently.”⁵⁸

The 48-hour target is a typical example of the one size fits all approach. One of the objectives of the NHS Plan, in 2000, was to guarantee for all patients access to a primary care doctor within 48 hours by 2004.⁵⁹ GPs delivered this target on time, but at the expense of patients being able to make advance appointments. This issue caused Tony Blair, then Prime Minister, some embarrassment on BBC Question Time after it was raised by a patient’s mother.⁶⁰ In the most recent GP Patient Survey, one in five patients was not still able to book ahead beyond 48 hours.⁶¹ Being able to see a GP quickly is important if you suddenly become ill, but patients managing a long-term condition, or who do not need to see a GP urgently, may prefer to plan their visit. The very initiatives which were designed to improve patient experience have actually incentivized negative behavior. Top-down control means that flexibility in approach has been lost along with the ability to recognise the different needs of different patients.

The provision of out-of-hours care provides a similar example. Under the General Medical Services (GMS) contract implemented in 2004, GPs were offered the chance to opt out of providing out-of-hours care, which is the GP service delivered between 6:30 pm and 8:00 am on weekdays and at all times during weekends and public holidays. By January 2005, less than 10 % of GP practices were left delivering out-of-hours care to their patients.⁶² The responsibility for providing this service transferred to the relevant PCT. The result has been that continuity of patient care has been damaged and patients do not feel they are receiving a good service. In a recent survey by the Commonwealth Fund, 15% of GPs said their patients often experienced problems because care was not well coor-

57 Royal College of General Practitioners. *The future direction of general practice. A roadmap.* 2007

58 Corrigan, P. *Registering choice: how primary care should change to meet patient needs.* The Social Market Foundation, 2005. Chap 1. pp17

59 NHS. *The NHS Plan. 2000;* Department of Health. *Priorities and Planning Framework 2002/2003.* 2001

60 <http://news.bbc.co.uk/1/hi/health/5102750.stm>

61 *The GP Patient Survey 2008/09 Summary Report*

62 NAO. *NHS Pay Modernisation: New Contracts for General Practice Services in England.* February 2008.

minated across multiple sites or providers.⁶³ The National Audit Office found that one in five patients were dissatisfied with their experience of out of hours care.⁶⁴

But not only is the out-of-hours service worse in the eyes of patients, it costs more too. Where GPs chose not to provide out-of-hours care they sacrificed an average of £6,000 per annum to pass on responsibility for providing it to their local PCT. The figure of £6,000 did not reflect the full cost of providing the service, but, instead was determined by negotiations between the NHS Confederation (the NHS employers' organisation) and the GP Committee of the British Medical Association.⁶⁵ After the introduction of the new contract the Department of Health made provision of £322 million to reflect the known costs of the existing out-of-hours service, but the actual costs of the new service were estimated to be £392 million, exceeding the initial budget by 22%.⁶⁶

Because of the problems created by the 48-hour target and the opt out of providing out-of-hour care, improving routine access to GP services in the evening and weekends has now become a national requirement.⁶⁷ PCTs are required to ensure that at least 50% of GP practices in their area offer extended opening to their patients.⁶⁸ This target has now been exceeded with over 77% of practices now offering extended opening hours, at a cost of £83 million per annum,⁶⁹ but has the problem of poor access been solved? A survey for GP newspaper found that 10% of GPs reported less than a quarter of their extended hours appointments were being filled.⁷⁰ So in these practices 75% of the nationally mandated extended hours are being wasted.

Financial disincentives restrict patient choice

Alongside improving access to primary care another one of the key objectives of the General Medical Services (GMS) contract was to redistribute funding for GP practices in a more equitable way.⁷¹ Essential services in primary care, broadly defined as treating those who are sick or believe themselves to be sick⁷² are funded via the 'Global Sum' payment, which also includes provision for staff costs. Practices can choose not to provide of out-of-hours care and additional services, such as vaccinations and immunizations, cervical screening and maternity medical services and this reduces their Global Sum payment.

The Global Sum payments are allocated to each GP practice by its PCT according to its weighted practice population, which is calculated using a formula with adjustments according to the age and needs of the practice population. This capitation process from PCT to practice level uses a different formula to the allocation from Department of Health to PCT level. We will consider the resource allocation to PCT level later in this report. For the moment, the key issue is that the benefit of capitating funds according to need are masked by a number of additional fixed payments which distort the market in primary care: the Minimum Practice Income Guarantee and seniority payments. The prohibition of the sale of goodwill on GP practices further adds to market distortion by preventing the sale GPs practices at true and fair value.

Minimum Practice Income Guarantee

During negotiations on the 2004 GMS contract, a deal was struck which ensured that no GP practices would lose out on funding under the new Global Sum allocation. The Government gave this concession to protect the historical income of GPs in

63 Cathy Schoen, Robin Osborn, Phuong Trang Huynh, Michelle Doty, Jordon Peugh, and Kinga Zapert. *On The Front Lines Of Care: Primary Care Doctors' Office Systems, Experiences, And Views In Seven Countries.* HEALTH AFFAIRS ~ Web Exclusive. 2006. DOI 10.1377/hlthaff.25.w555

64 NAO. *The Provision of Out-of-Hours Care in England.* May 2006

65 House of Commons Committee of Public Accounts. *The Provision of Out-of-Hours Care in England.* Sixteenth Report of Session 2006–07

66 NAO. *The Provision of Out-of-Hours Care in England.* May 2006

67 Department of Health. *The Operating Framework 2008-2009.* 2007

68 Department of Health. *The Operating Framework 2008-2009.* 2007

69 NHS Information Centre. *Investment in General Practice 2003/04 to 2008/09 England, Wales, Northern Ireland and Scotland.* September 2009.

70 Healthcare Republic. <http://www.healthcarerepublic.com/news/927605/> Accessed on 14 October 2009.

71 NAO. *NHS Pay Modernisation New Contracts for General Practice Services in England.* 2008

72 NAO. *NHS Pay Modernisation New Contracts for General Practice Services in England.* 2008

the first few years of the new GMS contract; this is known as the Minimum Practice Income Guarantee (MPIG). Practices losing out under the Global Sum allocation receive a correction factor payment which lifts income back to historic levels. As a result, nearly all practices receive a Global Sum payment which is based on historic income rather than the PCT to GP practice allocation formula. As from April 2009, the MPIG is being phased out; however, there is no timescale for it to be removed completely, with the Department of Health still “examining other ways to resolve the issue of those GP practices that remain heavily reliant on correction factor payments

[MPIG].”⁷³ The concern is that MPIG will be replaced by another fixed payment which will entrench old ways of working.

The Minimum Practice Income Guarantee costs about £325 million annually,⁷⁴ which equates to 4% of the total expenditure on GP services in England.⁷⁵ Around 93% of GMS practices receive a correction payment under the MPIG although the amount received is

unevenly distributed across practices.⁷⁶ For an average list size of 6,500⁷⁷ patients, a practice receiving a median correction factor payment of £12 per patient would receive an additional £78,000 compared to a practice receiving no payments at all. By way of comparison, the current capitation General Medical Services payment for providing primary care services per registered patient is £54.72.⁷⁸ Typically, therefore, 22% of payments for primary care services are provided on a historical fixed basis rather according to defined patient need.

Paying such a large fixed sum in addition to a capitated amount has two implications. First, it provides a disincentive for GPs to take on new patients as the value of payments on a per patient basis falls with each additional patient joining the practice. Second, it limits the ability to redistribute funding to the most deprived and under-doctored areas. Distributing funds in this way would provide a level playing field for competing providers of primary care services to enter areas where their services are needed most. We will discuss how this can be achieved later in our report.

“ Under the new GMS contract the pay of GP partners has risen by 50% over the last four years, while that of salaried GPs has only risen by 17% ”

73 Department of Health. Letter to SHA Directors of Commissioning: GP contract agreement 2009/10. October 2008.

74 House of Commons Hansard Written Answers for 01 Sep 2008. <http://www.parliament.the-stationery-office.com/pa/cm200708/cmhansrd/cm080901/text/80901w0066.htm>

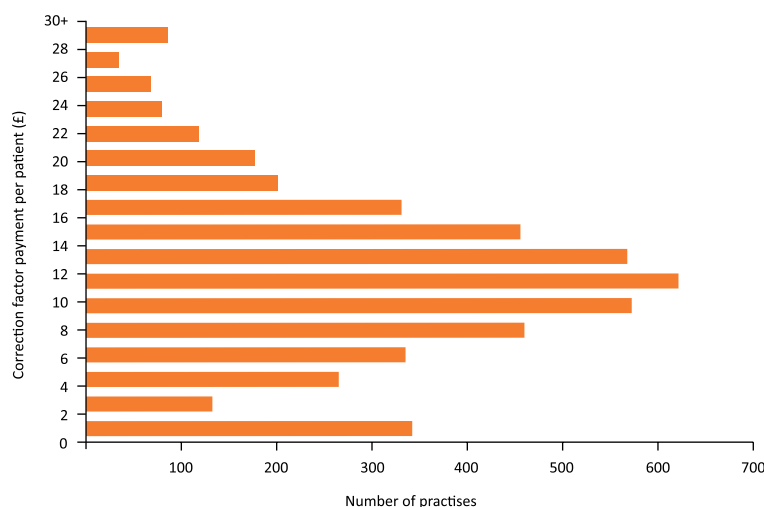
75 Calculations based on 2007/08 accounts of England PCTs in Annex 1 of NHS Confederation. NHS Employers’ evidence to the Pay Review Body on Doctors’ and Dentists’ remuneration 2009/2010 – General Medical Services. November 2008

76 House of Commons Hansard Written Answers for 01 Sep 2008. <http://www.parliament.the-stationery-office.com/pa/cm200708/cmhansrd/cm080901/text/80901w0066.htm>

77 NHS Information Centre. NHS Staff 1998 - 2008 (General Practice). 2009

78 House of Commons Hansard Written Answers for 01 Sep 2008. <http://www.parliament.the-stationery-office.com/pa/cm200708/cmhansrd/cm080901/text/80901w0066.htm>

Figure 5: Distribution of correction factor

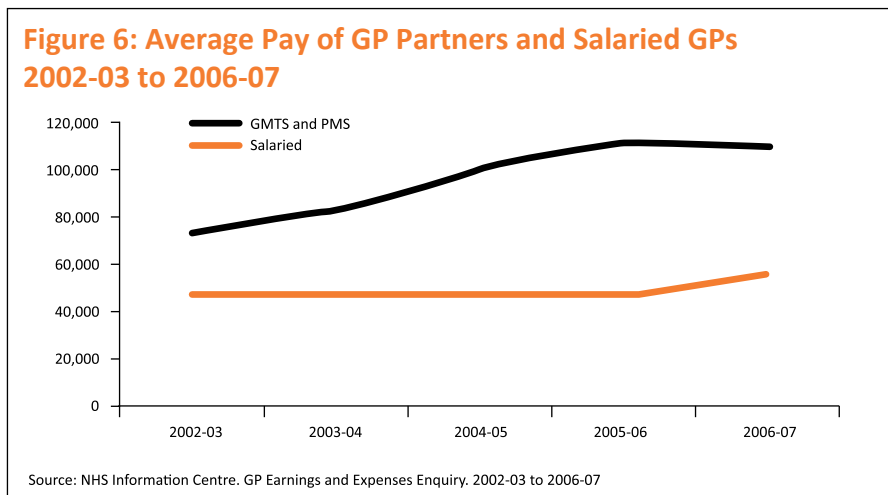


Source: House of Commons Hansard Written Answers for 01 September 2008.

Seniority Payments

Seniority Payments are only paid to those GP's who have served for at least 2 years in an eligible post. An eligible post is a GP partner, single-handed practitioner or a shareholder in a limited company that is a GMS contractor. Salaried GPs do not qualify; instead their seniority should be reflected in their overall salary.⁷⁹ The amount paid for each GP starts at £600 after 6 years service as a doctor increasing incrementally to £13,900 after 47 years.⁸⁰ Seniority payments under the GMS contract are worth approximately £80 million each year – around 1% of the total budget for GP services in England.⁸¹ Seniority payments reward longevity and experience, not merit or clinical outcomes for patients.

Under the new GMS contract the pay of GP partners has risen by 50% on a cumulative basis over the last four years, while that of salaried GPs has only risen by 17%.⁸² In addition, the number of partnerships available to new GPs is falling. Salaried GPs made up 9% of the workforce in 2004; this has now doubled to 20%.⁸³ It is not surprising therefore to hear that there is growing discord between salaried and partnered GPs, with recent moves by some salaried GPs to leave the British Medical Association.⁸⁴



Prohibition on the sale of GP goodwill

Goodwill is an accounting term and may be described as the sum of the intangible attributes of a business which contribute to its success, such as favourable location, good reputation, the ability and skill of its employees and management and its long standing relationships with suppliers and customers.⁸⁵ For accounting purposes goodwill is considered an intangible asset and only tends to enter the accounting system in connection with its valuation in the price of acquisition of a business.

When the NHS was established in 1948, the Government compensated GPs for giving up their right to sell goodwill in order to become part of the NHS. This ban on the sale of goodwill for a medical practice has remained almost in full until the present day. Accountants and solicitors, on the other hand, can sell their share of goodwill upon retirement; similarly they expect to pay for goodwill on joining a practice. The British Medical Association says that “goodwill... may be considered as the value of the super profits that the practice can earn where the fees from such work substantially exceed the cost of the provision.”⁸⁶

79 British Medical Association. General Practitioners Committee. Focus on Seniority payments. September 2005 Updated January 2009

80 GPC. Focus on seniority payments. August 2009

81 NHS Employers. NHS Employers' evidence to the Pay Review Body on Doctors' and Dentists' remuneration 2009/2010 – General Medical Services. 2008

82 NHS Information Centre. GP Earnings and Expenses Enquiry. 2002-03 to 2006-2007

83 NHS Information Centre. NHS Staff 1998 - 2008 (General Practice). 2009

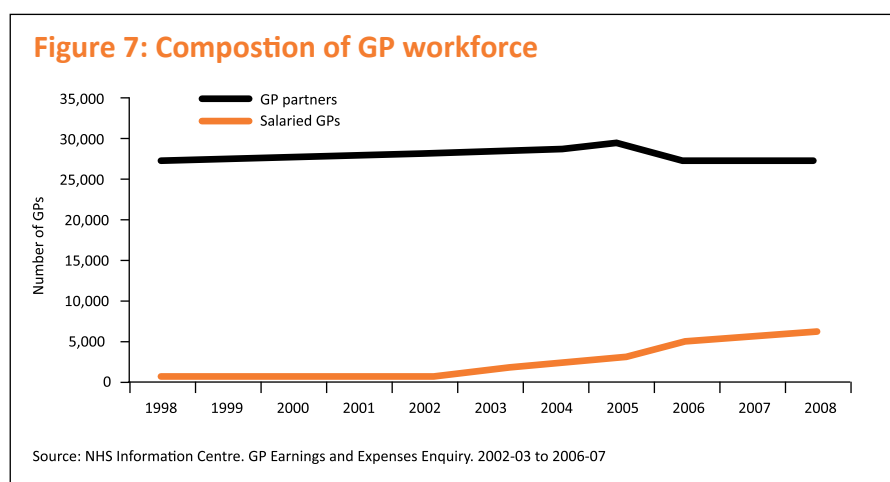
84 Pulse Today. 7th September 2009. http://www.pulsetoday.co.uk/story.asp?sectioncode=23&storycode=4123583&cid=salaried_ructions_090909# accessed 14 October 2009.

85 Glautier & Underdown. Accounting Theory and Practice. 5th Edition.

86 General Practitioners Committee. The new GMS Contract explained. BMA June 2004.

The 2004 GMS contract stated that the existing arrangements prohibiting the sale of goodwill of a medical practice would continue. However, the Department of Health subsequently changed this position to ensure that there were no barriers to prevent alternative providers from providing certain services such as out-of-hours services, that GPs no-longer wished to provide. The easing of the restrictions also applied to enhanced and additional services, but not to essential services.⁸⁷ As a result many practices have set up separate companies to provide enhanced services, and goodwill may be traded in relation to the enhanced services provided by these separate entities.

At the time of the GMS contract, the principle concern about lifting restrictions on the sale of GP goodwill was that it would fragment primary care services and that young GPs would not be able to afford to take up partnerships.⁸⁸ While it is certainly been the case that services have been fragmented by allowing GPs to opt out of providing out of hours cover, it has been the introduction of a two tier GP contract that has seen the number of partnerships fall and the number of salaried positions increase.



GPs are self employed contractors and the practices that they have built up have little or no value to those GPs. A GP's business is only of value to them if they continue to work at that practice. By allowing the sale of all goodwill associated with each GP practice, the option for well-managed practices to buy out poorer ones is realised. Furthermore, popular GP practices could raise funds to invest in developing new services based on the true capital worth of their practice.

The valuation of GP goodwill is complex. However, it is suggested that a valuation of 50% of practice turnover is not unusual, which has been calculated as £160,000 for each GP in a four GP 10,500 patient practice.⁸⁹ Since this value currently belongs to the Secretary of State, it is both a source of financial investment for primary care – up to £3.5 billion – and a powerful bargaining tool in future contract negotiations, since the proposals in this report require that the 2004 GMS contract would need to be revised.

Patients have little or no say in NHS commissioning

Commissioning is the process of ensuring that the health services provided in an area meet the needs of its population. It is a complex process with responsibilities ranging from assessing population needs, prioritising health outcomes, procuring

87 The Primary Medical Services (Sale of Goodwill and Restrictions on Subcontracting) Regulations 2004

88 BBC News. Law change 'to harm GP services'. Thursday, 25 March, 2004. Accessed on 24 October 2009. <http://news.bbc.co.uk/1/hi/health/3567127.stm>

89 Healthcare Republic. Practice Finance – buying and selling goodwill. Laurence Slavin, Chartered Accountant, Ramsay Brown. August 2009.

products and services, and managing service providers. Since patients can only choose from among services that already exist, commissioners try to supplement individual choices with an overview of the needs of the whole local population.

In 1999, 481 Primary Care Groups (PCGs) were created to hold health budgets and commission services on behalf of their local populations of approximately 100,000 people. They replaced thousands of GP fundholders and other commissioning arrangements which Labour had committed to abolish in the 1997 election. Primary Care Groups were considered to be in the best position to improve local health and reduce inequalities, by advising on the use of a unified budget. Introduced at the same time, the unified budget allowed PCGs to allocate resources for primary or secondary care according to local needs and circumstances. Unlike GP fundholding, membership of a PCG was compulsory for GP practices.

Over time Primary Care Groups were encouraged to become Primary Care Trusts and, in 2002, the remaining District Health Authorities and Primary Care Groups were abolished and 303 Primary Care Trusts were created, covering on average a population of 170,000. At the same time 28 Strategic Health Authorities were also created. In 2006, in order to strengthen management capability, reduce transaction costs and improve purchasing and commissioning power, the PCTs were merged to create 152 larger organisations each covering an average population of 340,000.

In the past, the relative weakness of PCT commissioners compared to service providers such as Foundation Trusts has made it difficult to re-shape services to reflect changing patterns of need. A great deal of commissioning has merely entrenched existing services by simply purchasing ‘last year plus inflation’. The view held by many in research and policy circles, is that commissioners have yet to come of age in the NHS. Early evaluations by the Department of Health suggested that commissioning by PCTs was weak.⁹⁰ The NHS commissioning programme has been re-launched and re-branded as ‘World Class Commissioning’, but evidence suggests that expertise in commissioning in the NHS is being delivered by services bought in from the private sector.⁹¹ The Health Select Committee has recently begun an inquiry into commissioning.⁹²

Commissioners need a good understanding of the needs and concerns of local people. However, instead of allowing a dialogue with the public about commissioning to evolve and develop, NHS bodies have been given a legal duty to engage with the public, because with a ‘predict and provide’ approach, everything has to be mandated. Section 242 of the consolidated NHS Act 2006 (formerly Section 11 of the Health and Social Care Act 2001) places a duty on NHS trusts, Primary Care Trusts and Strategic Health Authorities to make arrangements to involve patients and the public in service planning and operation, and in the development of proposals for changes. This legal duty has become necessary because patients aren’t in control, they have no effective input into what services are commissioned for their local area. In adopting to legislate to improve the patient voice, there has been an explicit shift from a model of delivering public services through ‘command and control’ to one of ‘voice’.⁹³

Although PCTs have overall responsibility for commissioning services for their population others take commissioning decisions. A key element of focus for

“ The relative weakness of PCT commissioners compared to service providers such as Foundation Trusts has made it difficult to re-shape services to reflect changing patterns of need ”

90 Department of Health. Overview of the PCT Fitness For Purpose and Development Programme. May 2006.

91 The King’s Fund. Building World Class Commissioning, what role can external organisations play? 2009

92 House of Commons Health Select Committee Press Notice. New Inquiry – Commissioning – Terms of Reference. 9 July 2009.

93 Julian Le Grand. The politics of choice and competition in public services. The political quarterly, Vol 78, No. 2, April-June 2007.

improving commissioning skills and shifting services into the community has been the development of Practice Based Commissioning (PBC), but studies have found that this initiative “seem[s] to have been little impact in terms of better services for patients or more efficient use of resources.”⁹⁷

Campaign 4 Pease Potage Hospital

The Surrey and Sussex Healthcare NHS Trust is among the worst performing acute hospitals in the country. Ever since its creation, on 1st April 1998, with the merger of Crawley, Horsham and East Surrey NHS Trusts, it has been beset by problems. It has consistently been in the bottom 5% of acute hospitals as rated by various incarnations of the hospital rating system.⁹⁴

A review of hospital services in North West Sussex, in 2002, found that East Surrey Hospital was too small and recommended that a new hospital be built at Pease Pottage, since the area was projected to have an expanding population.⁹⁵ However, these plans were shelved and services continued to deteriorate at the existing East Surrey Hospital. Following the consistently poor record of performance at their local hospital a cross-party campaign group was set up by a group of local patients, councillors and community leaders in 2006 to re-new the campaign for a new hospital.

This campaign is unique in that it has the support of the majority of referring GPs in North West Sussex as well as over 12,000 patients that have signed up to the campaign. It is supported by both Local Authorities – Horsham and Crawley Councils – as well as West Sussex County Council. Cognizant of the wishes of their local residents, the councils have expressed an interest in forming a public-private partnership and are prepared to commit substantial funds to the project. The only public bodies opposed to the new hospital are the Primary Care Trust and its directing Strategic Health Authority, but it is these two bodies that are dictating what provision is offered.

A recent review of healthcare and health services in the north-east of West Sussex, in 2009, commissioned by the Primary Care Trust, did not side with the campaigners for a new hospital, but interestingly it found that, “the acute and community hospital system was working at full capacity and that this was an unsustainable position.”⁹⁶

The impasse continues. Local hospital services are of poor quality and at breaking point. Local patients, professionals and elected representatives have suggested a solution, backed with funds, which the State opposes. Patients and professionals are not in control.

94 Care Quality Commission. Surrey and Sussex Healthcare NHS Trust performance ratings. http://2009ratings.cqc.org.uk/findcareservices/informationabouthealthcareservices/overallperformance/searchfororganisation.cfm?cit_id=RTP&widCall1=customWidgets.content_view_1 Accessed 14 October 2009.

95 South East Surrey and North West Sussex Health Services (SESNEWS) Report (Bagnall Review) January 2002.

96 North East Review Report. Professor Sir Graeme Catto. January 2009.

97 The King’s Fund. Practice Based Commissioning. Reinvigorate, replace or abandon? 2008

98 Audit Commission. Healthcare Commission. Is the treatment working? Progress with the NHS system reform programme. June 2008

Practice Based Commissioning

Not only did these successive re-organisations temporarily reduce commissioning capability, but commissioning at PCT level began to be seen as increasingly remote from individual patients and doctors. Enter Practice Based Commissioning (PBC) which was introduced in 2005 to return power to frontline professionals to design and commission more responsive services. In order to spread its uptake incentive payments were made to nearly all GP practices which cost some £98 million in 2006. However, research by the Audit Commission found that PBC was being led by a few enthusiastic practices, mainly former GP fundholders. Moreover, in 2008 PCTs reported that PBC had yet to deliver benefits for patient care.⁹⁸

The main difference between PBC and the system of GP fundholding is that budgets are indicative, not real, and as a result a significant proportion of GPs have

not engaged in the process. The most recent Department of Health GP practice survey found that 26% of practices had not commissioned any new services and 35% had only commissioned one or two new services since the introduction of PBC four years earlier. There has also been poor service innovation with only 53% of practices providing more services themselves; and 66% saying that indicative budgets have made little difference to their practice. Only 29% of GP practices think that PBC has improved patient care.⁹⁹

The replacement of GP fundholding, Practice Based Commissioning, has not been a success.¹⁰⁰ It is not supported by GPs and has not delivered a step-change in commissioning skills and capacity.¹⁰¹ On the whole, GPs tend to be more interested in directly providing services on a small scale and in a few clinical areas rather than getting involved in commissioning services for an area. There will, however, be a few entrepreneurial GPs that will engage in commissioning services, so it is important to design a mechanism where they are in control.

Specialised commissioning

Not only is the status quo in commissioning failing to meet the needs of the majority of patients, but specialised commissioning arrangements are also failing to meet the needs of the few people with rare and complex conditions. Specialised services are those services provided in relatively few specialist centres to catchment populations of more than a million people. They tend to be found in larger hospitals in cities and regionally-commissioned specialist services include kidney transplants, secure forensic mental health services and services for very rare cancers. The evidence suggests that specialised services for complex conditions cannot be sensibly planned, procured and delivered at a local level.¹⁰² It is the very essence of the NHS that everyone counts in this comprehensive service and no-one should be left behind, simply because they are unlucky enough to develop a rare and complex condition. But the NHS has a tendency to muddle which services are best delivered locally and which are best delivered nationally.

Currently, specialised commissioning is delivered at two levels. The National Commissioning Group (NCG) covers extremely rare conditions where the national caseload is fewer than 400 people and includes services such as heart and lung transplantation. The total annual budget is £346 million and was previously delivered by a central Department of Health budget. From 2007-8, however, funding has been given to PCTs and then levied to the NCG on a fair shares basis. This system works well for patients, and feedback is good. But the way money is allocated and then withdrawn causes resentment with PCTs.

The second level is commissioning by one of ten Specialised Commissioning Groups (SCGs). They were established following a report into Specialised Commissioning, in 2006, by Sir David Carter which recognized that Primary Care Trusts were not collaborating effectively for patients with rarer conditions.¹⁰³ As a result, specialised services were arranged to be either commissioned regionally, by 10 Specialised Commissioning Groups, (SCGs) or nationally by the National Commissioning Group. The division depends on the rarity of the condition or treatment – each SCG acts on behalf of a population of about five million – and the funding to commission these specialised services - some £4.6 billion each year - is given to PCTs. However, the 10 regional Specialised Commissioning Groups are all formal sub-groups of their Primary Care Trusts and so the control of this commissioning still lies with 152

99 Department of Health. Practice based commissioning GP practice survey Wave 7. July 2009.

100 Audit Commission. Healthcare Commission. Is the treatment working? Progress with the NHS system reform programme. June 2008

101 Department of Health. Practice based commissioning GP practice survey Wave 7. July 2009.

102 Sir David Carter. Review of Commissioning Arrangements for Specialised Services. Report to the Department of Health. June 2006.

103 Sir David Carter. Review of Commissioning Arrangements for Specialised Services. Report to the Department of Health. June 2006.

PCTs. The result is that none of the 35 specialised services are being commissioned by all 10 Specialized Commissioning Groups and no one Specialized Commissioning Group commissions all 35 services. Consequently, care for patients with rare conditions such as Muscular Dystrophy in many parts of the country currently fall well below a minimum acceptable level.¹⁰⁴ Compared to our European neighbours, the UK lags behind in the provision of specialist services, support for independent living and survival into mid-adulthood for men with Muscular Dystrophy.¹⁰⁵ Similar shortcomings are found in the care for patients with Parkinson's disease, and spinal injury.¹⁰⁶ Obviously there are no such unacceptable variations in care for the conditions commissioned by the National Commissioning Group.

As is the case with these complex and rare diseases, there is usually only ever one best way of providing care, yet the current arrangements encourage unnecessary multiplication of commissioning processes. Specialist knowledge tends to lie with providers, not commissioners. And small activity volumes make it virtually impossible for patients to have a choice of provider, since high costs of entry mean there is a limited role for competition to improve quality. Patients' groups have to spread limited resources into ensuring services commissioned by the ten SCGs are uniform. Moreover, because the power relationship of the SCGs rest with their constituent PCTs, it is the PCTs that choose what is commissioned. Recent history has shown us that, in times of austerity, PCTs will pull money away from commissioning services for patients with rare and costly diseases to shore up expenditure elsewhere.¹⁰⁷ The difference between the successful national commissioning and the patchy SCG commissioning shows how centralisation of these types of service can improve care for patients who would otherwise get left behind.

Conclusion

The political rhetoric and intended policy direction over the last two decades has been about strengthening primary care and making it easier for patients to change doctors. However, the results suggest that implementation has been flawed, possibly derailed by changes in government; compounded by a misunderstanding of the negotiating power of doctors.

There is no effective choice for patients in primary care. Financial disincentives and arbitrary geographical boundaries have not produced enough doctors where they are needed. Patients do not have enough say in the services that are on offer, nor where they are offered. We believe that a model of choice and competition should be extended into primary care; it should be set free to innovate and lead the drive in reducing our reliance on expensive acute hospital care. Patients need to be put in control.

Recommendations

The fixed payments which distort the market in primary care should be removed, including the Minimum Practice Income Guarantee and Seniority Payments.

The prohibition on the sale of goodwill in GP practices should also be lifted. However, simply lifting this prohibition would automatically create value in the region of £3.45 billion in the hands of GPs. Since further recommendations in this report require that the GMS contract be renegotiated we believe that this value be used in the negotiation process in a, "something for something deal".¹⁰⁸

104 All Party Parliamentary Group for Muscular Dystrophy. Access to Specialist Neuromuscular Care: The Walton Report. 2009

105 All Party Parliamentary Group for Muscular Dystrophy. Access to Specialist Neuromuscular Care: The Walton Report. 2009

106 All Party Parliamentary Group for Parkinson's Disease. Please mind the gap: Parkinson's disease services today. July 2009

107 Sir David Carter. Review of Commissioning Arrangements for Specialised Services. Report to the Department of Health. June 2006

108 Rt Hon Alan Milburn MP, Secretary of State, Speech to the HR in NHS Conference, 2 July 2002. Quoted in National Audit Office. NHS Pay Modernisation: A New Contract for NHS Consultants in England. April 2007.

2

Making the case for choice in healthcare

At present patients and citizens do not have meaningful choice in primary care. Some of the problems we discussed in the previous chapter directly restrict patient choice: closed practice lists, areas of under-doctoredness, funding disincentives and undifferentiated services. It is unlikely that these barriers would have arisen if primary care provision was designed around the needs of patients.

This means we are missing out on the considerable benefits of choice. Choice is good, both intrinsically, and as a mechanism for achieving change. Extending patient choice into primary care can improve outcomes for patients, produce efficiency savings and even help to support the democratic process through active citizenship. Choice can empower patients, by engaging them in a decision-making process – choosing their GP – from which they were previously excluded. Our aim is for patients and citizens to actively consider what they want most from their doctor or primary care provider. But also, so long as there are alternatives, greater choice introduces competitive pressures. If patients start choosing, primary care providers will start to respond directly to patients and citizens and their differing needs and wants. If a primary care provider started to lose patients, it would be a sign that services need to improve.

However, just providing choice is no panacea. For choice to be meaningful, institutions need to be built around supporting patient decision making. Pro-competitive strategies, coupled with adequate support for marginalised or more vulnerable patients is essential, so that health inequalities are not widened.

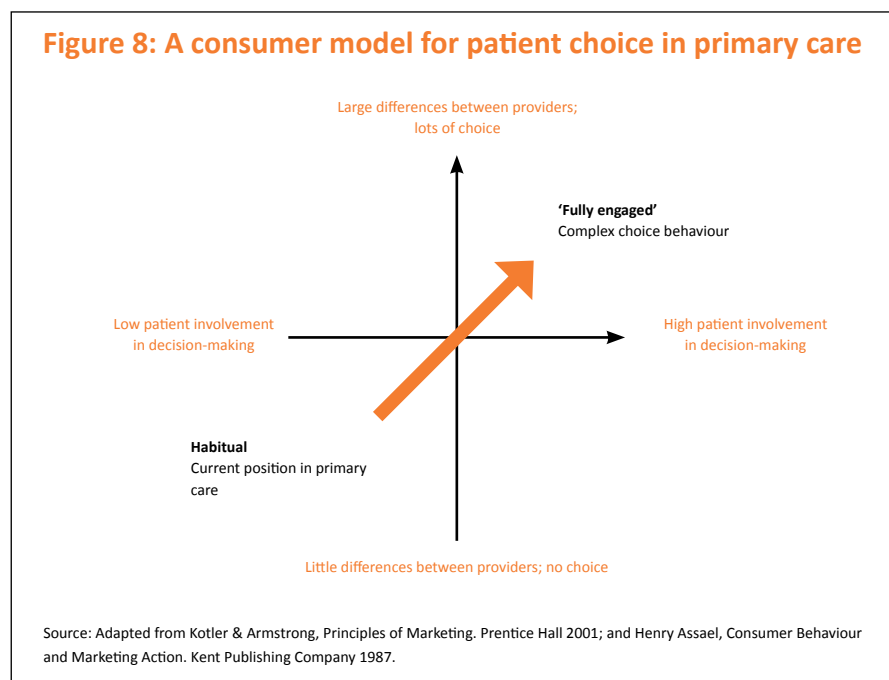
Rational choice theory

Choice reflects a strict preference of one thing over another. *Rational choice theory* is a framework for understanding choice in terms of social and economic behavior. It suggests that in making choices an individual should be faced with a set of alternatives, such as different primary care providers or GP practices and that there should be different possible outcomes for each choice. For example, one GP practice could be near to the patients work while another GP practice might offer longer appointments. Rational choice theory says that people will maximize their benefits and minimize their costs. So in our example, the patient that values a GP practice near to their work more than a practice offering long appointments will choose the practice near their work. However, if there is a GP practice offering long appointment and is near to the patients work, then that will be the preferred option.

Two assumptions are necessary under this model: first, that patients have adequate information about what will occur as a result of any particular choice they make. Second that patients have the time and ability to weigh up these choices. At present, it is difficult for patients to weigh up their options – as they do not have access to good information, or the tools that will help them make these choices easily. Without access to comparable information patients will not be able to align their preferences with their choice of preferred provider of primary care services.

In the UK, the easiest choice in primary care to make is no choice at all. People just are not used to it. The way healthcare services are provided is decided centrally: practice boundaries are decided by the Primary Care Trust and there is little or no differentiation in the services on offer. Limited choice, both in terms of the number of providers to choose from and the range of services on offer, is reflected in habitual behaviour.

One of the aims behind a pro-choice policy is to increase patient involvement in decisions about their healthcare. The challenge is to turn people from passive, habitual consumers of primary care services to fully engaged citizens, displaying complex choice behaviour. Below is a suggested model of choice in primary care which has been adapted from a model of complex consumer buying behaviour.



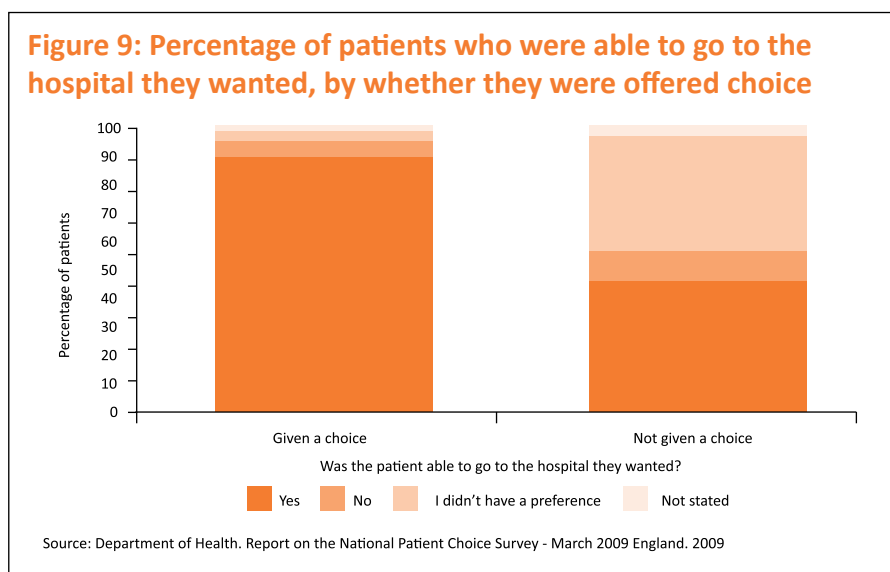
109 Sudore RL, Mehta KM, Simonsick EM, Harris TB, Newman AB, Satterfield S, et al. Limited literacy in older people and disparities in health and healthcare access. *JAmGeriatrSoc*. 2006;54(5):770-6.5.

110 Baker DW, Wolf MS, Feinglass J, Thompson JA, Gazmararian JA, Huang J. Health literacy and mortality among elderly persons. *Archives of Internal Medicine*. 2007;167(14):1503-9.

111 Health Literacy - a special interest group of the Society for Academic Primary Care. <http://www.healthliteracy.org.uk/> accessed on 20 October 2009.

If patients are to have more choices in primary care, indeed more choices across the NHS, we need to have some understanding of the health literacy of the population. We must be able to show that patients have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions. Evidence from the USA shows that low health literacy is linked with poorer health, higher prevalence of co-morbidities, poor access to health care¹⁰⁹ and ultimately higher mortality.¹¹⁰ There is, however, no information on health literacy in England.¹¹¹

Despite this lack of formal information, there is some evidence that the process of being offered and discussing choice helps patients engage in healthcare decision making. The 2009 National Patient Choice Survey found that 41% of patients not given a choice by their GP were indifferent about the hospital that they went to. When patients were given a choice of hospital, only 4% said they were indifferent about their selection, with 89% saying they went to the hospital they wanted. If patients are given a choice they will engage in the process of selection, and the experience of secondary care reveals that choice leads to satisfied patients. And furthermore, patients' ratings of their own care shows that those who had chosen an alternative hospital tended to have a more positive view of their care than those who stayed put, particularly if their care had been in an NHS treatment centre specialising in elective surgery or in the private sector.¹¹²



Do patients actually want choice?

Public survey data by the Consumers Association in 2004 show a high preference for choice in primary care with nearly 90% of survey respondents agreeing that people should be able to choose their GP and over 70% agreeing that patients should be able to choose whether to see a GP near their home or work; and at an appointment time convenient to them.¹¹³ A survey of patients conducted by the Medical Technology Group for this report found that 88% of patients thought that people should be able to choose their GP.

It is also illustrative to compare the satisfaction levels in the UK to those in the rest of Europe. A comparative survey of European patients' views on choice in health systems shows that the UK scores particularly poorly.¹¹⁴ The study found that only 30% of patients in the UK were satisfied with the opportunities to make choices about their healthcare, whereas in Spain the figure was more than double at 73%.

The European wide survey also offers some data on preferences for choice in primary care. It found that the overwhelming majority of patients in the countries surveyed thought that there should be a free choice of primary care doctor. However, compared to other countries the UK had one of the lower scores

112 Coulter, A., Le Maistre, N. and Henderson, L. (2005) Patients' experience of choosing where to undergo surgical treatment. Oxford: Picker Institute.

113 Which Choice? Health. Which? 2005.

114 Angela Coulter, Crispin Jenkinson. European patients' views on the responsiveness of health systems and healthcare providers. *European Journal of Public Health*, Vol. 15, No. 4, 355–360. 2005

with 87% of patients thinking they should be able to choose GP; the highest was Germany and Poland with 98%. Patients were also asked whether they had sufficient information to support their choice of primary care physician. Again, the UK came towards the bottom of countries studied with only 40% of UK patients reporting that they had sufficient information, compared to 53% in Italy for instance.

The study noted, specifically, that overall less than half of all patients reported being able to make an informed choice of primary care doctor, even though such choice is, in theory, unconstrained in the countries surveyed. The study suggested that, one of the reasons for the difference in the extent to which patients expect choice and to be actively involved in decisions about their own health is because of the country’s prevailing medical and societal culture. If it is paternalistic, both patients and doctors are likely to assume that healthcare decisions are the responsibility of the state, or their doctor. The assumption is that, compared to the rest of Europe, we have a paternalistic ‘doctor knows best’ culture in healthcare.

European patients’ views on choice in healthcare			
% of patients answering yes			
	Are you satisfied with opportunities for choice in healthcare?	Should there be free choice of GP?	Is there sufficient information to support your choice of GP?
Spain	73%	89%	30%
Switzerland	70%	93%	52%
Sweden	45%	86%	31%
Germany	43%	98%	52%
Italy	38%	86%	53%
UK	30%	87%	40%
Poland	15%	98%	43%

Source: Angela Coulter, Crispin Jenkinson. European patients’ views on the responsiveness of health systems and healthcare providers. *European Journal of Public Health*, Vol. 15, No. 4, 355–360. 2005

More detailed information on UK attitudes towards choice in healthcare is seen in the British Social Attitudes Survey, which reports 53% of people want to be able to choose the date and time of their healthcare appointments; 63% their hospital; and 65% their treatment.¹¹⁵

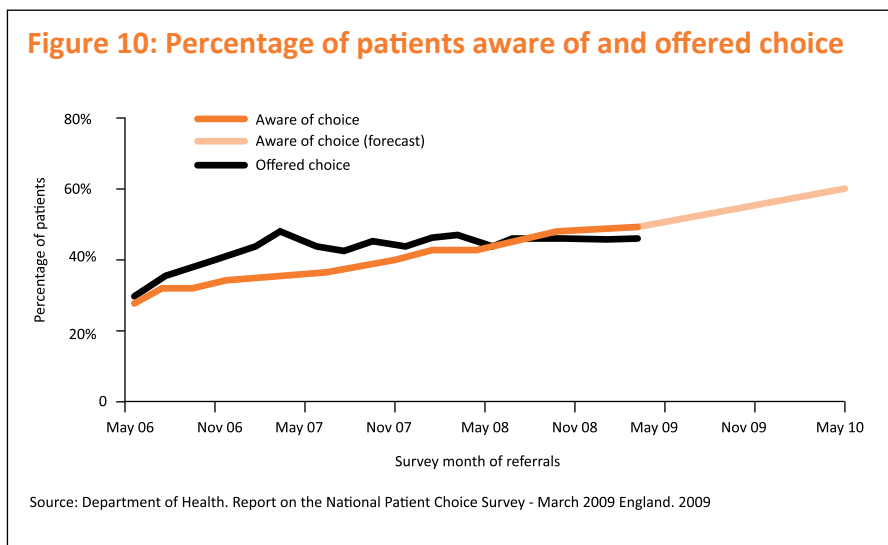
Choice of secondary care provider in the NHS is proving popular with patients. In one major pilot scheme, the London Patient Choice project, which ran from 2002 to 2004, patients waiting for elective surgery were given the choice of faster treatment at one of two alternative providers. Not all patients were offered choice, only those likely to have to wait more than six months for surgery at their ‘home’ hospital. Nevertheless, the ability to choose was popular: 67% elected for faster treatment; and 97% of those said they would recommend the scheme to others.¹¹⁶ A national choice scheme was rolled out in 2006, and from April 2008 patients have been able to choose to have their treatment at any hospital provider meeting NHS standards and costs in England.

So as choice becomes part of the core NHS offering, patients and citizens will expect ever more and if it is not available they will begin to question why their options are being limited. Over a 21 month period, from June 2006 to March

115 Public Responses to NHS Reform, Appleby and Alvarez, British Social Attitudes Survey 22nd Report, 2005 as quoted in Department of Health. Choice matters: Increasing choice improves patients’ experiences. 2006

116 Picker Institute. Patients’ experience of choosing where to undergo surgical treatment. Evaluation of London Patient Choice scheme. 2005

2009, the number of patients becoming aware of choice in healthcare increased dramatically from 29% to 50%.¹¹⁷ The 2009 National Patient Choice Survey found that more patients are aware that they are entitled to a choice of hospitals before they visit their GP than are actually offered it.¹¹⁸ This growing awareness of choice will itself become the driving force for change, as patients assert their right to choose. Failure to respond to the gap between what people expect and what choices they have on offer will lead to patient dissatisfaction and disengagement. There are also powerful generational differences which will help drive the cultural change for increased choice in healthcare. Compared to older generations, younger people expect a greater role for patients in healthcare decision making.¹¹⁹ Over time this generational difference will promote wider cultural change about patients' expectations and power relationship with doctors and the State.



The critics of choice in the NHS, and there are many, argue that it is only wanted by the better off and better educated and that letting patients choose will drive health inequalities and damage the NHS. But surveys tell a different story: 59% of people from managerial and professional backgrounds say they want choice, while among those in semi-routine and routine occupations those wanting choice rises to 67%.¹²⁰

Proponents of choice in public services are backed by the evidence which shows it is wanted by the majority of people, and importantly, it is wanted particularly by the people who need it most: the unemployed, individuals with low income and poor educational qualifications who use health services less than their relative to need.^{121,122} Studying take-up of choice in healthcare shows that exercising choice does not vary with social background, so long as long as patients are given adequate support. Again, evidence comes from the London Choice Project where an evaluation found that patients under 60, educated beyond statutory school leaving age, with above average earnings and 'good' health, were more likely to **consider** having their treatment at an alternative hospital. However, in practice, patients from all backgrounds were as likely to **choose** to have their treatment at an alternative hospital. When the actual take-up of choice is properly assessed, most of the differences between socioeconomic groups disappear.¹²⁴

117 Department of Health. Report on the National Patient Choice Survey - March 2009 England

118 Department of Health. Report on the National Patient Choice Survey - March 2009 England

119 Angela Coulter, Crispin Jenkinson. European patients' views on the responsiveness of health systems and healthcare providers. *European Journal of Public Health*, Vol. 15, No. 4, 355-360. 2005

120 Public Responses to NHS Reform, Appleby and Alvarez, *British Social Attitudes Survey 22nd Report*, 2005 as quoted in Department of Health. *Choice matters: Increasing choice improves patients' experiences*. 2006

121 Anna Dixon, Julian Le Grand. Is greater patient choice consistent with equity? *J Health Serv Res Policy* Vol 11 No 3 July 2006

122 Audit Commission. *Choice in Public Services*. September 2004.

123 Picker Institute. *Patients' experience of choosing where to undergo surgical treatment. Evaluation of London Patient Choice scheme*. 2005

124 Picker Institute. *Patients' experience of choosing where to undergo surgical treatment. Evaluation of London Patient Choice scheme*. 2005

Difference in percentage of patients on hospital waiting lists willing to consider alternative hospital before surgery and percentage actually

		% "definitely" or "possibly" willing to consider alternative hospital		% opting for alternative hospital	
		% of patients	% difference	% of patients	% difference
Age-group	over 60	76%	12%	65%	4%
	under 60	88%		69%	
Education status	basic*	79%	8%	65%	2%
	higher	87%		67%	
Employment status	not employed	77%	13%	63%	10%
	employed	90%		73%	
Household income	below average**	79%	14%	68%	-1%
	above average	93%		67%	
Health status	poor***	79%	5%	69%	-3%
	good	84%		66%	

* Completed education at statutory school leaving age
 ** Below £20,000 per annum
 *** "Fair", "poor" or "very poor" on six-point scale
 Source: Picker Institute. Patients' experience of choosing where to undergo surgical treatment. Evaluation of London Patients Choice scheme. 2005.

The level of support given to patients was an important feature of the London Choice pilot, and may have addressed the potential for inequalities between socio-economic groups. The majority of patients selecting treatment at an alternative hospital took up the offer of free transport and the study cited this as being a key factor in promoting high rates of uptake of the alternative hospital. In addition, patient care advisors guided patients through the process of choosing a hospital, helping them to make a decision and coordinating the arrangements for those who opted to go to an alternative hospital.¹²⁵ Patients highly valued this supported choice mechanism with 93% of patients rating the quality of service provided by the patient care advisors as "good", "very good", or "excellent".¹²⁶

A recent study in the British Medical Journal has confirmed the equity findings from the London Choice Project. It has studied NHS waiting times and their link with deprivation over the period 1997 to 2007 for hip and knee replacements and found specifically, "In 1997 waiting times and deprivation tended to be positively related. By 2007 the relation between deprivation and waiting time was less pronounced, and, in some cases, patients from the most deprived fifth were waiting less time than patients from the most advantaged fifth." The implication, as the authors note, is that the reforms of choice and contestability introduced into the secondary care market did not harm equity, as had been feared.

Can giving choice to patients improve their health?

To date NHS reform has focussed mainly on organisations that provide healthcare, or in economic terms, supply side reform. Demand side reform is fundamental to improving healthcare and this can be achieved by better empowering and engaging patients and citizens.¹²⁸ Engaged patients become more aware of their condition and more likely to seek out information and resources for effective self-care. Empowering patients through choice dips into an, as yet, untapped resource which will help reduce the overall burden of healthcare.

125 Picker Institute. Patients' experience of choosing where to undergo surgical treatment. Evaluation of London Patient Choice scheme. 2005

126 Picker Institute. Patients' experience of choosing where to undergo surgical treatment. Evaluation of London Patient Choice scheme. 2005

127 Cooper Z, McGuire A, Jones S, Le Grand J, Titmuss R. Equity, waiting times, and NHS reforms: retrospective study. *BMJ*. 2009; 339:b3264.

128 Segal, L. (1998) The importance of patient empowerment in health system reform *Health Policy* 44(1)

The Wanless Review, *Securing our Future Health: Taking a Long-Term View*, suggested that patients themselves can contribute to improving productivity in the NHS. It was the first ever evidence-based assessment of the long-term resource requirements for the NHS, and calculated that the cost to the NHS of not engaging the public in their health could be as much as £30 billion by 2022. The review made it clear that increasing funding would not succeed in transforming the health service unless it was accompanied by radical reform to tackle underlying problems such as poor access to services, poor quality of care and poor outcomes. It proposed three scenarios based upon differing levels of public engagement in health:

Slow uptake – there is no change in the level of public engagement: life expectancy rises by the lowest amount in all three scenarios and the health status of the population is constant or deteriorates.

Solid progress – people become more engaged in relation to their health: life expectancy rises considerably, health status improves and people have confidence in the primary care system and use it more appropriately.

Fully engaged – levels of public engagement in relation to their health are high: life expectancy increases go beyond current forecasts, health status improves dramatically and people are confident in the health system and demand high quality care.

The Review argued that the ‘Fully engaged’ scenario could be realised only by achieving a dramatic improvement in public engagement in healthcare: twice the number of patients would need to self-care; health-seeking behaviour would have to increase, with each patient making an average of one additional visit to their GP each year.¹²⁹

Health outcomes under the Wanless Scenarios			
	Slow uptake	Solid progress	Fully engaged
UK life expectancy at birth by 2020	Men: 78.7 Women: 83.0	Men: 80.0 Women: 83.8	Men: 81.6 Women: 85.5
Acute ill health among elderly	20% increase	5% reduction	10% reduction
Obesity prevalence rates	No change* Men: 17% Women: 21%	Meets Health of the Nation target Men: 6% Women: 8%	Health of the Nation target met rapidly and maintained Men: 6% Women: 8%
Health inequalities: gap in life expectancy**	No change	Meets Public Service Agreement target: At least 10% reduction	Public Service Agreement target met rapidly and exceeded: At least 10% reduction

* % of adults obese including morbidly obese. Based on 1998 data (most recent available at the time)
 ** Gap in life expectancy between the fifth of areas with the worst health and deprivation indicators (the Spearhead Group) and the England average.
 Source: Derek Wanless. *Securing our Future Health: Taking a Long-Term View*. HM Treasury. 2002.

Since the publication of the Wanless Review in 2002, data on the health status of the population suggests that the UK is on a path somewhere between ‘Slow uptake’ and ‘Solid progress’.¹³⁰ Some trends, such as obesity levels, have not been reversed although it should be noted that the forecast figures given in the Wanless scenarios were based on projections from 1998. Today obesity levels are around 24% for men and women,¹³¹ compared to 22% for men and 23% for women in 2002 when the Wanless Review was published. It should also be noted that, the Govern-

129 Wanless. *Securing our Future Health: Taking a Long-Term View*. HM Treasury. 2002

130 Derek Wanless, John Appleby, Anthony Harrison, Darshan Patel. *Our Future Health Secured? A REVIEW OF NHS FUNDING AND PERFORMANCE*. King’s Fund. 2007

131 Based on 2007 data. NHS Information Centre: *Statistics on obesity, physical activity and diet: England, February 2009*

ment's target to reduce the gap in life expectancy between the most deprived areas and the England average has been missed.

Can choice help improve the NHS?

The term 'choice' is in itself politically persuasive and the choice agenda has been pursued by politicians in the UK and the rest of Europe. Writing in the British Journal of General Practice, Bryant et al note:

*"Policy preference for the word 'choice' (which suggests options) over 'decision' (which suggests process and effort) may seem a more palatable way of phrasing what are often difficult cognitive and emotional tasks with potentially life-changing outcomes."*¹³²

They suggest that framing decisions as choices may make options seem more attractive, even if, in reality, these choices do not confer any additional benefit to patients. However, extending choice into primary care is important because it gives real options to patients and citizens; it gives them a real and meaningful input into the NHS. Patients with the power of exit are in control.¹³⁴

The appeal of the simple economic argument in favour of choice is strong: introducing choice and competitive pressure helps make organisations more efficient. They reduce costs and improve their services in order to attract patients, and such continual drive for improvement is good for the health-care economy. Patient choice acts as a major driver for efficiency and service improvement.

Systematic reviews of choice and competition in the NHS are limited to a few specific examples.^{135,136} The internal market in hospital care that operated between 1991 and 1997 encouraged competition between NHS hospitals for contracts for hospital care from District Health Authorities and much smaller GP fundholders. Reviews suggest that increased competition resulted in lower costs; with those hospitals that had greater business from fundholders posting lower prices. Fundholders were also beginning the movement of services from secondary care to cheaper and more convenient primary care settings since they were able to attract on-site services from specialists.¹³⁸ In addition, hospital efficiency increased by an average of 1.7% per annum, but after fundholding was abolished in 1997; efficiency fell by an average of 1.6% per annum.¹³⁹ GPs became better at allocating resources as they responded to fundholding incentives and referral rates amongst fundholding practices fell. Admissions for elective procedures amongst fundholding practices were 3.3% lower than they would have otherwise had been.¹⁴⁰ Furthermore, fundholding may have helped reduce waiting times by about 8%.¹⁴¹ However, it should be noted that because information on quality was limited (and still is) a number of studies found that the quality of care actually fell during the period of the internal market. Professor Carol Propper, the author of a number of reviews of clinical quality and fundholding commented:

*"This combination of falls in price and quality fits with the predictions of economic theory: where demanders are sensitive to price and quality information is weak, both prices and quality are likely to fall as competition increases."*¹⁴²

132 LD Bryant, N Bown, HL Bekker, et al. The lure of 'patient choice'. British Journal of General Practice, October 2007. 822 - 826

133 LD Bryant, N Bown, HL Bekker, et al. The lure of 'patient choice'. British Journal of General Practice, October 2007. 822 - 826

134 Albert Hirschman. Exit, Voice, and Loyalty: Responses to Decline in Firms, Organizations, and States. Cambridge, MA: Harvard University Press. 1970.

135 Carol Propper, Deborah Wilson and Simon Burgess. Extending Choice In English Health Care: The implications of the economic evidence. CMPO, The University of Bristol. August 2005

136 Fotaki M, Roland M, et al. What benefits will choice bring to patients? Literature review and assessment of implications. J Health Serv Res Policy Vol 13, No 3. July 2008.

137 Propper C, Wilson D and Söderlund N, (1998), 'The effects of regulation and competition in the NHS internal market: the case of general practice fundholder prices', Journal of Health Economics, 17 (6): 645-73. Propper C, (1996), 'Market structure and prices: the responses of hospitals in the UK National Health Service to competition', Journal of Public Economics, 61 (3): 307-335.

138 Harris A. Specialist outreach clinics. BMJ 1977;308:1053

139 Le Grand, J (2002). 'The Labour Government and the NHS'. Oxford Review of Economic Policy, vol 18.

140 Dushiesko M, Gravelle H, Jacobs R, Smith P (2003). The Effect of Budgets on Doctor Behaviour: Evidence from a natural experiment. Discussion Papers in Economics no 2003/04. York: Department of Economics and Related Studies, University of York. Available at: www.york.ac.uk/depts/econ/documents/dp/0304.pdf

141 Propper C, Croxson B, Shearer A (2002). 'Waiting times for hospital admissions: the impact of GP fundholding'. Journal of Health Economics, vol 21, no 2, pp 227-52.

142 Carol Propper, Deborah Wilson and Simon Burgess. Extending Choice In English Health Care: The implications of the economic evidence. CMPO, The University of Bristol. August 2005

We will address the issue of information later. But for now we should note that for all the gains in quality, efficiency and system responsiveness, these improvements applied only to patients of fundholders. Thus the choice given to GPs had negative implications for patient equity¹⁴³ and so the lesson to be learned is that extending any system of GP fundholding must be applied equally to all practices and providers.

The experience of competitive tendering for support functions in the NHS also offers some direction. In 1983, the Department of Health published guidance asking health authorities to test cost effectiveness by subjecting the award of contracts for provision to competitive tender. Subsequent evaluations shows that competitive tendering did save the NHS money, but the extent of these savings varies between 6% - 20%.^{144,145} Concern was raised over the inability to sustain these large cost reductions with commentators suggesting imperfect market conditions such as information asymmetry; ‘cherry-picking’ and increased efficiency of the public sector in bid preparation and tendering.¹⁴⁶

The introduction of Independent Sector Treatment Centres (ISTCs) has been widely criticised, but they offer another lesson on how choice has the potential to improve healthcare. ISTCs were introduced in 2003 to increase NHS capacity. The aim was to separate routine hospital surgery from emergency work in order to clear waiting lists, but also to introduce external competition for NHS hospital trusts. The introduction of ISTCs would have been a valid model of competition if they had been paid in the same way as other providers. However, for the first five years ISTCs were paid guaranteed revenue regardless of whether the activity was undertaken. The second wave of ISTCs was paid on a slightly different basis, but were still guaranteed and paid for a particular volume of patients regardless of actual activity. In 2007/08, ISTCs only contributed to 1.7% of elective hospital activity, which is not a large enough scale to introduce system wide competitive pressure and improvement. In an early evaluation, the Audit Commission found that patients’ appetite for choosing ISTCs was small, but satisfaction was high. More importantly, it found evidence that some providers within local health economies felt that the fear of real competition introduced by ISTCs has produced increases in overall efficiency.¹⁴⁷ As the Audit Commission noted, “the fear of the impact of choice” is leading to a change in attitude of providers.¹⁴⁸ Organisational reputation appears to be important - even in the NHS - which is the expected and appropriate response to competition.

Conclusion

Choice is becoming entrenched in the nation’s relationship with public services; it is core to the new NHS offering. In an era when NHS spending is going to be under intense pressure, the choice agenda should be embraced as a way to generate value in the relationship between the patient and the NHS. However, choice and competition can only succeed in delivering better value and improving public services if institutions and markets are appropriately designed. We need to be cautious in the design of competitive measures so that information is not restricted, and most importantly, so that choice benefits those that need and want it the most.

143 Mannion R. Practice based budgeting: lessons from the past; prospects for the future. Report to the Department of Health. York Centre for Health Economics. 2005

144 National Audit Office, Competitive Tendering for Support Services in the National Health Service, 1987. As quoted in Serco Institute. Competitive Edge. Does Contestability Work? 2007

145 Robin Milne and Robert Wright, ‘Competition and costs: evidence from competitive tendering in the Scottish National Health Service’, *Scottish Journal of Political Economy*, Vol 51(1), February 2004.

146 Serco Institute. Competitive Edge. Does Contestability Work? 2007

147 Healthcare Commission and Audit Commission (2008) *Is the treatment working? Progress with NHS system reform programme*. London: Healthcare Commission.

148 Healthcare Commission and Audit Commission (2008) *Is the treatment working? Progress with NHS system reform programme*. London: Healthcare Commission.

3

Understanding the power of choice in primary care

Despite choice of GP being a fundamental aim when the NHS was created, there is precious little data on what patients want most in primary care. Resistance to extending choice in public services, especially in healthcare comes from the concern that the affluent and educated would have better access to information and will exercise better choices.¹⁴⁹ But the provision of better information is a relatively simple problem to solve. The key issues about extending choice in primary care are understanding why people select one GP practice over another and whether these choices can have any impact on improving healthcare.

On what factors will patients choose?

As we have seen, choices reflect a person's preference for one thing over another. These preferences are unique to each person, but rational individuals will choose to maximize the benefit to themselves, and to minimize any potential costs. In selecting a primary care provider patients have to make trade-offs – for example, picking a practice with longer opening hours which might be further away from their home. Patients will make choices based on a few key preferences, or determining factors.

In secondary care, where choice has been a policy priority for a few years, there are a range of studies looking at patient preferences. The London Patient Choice Project is a rich source of data, and one assessment of this pilot study has found that patient choice behaviour is complex and suggested that choice depends on the circumstances under which it is offered.¹⁵⁰ For example, people were less likely to choose an alternative hospital with a shorter waiting time the further the location of the hospital was from their home. For every hour of travel, patients required a reduction in waiting time of around 2.1 months to choose the alternative hospital. The study also revealed a strong preference not to travel abroad, even if their transport was paid for by the NHS. Patients required a substantial reduction in waiting time, of around 5.4 months, to take up surgery abroad. Moreover, independent polling shows that 85% of people agree that access to a good local hospital was more important than having more hospitals to choose between.¹⁵¹ In terms of secondary care, patients want good local services: access is a key determining factor.

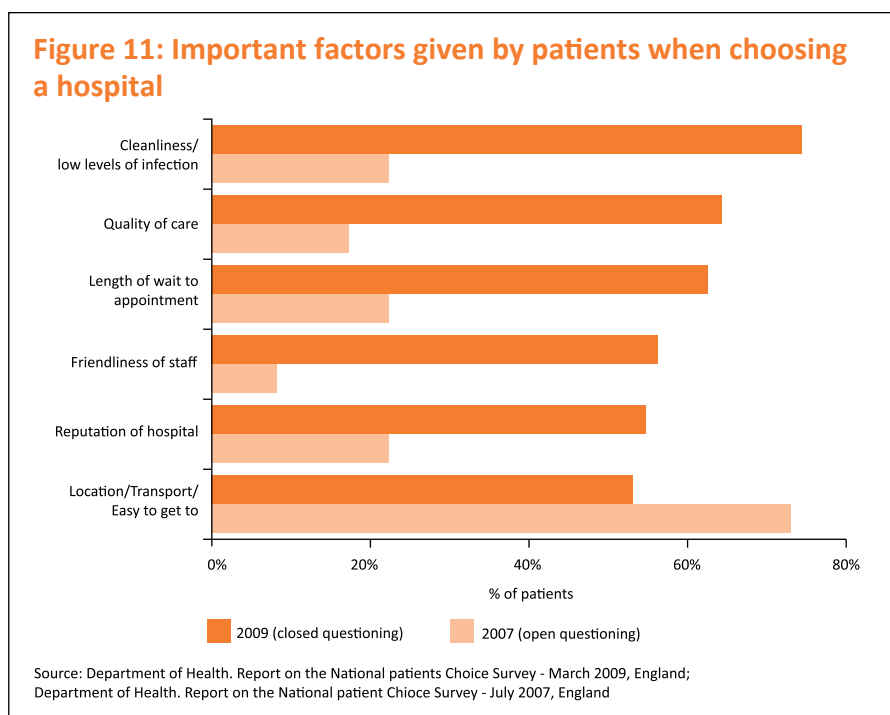
Interestingly, however, the most recent National Patient Choice Survey suggests that access is no longer the key determinant for patients choosing hospitals. In

149 Fotaki M, Roland M, et al. What benefits will choice bring to patients? Literature review and assessment of implications. *J Health Serv Res Policy* Vol 13, No 3. July 2008.

150 RAND, King's Fund and City University. London Patient Choice Project Evaluation. 2005

151 Choices in Healthcare. 2005 Qualitative Research. As in cited in *Which Choice? Health. Which?* 2005

March 2009, most – 74% - of patients selected ‘hospital cleanliness and low infection rates’ as an important factor when choosing a hospital, compared to only half – 53% - who selected ‘location and transport considerations’ as being important.¹⁵² The reduced emphasis on access should be read with caution, however. There was a change in survey methodology, in mid-2007, when respondents were asked to select from a list of possible factors, rather than respond to an open ended question. National Patient Choice Surveys prior to 2007, where patients were asked open ended questions, show that location and accessibility are overwhelmingly the most frequently mentioned factors for patients making choices in secondary care. This change could, of course, also be in response to a switch in patients’ concerns about the high levels of MRSA and hospital acquired infections, although during 2007 MRSA rates and focus on hospital acquired infections in the media was much higher than in 2009.



During the course of our research we heard from a number of highly informed sources who suggested that, in relation to primary care services, patients were most likely to switch to new providers because of improved access and convenience. There is, as noted previously, very little research or published data on what factors influence patient choice in primary care, but the available data is consistent.

One study, published in the British Journal of General Practice in 1993, surveyed patients that had switched their GP without moving house.¹⁵³ Although limited to one geographical area the results give a significant illustration of why patients leave one practice and move to another. The principle reason cited for leaving a practice was ‘distance a problem’, whereas for choosing a new one ‘convenience’ was the top reason given. This study is important because it measures actual actions rather than potential choices, which is strong evidence that, more than anything else, patients want convenient access to GP services.

152 Department of Health. Report on the National Patient Choice Survey - March 2009. England

153 Brenda Billingham and Michael Whitfield. Why do patients change their general practitioner? A postal questionnaire study of patients in Avon. British Journal of General Practice, 1993, 43, 336-338.

Reasons given by respondents for changing and choosing new doctor

Reasons for changing GP	% of Respondents	Reasons for choosing GP	% of Respondents
Distance a problem	41%	Convenience	53%
Lost confidence in doctor	21%	Good/better services	37%
Long waits	13%	Recommendation/reputation	36%
Doctor not interested	10%	Other family members with GP	14%
Doctor rude/behaved badly	10%	Good/better facilities	9%

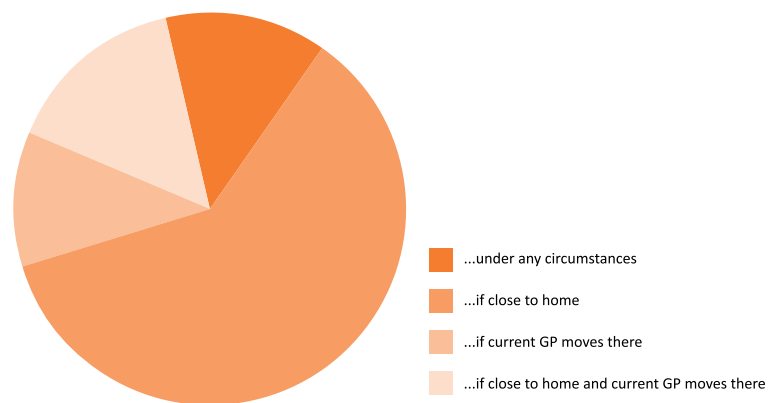
Note: Respondents often cited more than one reason

Source: Billingham B and Whitfield M. Why do patients change their general practitioner? A postal questionnaire study of patients in Avon. British Journal of General Practice. 1993. 43: 336-338

A second smaller study, published in the British Medical Journal in 1989, also surveyed patients that had recently switched GP. It also found that the most common reason for selecting one GP practice over another was because the patient believed it to be the closest one to their home.

There are, of course, valid criticisms of basing national policy on small, geographically limited samples. We have, therefore, taken data from the available nationally representative surveys on choice in primary care and compared these to a robust survey to which we have been granted access. This comprehensive and nationally representative survey was conducted for Virgin Health in 2006 and specifically sought people's views on whether they would consider attending a new primary care facility. The facility would contain a number of GPs, and other healthcare professionals (e.g. physiotherapists) and other services such as a pharmacy and x-ray.

Figure 12: Respondents would be interested in trying new health centre...



Source: Data courtesy of Virgin Health. A nationally representative sample of 1,500 adults conducted in February 2006.

154 Salisbury CJ. How do people choose their doctor? BMJ 1989; 299:608-10

This offering is, of course, an attractive proposition and, unsurprisingly, 81% of respondents said they would be interested in trying the new primary care

facility. More interesting, however, is the breakdown of why people said they were interested in trying it: 59% said they would switch their GP¹⁵⁴ and use the new service if it was close to their home, whereas only 27% wanted their existing GP to move there in order to try the new facility. Moreover, the top five determining factors for patients related to issues about access to services, rather than quality and standards of medical care.¹⁵⁵ These results are mirrored in another survey by the Consumers Association conducted in 2004. This survey asked patients to list the three most important factors for choosing a GP and found that closeness to home (53%); and waiting times for appointments and treatment (44%) scored higher than ability to see the same doctor each time (26%).¹⁵⁶

These two surveys suggest that there is a real appetite for choice in primary care and that the key determining factor is convenient access. The implications of this are profound. In general, we find that the public view primary care services as a homogenous consumer product, with access and convenience being seen as more important than personal relationships with a doctor.

Determining factors for choosing a new primary care provider	Most important to you for a new health centre. % selecting *	Most important factors in choosing a GP. % selecting **
Access		
Option to receive treatment there and then	94 %	
Ability to see GP in 24 hours	94 %	
Emergency walk-in appointments	94 %	
Friendly and welcoming receptionist	93 %	
Closeness to home		55 %
Waiting time to be seen and treated		44 %
Doctor-patient relationship		
Ability to choose GP	79 %	
Ability to see same GP on each visit	77 %	25 %

* Data courtesy of Virgin. A nationally representative sample of 1,500 adults conducted in February 2006. Base: 1,215 adults surveyed who are quite or very interested in the new surgery.

** Quality in Healthcare Omnibus survey (Consumers Association 2004). A nationally representative survey of almost 2,000 adults conducted in March 2004.

It is also worth mentioning the National Patient Choice Survey which is a satisfaction questionnaire sent to patients in each Primary Care Trust area. One study of the data from this survey has suggested that high levels of confidence and trust in the doctor are the best predictors of overall patient satisfaction.¹⁵⁷ However, as the study itself notes patient satisfaction cannot necessarily predict choice behaviour. Our analysis suggests that patients generally choose between practices, not individual doctors, and we believe that this understanding of patient satisfaction may be more relevant when looking at how patients choose between GPs once they have decided which practice they prefer. Our analysis is supported by a small survey of patients, conducted by the Medical Technology Group, for this report which found 63% of patients said the most important choice was being able to choose a practice where they could nominate one or more professionals to provide their care, whereas only 35% of patients said that choice of individual GP was the most important factor.¹⁵⁸

155 Respondents rating as very important or quite important.

156 Quality in Healthcare Omnibus survey (Consumers Association 2004). A nationally representative survey of almost 2,000 adults conducted in March 2004. Which Choice? Health Policy Report 2005.

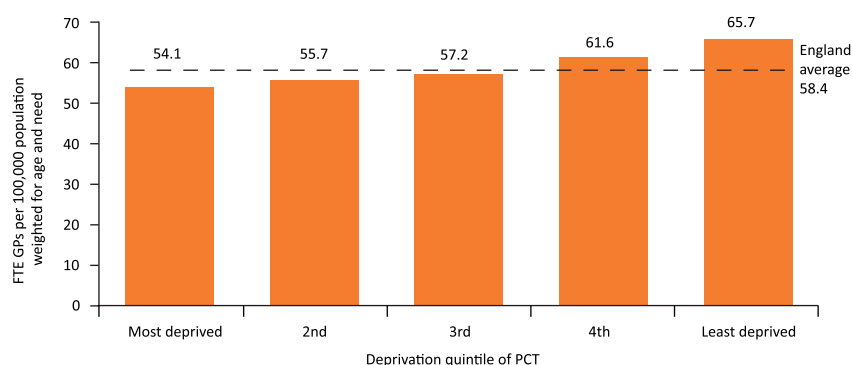
157 Ruth Robertson, Anna Dixon, Julian Le Grand. Patient choice in general practice: the implications of patient satisfaction surveys. *Journal of Health Services Research & Policy* Vol 13 No 2, 2008: 67–72

158 A survey of 272 patients on behalf of the Medical Technology Group.

Unlocking the paradox of choice in primary care

Understanding that patient access is the key determining factor for primary care services lets us unlock the market in primary care to help those with the greatest need for healthcare. We have already seen that there is a shortage of doctors relative to need: more than three-quarters of PCTs in the most deprived fifth (46 out of 61) had GP levels below the England average level and nearly two-thirds of PCTs in this fifth (37 out of 61) were more than 10% below the England average level.¹⁵⁹ Moreover, there is an even greater shortage of doctors relative to need where resident populations are both deprived and elderly.¹⁶⁰

Figure 13: Number of GPs per 100,000 weighted population by area deprivation



Source: Department of Health. Tackling health Inequalities. 10 years on. 2009.

159 Tackling Health Inequalities: 10 Years On - A review of developments in tackling health inequalities in England over the last 10 years. Department of Health. May 2009

160 Asthana S, Gibson A. Deprivation, demography, and the distribution of general practice: challenging the conventional wisdom of inverse care. *British Journal of General Practice* 2008; 58: 720-728.

161 Anna Dixon, Julian Le Grand. Is greater patient choice consistent with equity? *J Health Serv Res Policy* Vol 11 No 3 July 2006

162 Appleby J, Alvarez-Rosete A. Public response to NHS reform. *The British Social Attitudes Survey 22nd report*. 2005

163 Tackling Health Inequalities: 10 Years On - A review of developments in tackling health inequalities in England over the last 10 years. Department of Health. May 2009

164 Macinko J, Starfield B, Shi L. The contribution of primary care systems to health outcomes within organization for economic cooperation and development (OECD) countries, 1970-1998. *Health Serv Res* 2003;38:831-65.

Access to GPs in areas of deprivation is a key issue, since inconvenient access to primary care services disproportionately affects the poor because the costs of public transport and taking time off work are greater for lower-income groups.¹⁶¹ However, it is these very patients that want choice the most: 67% of routine and semi-routine want choice compared to 59% of the managerial and professional class; 70% of those earning less than £10,000 per annum wanted choice, compared to 59% of those earning more than £50,000 per annum, and 69% of those with no educational qualification wanted choice, compared with 56% of those with a higher educational qualification.¹⁶² So by designing appropriate incentives the market in primary care can be made to work for those that will benefit the most: the disadvantaged and those that currently have the greatest inequalities in health.

Rising health inequalities

Improving the health of the population is, of course, a priority for all Governments. In the last decade, no-one can dispute that there have been **real terms** improvements in the health of the nation: life expectancy has increased; infant mortality has fallen.¹⁶³ But in a state funded universal healthcare system, **relative** outcomes for different sections of society are also important. Health inequalities matter because, not only do they persist throughout life; they cross generations. Addressing the relative difference in health between social groups and areas of deprivation should be as much a focus for Government as improving the overall health of the population.

The most cost effective way to improve the health of populations is through primary care.¹⁶⁴ International evidence demonstrates that the greater the supply

of GPs the lower the level of mortality,¹⁶⁵ while studies in England show that costly hospital use is increased where there are fewer GPs.¹⁶⁶ If the supply of GPs can be directed to where they are needed most then the overall benefits to society will be greater. Primary care improves the health of local populations by offering a means for delivering primary prevention strategies such as smoking cessation, and influenza immunisation. It is the main portal for early detection and screening for diseases such as breast, prostate and colorectal cancer, cardiovascular disease and diabetes. And strengthening primary care can help prevent unnecessary and costly hospitalisations for conditions such as congestive heart failure, diabetes, hypertension and pneumonia, all of which can be managed adequately in the community by a primary care team.

Of course, inequalities in health arise not just because of inequalities in health-care, but because of inequalities in society. The wider social determinants of health relate to social, economic and cultural factors. These all contribute to variation in life expectancy. Improving the health of the nation also requires improving education, reducing levels of unemployment and improving housing. However, we should be clear that poor access to high-quality healthcare can, and does, contribute to the growing health inequalities between social groups. In the short to medium term, NHS interventions such as the prevention and effective management of risk factors in primary care are most likely to deliver reductions in health inequalities, particularly life expectancy.¹⁶⁷

In 1998, an *Independent Inquiry into Inequalities in Health* (Acheson Inquiry) presented data from the mid-1970s onwards which showed a widening gap in health between different social groups. It identified areas for policy development which were likely to reduce these inequalities.¹⁶⁸ A decade later, a review of progress found that there had been significant improvements in the health of the nation, but that considerable variation in health outcomes still persist, and in some areas the inequalities have actually increased.¹⁶⁹

Longevity and healthy life expectancy

A major strand of Government work to tackle health inequalities has been to focus on reducing the gap in life expectancy between a group of Local Authority areas with the worst health indicators and the England average. The areas with the worst health are termed the ‘Spearhead’ areas and are made up of the 70 Local Authorities in England that are in the bottom fifth in three or more of the following indicators: male life expectancy at birth, female life expectancy at birth, cancer mortality rates in under 75s, cardiovascular disease mortality rate in under 75s and average score on the Index of Multiple Deprivation 2004.

It is not disputed that over the last decade life expectancy for all groups across England has risen.¹⁷⁰ But these improvements have benefitted some groups disproportionately because inequalities in life expectancy between some social groups and geographical areas are rising. The Government has missed its own life expectancy target which was to achieve a 10% reduction in the relative gap (i.e. percentage difference) in life expectancy between the Spearhead areas and England as a whole. Furthermore, the increase in inequalities in life expectancy among social classes shows a persistent and long term rise - since the 1970’s the gap between males in manual and non-manual positions for instance has increased from 2.1 years to 3.3 years.¹⁷¹

165 Gulliford MC. Availability of primary care doctors and population health in England: is there an association? *Journal of Public Health Medicine*. 24:252-254. 2002.

166 Macinko J, Starfield B, Shi L. Is primary care effective? Quantifying the health benefits of primary care physician supply in the United States *International Journal of Health Services* 2007; 37(1): 111–26.

167 HM Treasury/Department of Health (2002) *Tackling Health Inequalities: A Summary of the Cross Cutting Review*.

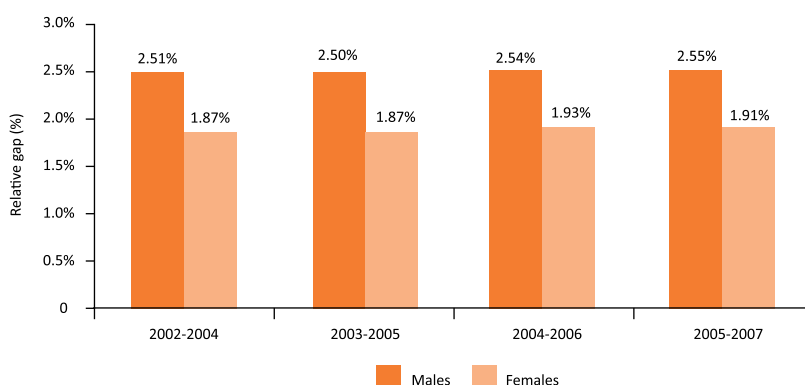
168 *Independent Inquiry into Inequalities in Health*. Department of Health. November 1998.

169 *Tackling Health Inequalities: 10 Years On - A review of developments in tackling health inequalities in England over the last 10 years*. Department of Health. May 2009

170 *Tackling Health Inequalities: 10 Years On - A review of developments in tackling health inequalities in England over the last 10 years*. Department of Health. May 2009

171 *Healthcare Commission. Are we choosing health? The impact of policy on the delivery of health improvement programmes and services*. July 2008

Figure 14: Relative gap in life expectancy between Spearhead areas and England population

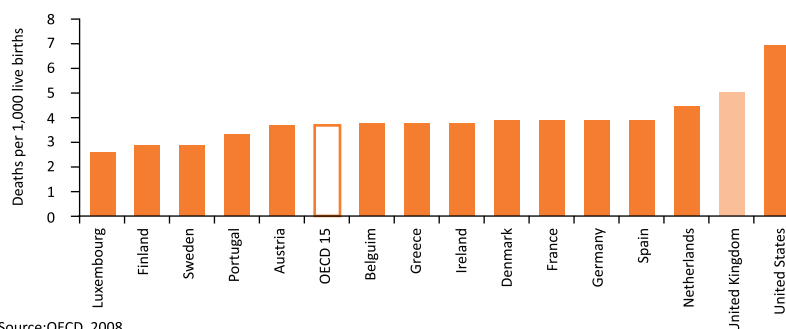


Source: ONS. Life expectancy at birth and at age 65 by local areas in the United Kingdom; Department of Health. Tackling health inequalities: the spearhead group of Local Authorities and Primary Care Trusts. 2004
 Note: relative gap in life expectancy = difference in England average and average of Spearhead Local Authorities/ England average.

Infant Mortality

Infant mortality is a good indicator of the health of a population as it is sensitive to a wide range of factors such as economic development, social well-being, and the quality of the environment that also impact the whole population.¹⁷² With increasing prosperity and improvements in general living conditions there has been a downward trend in infant mortality in England and Wales since the 1970s, from 17.7 per 1,000 live births in 1970 to 4.8 per 1,000 live births in 2007.^{173,174} This is good progress, but, we have the highest infant mortality rate in Western Europe and lag well behind the OECD 15 average for this broad measure of population level health. Among the OECD countries, only the USA has a higher rate of infant mortality.

Figure 15: Infant mortality, OECD 15 comparison, 2006



Source: OECD, 2008
 Note: Data for Belgium and United States refers to previous year. No recent data available for Italy.

172 D D Reidpath, P Allotey. Infant mortality rate as an indicator of population health. J Epidemiol Community Health 2003;57:344–346

173 ONS. Geographical trends in infant mortality: England and Wales, 1970–2006. Health Statistics Quarterly 40. Winter 2008

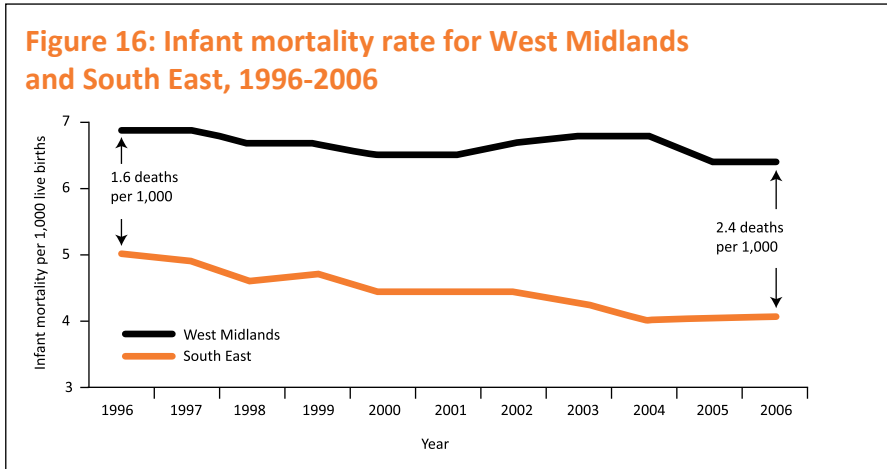
174 Births, perinatal and infant mortality statistics, England and Wales and Government Office Regions and Strategic Health Authorities in England, 2007: Health Statistics Quarterly

175 Tackling Health Inequalities: 10 Years On - A review of developments in tackling health inequalities in England over the last 10 years. Department of Health. May 2009

Examining the UK national figures shows that infant mortality varies considerably across geographic regions and social class. Infant mortality is higher in manual groups compared to the average for all social classes and, over the last ten years, this gap has not diminished.¹⁷⁵ Looking geographically, the infant mortality rate in the West Midlands, in 1996, was 38% higher than in the South East. By 2006 this gap had risen to 60%.

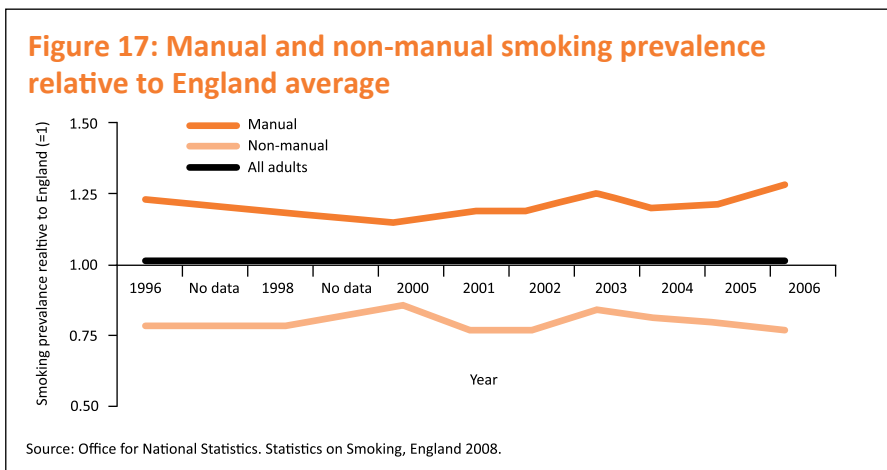
Of course we appreciate that wider demographic, social and economic factors also need to be addressed to help reduce health inequalities such as infant mortality;

however, the fact still remains that these inequalities have increased in a decade of increasing prosperity and NHS funding.



Lifestyle Factors: smoking, obesity, alcohol

Smoking is the biggest single cause of preventable illness and premature death. In 2005, it was estimated that about 82,000 deaths in England were caused by smoking, with a larger proportion of men (23%) than women (13%).¹⁷⁶ In the last 25 years, the UK has made considerable progress in reducing smoking prevalence, which has decreased from 45% in 1974 to 21% in 2007. However, the differentials in smoking prevalence between social classes persist and are widening.¹⁷⁷ The consequence is that those in lower socio-economic groups are more likely to smoke and, therefore, more likely to die prematurely from smoking related diseases.



Alcohol misuse can result in serious ill health and contributes considerably to crime and anti-social behavior. Alcohol-related hospital admissions have more than doubled in the last 10 years¹⁷⁸ and mortality in the UK from liver disease and cirrhosis now exceeds that of the EU15 average.¹⁷⁹ Excessive alcohol consumption is in some regions higher in professional and managerial groups, but there is also considerable geographic variation in consumption patterns. For example, the rate of admissions, in 2006, to hospital in the North West for alcohol-specific conditions was more than twice as high as that in the East of England.¹⁸⁰

176 Are we choosing health? The impact of policy on the delivery of health improvement programmes and services July 2008

177 Department of Health. Tackling Health Inequalities: 10 years on. May 2009

178 NHS Information Centre. Statistics on Alcohol: England 2009; and NHS Information Centre. Statistics on Alcohol: England 2008

179 OECD Health Data 2008. December 2008

180 NHS Information Centre. Statistics on alcohol: England 2008. May 2009

Obesity, another lifestyle disease that is a preventable cause of ill health and drain on NHS resources, has seen its prevalence in the UK treble since the 1980s.¹⁸¹ Approximately, 24% of adults in England are now classified as obese.¹⁸² Obesity increases the risk of heart disease, hypertension, cancer in later life and type 2 diabetes. England has the highest rates of obesity in Western Europe, with childhood obesity in England rising at the fastest rate in Western Europe.¹⁸³ Moreover, obesity links directly to deprivation, especially in children. The National Child Measurement programme shows prevalence of children in reception year and year 6 classified as obese in schools located in the most deprived areas is significantly higher than children classified as obese in schools located in the most affluent areas.¹⁸⁴

The Health Select Committee has suggested that the main causes of health inequalities are due to lifestyle factors - smoking, excessive drinking and poor nutrition - rather than problems in gaining access to healthcare services.¹⁸⁵ However, around the developed world strengthening primary care and increasing the supply of primary care doctors has been found to have a positive impact on population level health.¹⁸⁶ Reducing obesity rates are a direct example of this: a recent study has shown that a 10% increase in GP supply is associated with reductions of around 4% in Body Mass Index.¹⁸⁷ The case for strengthening primary care services is strong. In 2007, a large USA-based international review of all studies on general practice has quantified the health benefits of GPs. The findings suggested that an increase of one GP per 10,000 population was associated with an average mortality reduction of 5.3%.¹⁸⁸ Primary care can save both costs and lives.

Notwithstanding a stronger role for primary care, tackling lifestyle diseases represent a serious public health challenge. In other published work, we have made a number of recommendations on how to tackle the rising tide of obesity; to minimize the harms from alcohol misuse and to ensure the burden of dealing with smoking-related diseases does not rest with the taxpayer. Because the effects of public health initiatives take a number of years to filter through, it has been suggested by the Conservative Party that public health budgets should be ring-fenced. This suggestion follows evidence that, in the past, public health budgets have been used to finance Primary Care Trusts' running costs when budgets came under pressure.¹⁸⁹ We agree with this approach, not least because it facilitates the choice mechanisms described in this report, but more importantly, population based public health assessment and planning should be transferred to a strategic level and not rest with individual GPs.

Conclusion

The most important factor for patients in deciding which GP practice is best for them is access. Patients and citizens want good local services, but deprived areas that require more GPs and primary care services do not have sufficient provision to meet defined need. The general concern that extending choice in public services will drive inequalities has been proven not to be the case in healthcare. By giving real choice to those that need it most, and by incentivising GP practices and primary care providers to move into areas of greatest need, inequalities in access to healthcare and, consequently, inequalities in health outcomes will be reduced.

181 The Information Centre for Health and Social Care. Health Survey for England 2005: Updating of trend tables to include 2005 data. London: The Information Centre for Health and Social Care; 2006

182 NHS Information Centre. Statistics on obesity, physical activity and diet: England. February 2009

183 Healthcare Commission & Audit Commission. Are we choosing health? July 2008

184 NHS Information Centre. National Child Measurement Programme 2007/08 school year headline results. December 2008.

185 House of Commons Health Committee. Health Inequalities. Third Report of Session 2008-09. March 2009.

186 Macinko J, Starfield B, Shi L. Is primary care effective? Quantifying the health benefits of primary care physician supply in the United States International Journal of Health Services 2007; 37(1): 111-26.

187 Morris S, Gravelle H. GP supply and obesity. Journal of Health Economics 27 (2008) 1357-1367

188 Macinko J, Starfield B, Shi L. Is primary care effective? Quantifying the health benefits of primary care physician supply in the United States International Journal of Health Services 2007; 37(1): 111-26.

189 House of Commons Health Committee. Health Inequalities. Third Report of Session 2008-09. March 2009.

4

How do we give choice to patients?

Real healthcare reform can only be driven by putting patients in control of their health service. In order to give real choice to patients the system of resource allocation needs a fundamental shift towards allocations which can enable both patient choice, and encourage primary care providers to move into areas where their services are needed most. Thus far innovative service redesign in the NHS has been hampered by a top-down approach to resource allocation.

1. Allocating resources in the NHS

The Department of Health allocates 80% of NHS resources to Primary Care Trusts (PCTs) on the basis of the relative health needs of their populations. Under these allocations, the 152 PCTs in England will receive a total of £164 billion over the two years from 2009 to 2011. This is equivalent to 5.3% of GDP per annum. Each PCT is given a single total allocation based on a capitated resource allocation formula, the results of which vary considerably between regions. For example, in 2009-10 Islington PCT received £2,143 per head of population whereas Leicestershire County and Rutland PCT received £1,253. The England average was £1,540 per head of population.¹⁹⁰

Top ten funded PCTs per head of population (2009-10)	£	Bottom ten funded PCTs per head of population (2009-10)	£
Islington PCT	2,143	Suffolk PCT	1,327
City and Hackney Teaching PCT	2,136	Milton Keynes PCT	1,316
Liverpool PCT	2,031	Oxfordshire PCT	1,308
Newham PCT	2,014	Berkshire West PCT	1,301
Tower Hamlets PCT	2,014	South Gloucestershire PCT	1,298
Knowsley PCT	2,007	Bedfordshire PCT	1,293
Lambeth PCT	1,983	Buckinghamshire PCT	1,291
Hammersmith and Fulham PCT	1,886	Cambridgeshire PCT	1,287
Lewisham PCT	1,876	Mid Essex PCT	1,269
Salford PCT	1,876	Leicestershire County and Rutland PCT	1,253

Source: 2009-10 and 2010-11 PCT recurrent revenue allocations exposition book. Department of Health. Table 1.

The allocations to PCTs cover three components: hospital and community health services, which accounts for 76.3% of the total; prescribing accounts for 12.4%;

¹⁹⁰ Department of Health. 2009-10 and 2010-11 PCT recurrent revenue allocations exposition book. December 2008.

and primary medical services for 11.3%. These allocations are not broken down into separate blocks each of which can only be used for a particular type of service, rather it is for PCTs to determine how best to use their resources to meet their local needs and priorities, within national standards and the direction and requirements set out by the Department of Health. A more detailed breakdown of spending is available from the returns made by PCTs, as shown in the table below.

Component of PCT spending	£ billion in 2006-07 (from PCT returns)
Hospital and Community Health Services	46.8
<i>of which</i>	
General and acute	26.9
Mental health	6.5
Maternity	1.6
Accident and emergency	1.6
Learning difficulties	2.0
Community health services	5.5
Other contractual	1.8
HIV/AIDS	0.4
Prescribing	7.5
Primary Medical Services (general practice)	6.9

Source: 2009-10 and 2010-11 PCT recurrent revenue allocations exposition book. Department of Health. Table 4.

Currently PCTs are responsible for ensuring that practices receive an indicative budget that is a 'fair share' of the resources available to the PCT. However, the consequence of such wide variation in per capita funding at PCT level is that areas with identical need within, say, Rutland and Islington could, because the allocation is made on a PCT wide basis, have large variations in funding at the level of individual general practice. Such variations might allow for GP practices with similar needs in different parts of the country to adopt different standards of care in terms of both the quantity and quality of treatment.

Resource allocation in the NHS is not a settled issue. In 1976 the Resource Allocation Working Party had to interpret the underlying objective of its own terms of reference as, "to secure through resource allocation equal opportunity of access for people at equal risk".¹⁹¹ At that time allocation of funds to the Regional Health Authorities were calculated on just three elements: population; demography based on national average costs; and additional need based on Standardised Mortality Ratios. Following the first significant review of the allocation formula, in 1988, a measure of deprivation was introduced as a factor for distributing funds.

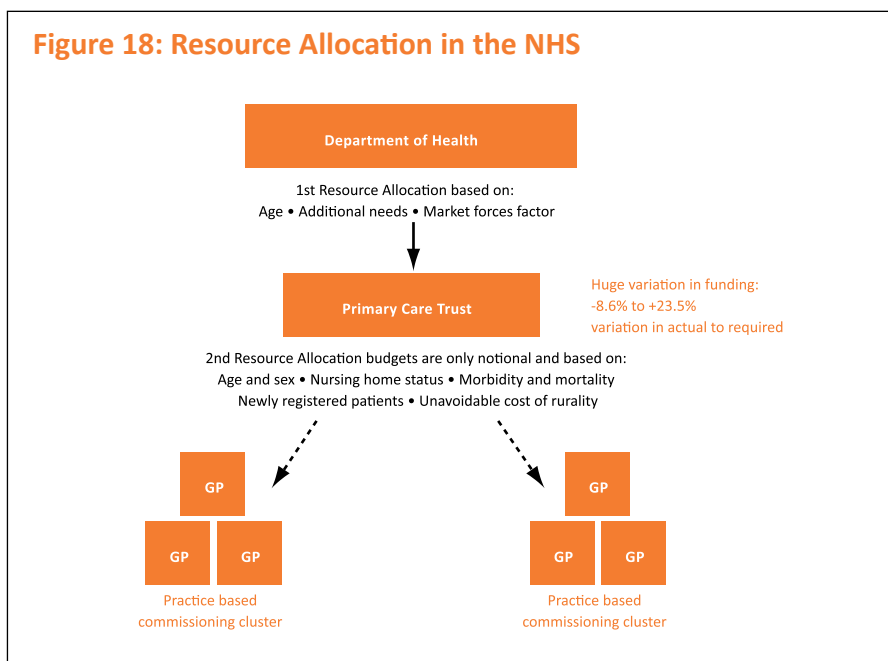
The single guiding principle of resource allocation, that of 'equal access for equal risk' remained paramount until 1999 when the then Minister of State requested the Advisory Committee on Resource Allocation (the successor to the Resource Allocation Working Party) to develop a formula "to contribute to the reduction in avoidable health inequalities."¹⁹² The shift was silent, but fundamental. The focus of NHS funding had shifted from seeking equity in access to reducing inequity in health outcomes. However, the mechanism for achieving the reduction in health inequalities is applied over too large a population to be effective. The health inequalities assessment for resource allocation is made at PCT level, whereas previously Local Medical Practice Committees used the Under

191 Department of Health. Sharing resources for health in England: Report of the Resource Allocation Working Party. September 1976.

192 Parliamentary Question on Health Allocation (Review) Hansard 5 Nov 2002 : Column 259W.

Privileged Access Score to allow GPs to move into under doctored areas. The Medical Practice Committee system was abolished in 2002.

Over the years, there have been accusations that various revisions to the resource allocation formula have favoured both Conservative and Labour areas. In 1996, the Health Select Committee was presented with evidence that a Ministerial decision limiting the redistribution based on deprivation favoured Conservative constituencies such as East and West Surrey ahead of Labour ones such as Camden and Islington.¹⁹³ In 2005, the NHS reported financial deficits mainly in the south east in, what were described by the then Secretary of State, “healthy wealthier parts of the country”.¹⁹⁴ However, these deficits were investigated by the Department of Health and found to be due to excess spending rather than reduced resource allocation.¹⁹⁵ More recently, in 2008, a study has suggested that a more pronounced and consistent pattern of inverse care is found with respect to affluent but ageing populations, rather than deprived ones. Crucially, however, it found that GP practices serving the oldest and most deprived populations have the worst GP availability of all.¹⁹⁶



For over 30 years, huge amounts of public funds have been allocated through the Department of Health through different revisions of the resource allocation formula, but the process has a number of unresolved issues. There is a persistent problem of ‘list inflation’, which is the term given to the difference between the two available data sets on population size: the Office for National Statistics projections based on the Census and lists of patients registered with GP practices. The latter are thought to be 102% of the former.¹⁹⁷ This has obvious implications for moving towards a more granular form of resource allocation, since a 2% margin of error equates to £1.7 billion overfunding. Levels of list inflation differ between PCTs, with further variation between age bands and between male and female populations. No simple reason for this variation has been found.¹⁹⁸ Accurate population figures are important because they form the starting point for the calculation of the weighted capitation formula. The robustness, reliability and ac-

193 Health select committee (1996a) Allocation of Resources to Health Authorities Report. Volume 1. Session 1995-96. HC 4771. haven't seen original

194 House of Commons Health Committee. NHS Deficits. First Report of Session 2006-07. HC 73-I

195 Department of Health. Explaining NHS Deficits - 2003/04 - 2005/06. February 2007.

196 Asthana, S. and Gibson, A. (2008). Deprivation, demography and the distribution of general practice: challenging the conventional wisdom of inverse care. *British Journal of General Practice*, October 2008, 719-27.

197 Personal communication.

198 Department of Health. Report of the Advisory Committee on Resource Allocations. December 2008.

curacy of GP lists are, therefore, crucial in delivering a fair and equitable outcome to the resource allocation process and enabling choice for patients.

Three elements are used in the first resource allocation formula distribution from the Department of Health to PCT level to set weighted capitation targets: 1) age distribution; 2) additional need over and above that relating to age (e.g. mental health); and 3) unavoidable geographical variations in the cost of providing services (the Market Forces Factor). The outcome of the calculation in the formula is not the sole determining factor for resource allocation to PCTs. The formula produces the target share of resources which is measured against current allocations. Any difference between the two – the difference from target – is covered by a pace of change policy which moves from actual allocation to target allocation over a number of years. The rate of this movement is a Ministerial decision and, in 2009-10, PCT allocations varied from their targets by minus 10.6% in Bassetlaw PCT to plus 23.8% in Richmond & Twickenham PCT. In other words, some PCTs now have nearly a quarter of their target allocation too much given their population demographics and health care needs while others have over 10% too little.¹⁹⁹

PCTs most underfunded (2009-10)	%	PCT Deprivation rank (out of 152)	PCTs most overfunded (2009-10)	%	PCT Deprivation rank (out of 152)
Bassetlaw PCT	-10.6	72nd	Richmond & Twickenham PCT	23.8	150th
Barnsley PCT	-9.3	34th	Westminster PCT	22.7	46th
South Staffordshire PCT	-7.9	117th	Kensington & Chelsea PCT	22.1	70th
Lincolnshire Teaching PCT	-7.5	103rd	Hammersmith & Fulham PCT	16.4	33rd
Leicester City PCT	-7.5	21st	Lambeth PCT	14.9	9th

Sources: Department for Communities and Local Government. Indices of Deprivation 2007. Department of Health. 2009-10 and 2010-11 PCT recurrent revenue allocations exposition book.

Structural reorganisation is a feature of the NHS and this has a knock-on effect for resource allocation. Both the introduction of GP fundholding - which required allocating budgets for hospital services at practice level - and Practice Based Commissioning (PBC) have caused difficulties for resource allocation. When fundholding was introduced the intention was that fundholding practices would be funded on a capitated basis (i.e. according to the number of people and their health needs). However, delays in developing a capitation formula meant that GP fundholders were funded according to past activity. Since the majority of fundholders were located in the suburbs this merely perpetuated historical inequities in healthcare, and resulted in inequitable allocation of resources based on whether practices opted into fundholding or not.^{200,201}

Successive iterations of the resource allocation formula have generated an ever more complex funding landscape. Of course it is important that the formula allocates resources efficiently. However, at one time it was thought that allocation for additional need using Standard Mortality Ratios was unnecessarily crude, although that thought has now been dispelled. Indeed, experts on resource allocation

199 Department of Health. 2009-10 and 2010-11 PCT recurrent revenue allocations exposition book. December 2008.

200 J Dixon Can there be fair funding for fundholding practices? *BMJ* 1994;308:772-775

201 Dixon J, Dinwoodie M, Hodson D, Dodd D, Poltorak T, Garrett C, et al. Distribution of NHS funds between fundholding and non-fundholding practices. *BMJ* 1994;309:30-4.

applying state-of-the art techniques of estimation to analyse data on utilisation cannot produce uncontested weightings for additional need.²⁰² Furthermore, the introduction of the NHS tariff system, Payment by Results, has given rise to concerns that another of the weightings applied to the formula, the Market Forces Factor, merely subsidises costs of some providers. Fundamentally, therefore, we have to accept that there is no single best way of allocating resources. There will always be winners and losers since only a fraction of the individual variability in healthcare costs can be accurately predicted.²⁰³ The marginal gains from producing detailed weightings of small components of spending are more than erased by the lack of transparency from a system which is unnecessarily complex. For such a large allocation of public resources, for the purposes of democracy and accountability the process of distribution needs to be transparent for professionals and for patients in order to promote confidence in the NHS.

A new transparent system of allocation

We suggest that resource allocation in the NHS should be distributed by the Department of Health, or by any new independent board, to a much more granular level - down to individual postcode level of just 15 households - and that the second resource allocation process performed by Primary Care Trusts should be abolished. In order to realign the balance in favour of transparency we suggest that the NHS resource allocation formula should be weighted on a capitation basis with just three elements rather than as at present. The three elements are: age, postcode and an additional 'patient premium' to act as an incentive to GPs to provide healthcare to patients in areas with the worst health and deprivation indicators. We propose that healthcare funding should be distributed directly to GPs, who will then provide or commission the health care for their registered patients or primary care providers. This process has already been trialled in the NHS in the late 1990s with the Total Purchasing Pilots, which we will consider later in this chapter.

For both patients wishing to switch GP, and GP practices taking on a new patient, the process will be simple. Only two variables will need to be known - date of birth and postcode - in order for the correct level of funding to be made available. Intuitively allocation based on age and postcode is a seemingly crude method on which to base the distribution of huge amounts of NHS funds. However, the age structure of the population has long been recognised as a principal cause of variation in the level of demand for health services. The very young and the elderly, whose populations are not evenly distributed throughout the country, tend to make more use of health services than the rest of the population. Therefore, an age related need adjustment is necessary to allow for varying health care needs associated with the age structure of local populations.²⁰⁴ Indeed, for most diseases age is a more significant determinant of morbidity and mortality than deprivation.²⁰⁵ The case for allocating funds based on age and deprivation, based on postcode, addresses the two biggest determinants of disease and their associated costs.

Geo-demographic segmentation of populations is already used widely in the private sector. The two largest geodemographic consumer classification systems in the UK are MOSAIC by Experian and ACORN by CACI. MOSAIC Public Sector is a geodemographic classification which classifies all UK citizens on the basis of their needs for public services. The marketing material for MOSAIC Public Sector

202 Review of the Weighted Capitation Formula. Professor Gwyn Bevan. Report to the Secretary of State for Health. June 2008.

203 Martin S, Rice N, Smith PC. Risk and the GP budget holder. York: Centre for Health Economics, 1997.

204 Department of Health. Report of the Advisory Committee on Resource Allocations. December 2008.

205 Asthana S, Gibson A, Moon G, et al. The demographic and social class basis of inequalities in morbidity: a comparison. *J Epidemiol Community Health* 2004; 58(4): 303–307. To re-read this reference.

suggests that Directors of Public Health in PCTs are already using these tools, “The Mosaic analysis provides us with a sharper definition of deprivation than can be obtained by using the Indices of Deprivation alone,”²⁰⁶ reads one comment.

Existing Problems HealthACORN Local Authority rank (England only)	Spearhead Primary Care Trust Primary Care Trust	Non-spearhead Primary Care Trust
1. Easington	County Durham PCT	
2. Bolsover	Derbyshire PCT	
3. Sedgfield	County Durham PCT	
4. Knowsley	Knowsley PCT	
5. Barnsley	Barnsley PCT	
6. Wansbeck	Northumberland Care Trust	
7. South Tyneside	South Tyneside PCT	
8. Gateshead	Gateshead PCT	
9. Tendring		North East Essex PCT
10. Sandwell	Sandwell PCT	
11. Liverpool	Liverpool PCT	
12. Stoke-on-Trent	Stoke-on-Trent PCT	
13. Barking & Dagenham	Barking & Dagenham PCT	
14. Sunderland	Sunderland PCT	
15. Derwentside	County Durham PCT	
16. Wear Valley	County Durham PCT	
17. Hartlepool	Hartlepool PCT	
18. Doncaster	Doncaster PCT	
19. St. Helens	Halton & St. Helens PCT	
20. Blackpool	Blackpool PCT	
21. Salford	Salford PCT	
22. Redcar & Cleveland	Redcar & Cleveland PCT	
23. Wakefield	Wakefield PCT	
24. Chester-le-Street	County Durham PCT	
25. Blyth Valley	Northumberland Care Trust	
26. Wyre	Blackpool PCT	
27. Walsall	Walsall PCT	
28. Rotherham	Rotherham PCT	
29. Mansfield	Nottingham PCT	
30. Newcastle-under-Lyme		North Staffordshire PCT

Sources: Department of Health. Health Inequalities: Revised list of Spearhead Group of Primary Care Trusts. 14 September 2006.
HealthACORN Local Authority Rank – Existing Problems. <http://www.caci.co.uk/acorn/healthacorn.asp> accessed 18 September 2009.

HealthACORN has been developed by CACI and market research company, TNS, and is a classification of census output areas designed to discriminate across factors relating to current and future health. The HealthACORN factors for segmentation are: indicators of existing health, lifestyle indicators and levels of food consumption which are derived from census data and surveys of food consumption and health and consumer lifestyles. The classification has 4 major groups, which are subdivided into 25 types and can be further subdivided into 60 sub-types. The four major groups are:

206 Mosaic Public Sector Website. Accessed on 25 September 2009. http://www.experian.co.uk/www/pages/what_we_offer/products/mosaic_public_sector.html

Existing problems – high levels of serious illness and poor diet and consumption patterns

Future problems – high levels of severely unhealthy lifestyles, likely to lead to serious illness

Possible future concerns – generally good health but with some potentially unhealthy lifestyle traits

Healthy – good health with few lifestyle issues

Further, it is interesting to compare the HealthACORN major grouping of ‘Existing problems’ which ranks local authorities according to their level of serious illness and poor diet and consumption patterns against the Spearhead group of Primary Care Trusts which have been identified by the Department of Health as having the worst levels of health and deprivation. The table shows a remarkably good correlation between the top 30 Local Authorities based on the ‘Existing Problems’ HealthACORN typing and the PCTs with the worst level of health inequalities as identified by the Department of Health, but HealthACORN offers a much more granular view and highlights local authorities such as Tendring and Newcastle-under-Lyme which are not part of the Spearhead programme.

An incentive to change behaviour – the Patient Premium

There are undoubtedly more sophisticated ways to adjust for healthcare costs than to use these indicators and we are aware of on-going work supported by the Department of Health in this area. But while these methods might be better in terms of cost compensation, we suggest they lose out in terms of timeliness, transparency and the ability to produce an incentive effect. We believe that, in addition to accounting for costs, there should be an element of incentive for GPs or primary care providers to move into areas of greatest need, to help foster choice and reduce inequalities.

Successive governments have sought to develop general practice as the building block of the NHS. However, by focussing on current expenditure and requiring incremental improvement on a yearly basis, NHS resource allocation has merely helped entrench existing ways of working and patterns of delivery. It has not been conducive to innovative service delivery, and, with the removal of the Under Privileged Access score, it no longer offers an incentive to for GPs to take the lead in developing alternatives to expensive hospital care. It could be argued that there is already an element of incentive in the resource allocation formula since the reduction of avoidable health inequalities is now a determinant of resource allocation. However, as we have seen earlier, this incentive effect has not been sufficient, since there are still not enough GPs working in areas where they are needed most.

We propose a method of direct incentivisation – the ‘patient premium’. The ‘pupil premium’ is already part of both Conservative and Liberal Democrat policy on school funding as a means to address the social inequities in school admissions. This idea behind using financial incentives to address social inequalities was introduced into UK political thought in 1989 by Julian Le Grand in his edited book *Market Socialism*.²⁰⁷ Also, work by Professor Sir Brian Jarman in the 1980’s on underprivileged access in healthcare led to the

207 Julian Le Grand and Saul Estrin ed. *Market Socialism*. Clarendon Press 1989.

introduction of the Under-Privileged Access Score in the Resource Allocation Formula.

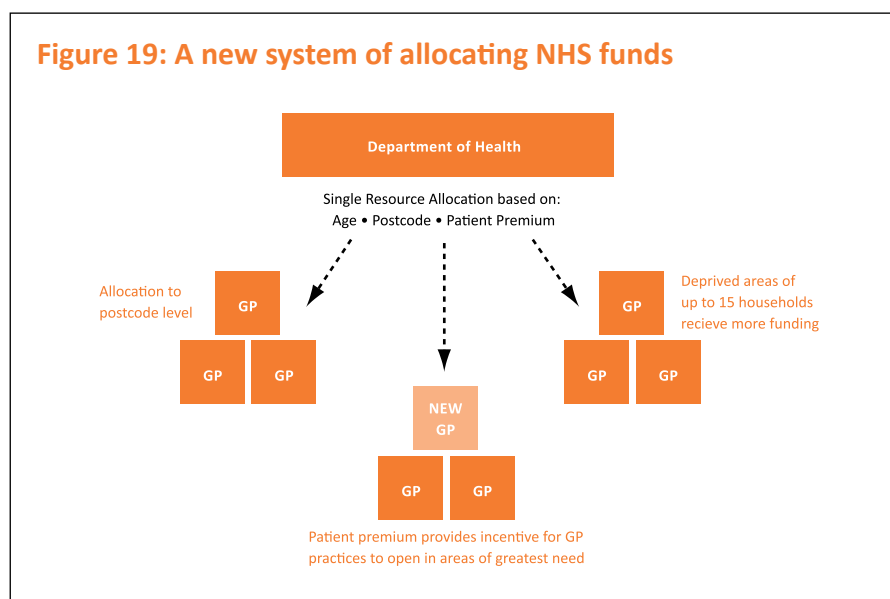
In order to encourage the shift of medical care out of hospitals and into primary care, we propose that the funding for the patient premium should be taken from the Hospital and Community Health Services (HCHS) component of the NHS resource allocation. Since we propose to simplify the resource allocation formula to a one stage process, it is not possible to give an accurate figure for the premium. However, using the England average GMS allocation of £54.72, per patient the most deprived postcodes might expect an amount in the region of £11.00, per patient per year although payments should be phased in with less deprived areas receiving a lower level of premium so that there is not an abrupt cut off.

The ‘patient premium’ is a clear incentive to providers of primary care services to help reduce the inequalities in health in a cash-limited healthcare system. In moving funding from the HCHS component of the NHS resource allocation the objective is to drive healthcare out of hospitals, thereby reducing growth in healthcare costs. However, the amount taken from the HCHS component to fund the ‘patient premium’ should be matched by an equal reduction in acute hospital tariffs. This will prevent community services from receiving a reduced level of funding as well as drive efficiency and best practice in acute hospitals. We have previously recommended that the NHS adopt a best practice tariff in our earlier report on healthcare, *All change please*.

Fundamental to our proposals is to allow GP practices and primary care providers to use any underspend to improve care for their patients and, in addition, there should be an element of bounty for the primary care provider to invest in new services to meet this objective. Currently the prohibition of the sale of the goodwill attached to a GP practice limits the ability of GPs to raise money to invest in improving primary care facilities for their patients.

We recognise that there are theoretical issues in resource allocation based on age, postcode and a patient premium, which are described elsewhere in the literature.²⁰⁸ However, we believe that any disparity they might produce

Figure 19: A new system of allocating NHS funds



208 Carr-Hill R, Rice N, Smith PC. Towards Locally Based Resource Allocation in the NHS. York Centre for Health Economics. 1998

will be much less than the variation seen in the present system: some PCTs receive 23.8% too much funding given their population demographics and healthcare needs while others receive 10.6% too little. Furthermore, we suggest that by having a more transparent system of resource allocation, the NHS, the public, the media and academia will begin to engage in a process of peer review and refinement of the resource allocation process. For the last 30 years review of the resource allocation formula has proceeded on an ad-hoc basis. A system of formal review should be a first step for any new government and this process should start with engagement with the NHS; its patients, professionals and citizens.

Recommendations:

- Resource allocation in the NHS should be distributed directly from the Department of Health, or any new independent board, to GP practices or primary care providers. The method for allocating funds should be based on age, postcode and a 'patient premium'. The premium element should be funded by a re-allocation from the Hospital and Community Services (HCHS) budget and would act as an incentive to providers to deliver healthcare where it is needed most.
- Resource allocation budgets should continue to be broken down by speciality area such as acute, mental health, maternity, etc, so that they can easily be passed on from GP practices to Primary Care Commissioning Clusters or other providers or commissioners, if required. A separate amount for out-of-hours cover should be added to the allocation. Those primary care providers that want to provide out-of-hours cover themselves might find it offers a competitive advantage to attract patients to their service.

However, as we have seen, all the improvements in quality, efficiency and system responsiveness gained from a system of GP fundholding only applied to patients of fundholders. By the time it was abolished in 1997, only 50% of GP practices were fundholders. This has negative implications for patient equity and raises important questions in terms of how to implement a national policy of fundholding.²⁰⁹ One suggestion is to make GP fundholding compulsory, but introducing a system of GP fundholding would require a re-negotiation of existing GP contracts. And since not every GP practice would automatically want to be a fundholder a two tier system of GP fundholders and non-GP fundholders would be inevitable. We suggest that fundholding could be re-introduced on a national basis either by introducing incentives to encourage large primary care providers or GP practices to enter areas where there is resistance to fundholding – thereby offering a competitive mechanism for unwilling GP practices to take on fundholding responsibilities - or by using the sale of GP goodwill as a bargaining tool. This is currently owned by the Secretary of State and has considerable value to GPs – about £160,000 per GP.²¹⁰

209 Mannion R. Practice based budgeting: lessons from the past; prospects for the future. Report to the Department of Health. York Centre for Health Economics. 2005

210 Healthcare Republic. Practice Finance – buying and selling goodwill. Laurence Slavin, Chartered Accountant, Ramsay Brown. August 2009.

Total Purchasing Pilots

GP fundholding was introduced into the NHS in 1991. Under this scheme GP practices could opt to hold a budget to purchase some services on behalf of their patients, mainly elective operations in hospital and community health services. The rationale behind fundholding was that giving hard budgets to GPs would make them aware of the cost implications of their clinical decisions. Indeed, fundholders had greater freedom than Health Authorities to innovate and shift resources between providers. However, Health Authorities retained responsibility for about four-fifths of the budget for hospital and community services for fundholding practices and the entire budget for non-fundholding practices.

A logical extension of the fundholding scheme was to have GPs holding the entire budget on behalf of their patients, and this concept was pioneered from the bottom-up by innovative and enthusiastic general practitioners. A national pilot scheme – Total Purchasing Pilots - covering some eighty practices was set up and ran from 1996 to 1998. The theory behind the pilots was that it would combine the best of top-down, strategic purchasing for the needs of a population, with bottom-up responsiveness to the needs of individual patients. Devolving entire budgets to GP practices had the potential to develop integrated purchasing and provision, thereby strengthening the provider role of general practice where unit treatment costs are significantly less.

The fundholding and total purchasing model incorporated three ways of managing risk. First, eligible practices required populations of at least 11,000 to become fundholders, although this threshold was successively lowered to a minimum size of 5,000 patients. Second, expenditure on elective inpatient admissions could be deferred and overspends of 5% were allowed. Third, a “stop loss” arrangement, in which any referral costing more than £6,000 was met by the patient’s health authority rather than the practice budget.

In practice, none of the total purchasing pilot sites purchased the entire range of services for their patients, rather there was selective purchasing coinciding with areas of GP expertise or where they had a special interest in achieving change. As a result there was diversity in approach taken: most practices became commissioners, holding a delegated budget and directly purchasing care; some co-purchased care with their overseeing Health Authority; or focused on primary care development. Consequently, evaluation of the pilots was limited to self-reported progress.²¹¹ The most frequently mentioned priority for service change was reducing the number of emergency admissions or attendances at Accident & Emergency. The achievements for the pilots were compared to changes in Hospital Episode Statistics and this analysis showed a high level of consistency between reported and actual success. Length of stay was reduced in 13 of the 16 commissioner and co-purchaser pilots. However, in terms of meeting objectives the pilots reported more success in reducing length of stay (64%) than reducing emergency admissions (44%). Greatest success was for developing the primary healthcare team (87%) and improving information/population needs assessment (84%).

The pilots which opted for the commissioner-type model tended to be the highest “achievers” and were the only ones that reported achieving all of their main objectives in services related to total purchasing. It should be noted that, the highest achieving pilots were also in the top quarter for direct management costs, although

211 Goodwin N, Mayes P, et al. Evaluation of total purchasing pilots in England and Scotland and implications for primary care groups in England: personal interviews and analysis of routine data. *British Medical Journal*. 1998 July 25; 317(7153): 256–259

these pilots did invest significantly in information systems. Moreover, in half of the pilots the practices agreed with their local health authority the right to use any under-spends for the benefit of their own patients.

Because of the issues of inequity in provision highlighted previously, New Labour committed to abolish the GP fundholding scheme. As a result, the total purchasing pilots were not rolled out nationally and GP fundholding was replaced in 1999 by centrally controlled Primary Care Groups, the precursor of today's Primary Care Trusts.

2. How will a new funding allocation drive competition in the NHS?

If we accept that consumer choice in public services is a good thing, then standard economic theory suggests that greater choice will drive quality, innovation, and efficiency. We believe that competing providers of primary care services will move into under-doctored areas where there are greater funds available to improve the health of disadvantaged populations. Indeed, the most recent peer-reviewed evidence suggests that using market based reforms in secondary care actually reduce inequalities.²¹² However, the system we create in primary care should give all patients real choice so that services are improved across the country and in all areas.

Bigger or smaller GP practices

A valuable lesson from both GP fundholding and the Total Purchasing Pilots is that there are problems in managing risk for small populations, especially at the level of a typical GP practice of 6,500 patients.^{213,214} For the practice budget to be effective it has to be designed to be able to cope with the risk in random variation in expenditure caused by the unpredictability of disease. Neither economists nor doctors are sufficiently skilled to accurately predict the precise timing or severity of disease, so large and random deviations in spending are inevitable. It is how the design of the system accounts for these variations that is important.

One of the most obvious mechanisms for reducing this risk is to aggregate individual patient budgets into larger populations so that the variability in average spending diminishes. This principle of risk pooling lies behind the allocation of funds to Primary Care Trusts, where the average population is some 340,000 and the range is 92,000 to 1.2 million. The larger the risk pool, the lower the risks of over-spending. But if we are to have allocation of funds to the level of an individual postcode, how many patients would need to register at a single practice in order to sufficiently diversify the risk?

Following the introduction of GP fundholding in the early 1990's, a number of studies considered the minimum practice size necessary to be able to adequately manage financial risk.^{215,216,217,218} These studies quickly concluded that small risk pools – such as those used in the latter stages of fundholding – would be expected to produce significant overspends. In modelling the case of rare and costly referrals one of the studies²¹⁹ found that a risk pool of 7,000 patients had a comparatively high degree of risk, which decreased appreciably when the risk pool increased to 30,000. Beyond this size diminishing marginal returns were seen.

212 Cooper Z, McGuire A, Jones S, Le Grand J, Titmuss R. Equity, waiting times, and NHS reforms: retrospective study. *BMJ*. 2009;339:b3264.

213 Goodwin N, Mayes P, et al. Evaluation of total purchasing pilots in England and Scotland and implications for primary care groups in England: personal interviews and analysis of routine data. *British Medical Journal*. 1998 July 25; 317(7153): 256–259

214 NHS Information Centre. General and Personal Medical Services England 1998 – 2008. March 2009.

215 Martin S, Rice N, Smith PC. Risk and the GP budget holder. York: Centre for Health Economics, 1997.

216 Crump BJ, Cubbon JE, Drummond MF, Hawkes RA, Marchmont MD. Fundholding in general practice and financial risk. *BMJ* 1991;302:1582-4.

217 Bachmann MO, Bevan G. Determining the size of a total purchasing site to manage the financial risks of rare costly referrals: computer simulation model. *BMJ* 1996; 313: 1054-1057

218 Carr-Hill R, Rice N, Smith P. Towards Locally Based Resource Allocation in the NHS. York: Centre for Health Economics, 1998

219 Bachmann MO, Bevan G. Determining the size of a total purchasing site to manage the financial risks of rare costly referrals: computer simulation model. *BMJ* 1996; 313: 1054-1057

Obviously, a pool of 30,000 is somewhat larger than the current practice average of 6,500 patients. However, the trend in general practice over the last 30 years has been away from single-handed practices towards larger practices employing more GPs and thus registering a larger number of patients. More than half of all GPs today work in partnerships of six or more, compared with less than one in ten in the 1970s. Under a system with more granular allocation of funds a number of practices might come together to pool budgets and reduce risk, and effectively become large fundholders. This was the case in the 1990s with GP multi-funds – where many fundholders pooled their funding resources – the bottom-up precursor of today's PCTs. Indeed, the Royal College of General Practitioners has suggested that with a federated approach of primary healthcare teams and practices working together virtually all health problems could be dealt with in primary care.²²⁰ Larger aggregations of federated GP practices would also see reductions in the management costs of negotiating and monitoring contracts with providers.

Today, the typical GP has fewer than 1,600 registered patients, so a federation of about 20 GPs would be necessary to generate a sufficient risk pool of 30,000 patients. This figure might be too large to drive real choice for many patients in rural or semi-rural areas, although managing the risk of random variation in expenditure through insurance would permit much smaller practice sizes. For a practice of 10,000 patients it has been suggested that insurance payments of between 1.2 – 2.5% of the total practice budget would be necessary.²²¹

High cost patients

To some extent the large and unpredictable deviations in healthcare spending are caused by a few very expensive procedures or patients. The GP fundholding scheme recognized that this pattern was almost completely unpredictable and excluded from the resource allocation process certain procedures and costs in excess of £6,000 incurred by any one patient in any one year. Today, even with the allocation of funds to PCT level the cost of treating rare and complex cases are such that it is necessary to commission services for these conditions at regional and national level. We have already highlighted the problems caused by allocating funds to PCT level then expecting co-ordinated regional Specialised Commissioning Groups to be a success. For now, we should acknowledge that one major effect of excluding high cost patients from the allocation process is to reduce financial risk, which in turn allows a model of choice and contestability to work in primary care. We will consider how specialised commissioning should be arranged later in this report.

Making choice happen in primary care

Although it is a critical step, freeing the allocation of funds to a more granular level will not, in itself, be sufficient to drive patient choice. Choice in schools policy works because there is an inbuilt mechanism to ensure choice takes place – children get older and move to different schools. But, there is no culture of choice in primary care, rather a tendency towards viewing the doctor-patient relationship as paternalistic. Decisions about which GP practice a patient can register with and visit largely rest in the hands of Primary Care Trusts, on behalf of the State. Conse-

220 The Royal College of General Practitioners. *The Future Direction of General Practice. A roadmap.* 2007

221 Bachmann MO, Bevan G. Determining the size of a total purchasing site to manage the financial risks of rare costly referrals: computer simulation model. *BMJ* 1996; 313: 1054-1057

quently, as we have suggested, the default position in primary care is no choice at all: public engagement in healthcare is low.

We propose to create a culture of choice in primary care by making registration with a GP or primary care provider an active process. Everyone should be asked to choose their GP or primary care provider once every two years. We suggest two years as a starting point, since the balance between creating contestability in the primary care market and convenience for patients needs to be achieved. An option for subsequent cycles of choice would be to allow patients to opt-in to providers for periods between 2-5 years. Not only will this process of choosing GP engage patients more in their own healthcare, thereby reducing burdens on the NHS, but it will also allow smaller GP practices to become more viable, thereby creating a virtuous circle of choice and contestability.

The obvious concern about implementing a process of choice in primary care is that it would create bureaucratic burden and where that burden would lie. We recognise that our proposal would lead to considerable change the first time it is run, but the fact that at the moment this change is hidden is the point. Creating a culture of choice in primary care requires a change in the mindset for the public. Resetting the default position of no choice at all will not be easy. We suggest, therefore, that the initial costs might be in the region as for a general election – some £80 million - but that annual rolling costs would be much reduced. An infrastructure for delivering information to patients registered with GPs already exists in the national GP patient survey. These surveys of patient opinion would no-longer be required because patients would be exercising their views through choice rather than completing questionnaires and the £10 million cost for 6.9 million surveys each year sets a benchmark for the bureaucratic costs of our proposals.²²²

Creating this process of active choice in primary care registration allows us to utilise another method of reducing the effect of large and unpredictable deviations in healthcare spending. By allowing budgets to be set for a period of more than one year, risk created by smaller pools of patients is reduced.²²³ A programme of active patient choice repeated once every few years would enable GP practices to offset underspends in one year against overspends in another. Longer budgetary periods would allow the Department of Health, or any new primary care regulator, to become aware of serious financial problems to come to light during, for example, an annual financial audit. Using the threshold of 30,000 patient years as being a sufficient risk pool, a two year cycle of active choice of primary care provider would allow primary care providers to be viable with smaller pools of patients of just 20,000. Choice is only effective for patients if they have alternatives to switch to, so by using the combined methods of insurance, risk pooling and longer budgetary cycles real choices and alternatives can be extended to a greater proportion of the population.

Supporting choice for all

The argument against extending choice in public services, especially in healthcare, is that it will be socially divisive and that it will drive inequity. The argument goes that people who are better educated or wealthy are more able to switch services, and that choice policies, particularly expanding the choice of provider, will enable them to do even better.²²⁴ But as we have seen earlier this is not the case in

222 Parliamentary Written Answer. House of Commons Hansard. 26 Jan 2009 : Column 226W

223 Martin S, Rice N, Smith PC. Risk and the GP budget holder. York: Centre for Health Economics, 1997.

224 Fotaki M, Roland M, et al. What benefits will choice bring to patients? Literature review and assessment of implications. *J Health Serv Res Policy* Vol 13, No 3. July 2008.

healthcare, in both the London Choice Project and with the recent analysis of NHS waiting times patients were supported in their choice, by patient care advisors and GPs respectively.

To prevent any possibility of driving the inequalities we are trying to tackle, it is important that the most vulnerable patients receive help and support to make their choices. The most important aspect will be levelling the differential in access to information, since evidence from the USA shows that relatively socially advantaged groups are significantly more likely to use performance data to make choices in healthcare.²²⁵

Even before the recession of 2009, there was no public enthusiasm for paying more through higher taxes to have greater choice in public services.²²⁶ Although there has been a universal political commitment to protect NHS spending, changing demographics and the rising costs of delivering healthcare means that the NHS is about to enter a period of previously unseen spending restraint.²²⁷ Extending choice into primary care can only work if it can be introduced in a way which delivers value for money and, crucially, better value for money than other improvement mechanisms.

Health Trainers are a recent Department of Health initiative that have shown success in accessing people who are in circumstances that put them at a greater risk of poor health. Typically their work involves encouraging people to stop smoking, take more exercise, eat more healthily, drink sensibly and practice safe sex. They often come from, or are knowledgeable about, the communities they work with and nearly half of Health Trainer clients are drawn from the 20% most deprived communities in the country.²²⁸

Health Trainers work towards a nationally recognised accreditation and there has been considerable enthusiasm for the concept among third party organisations, such as the Army, Royal Mail, the National Pharmacy Association and the Football Foundation. So far they have been implemented on a small scale, but with encouraging results. 3,100 Health Trainers or Health Trainer Champions have either been trained or are in training, with 60,000 patients having already been seen. Currently all Spearhead PCTs – those with the worst health and highest levels of deprivation – are covered by a Health Trainer service, and in total 88% of PCTs have some form of Health Trainer service.²²⁹

We propose that Health Trainers should be used as the mechanism for supporting patient choice in primary care in the most disadvantaged areas. A recent London evaluation of Health Trainers gives annual costs to the NHS of £125,000 per annum, which equates to £19 million nationally.²³⁰ Any additional funding requirements could come from the savings of removing MPIG and seniority payments which currently cost £405 million annually.

Conclusion

Resource allocation in the NHS is a complex process where various measures and adjustments are made based on predicted need of the population. However, these complex calculations are undermined by overfunding of affluent PCTs and underfunding of deprived PCTs. Moreover, there are no direct financial incentives to encourage GPs or primary care providers to move into areas where they are needed most. Resources need to be allocated on a much more consistent and predictable

225 Schneider EC, Epstein AM. Use of public performance reports: a survey of patients undergoing cardiac surgery. *JAMA* 1998;279:1638-42.

226 Audit Commission. Choice in Public Services. September 2004.

227 Kings Fund How cold will it be.

228 Department of Health. Health Trainers – review to date. July 2009

229 Smith D, Gardner B, Michie S. National Health Trainer End of Year Report 07- 08. University College London.

230 Rushbrook Billington Ellis. London Hub Evaluation Report. 2009 The London Health Trainer Hub.

level so that avoidable inequalities in health can be reduced. By focusing on the biggest drivers of spending on health – age and deprivation – allocations would be more equitable. And by offering a financial incentive – the ‘patient premium’ – GPs and primary care providers would move into areas where they are need and where it is most convenient for patients. But if the market in primary care is to be stimulated through choice; then choice needs to happen.

Recommendations:

- Resource allocation in the NHS should be distributed directly from the Department of Health, or any new independent board, to GP practices or primary care providers. The method for allocating funds should be based on age, postcode and a ‘patient premium’. The premium element should be funded by a re-allocation from the Hospital and Community Services (HCHS) budget and would act as an incentive to providers to deliver health-care where it is needed most.
- Resource allocation budgets should continue to be broken down by speciality area such as acute, mental health, maternity, etc, so that they can easily be passed on from GP practices to Primary Care Commissioning Clusters or other providers or commissioners, if required. A separate amount for out-of-hours cover should be added to the allocation. Those primary care providers that want to provide out-of-hours cover themselves might find it offers a competitive advantage to attract patients to their service.
- Registration with a GP should become an active process that needs to be repeated every two to five years. This would drive competition and contestability into the primary care market. The process of decision making would better engage patients in their own healthcare as well as give a longer budgetary cycle to GP practices, which would also help reduce unavoidable variation in healthcare spending. Health Trainers should be used as the mechanism for supporting patient choice in primary care in the most disadvantaged areas.

5

How the system might work in practice

1. Primary care needs better information

We have shown how the process of selecting a GP could become more active and more frequent. Patients should be able to change doctors if they are unhappy with aspects of their care or simply move to a more convenient service. We have proposed a mechanism for changing doctors which is simple and will not worsen health inequalities. However, both patients and their Health Trainers must have access to high-quality standardised information so that they can make informed decisions about the range of services on offer.

How do patients choose a GP practice?

As we have seen earlier, 30% of people say they don't know where to obtain information about the different GP practices in their area. The most cited information resource, but for only 35% of patients, is 'media' – including the internet. Leaving aside the variation between social groups in internet access, the NHS Choices website does provide patients with some basic information on primary care services. Each GP practice lists opening times, names of doctors and a map. Performance information is limited to the National GP Patient Survey, which focuses solely on making appointments, and the Quality and Outcomes Framework (QOF). Most people will have little understanding of QOF which is essentially a pay-for-performance framework for doctors.

There are a number of other problems with the NHS Choices website: information is incomplete for many practices; individual practices cannot be compared to one another side by side on specific qualities that might be important to many patients' e.g. expert patient programmes, diabetes clinics, weekend opening times. And the available performance metrics are essentially meaningless, since it is not clear to patients what the QOF actually measures.²³¹ In any event, there is actually relatively little variation between GP practices on offer using QOF as a measure. In 2006/2007, practices in England achieved on average 95.4% of the 1,000 points available.²³²

Information improves outcomes

Our previous report, in 2007, on health outcomes, Measure for measure, identified the benefits of improved information in healthcare. It recommended, amongst

231 The QOF measures 'good practice', such as 'the percentage of patients with coronary heart disease whose notes have a record of blood pressure in the previous 15 months' rather than outcomes e.g. 'percentage of patients diagnosed with coronary heart disease needing emergency treatment for cardiac arrest'.

232 Gravelle H, Sutton M, Ma A. Paying doctors for quality. Research in Public Policy Spring 2008. 6-9

other things, that Government explicitly recognise the three different uses for information: accountability to the public; choice and assertiveness for patients and improvement for providers. There is now political consensus and commitment to move towards publishing outcome based data in the NHS, and although difficult to accomplish, this commitment should include a measure for primary care.

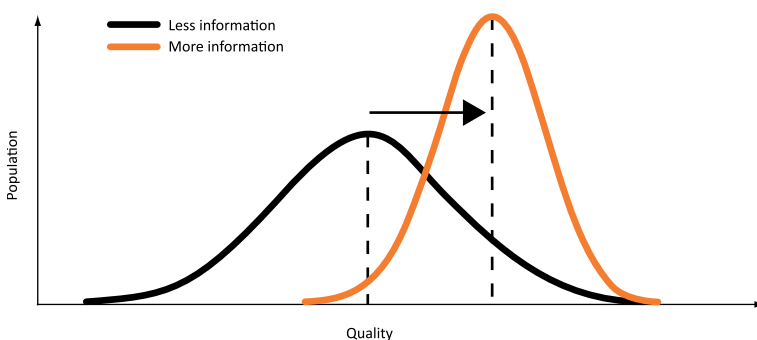
Good quality, accessible, standardised information can help medical professionals improve their clinical skills as well as allow patients to make informed choices between primary care providers. Systematic assessment and feedback of doctors' performance over a number of years has been demonstrated to improve clinical performance.²³³ Indeed, part of GP training involves recorded assessments of patient consultations being used, discussed and assessed in order to improve GP performance. It is wrong to exclude patients from this process as part of the paternalistic, doctor knows best approach.

Measuring clinical outcomes in primary care is complex, but that does not mean this should not be done. GPs play a fundamental role in managing serious and long-term conditions and it is important for patients to know that they are receiving high quality care. At present, patients and GPs have nothing against which to compare the outcomes of people with conditions similar to their own registered at different primary care providers.

Narrowing the Bell curve

A difficult concept for us all to accept is that we might only be average at our jobs, but that is the consequence of normal distribution. There are average teachers, taxi drivers, policy makers and doctors. Individual abilities are spread over a broad range in all professions – the normal distribution or when plotted graphically as below, the bell curve.

Shifting the Bell Curve



Many people like to think that their GP practice is the best, but the reality is quite different. If we were able to plot the performance of all GP practices in England what we would find is a bell curve: a handful of practices with relatively poor outcomes for their patients, a handful with remarkably good results, and a great indistinguishable middle. The majority of doctors, just as in other professions, are average.

However, the interesting point is what happens to the shape of the bell curve once patients have access to information about how good their doctor is, and, more importantly, how doctors compare their ratings to their professional peers. Peer to peer architecture and benchmarking relative performance are key to improving

233 Velsoki J et al. Systematic review of the literature on assessment, feedback and physicians' clinical performance. *Medical Teacher*. Vol 28. No.2 2006: 117-128

standards in healthcare. The results from two disease areas in the USA help explain the phenomena. The first example is the radical transformation in the median age of death for sufferers of cystic fibrosis. In 1957, the average patient with cystic fibrosis died by age three. By 2003, life expectancy had shot up to 33 years. Why? All because comparative information on mortality rates were painstakingly collected and then published. This showed that one centre was light years ahead of everyone else in terms of survival, and when their data were published every centre began using their treatment protocols.²³⁴

Second is cardiac surgery. Since 1989, hospitals in New York have been required to provide publicly available clinical data on cardiac surgery. This is to set a benchmark against which hospitals could assess the quality of their care and also to give patients information to aid their selection of hospitals providing cardiac surgery. Over the four year period from 1989 to 1992, the risk-adjusted mortality rate for coronary artery bypass grafting (CABG) fell by 41%.²³⁵ As a comparison, the mortality rates of general Medicare patients fell only 18% between 1987 and 1990.²³⁶ Furthermore, variation between providers, as measured by standard deviation, fell from 2.28% to 1.27% – evidence that the bell curve had narrowed, as shown in the graph above. This narrowing of the bell curve was achieved through a combination of factors: individual surgeons with high mortality rates stopped operating²³⁷ and poorly performing hospitals received additional support and advice from the Cardiac Advisory Committee.²³⁸ Poorer performers sought to understand the precise causes of their higher mortality rates and took steps to improve.

Information is a powerful force for improving healthcare.

234 Gawande, Atul. *Annals of Medicine: The Bell Curve*. The New Yorker. 6th December, 2004.

235 Hannan, E.L et al. *Improving the Outcomes of Coronary Artery Bypass Surgery in New York State*. JAMA. March 9, 1994. Vol. 271, No. 10

236 Peterson et al. *Changes in Mortality after Myocardial Revascularization in the Elderly*. 1994. *Ann Intern Med*. 1994; 121:919-927

237 Chassin M et al. *Benefits and Hazards of Reporting Medical Outcomes Publicly*. NEJM. 1996. Vol 334:394-398.

238 M et al. *Benefits and Hazards of Reporting Medical Outcomes Publicly*. NEJM. 1996. Vol 334:394-398.

239 Keaveney, SM. *Consumer Switching Behaviour in Service Industries: An Exploratory Study*. Journal of Marketing. 59. 71-82. FIND

240 East et al. *Customer Tenure, Recommendation and Switching*. Journal of Consumer Satisfaction, Dissatisfaction and Complaining Behaviour. 2001. Vol 14. 46-54

241 Jha, AK., Orav, EJ., Zheng, J., and Epstein, AM. *Patient's perception of Hospital Care in the United States*. N Engl J Med; 359: 1921 - 31

What type of information would be helpful to patients?

As we have seen, currently available information on different primary care providers is poor. The result is that 30% of people don't know where to look for information. Informal information like word of mouth necessarily includes an element of patient experience as friends and family may describe their own experiences of their visit to a particular GP or hospital. Ultimately, however, information based on patient experiences works along the principle of recommendation, which has been shown to be a powerful influence on consumer choice. One study of consumer switching behaviour in service industries found that around 50% of new suppliers are chosen by word-of-mouth.²³⁹ Another study, which considered why consumers switched services for hairdressers and supermarkets, found that 65% and 72%, respectively, stated that personal recommendation was the main reason for switching.²⁴⁰

Therefore, in order to drive choice patient information does not have to focus solely on clinical outcomes. In the absence of a primary care metric, simple performance measures can provide a good proxy for clinical performance since high patient satisfaction correlates positively with good quality clinical care.²⁴¹ Small things, like friendly receptionists or prompt answers to phone calls, reflect good organisational discipline. It is because of the absence of reliable and comparable information on quality in primary care that we have seen the development of patient rating and feedback sites. These sites focus on using the best available proxy measure for high quality healthcare: patient satisfaction.

Despite concerns that negative feedback will reflect unfairly on good doctors,²⁴² patient feedback may actually reduce the risk of litigation by identifying problems, such as poor communication skills, early on.²⁴³ Patient rating and feedback is good for other patients; the challenge is to convince resistant professionals that the nature of the paternalistic doctor-patient relationship needs to change.²⁴⁴ By providing an alternative to word-of-mouth recommendations from family and friends, patient rating sites are arguably more equitable as patients can read the reviews posted by others from a variety of backgrounds.

Although they have received criticism in the UK, rating websites dedicated to healthcare are popular in the USA. They have been created by entrepreneurs and insurance companies in response to the lack of quality information on professional services. Indeed, surveys in the USA indicate that patients themselves consider patient satisfaction surveys the fairest way to measure and compare the quality of care, even when compared to official regulators.²⁴⁵ In the absence of a primary care metric rating websites in the UK such as iwantgreatcare.org are the best comparative tool that patients have.

Rate your doctor

- **HealthGrades:** combines hospital outcome data with patient reviews and ratings of individual physicians. General information is provided free although more detailed reports attract a fee. Patients can rate doctors on a 5 point scale from poor to excellent on 8 possible metrics including: **urgent appointments, time with patients, listening and answering questions, and recommendation.**
- **IWantGreatCare.org:** a UK-based site independent of the NHS, which invites patients, relatives and colleagues to score doctors 0-100% on **trust, listen and recommend.** They can also rate the location of the practice on cleanliness, dignity and respect, politeness, efficiency and quality of nursing care. Information is collected on its own and through PCT websites and provided free of charge to patients. The site currently has reviews of 25,000 of the UK's 34,000 GPs.
- **RateMD:** patients rate hospital and primary care physicians on a score of 1-5 on **punctuality, helpfulness and knowledge.** The latter two metrics are averaged to produce an overall quality score. Information for patients is free and includes ratings of some UK doctors.
- **WellPoint:** 'Zagat Guide' for customers of WellPoint health insurance in the USA. Patients score doctors out of 3 on **trust, communication, availability and environment** and can also leave written comments. No ratings are revealed to doctors or patients until 10 are collected. Nearly 90% of consumers recommend their doctors.

A key feature of rating websites is that they provide information at a number of different levels. First, basic factual information: opening times, locations, facilities etc. This is an important dimension and allows consumers compare services according to which factors they consider important. Second, an overall rating plus sub-ratings based on relevant metrics of performance. For example, appointment availability, trust and recommendation are highly relevant in primary care. Third, reviews written by consumers, relatives, carers, or colleagues based on personal experience.

242 McCartney M. Head to Head. Will rating sites improve the quality of care? No. *BMJ* 2009; 338: b1033

243 Kinnersley P and Edwards A. Complaints against doctors. *BMJ* 2008 Vol. 336:841-2

244 See for example, Carlowe, J. Doctors condemn NHS comparison website. *BMJ* 2009; 339:b3341.

245 Bright B. Public interest in rating and using consumer ratings of doctors. *Wall St Journal* 2008 Feb 23. http://online.wsj.com/article/SB120292044107465659.html?mod=home_health_right.

The NHS is slowly appreciating the importance of patient experience. Patients can rate and review hospitals through the NHS Choices website and this has just been extended to include GP practices. However, we believe that there should be a clear divide between official and informal sources of information. The NHS should focus on producing standardised, meaningful and accurate information on quality of care and outcomes, whereas personal experience and informal information should be independent and free from the appearance or threat of manipulation or bias.

Consumers must be able to trust the information on which they base their decisions. For example, following allegations of conflict of interest, the New York Attorney General has mandated an industry funded non-profit organization to establish a new, independent database on health insurance reimbursement rates.²⁴⁶ The database will, for the first time, allow healthcare consumers in the USA to find out in advance how much they may be reimbursed for common medical services in their area. Previously the database was controlled by the health insurance industry and manipulation of data was alleged. The NHS is not without its own allegations and history of gaming, so it is important that patient rating is maintained independently from the NHS.

If the internet is to be one of the key ways in which patients receive information about GPs and primary care, it is essential that the conduit for delivering this information to patients – Health Trainers – are able to service the needs of their clients. Health Trainers must have access to high-quality standardised information. Whether this means equipping Health Trainers with laptops or ensuring that there is some form of ‘best buy’ tables and independent feedback on GPs each area are practical issues. However, any information should be comprehensible to its intended audience and what works for different sets of patients will develop as data on health literacy in the UK grows.

Recommendations:

- Improving information is fundamental to unlocking the potential health gain from a market in primary care. It should be a priority for the Department of Health to focus on developing meaningful measurements of performance in primary care. In the meantime, and since patient feedback is a good measure of high quality clinical care, independent sources of rating and patient feedback should be promoted and encouraged.
- Health Trainers should be equipped with the means to deliver meaningful information to those households where they are supporting choice of primary care provider. Developing a knowledge base of health literacy in the UK will ensure that the most deprived patients are supplied with relevant information.

²⁴⁶ Office of the Attorney General. State of New York. Press announcement on 13th January 2009. http://www.oag.state.ny.us/media_center/2009/jan/jan13a_09.html

²⁴⁷ Audit Commission. Making Ends Meet. October 2003

2. Possible changes for the NHS commissioning landscape

The Audit Commission describes commissioning as, “the process of specifying, securing and monitoring services to meet people’s needs at a strategic level. This applies to all services, whether they are provided by the local authority, NHS or other public agencies or by the private or voluntary sectors.”²⁴⁷

As we have seen earlier, PCT based commissioning of health services is yet to demonstrate that it has delivered real and tangible improvement in health outcomes. High quality commissioning is patchy, and success is often based on the competence of the individual commissioner; methods, approaches and tools are rarely systematic or embedded into PCTs.

Although PCTs are the largest budget holders in their local health economies, they are often seen as the weakest organizations. They have struggled to make an impact, lacking prominence or importance like acute hospitals, close relationships with patients like GPs or real engagement and accountability to patients and citizens as with local authorities. As relatively newer organizations, formed in 2000 then merged in 2006, they have struggled to find their place within a system dominated by the professions and often find themselves out-manouvered by the more powerful service providers such as Foundation Trusts.

There are 152 PCTs each with management boards with a full quota of executives and non-executives. Although it is difficult to quantify staff numbers and growth, the number of staff employed supporting central NHS functions has increased by 48% in the last decade.²⁴⁸ The water is muddied further by pan-PCT clustering, procurement hubs and collaborative commissioning arrangements – a vast industry busy supporting centralised service planning. There is no central NHS directory of commissioning and procurement organisations.

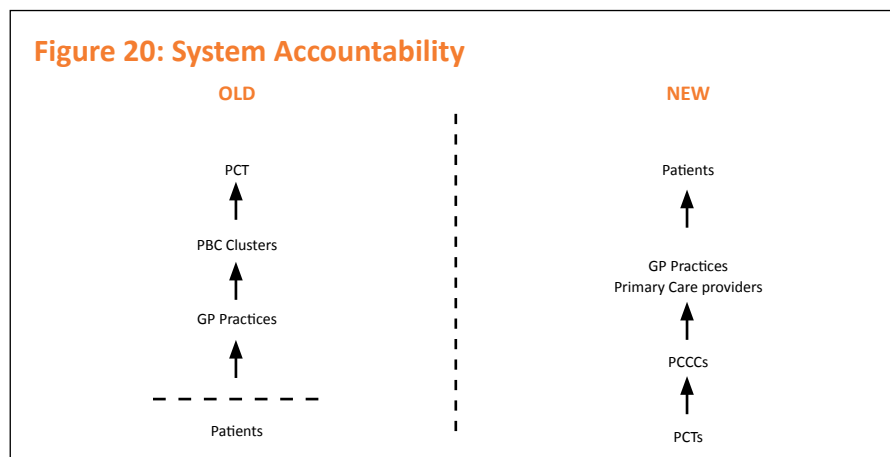
Perhaps though the biggest challenge is the lack of proximity to the patient – PCTs are often distant carrying formulaic and artificial interactions with the public. Front-line clinicians know that the real essence of our NHS is the interaction between patient and a professional.

This is where function has followed form, PCT commissioners have been handicapped by complex structures, but the fundamental issue is the disconnection of the patient and professionals from commissioning decisions. We acknowledge that by giving patients a choice of primary care provider and, at the same time, giving these providers the total allocation of healthcare funds, the purchaser-provider split will be undone.

However, we believe that two important changes in the balance of power in the system will add accountability. First, we will essentially move from a geographic health insurance model where the State selects services through its PCTs, to a patient-led model, where the patient selects GP practices or primary care providers who will drive the commissioning process because they now have real financial input. Second, GPs will commission services, not based on broad brush predictions made by PCT based commissioners, but based on the needs of their patients. They will prioritise investments and manage within their budgets. Patients and professionals will be in control, not PCTs and the State.

The benefit of this approach is a greater level of personalization and patient engagement in health decisions, and so a greater chance of success in tackling the key issue for the future – the rising demand for NHS services. We have known for many years that prevention, particularly in the case of chronic diseases, represents our best chance of securing the NHS for future generations. By giving budgets to GP practices and primary care providers who are closest to the patient we will allow them to invest in order to deliver services that are better for the patient and better value for money for the taxpayer.

248 NHS Information Centre. NHS Hospital and Community Health Services Non-Medical Staff. England 1998-2008. March 2009.



The general concern about giving budgets to GP practices to commission services has been that this will add complexity and fragmentation into the system. We disagree. A logical consequence of a bottom-up approach of commissioning services will be system simplicity and reduced inequality in access to services. The evidence from GP fundholding and the Total Purchasing Pilots was that GPs did not commission everything themselves. Systems such as the central London Multifund emerged where many practices grouped together to commission similar services.

We believe that widespread concerns about the skills and capacity of PCT based commissioners will see Primary Care Commissioning Clusters (PCCCs) form relationships with other organizations to help commission services. If, as we have suggested earlier, the allocation of funds to GP practice or primary care provider level retains the divisions for 'acute', 'maternity', 'mental health' etc then it will be easy for these funds to be passed on to PCCCs or other commissioning organisations. However, although this model sounds similar to existing structures, the nature of the relationships will be fundamentally different and power to effect service change will rest with patients not the State. The commissioning landscape will have fewer organizations and patients will have improved input into the commissioning process.

Annual Commissioning Cycle

The crux of the current commissioning process performed by PCTs is an annual cycle of activity to identify the health needs of a population of people and to make prioritized decisions to secure care to meet those needs within available resources.

By shifting commissioning to those who have most contact with patients the process will be more directly focused on the needs of patients. The needs assessment will be more specific and personal and a range of elements around patient and system engagement will be simplified. There will be four key steps in the cycle:

- **Planning Phase:** Identify the needs of the population being commissioned for and define the service needs of that population
- **Service Design Phase:** Having identified the needs to establish the requirements on the NHS and other providers
- **Procurement Phase:** To identify and select the best providers to deliver the services identified
- **Monitoring Phase:** To performance manage providers against service level agreements

The different stages of the commissioning cycle call for different capabilities. There is no reason for a significant structural change to the NHS in order to make a reality of our proposals; the structures will remain, but the accountability will be reversed. The key activities in the commissioning cycle will be split between Patients, Primary Care Commissioning Clusters and the existing primary care trust structures which will adopt a more strategic role:

- **Patients:** By choosing to receive their healthcare from different GP practices patients will have an increased input into the commissioning process. This will replace ineffective voice mechanisms currently in place.
- **GP Practices or primary care providers:** Patient choice and contestability will drive GP practices and primary care providers to commission services that their patients want.
- **Primary Care Commissioning Clusters (PCCCs):** These bodies will be responsible for translating the needs of their populations and marrying funding with those needs. They will be accountable for reviewing the performance of contracts to ensure that their patients are receiving the best available care. Some primary care providers might be big enough as a single organization to fulfill this function.
- **Primary Care Trusts:** Will become a strategic commissioning body and will manage the commercial and contractual arrangements with provider organisations on behalf of the Primary Care Commissioning Clusters. They will support the commissioning clusters in specifying service needs; collect and analyse data on behalf of the PCCCs, although the PCCC is ultimately responsible. They will aggregate the requirements across a range of PCCCs to utilize the ability to achieve economies of scale in purchasing from providers.

In the early days of implementation, PCTs will be called on to support an effective shift of activity. Over time organic change will lead to a simplification of the PCT and commissioning landscape. PCT bodies will have a much reduced, technocratic and administrative role. Over time it is assumed that no more than 50 such organisations will be needed. This will generate a significant administrative saving for the NHS.

We recognise that our system raises a potential conflict of interest for GPs or primary care providers as both commissioners and providers. In the USA, the issue of doctor self-referral has been argued to encourage over-utilisation of services which in turn drives up healthcare costs. As a result there has been enactment of 'Stark' legislation, which regulates referrals by doctors to healthcare facilities with which they have financial relationships. In a budget limited system like the NHS, increases in total healthcare costs would not be possible, although if left unchecked GP practices and primary care providers would have the potential to fully utilise budgets on an annual basis rather than make savings to invest in improving services for their patients. Critics also suggest that the commissioner provider conflict would create a captive referral system, which would limit competition by other providers.

The issue of doctor self-referral is somewhat of a double-edged sword for the NHS. While delivering more services in primary care has been the desired direction of policy for decades, the system needs to be designed in such a way as to

prevent abuse. We do not propose to offer all the answers here; however, oversight by a regulator would offer protection by having access to comparable data from PCCCs on referral rates and outcomes. We recognize that further examination and evaluation of this issue is required and we would not exclude 'Stark' type legislation as an option.

Specialised Commissioning

Specialised services are those services provided in relatively few specialist centres to catchment populations of more than a million people. They tend to be found in larger hospitals in cities and regionally-commissioned specialist services include kidney transplants, secure forensic mental health services and services for very rare cancers. The evidence suggests that specialised services for complex conditions cannot be sensibly planned, procured and delivered at a local level.²⁴⁹

Using nothing but choice and contestability to deliver health services for complex and specialised commissioning would not work. We have already seen that the current system of ten Specialised Commissioning Groups being controlled by 152 PCTs has produced unacceptable variation for many of the 35 specialist services that should be uniform across the country. For rare conditions such as transplants, complex spinal injuries and Duchenne Muscular Dystrophy there should be little or no variation. Patients want the best treatment and for these specialized conditions there is only one way of delivering best care. National specialised commissioning does provide a single, best-practice delivery method, with a careful focus on standards.

We propose that funding for specialist conditions should be taken out of the financial allocations that we have described earlier. Specialist services account for about 10% of the total PCT expenditure on hospital services - some £4.6 billion - and we believe that, in the interim, this amount and the associated commissioning responsibility should be allocated directly to the National Commissioning Group. During a period of heavy change for the commissioning landscape, we believe that specialist services would suffer disproportionately if they were left to be commissioned by Primary Care Commissioning Clusters. Over time, and as certainty in the strategic commissioning landscape returns, the commissioning of specialist services could be returned to regional level. However, when and if this change takes place funding for specialist services should continue to be allocated directly from Departmental budgets.

Conclusion

Good information is fundamental for a market based mechanism to operate efficiently, but in primary care information is poor. In the absence of meaningful measures that patients can understand, then patient satisfaction is a good proxy for high quality clinical care. Allowing patients to rate their doctors should be encouraged.

Our proposed changes to the allocation of resources in the NHS will have implications for the commissioning landscape. There are undoubtedly detailed changes that need to be made which are beyond the scope of this paper. However, the key point is that many of the existing structures will remain; it is the accountability that will be reversed.

249 Sir David Carter. Review of Commissioning Arrangements for Specialised Services. Report to the Department of Health. June 2006.

Recommendations:

- Improving information is fundamental to unlocking the potential health gain from a market in primary care. It should be a priority for the Department of Health to focus on developing meaningful measurements of performance in primary care. In the meantime, and since patient satisfaction is the best available measure of high quality clinical care, independent sources of rating and patient feedback should be promoted and encouraged. We believe that the NHS Choices website should be run by an independent organisation such as the Consumers Association.
- Health Trainers should be equipped with the means to deliver meaningful information to those households where they are supporting choice of primary care provider. Developing a knowledge base of health literacy in the UK will ensure that the most deprived patients are supplied with relevant information.
- Funding for national specialised commissioning and specialised services, such as Muscular Dystrophy should not be included in the resource allocation to GP practices or primary care providers. It should instead be given to the National Commissioning Group and delivered centrally until the landscape for strategic commissioning bodies stabilises. There would be significant cost savings from centralizing these services as well as considerable improvements in the care for patients with the rarest conditions.



Currently, in primary care there is no real choice for patients. Financial disincentives, arbitrary practice boundaries and undifferentiated services have not delivered choice for patients or enough doctors where they are needed most. But, choice of GP was the original NHS offer: “Don’t forget, choose your doctor now” said the leaflets and advertisements when the NHS was created in 1948.

Choice is good, both intrinsically, and as a mechanism for achieving change. However, choice and competition can only succeed in delivering better value and improving public services if institutions and markets are appropriately designed. Thus far innovative service redesign in the NHS has been hampered by a top-down approach to resource allocation.

In this report we show how extending choice in primary care through a new system of resource allocation can improve outcomes for patients, produce efficiency savings and, most importantly, empower and engage patients in their own healthcare.

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