The Commercialisation of General Practice

Trading away our healthcare: The implications of commercialisation for the English patient

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England and Wales

- Health and Social Care (Community Health and Standards) Act 2003. London: Stationery Office, 2003.
- National Health Service (General Medical Services Contracts) Regulations 2004. London: Stationery Office, 2004.

Scotland Three Acts

- National Health Service Reform (Scotland) Act, 2004
- Primary Medical Services (Scotland) Act, 2004
- Smoking, Health and Social Care (Scotland) Act, 2005

Five elements of reform

1. contracts are with providers/firms not GPs
2. ‘incorporated’/’shareholder’ companies can provide clinical care
3. providers can be linked to the health service by commercial contracts
4. primary and secondary care services can be taken over by commercial providers
5. national regulation has been set aside

Market mechanisms

- Break up and comodification of care and services- unbundle
- Alternative medical providers
- Deregulation of' services- proleteriansation of workforce -changing skill mix- quality?
- Uncouple funding from staff and services- global sum
- Competition with high street providers
- Privatise commissioning functions
- Vertical and horizontal integration

What does this mean

- Changing skill mix - planning norms are set aside
- Substitute untrained, semi skilled or volunteer staff
- Range of new service providers- quality and safety?
- Commercial conflicts?
- Rising inequalities in provision
- Reduced entitlements
- User charges and copayments

How is it being done

- Breaking up integrated services and putting them out to tender
- Breaking up commissioning services and putting them out to tender
- Breaking up the assets base and putting it out to tender- polyclinics and LIFT
- Breaking up support functions and putting it out to tender
- And then horizontal and vertical integration plus charges plus reducing entitlements

Reform of primary care contracting

- From 1948 until 1997 GPs were contracted to work for the NHS under the original General Medical Services (GMS) contract between the Secretary of State and the individual practitioner, on terms determined and negotiated nationally.
- The 2004 reforms replaced this system with one in which only salaried GPs have a direct relationship with the health service. Under the new system "PCTs/health boards can provide primary services directly or by making **arrangements** (by '**contract**' or '**agreement**') with a range of '**providers**'.

Contracts are with providers

- Practices or providers, not individual GPs, enter primary medical services contracts with ‘primary care organisations’.

Commercial contracting

- The contract reforms also allow for a choice of legal status with respect to the contract itself. Arrangements between health boards/PCTs and contractors can be based either on commercial (legal) contracts or on NHS ‘contracts’ (service level agreements).
- NHS contracts are non-legal agreements, or service level agreements (SLAs), between NHS bodies. Disputes will be dealt with via the NHS Dispute Resolution Procedure. Commercial contracts are enforceable in courts under private law.

Four contracting routes

Revised nationally negotiated GMS contracts for essential services only,

Primary care trust medical services contracts which enables PCTs to employ GPs directly on salary,

Personal medical services (PMS) contracts, negotiated locally, which allow PCTs to contract with practices or individual GPs to provide a variety of different mixes of primary care services,

Health Board/PCT Primary Medical Services contracts which allow commercial firms to provide any combination of primary and secondary care services (required the 2004 primary legislation)

HBPMS can be used to provide:

- Essential services
- Additional services
- Enhanced services
- Out of Hours services
- A combination of any of the above

Enhanced services can include services currently provided in hospitals.

National regulation has been diluted

Local negotiation has been facilitated by providing primary care providers with greater flexibility with respect to staff terms and conditions, the mix of staff, and service quality. Furthermore, HBPMS contracts are flexible with respect to financial rewards - prices are not tied to the new quality framework system of bonuses but are negotiated separately.

So locally determined standards replace the Red Book.

Number of APMS contracts awarded and out to tender by SHA region

SHA	responses out of total	No of APMS contracts	*APMS contracts currently out to tender*
London	26/31	15	*2*
East of England	14/14	9	*4*
South East Coast	7/8	3	*4*
South Central	9/9	6	*8*
South West	13/14	3	*6*
East Midlands	8/9	5	*3*
West Midlands	17/17	15	*5*
Yorkshire and the Humber	15/15	2	*4*
North East	8/11	3	*0*
North West	24/24	8	*30*
Total	***141/152***	***69***	***66***

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Commercial providers of primary care in England

Provider	**No of practices**	***Locations***
APMS Medical Solutions	1 APMS	*Lambeth*
Aston Healthcare	9 (1 under APMS)	*Liverpool; Newton Le Willows; Nottinghamshire*
AT Medics	6 (under both APMS and GMS)	*Various locations in London*
Atos healthcare	2 APMS (in addition 2 Walk-in Centres)	*Berkshire West; Tower Hamlets; Manchester; Canary Wharf*
Care UK	4 APMS (including Walk-In Centre and prison healthcare services), also OOH	*Dagenham; Southend-on-Sea; Newcastle; Chelmsford and Wellingborough*
Chilvers McCrea	8 under APMS, total of 35 practices (including 2 Walk-in-Centres)	*Various locations in London, East of England, South Central, East and West Midlands and North West*
FMC Health Solutions/One Medicare	7 (under APMS, GMS, PMS)	*Leeds and Wakefield District*
Harmoni Ltd/Badger Harmoni	20 (contract forms not all known)	*2 APMS for OOH in North East Essex and South Staffordshire, another 5 practices in Buckinghamshire, 8 in London, 2 in North Somerset and 4 in West Hertfordshire; Badger is major provider of OOH services across the Midlands*
IntraHealth	8 (2 under APMS; 2 more practices open soon in Ashton, Leigh and Wigan)	*Dunstable; Wigan; various locations in County Durham*
Qube Medical Ltd	1 APMS	*Enfield*
Take Care Now (TNC) Ltd	1 APMS for OOH	*Great Yarmouth and Waveney*
United Health UK	*2 APMS*	*Derby*

Out of hours service providers

- NHS 24
- Ambulance services and A and E
- GP out of hours
- Community pharmacists
- First Responders- volunteers

Provision of OOH services

PCT	Provider	patient number	*contract value £*
Bury	BARDOC	192235	*1,333,000*
Devon	Devon Doctors on Call	753,000	*35,616,000*
Great Yarmouth & Waveney	Take Care Now	229	*not disclosed*
Herefordshire	n.a.	n.a.	*not disclosed*
Milton Keynes	MKDoc	n.a.	*1,010,278*
North East Essex	Harmoni	n.a.	*not disclosed*
Oxfordshire	Principal Medical Services, Serco Health and ASH Locums	n.a.	*2,363,000*
South Staffordshire	Badger Harmoni	611042	*not disclosed*
Wiltshire	*Wiltshire Medical Services*	*340,000*	n.a.

The Primary Care Foundation

- What the benchmark has revealed is a startling variation in performance around the UK. … striking differences in costs and the way patients are being treated.The cost per call to a service ranges from less than 30 to a massive 180. The cost per head of population varies from around 7 to more than 16.

Cost indicators are a poor measure of provision

- Risk pool - remote and rural areas, areas with high levels of deprivation and need
- Need GPs and nurses/ 1000 population
- Key is universal service obligation and access not spurious cost measures
- Cost indicators drive down quality and standards and work force provision - race to the bottom

Health Care Commission

- people often dont know which services to use, and too often have to repeat their story time and again because services dont always share information effectively. Navigating between services can be difficult and confusing for patients and this can have a real impact, especially on people with more complex needs, such as older people and people with disabilities. Integrating services across a local area will help address these challenges.

Extending the role of community Pharmacists

- Large chains employ 55% of workforce
- NHS income versus retail activities

Minister of Health 1981

- 'One knew there was a future for hospital pharmacists, one knew there was a future for industrial pharmacist, but one was not sure there was a future for the general practice pharmacists.'

DoH policy on community pharmacy

- Pharmacy in the Future 2000
- A vision for pharmacy 2003
- Choosing health through pharmacy- a programme for pharmaceutical public health 2005-2015 DoH 2005
- NHS (pharmaceutical Services) Regulations Act 2005

From dispensing to prescribing and treating

- Shift more prescribed drugs to OTC
- Pharmacists move from dispensing role to prescribing, medicines management and health promotion services - polyclinics
- Smoking cessation weight management immunisation and sexual health to contract directly with community pharmacists to provide certain services
- Out of hours
- Reform of control of entry - open up to big chains

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Local pharmaceutical Service (LPS) contracts NHS (PS) Reg Act 2005

- PCTs contract for service over and above dispensing
- Three tiers of service: essential additional (MUR) and enhanced

Pharmaceutical remuneration

- Global sum
- Recharge to PCTs for other services
- Retained purchase profit

Evidence

- None in support of increased clinical role
- Reduced quality when role changes from dispenser to prescriber
- Conflicts of interest commercial retail and OTC
- User charges

Extending the reach of health care industry to managing NHS funds

- The companiee want to position themselves to take the 80% of NHS funds that PCTS currently manage through commissioning
- Small contracts are simply entry points
- Merger and integration will follow once the HMOs have the funds and he services

PCT Commissioning Preferred suppliers

- AETNA HEALTH SERVICES (UK) LIMITED
- AXA PPP HEALTHCARE ADMINISTRATION SERVICES BUPA MEMBERSHIP COMMISSIONING
- CHKS LTD,
- DR FOSTER INTELLIGENCE
- HEALTH DIALOG SERVICES CORPORATION,
- HUMANA EUROPE, LTD KPMG LLP MCKESSON INFORMATION SOLUTIONS UK LIMITED McKinsey MCKINSEY & COMPANY, INC. UNITED KINGDOM NAVIGANT CONSULTING, INC
- TRIBAL CONSULTING
- UNITEDHEALTH EUROPE LIMITED
- WG CONSULTING HEALTHCARE LIMITED,

Where the 80% of PCT funds will go- PBC?

Framework for procuring External Support for Commissioners (FESC)

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Commissioning functions

- 1. Assessment of health needs
- 2. Reviewing Service Provision (jointly with Local Authority)
- 3. Deciding Priorities
- 4. Designing Services
- 5. Shaping the Structure of supply
- 6. Managing Demand
- 7. Commissioning of primary care services
- 8. Procurement for extended primary care services
- 9. Contracting and procurement for secondary care services
  Performance Management, Settlement and Review

Commissioning functions

- 10. PbR transactions
- 11. Budget and activity management
- 12. Performance management
- 13. PBC operating processes
- 14. Collection and analysis of patient feedback and GP intelligence

Patient and Public Engagement

- 15. Compilation and publication of PCT Prospectus
- 16. Referrals and advice on choices (inc. Choose and Book)
- 17. Responding to patient-initiated petitions to review service provision and quality
- 18. Development of effective strategies for patient, public and community engagement
- 19. Development and implementation of communications strategies

157 Preferred Suppliers for Commissioning functions

- Aetna AETNA HEALTH SERVICES (UK) LIMITED
- AXA PPP HEALTHCARE ADMINISTRATION SERVICES
- Bupa BUPA MEMBERSHIP COMMISSIONING LIMITED CHKS CHKS LTD,
- Dr Foster DR FOSTER LIMITED, trading as DR FOSTER INTELLIGENCE
- Health Dialog HEALTH DIALOG SERVICES CORPORATION, HUMANA EUROPE,
- KPMG LLP McKesson MCKESSON INFORMAT
- ION SOLUTIONS
- MCKINSEY & COMPANY, INC.
- NAVIGANT CONSULTING, INC Tribal
- TRIBAL CONSULTING LIMITED United
- UNITEDHEALTH EUROPE LIMITED
- WG CONSULTING

Privatising the asset base

- LIFT joint venture structure
- The relative shareholding of local LIFT companies is as follows:
  - local health economy stakeholders (20%)
  - private sector partner (60%)
  - national joint venture “Partnerships for Health” (20%)

Privatising Commissioing

- Framework contract for PCT commissioing
- 19 areas with preferred providers
- 80% of budgets will be held by private commissioners who can ontract with htemselves
- Information, monitoring, data , standards etc

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The function of joint venture shares

Why are shares important?

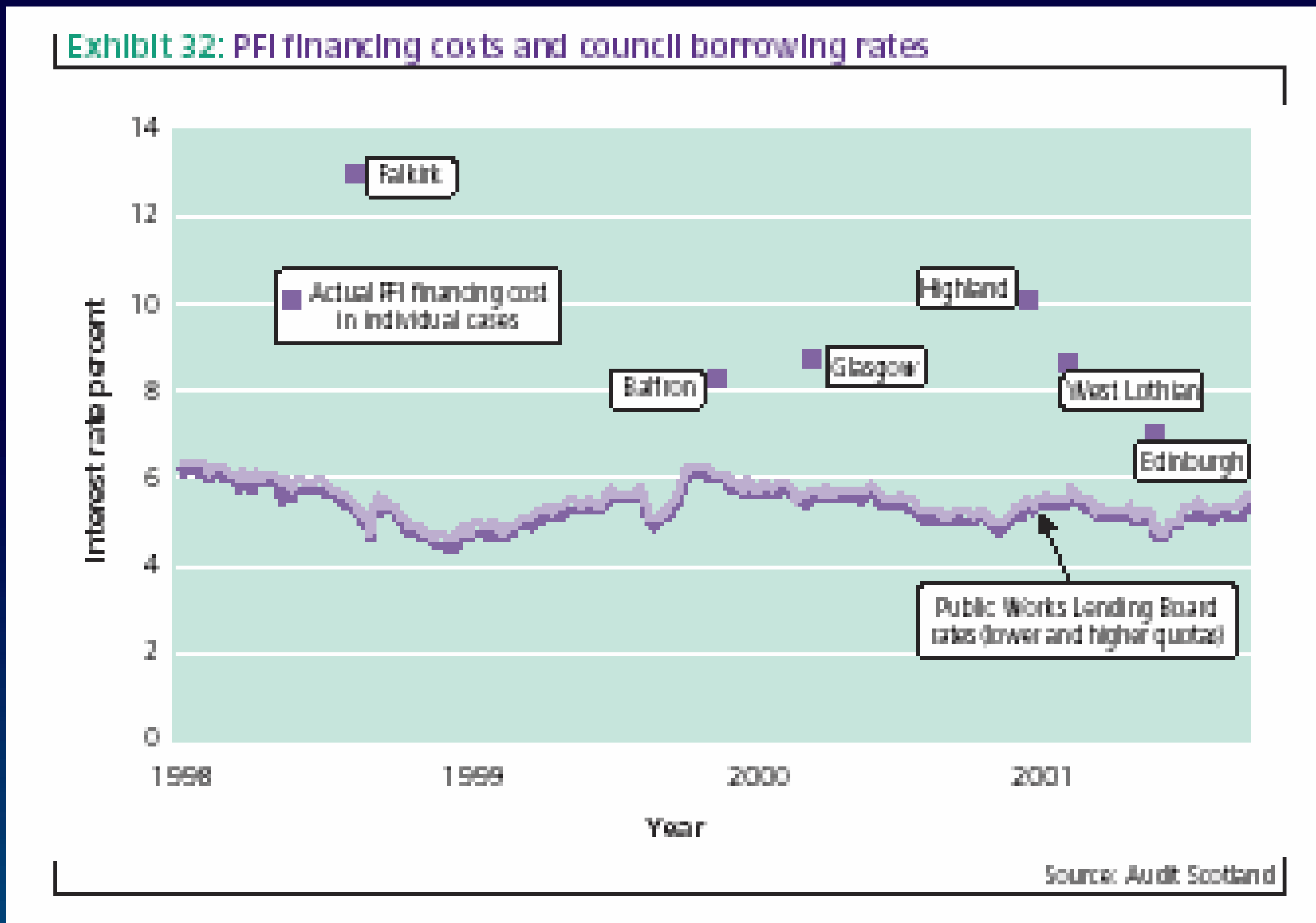
In the absence of public capital, the function of shares is to assume the commercial risks in a project in order to facilitate access to bank loans and therefore a cheaper form of finance

Range of interest rates in private finance

Table 1 Overall cost of capital for 6 Scottish PFI schools projects

Range of senior debt interest rates	Range of subordinated loan interest rates	Estimated returns on direct equity capital	Overall blended cost of capital for each PFI project
6 to 7% a year	10 to 16% a year	15 to 29% a year	7 to 13% a year

Source: Audit Scotland/Accounts Commission, Taking the initiative, 2002, p.58



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How LIFT works

- Each LIFT involves a number of linked contracts covering buildings and related services. The latest LIFT schemes include clinical services

- Although LIFT is privately financed, it is funded primarily from the public purse through annual payments to a LIFTCo (or Hubco)

- These payments are essentially a rent paid by tenants of the LIFT buildings (the majority of them GPs). All rents for GPs are reimbursed by the NHS through the GMS and PMS revenue streams

Bundling private finance - framework contracts

- Hub “is capable of delivering across the length and breadth of Scotland in support of a broad range of public services […]:
- social housing
- leisure (healthy living facilities)
- local authority and wider community infrastructure initiatives (e.g. regeneration)
- office accommodation.”

(Building better local services together)

The scale of the policy in England

- There are a total of 50 LIFT schemes in England
- Most involve groups of GP premises
- By May 2006, nearly 70 LIFT premises were operational
- 50 more buildings were expected to open in 2006 at a capital cost of nearly £1 billion, including £210 million public capital.

Evidence that LIFT rents are up to 8 times higher

(A) LIFT area	(B) Actual PCT funding for primary care accommodation 2004-05 (£)	(C) [1] Average annual cost per patient (£)	(D) [2] PCT funding for GP premises in LIFT buildings in 2004-05 on a annualised basis (£)	(E) [1] Average annual cost per LIFT GP patient (£)
East London	10,708,000	14.22	422,760	28.73
East Lancashire	2,815,000	5.58	2,451,480	32.88
Ashton, Leigh & Wigan	2,081,000	6.90	967,238	29.23
Barnsley	934,000	3.92	635,376	16.48
Sandwell	1,229,000	3.84	635,400	31.41
Barking & Havering [3]	3,432,000	8.20	0	0
2005/06 figures for Newham provided to PAC by Dr Kohli [4]				
Newham PCT	3,223,099	10.20	899,180	32.20

Source: PAC, 2006

The risks

- LIFT has not been evaluated
- In 2006 the Public Accounts Committee highlighted the higher costs of the new premises, the lack of substantive evidence about performance and value for money, and the absence of an assessment of the risks of the policy for different stakeholders - NHS, investors, patients and tenants

How is it being done

- Breaking up integrated services and putting them out to tender
- Breaking up commissioning services and putting them out to tender
- Breaking up the assets base and putting it out to tender-polyclinics and LIFT
- Breaking up support functions and putting it out to tender
- And then horizontal and vertical integration plus charges plus reducing entitlements

The risks

- Abandonment of traditional divide between business and clinical care
- New commercial networks
- Cost of commercial contracting
- Monitoring costs
- Service quality after deregulation

The key market structures

1. Commercial management can now run primary care
2. The GP monopoly in primary care has been abolished
3. Commercial contracting has replaced arrangements between NHS bodies
4. Market deregulation: local negotiation has replaced national standards

Why markets cant work in health care

- Information asymmetry-
- Transaction costs admin, prfits and marketting
- Competition means that allocative efficiency or fairness will disappear

Conclusion

Control and responsibility transferred to the commercial sector

The policy is unevaluated - who bears the risk and how are services monitored?

What will happen to equity - NHS dentistry and long term care?

Who will bear the costs?

Scottish Regional Treatment Centre, Stracathro. Comparison of contract specifications, ISD data returns, NHS Tayside figures and Price Waterhouse Coopers 10-month interim review figures				
HRG v3.5 activity group	**Annual volume as specified in contract**	**ISD data to end of January 2008**	**NHS Tayside report using data up to end of January 2008**	**PWC report using data up to end September 2007**
Joint replacement activity group	542	49	46	not available
Minor orthopaedics activity group	303	270	385	not available
General surgery activity group	1,110	142	698	not available
ENT activity group	144	134	114	not available
Plastic surgery activity group	113	113	166	not available
Urology activity group	412	178	216	not available
Overall Total Volume	**2,624**	**886**	**1,625**	**2,200**
Overall Total Value	**£5,667,464**	**£1,257,369**	**not available**	**£2,642,000**

Scottish Regional Treatment Centre, Stracathro. Comparison of value between the original contract, ISD data returns and Price Waterhouse Coopers 10-month interim review figures (excludes outpatients and additional value)			
Referring Health Board	**Annual value as set out in the contract (volume of procedures in brackets)**	**ISD data to end of September 2007 (volume of procedures in brackets)**	**PWC report using data up to end September 2007 (volume of procedures in brackets)**
Fife	not available	£115,676 (103)	£363,000 (not available)
Grampian	not available	£169,288 (145)	£678,000 (not available)
Tayside	not available	£243,341 (246)	£1,600,000 (not available)
Total	**£5,667,464 (2,624)**	**£528,305 (494)**	**£2,642,000 (not available)**

The ‘hub’ programme - the second primary legislation

- The new power granted health boards to enter joint ventures (the Smoking, Health and Social Care (Scotland) Act section 38 power) is a legislative requirement of the ‘hub’ programme.
- This programme is a private finance model for primary medical services based on the English ‘LIFT’ (local improvement finance trust) model

Reconfiguration function

The explicit link between 'hub' investment and primary care enhanced services:

"Ministers recognise that the current procurement strategy will not enhance joint working or help reconfigure primary care, intermediate care and community services. That is why hub is being developed." (Building better local services together)