



By the end of March every primary care trust in England should have commissioned a new health centre.

Jo Ellins, Chris Ham, and Helen Parker examine the effect of introducing competition into service provision

Opening up the primary care market



Government reforms to the National Health Service in England have sought to increase the choices available to patients and to stimulate competition between healthcare providers. The emerging market in primary medical care has been underpinned by the introduction of the alternative provider medical services (APMS) contract, which allows primary care trusts (PCTs) to contract services from organisations that are outside the NHS, including commercial companies and voluntary sector providers. The contract also enables PCTs to specify what they require of primary medical care

providers, rather than being constrained by the terms of the general medical services contract negotiated by the government and the British Medical Association.

PCTs were initially slow to promote choice and competition in primary medical care, and this led the government to launch the Equitable Access to Primary Medical Care programme in December 2007. Under the programme, every PCT in England is required to tender for a new general practitioner-led health centre offering bookable and walk-in services to registered and unregistered patients. The first centre opened in

Bradford last November. The programme is also funding 113 general practices in the 50 most underdoctored areas.

Supporters of the government's reforms have argued that these "create a framework to challenge GP service delivery and encourage innovation in order to meet people's changing healthcare needs."¹ Opponents have expressed concerns about the dangers of "the aggressive commercial takeover of general practice and other NHS clinical services."² Questions have also been raised about whether every PCT needs a new GP-led health centre.³ So who is right? We interviewed strategic health authorities, PCTs, and provider organisations⁴ to try to find out.

Where is the market opening up?

Before the launch of the equitable access programme, only a small number of PCTs had used a competitive tendering process for primary medical care services and even fewer had awarded contracts to non-NHS providers. Those that had done so were mostly trying to fill gaps in provision and increase access for underserved populations. By October 2008, more than 100 practices were being run by alternative providers—GP-led companies, corporate providers, and social enterprises (table). Most of the contracts had been awarded to GP-led companies, with the corporate providers UnitedHealth Primary Care, Care UK, and Atos having only 10 practices between them—hardly a commercial takeover of primary care.⁵

Number of general practices managed by new market entrants (October 2008)

Provider	Type	No of practices
Aston Healthcare	GP-led	9 in the Liverpool/Knowsley area
Atos Healthcare	Corporate	2 (1 in Manchester, 1 in London)
BK Health	GP-led	2 in the South Central region
Care UK	Corporate	3 (1 in Essex, 1 in London, 1 in Manchester)
Cedar Medical	GP-led	4 (3 in Basingstoke, 1 in Bristol)
Central Nottinghamshire Clinical Services	Social enterprise	1 in Kirkby-in-Ashfield
ChilversMcCrea Healthcare	GP-led	38 nationally
Concordia Health	GP-led	2 in south east London
Greenbrook Healthcare	GP-led	6 in Hounslow
IntraHealth	GP-led	8 practices (5 in County Durham, 2 in Manchester, 1 in Bedfordshire)
One Medicare	GP-led	5 in West Yorkshire
Pathfinder Healthcare Development	GP-led	5 in West Midlands region
SSP Health	GP-led	11 in north west of England
Hurley Group	GP-led	5 in London
The Practice plc	GP-led	6 in Wiltshire and Buckinghamshire
UnitedHealth Primary Care	Corporate	5 (2 in Derby, 3 in Camden)
Willow Bank	Social enterprise	1 in Stoke



Hear Chris Ham talk about opening up the primary care market at <http://podcasts.bmj.com/bmj/>

Letting the market in: Alan Johnson opens the Hillside Bridge Health Care Centre in Bradford, the first GP-led health centre in England

key performance indicators and monitoring arrangements. One PCT has developed a contract that includes targets relating to access, quality, service delivery, and value for money, with financial penalties for non-delivery of those targets. This PCT said the contract enabled it only to “pay for what they want and what they get” and, like others, would like to use APMS more widely.

Provider experience

Both providers and commissioners commented on the time and resources required for procurement. Although PCTs need to be able to compare bidders on criteria such as cost, workforce, and risk management, the sheer volume of information that is being requested seems to be discouraging some providers from bidding. Smaller organisations with limited resources are at a particular disadvantage.

The complexity of contracting also raises the question of whether the benefits of competitive tendering will outweigh the substantial transaction costs. New providers do seem to be delivering improvements in the quality and accessibility of care, with PCTs citing examples ranging from increased opening hours to the development of new services such as a mobile ultrasound unit and management of long term conditions.

Whether competition will raise the overall standard of primary medical care depends partly on how local practices respond to new providers in their area. New providers reported a mixed local reaction. Some had encountered resistance, especially from local GPs. In a small number of cases, efforts had been made to prevent them from joining local medical committees or practice based commissioning boards.

Level playing field?

Many PCTs raised concerns about the quality of business cases being submitted by local general practices and their ability to effectively compete against well resourced corporate providers and national GP-led companies. The Department of Health envisages that PCTs will be responsible for developing the provider market.⁷ However,

New primary medical care providers

GP-led companies—Set up by general practitioners to bid for general practice and other primary care contracts. Have access to the NHS pension scheme

Corporate providers—Investor owned companies, usually operating for profit. Do not have access to the NHS pension scheme

Social enterprises—Independent organisations, often set up by groups of healthcare professionals, that reinvest any profits back into the business. NHS staff transferring into new social enterprises and delivering NHS care can stay in the NHS pension scheme

GP-led companies have emerged in response to the perceived threat of new market entrants. Most were created to bid for a local contract, and many have subsequently expanded as services have been tendered in other parts of the country. The largest GP-led company, ChilversMcCrea Healthcare, was set up in 2001 by an NHS GP and nurse and describes itself as “a privately owned company [that] operates within the NHS.” It won its first contract in July 2003 and currently runs 38 general practices across England.

GP-led companies combine elements of the professional partnership model operating in traditional general practice with a more recognisably corporate infrastructure that may include staff in business development, finance, and human resource roles. Some GPs are company owners and directors, whereas others are salaried employees

delivering care in the practices run by these companies. As a hybrid type of provider organisation in primary care, the emergence of GP-led companies calls into question the validity of distinguishing providers on the basis of categories such as NHS and corporate.

Commissioner experience

The success of the primary medical care market depends on PCTs having a strong and effective commissioning function. However, early experiences of tendering have highlighted important gaps in their capacity and expertise. Trusts told us that they often lack the procurement skills needed to compare different types of data across bids and legal advice for contract negotiation and management. Similar shortcomings have affected the quality and effectiveness of commissioning out of hours services.⁶

Most contracts have focused on the provision of core general practice services, although typically with extended opening hours including evenings and weekends. However, PCTs are becoming increasingly aware of the opportunities presented by the APMS contract for developing primary medical care services and are beginning to use it to tailor services to local needs. For example, in one area a new provider has been commissioned to run a general practice offering enhanced mental and sexual health services.

PCTs also noted that the APMS contract gives them greater flexibility to stipulate the

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a potential conflict of interest arises if PCTs support and encourage local practices to bid, given that they are also responsible for ensuring open and fair competition. When does reasonable support for local practices turn into an unfair advantage? This lack of clarity makes competitive tendering vulnerable to legal challenge.

The issue of a level playing field is not straightforward. Corporate providers are unlikely to have the local knowledge, networks, and visibility of local GPs. This can make it hard to show commissioners how they will establish themselves within the local community and make links to other providers. They may also face problems in terms of developing financially viable bids and in recruiting staff because, unlike GP-led companies, they are not eligible for the NHS pension scheme. One corporate provider offered a pension scheme equivalent to that provided by the NHS, but its costs were 16% greater than the NHS scheme because of higher employer contributions. The key to the success of GP-led companies may lie in their ability to combine a corporate infrastructure, NHS experience, and access to the NHS pension scheme.

Patient choice

The government envisages that competition among providers will act as a catalyst for improving services and encourage greater responsiveness to patients. The theory is that local providers will take action to improve their performance when they begin to lose patients—and therefore income—to new providers offering a better quality or range of services.⁸ But for this to happen, patients will have to both recognise and respond to disparities in the quality of local services by choosing to leave practices with poor standards and registering elsewhere.

While patient choice features prominently in primary care policy,^{9,10} there is little evidence that it is happening in practice.¹¹ Of course, some patients have good reasons not to shop around for a general practice—for example, people with chronic conditions who value continuity of care and a stable GP relationship.¹² Nevertheless, far more attention has been paid to developing competition in primary care than to building an infrastructure to support patient choice.

PCTs raised concerns about low public awareness of the right to choose a GP and the shortage of reliable public information about the availability and quality of local services. Unless this changes, the potential benefits of a more plural provider market may not be realised.

Equitable access national procurement

The introduction of a national procurement programme has the potential to address health inequalities by increasing the number of primary care professionals in areas of unmet need, as well as broadening the range and availability of services provided closer to home. The provision of walk-in services at GP-led health centres may also benefit the working population.

But the programme is not without risks. PCTs have had to develop a new GP-led health centre whether or not there is unmet need. Some commissioners thought that the £1m allocated to each PCT to fund a GP-led health centre would have been better invested in developing services to meet local priorities. It is also unclear whether patients will actually use the new services, given patient loyalty and the lack of effort put into informing people of the choices available.

Parallels can be drawn with the experience of the independent sector treatment centres, which were established to provide additional diagnostic and elective surgical capacity for NHS patients. These centres receive a guaranteed level of funding regardless of the number of patients they treat. Some independent sector treatment centres have not attracted the number of patients planned when they were commissioned, leading to criticism that the resources could have been better spent within the NHS.¹³

The extent to which equitable access can bring in new providers is also in doubt, especially in the current financial climate. In September 2008, Virgin Healthcare announced that it was putting on hold its plans to bid for primary medical care contracts¹⁴ and other corporate providers and GP-led companies have also reviewed their involvement. In addition, some providers expressed concerns about the financial viability of the contracts on offer, particularly with regard to risk sharing arrangements. Some PCTs are expecting successful bidders to assume a greater

degree of financial risk over time, based on their ability to attract patients. Providers are reassessing their willingness to take on this risk, especially in areas where primary medical care services are already well provided. A related concern was that penalties for not delivering key performance indicators made some contracts unattractive to bidders.

Thus the national programme to procure additional primary medical care services may result in underused capacity in some areas and difficulties in attracting new providers into other areas. There is also a risk that new providers may unintentionally destabilise existing practices delivering a high standard of care to patients if they are offered guaranteed funding for the provision of services. These seemingly contradictory outcomes may occur simultaneously as a result of variations in the contracts being offered within the NHS and differences between areas in current provision of primary care.

Spare capacity and instability may be necessary to create the conditions for choice and competition, but their consequences will need to be managed if the government's policies are to deliver real benefits for patients.

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