CHOICE AND OPPORTUNITY: Responses to the Government's White Paper

26 November, 1996

Executive Summary

1. The most popular issue for debate on *Choice and Opportunity* is still its financial aspects. In particular, the commentators are outlining the following ideas:

   - The idea of a salaried service is generally welcomed but the problems it will also bring are being identified
   - The source of the funding for the initiatives is still being debated

2. The possible nature of the proposed changes is also still attracting attention:

   - The debate about whether the changes involve a big bang style deregulation or a truly incremental process is still ongoing.

3. Several innovative projects have been described in the more popular professional press.

1. Sources of information accessed:

- *Choice and Opportunity: primary care the future*: the government's White Paper and its press release
- Journals taken by the King's Fund (handsearched) which have contained useful sources:
  - *Nursing Times* 30 October 1996
  - *Purchasing in Practice* Issue 10, October 1996
  - *Nursing Standard* 30 October 1996, 13 November 1996
  - *Healthcare Parliamentary Monitor* 4 November 1996
  - *Health Service Journal* 7 November 1996, 14 November 1996
  - *General Practitioner* 8 November 1996
  - *Pulse* 9 November, 1996
  - *British Medical Journal* 9 November 1996
- Databases:
  - King's Fund's Unicorn database
  - Medline (on-line)
  - DHSS-Data
  - HealthStar (on-line)
  - World Wide Web

2. Information gleaned:

- The practicalities of the pilots have been discussed and examples of alternative working arrangements have been described.
- The potential of the White Paper's proposals have been debated and the possible deregulation of primary care has been suggested
- The issue of salaried GPs being employed by trusts and other bodies is still high on the professional agenda
- The issue about how the proposals are to be resourced has also been debated
- Workforce issues are still being highlighted
- The opposition political parties have been reported as giving more of their responses to the White Paper

3. The reactions in detail:

3.1 Practicalities and examples of working arrangements

With the theoretical issues having been debated for a couple of weeks now, the commentators in the professional press are starting to turn their attention to practical examples of new ways of working.

Stephen Dorrell has been reported as predicting that he will be approving pilot schemes in around 7% of UK practices to begin in April 1998[1]. In this article, Elliot states that this idea contrasts with the "previous ministerial insistence that change will be incremental" as the whole method of introduction of the pilots seems very similar to the way in which fundholding was introduced. Another article[2] in the same edition of *Pulse* points out the same thing, adding the caveat that although 7% sounds like a small percentage, pilots begun like this can expand very rapidly. The fundholding initiative began with only 7% of the workforce involved and has now developed to cover much more than that.

In several places actual innovations have been described:

- In South London one of the largest Total Purchasing Pilot Projects wants to buy a local cottage hospital, Carshalton Memorial, in order to make this the first GP-owned primary health care trust[3]. Dr Howard Freeman, a member of this pilot project and non-executive director of Merton Sutton and Wandsworth Health Authority predicts that the White Paper will signal turf wars between trusts and GPs both trying to corner the primary care market. Carol Grant, Chief Executive of Merton Sutton and Wandsworth NHS Trust which runs Carshalton Memorial Hospital said that this was the first she had heard of the GPs' proposals.

- Practices in Loughborough have held exploratory talks with a local trust about teaming up to deliver GP services[4]. The all-embracing GP co-operative which is intended to result from this collaboration is intended to go beyond out-of-hours and to debunk suggestions that the White Paper will lead to stiff competition between GPs and trusts. Instead, in this case, the two organisations would come together, ensuring that the entire town receives the same package of care.

- Premier Health Care Trust, a primary health care trust, in Burton-on-Trent, Staffordshire, is considering supplying GPs to practices all across the UK[5]. It would act as an employment agency for salaried GPs, supplying them along with practice nurses, district nurses and health visitors.

- A GP co-operative is considering including nurses, dentists and pharmacists as members of its organisation[6]. This is mainly due to the tax problems which could arise when the co-operative moves to a new building in the spring. If the GPs were to have to rent out some of the space, they could experience tax difficulties; however, if the building is owned by all members of the co-operative then there should be no problems.

- Dorset Doctors on Call (D-Doc) have voted overwhelmingly for Dorset Ambulance trust to manage them[7]. The trust will take care of the management and finance of the co-operative leaving the doctors free to undertake visits and to see patients. This would still leave the co-operative as an independent company.

- GPs in Leeds have secured payments for looking after patients in nursing homes[8]. Leeds Health Authority have agreed to pay them each £17.40 per nursing home per quarter. An Editorial piece in the *BMJ* also mentions this[9] and adds that this scheme is voluntary and that the rate paid is at the hospital practitioner grade.

  In return for this money the GPs will have to carry out clinical work which previously would have been done in a hospital. An example of this kind of work includes the management of behavioural disturbance in highly dependent mentally ill patients. The payments made will be separate from the GPs' GMS payments. The piece in the *BMJ* adds that Leeds Health Authority are also considering additional contracts for physiotherapists and community psychiatric nurses in relation to residential homes in order to reduce further inappropriate demands on GPs.

- Sunderland Health Authority, which has one of the worst recruitment problems in the country, is due to start canvassing the public on allowing nurse practitioners or pharmacists to take on some services traditionally performed by GPs[10]. This canvassing will take place through the citizens' jury they are establishing using their King's Fund grant. Christine Hancock[11] is also keen for nurses to take over some duties from the GP, the most notable of these being prescribing. She says that this will save time and resources and would help to deliver truly patient-centred care.

- The Cleveleys Group Practice in Lancashire is just one of several practices who are currently advertising for part-time workers or jobsharers[12].

As these new innovations emerge a framework for their containment is also starting to develop. One part of this framework is the BMA's voluntary guidelines which it published earlier this month on the non-core services the GPs are advised to stop providing for new patients next April unless they receive extra funding[13]. This list includes post-operative care, fertility treatment, endoscopy examinations and drug-dependent patients. Every GP has also been sent model contracts for non-core work and a pro forma letter to inform Health Authorities of the April changes. NAHAT has been reported as branding the BMA's actions as "irresponsible".[14]

Purchasing in Practice contained an illuminating article in last month's edition which looked at pilot projects designed to bring primary health care and social services closer together[15]. Although this is not directly relevant to *Choice and Opportunity*, some of the conclusions it draws make interesting reading. Most notable was the result that "[p]ilot projects developed in one practice...could not always been copied in a neighbouring practice". In this case, the success of the pilot "is often highly dependent on the circumstances and people concerned". This was a scheme which was conducted at local level, in a similar way to the proposed changes in primary care. It may be that the lack of the inter-regional transferability of the pilots is associated with work involved in the colloboration of two separate agencies; however, it could also have something to do with the fact that each pilot was not only implemented at local level but also developed there.

3.2 Potential implications of the White Paper proposals

The debate concerning the nature of the White Paper's proposals is still raging: do they amount to a Big Bang or are they going to be introduced truly incrementally? This debate is mainly ongoing within *Pulse*, the publication which likened the proposals to the *Financial Services Act* of 1986 in the first place.

Kingsley Manning of Newchurch & Co. has been quoted as stating that the changes will take the shape of a Big Bang with lasting repercussions[16]. He is also reported as stating that most GPs will be on salaries within ten years[17]. He sees massive scope for the private sector and large NHS trusts to be involved in primary care and states that there is no question that inner city hospitals and community trusts will move into primary care. He also sees the possibility for disease management or managed care packages possibly being developed. He responds to the "cool" reaction from the pharmaceutical companies by stating that they would be foolish to be slow to exploit the extension of community pharmacy which has been proposed.

Stephen Dorrell is adamant that his White Paper is not a Big Bang. Dr John Chisholm finds a middle ground in the analogy of Guy Fawkes night:

> "It's a bit like a fireworks display with all sorts of things going off. There will be some damp squibs and some exciting flashes."

Some in the GMSC (names have not been specified) are reported in the same publication that the White Paper will only affect a limited number of GPs[18]: namely, those in the inner cities who will benefit from the salaried option and those with a pioneering bent.

Elsewhere in *Pulse*, NAHAT's reaction to the question of the potential deregulation of primary care has been described[19]. NAHAT is cited as stating that a free-for-all in general practice will be prevented by the "checks and balances" included in the proposals. They have also identified three key controls retained by the government which should prevent the deregulation of primary care:

- The continued role of the Medical Practitioners' Committee in ensuring nation-wide GP coverage
- Stephen Dorrell's personal role in approving the pilots
- The retention of individual GPs' 24 hour commitment.

The involvement of the trusts is still being mentioned as well. NAHAT also state that "in inner cities it might be sensible for acute trusts to employ GPs", for example in the A&E

departments. Stephen Dorrell however has been quoted elsewhere as saying that it is highly unlikely that acute trusts will be involved in the pilots at all[20].

Derek Day of NAHAT is quoted as saying that it would be a "shame" if GPs became forced to refer only to one place[21]. This is implicitly supported by Dr John Chisholm of the GMSC who has been reported as outlining the four essential issues in the White Paper about which the GMSC is concerned. The first of these is the definition of the essential features of general practice[22]. The GMSC are concerned that the following features of general practice are not lost:

- The personal relationship between the GP and the patient
- The advocacy role of the GP
- Continuity of care
- The GP's gatekeeper role
- A service which is free at the point of use

The other three main concerns which the GMSC has in relation to *Choice and Opportunity* relate to resources, the workforce and the proper evaluation of the pilots. The GMSC does not believe that its own role will be undermined by the White Paper. It claims that as diversity increases there is all the more reason for a co-ordinated national view and national voice. John Chisholm is also personally concerned that the second White Paper on primary care will contain mechanisms for bypassing the notional rent scheme, the cost rent scheme, staff reimbursements and items of service.

Despite reporting on the opinions of others who do not see the White Paper as a Big Bang, *Pulse* itself continues to claim that the incremental changes seem to be advancing very speedily[23] and does not waiver from its original opinion. Julian Le Grand[24] is reported as agreeing with them. He agrees that the White Paper's proposals constitute deregulation but adds that "it is going to be quite carefully controlled". He identifies two dangers from the proposals:

- They may affect the purchaser-provider split
- They may blur the distinction between Hospital and Community Health Services (HCHS) and primary care

In the same article Tom Butler, Senior Research Fellow at the National Primary Care Research and Development Centre in Manchester gives an opposing view:

> "I think one of the major themes in the white paper is not so much deregulation but encouraging diversity. Deregulation in the sense that it is about allowing the market to determine the outcome is not what this is about."

He describes instead a situation where the managed, internal market tries to encourage innovative provision of services rather than a situation in which a market will determine them absolutely.

Niall Dickson[25] acknowledges that the proposals put forward by the White Paper will be significant and describes it as "another crucial phase of the demolition process" which, through the reforms, has "taken the national out of the NHS". He argues that, despite its arcane and anachronistic features, the GP Contract at least provided a set of national standards, a template. With the new White Paper proposals, so argues Dickson, there will be

no template "because local priorities are the new gods of the new NHS". He states that it seems likely that that the White Paper is a prelude to the end of the national contract.

He sums up *Choice and Opportunity* in a way which, although sardonic, also sheds some light on the reasons behind the conflicting, almost diametrically opposed opinions surrounding the White Paper; he describes it as:

> "[B]oring beyond measure - a mandarin's manifesto full of high-sounding words like choice and opportunity (its title), flexibility and fairness."

The language used within the document can be interpreted in many ways. The words are certainly "high-sounding" but have little substance. The document gives an impression to some of a future in which freedom and entrepreneurism will flourish and yet to others it presages deregulation and a lack of control.

3.3 Salaried GPs and employment by other bodies

The issue of salaried GPs has developed into a major theme surrounding the White Paper. Stephen Dorrell has been reported as assuring the profession that salaries are not a part of any blueprint for change in primary care[26]. Despite this, some commentators see a salaried service and practice-based contracts as being inevitable if *Choice and Opportunity* becomes law[27].

Such reassurances have been required due to some commentators predicting a future in which most GPs will be on a salary[28]. Gould reports in this article how he recently conducted a bidding exercise among a group of young GPs asking them at which point they would be prepared to accept a salaried service. The inducements he arrived at were £37,500 a year, a car and six weeks holiday.

In another article, Banks[29] gives some rough figures for the proportions of GPs in favour of salaries. At the 1992 annual conference of doctors training to be GPs he claims that the overwhelming majority of delegates wanted to become principals as soon as possible. by 1994 this figure had reduced to 30%. In 1996 a straw poll revealed that only 3 out of 150 were prepared to become principals on completing their training, whereas all of the 150 were prepared to work under salaried conditions. Banks continues this article by pointing out the dangers of salaries though: he insists that it harks back to the times before the Second World War where one GP could work for another.

General Practitioner provides the views of GPs across the country on the issue of salaries in two articles[30,31]. In general they all still seem to be very keen to take on salaried partners. Hancock[32] implies that it is a good idea by arguing that the next sensible step will be to bring nurses into the equation and to allow other organisations such as trusts to employ them under the same salaried conditions.

Some reasons given by GPs in the field for approving salaries are as follows[33,34]:

- One does not have to stay in the same practice all one's career
- The cost of buying into a practice is high and so having another option could act as an incentive for young doctors to go into primary care
- Salaried posts would offer recently qualified GPs a "breathing space" while they decided how to develop their careers

- It would allow GPs with special skills to pass on their knowledge before moving on to teach in another practice
- Employing a salaried GP instead of another partner would not affect the senior GP's practice profits.

Fewer points were made about the negative implications of salaries:

- Flexibility could affect a patient's continuity of care if it became too easy for a GP to move from one practice to another.
- The flexibility of part-time salaried contracts is a "misnomer" in general practice[35]. This commentator states that "[a]t best, it simply restores a near-normal quality of life at a financial cost". The part-time hours worked by a GP, it is implied, would equate to full-time hours in several other professions.
- Without a nationally agreed rate and national representation, the salaried option could be open to exploitation; ideally, it should be linked to pension rights.

This division in opinion is recognised in *General Practitioner*[36]. There are fears that a salaried service could fragment the NHS and result in a loss of independence for GPs. There is also a worry that it could open the door to privatisation. It is acknowledged however that the salaried option could overcome wide local variations in recruitment. This article recognises that all this debate could come to nothing if Labour win the next general election. Nonetheless, the importance of the idea of salaries is noted and it is suggested that guidelines should be drawn up now covering who can offer contracts, the rates of pay to be offered and the extent of clinical freedom still to be enjoyed by GPs.

3.4 Resourcing issues

Questions around the funding issue are still circulating. Some commentators are still debating the theory of whether any money can be found to support these initiatives whereas others are reporting the practical developments in this area.

An article in *Pulse*[37] explains that the Department of Health is devising a weighted capitation formula for GP budgets to allot cash to practices which are involved in the White Paper schemes. This would allow Health Authorities to scrap items-of-service payments and premises reimbursements for GPs opting for practice-based contracts. The Department is cited as wanting to move to weighted capitation in primary care as a cost saving measure and as a way of redressing the North-South imbalance in primary care funding. It is possible that the method of funding found could combine a socio-economic needs index with individual practice circumstances.

From the more theoretical angle, John Chisholm is still being quoted as stating that it would be "crazy" to take the money for the new schemes from the hospital sector when they are being starved of cash[38]. The initiative needs "pump priming money". This is supported in the *Healthcare Parliamentary Monitor*[39]. Here, Health Committee member Hugh Bayley (Labour Party, York constituency) is quoted as saying that Stephen Dorrell's plan for buying in care from salaried doctors for inner city areas would "mean nothing because the purchasers of care will not have the money to do it."

3.5 The medical workforce

Worries over the nature of the medical workforce are still prevalent in the professional press. John Chisholm[40] is cited in *Pulse* as being concerned about the Medical Practices Committee's lack of say over pilots. He believes that a national overview of the distribution of the workforce is necessary.

A government response to these GP concerns about recruitment, retention and morale is due to be published some time this month[41]. This will not have the status of a White Paper but is instead a detailed statement from the government. It has been dubbed the "GP Workforce".

3.6 Political responses

The Labour Party have been criticising *Choice and Opportunity* in a variety of ways. The latest issue of *Healthcare Parliamentary Monitor*[42] includes a synopsis of the political arguments:

- Chris Smith has said the Labour Party welcomes some elements of the proposed Primary Care Bill but that Stephen Dorrell must rule out any possibility of family doctor services being run by commercial organisations
- He states that the Government's proposals represent a vote of no confidence in fundholding by Conservatives
- He also believes that it will make it easier to privatise the NHS
- Opposition MPs have also expressed concern about:
    - The distribution of primary care funding
    - The survival of community pharmacies
    - The PFI's effect on community hospital schemes
    - Rationing of health care for the elderly
    - Non-availability of NHS dental care
- Simon Hughes, Liberal Democrat health spokesman has called upon Stephen Dorrell to give "five simple assurances" that
    - The health service should have the resources it needs
    - It should have extra staffing seen as necessary by review bodies
    - There should be national co-ordination of NHS schemes
    - The new primary care system should be free from commercial profit-making at the expense of the health service
    - Companies will not be able to employ people and make profits at the expense of patients
- Chris Smith has also been cited in the *Nursing Standard* as claiming that the government's emphasis on its proposed primary care changes has caused it to dump more important measures such as adoption and long-term care[43]

Niall Dickson[44] points out the problems that the Labour Party are having in opposing this White Paper, however; as any changes made will be "voluntary" and "evaluated" it is difficult for Chris Smith to depict "all this as a government set on coercing unwilling professionals into new and nasty arrangements". Secondly, Dickson points out that "Labour has long argued that salaried GPs are the answer to inner-city problems" and so implies that they cannot complain too much.

4. Conclusion

The practical aspects of the proposed changes to primary care are starting to be discussed and speculated. Those theoretical issues which are still appearing in the professional press surround the financial aspects of the changes. This is the most popular issue for debate on *Choice and Opportunity*. In particular, the commentators are outlining the following ideas:

- The idea of a salaried service is generally welcomed but the problems it will also bring are being identified
- The source of the funding for the initiatives is still being debated
- There is concern over the effects on the workforce
- The debate about whether the changes involve a big bang style deregulation or a truly incremental process is still ongoing.

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