The NHS revolution: health care in the market place

Competition in general practice

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UK general practitioners seem likely to face competition for their services. Can the market place improve on the weaknesses of primary care without affecting its strengths?

This article is part of a series examining the government's planned market reforms to healthcare provision

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General practice is bracing itself. After more than seven years of reform in the United Kingdom's acute sector, the political spotlight is now falling on primary care. A new contract was introduced in 2004 linking up to 20% of a practice's income to specified activities,[1] and further reform is on its way. General practice might be regarded by international observers as the jewel in the crown of the British health system,[2] but some policy makers are suggesting that it needs to be shaken up if it is to play its part in delivering a high quality, patient centred NHS. The government looks set to introduce some sort of competition into the primary care market. We explore the purpose of such a policy and its implications for patient care.

General practice reforms

Much of the discussion about the future of general practice focuses on the nature of reform, rather than on its purpose. What options are people advocating? Some think it best to leave quality improvement in the hands of the medical profession, with the emphasis on formative educational approaches. Others think that the answer lies in actively managing performance, using targets and incentives to deliver measurable improvement. But there are policy makers who believe that these approaches have failed to deliver the required nature and pace of change. The future, they suggest, lies in market based solutions, exposing NHS providers to greater competition. The government seems to agree. Alternative models of primary care provision are currently being introduced into communities that have failed to replace retiring general practitioners.[3] In addition, with its strong emphasis on promoting patient choice, the proposed white paper on care outside hospitals is likely to further expose general practices to competition.

MICHAEL DONNE/SPL

Walk-in centres suit patients who value accessibility over continuity of care

Current structure of general practice

Almost everyone in the United Kingdom is registered with a general practice, most of which deliver the full range of general medical services. About 80% of contacts with the NHS take place in general practice, which functions as the gate keeper for the less than 15% of these interactions which require referral to specialist services.

Several different models of general practice have emerged in recent years, but the dominant one is still that of general practitioners working in partnerships as independent contractors, selling their services to the NHS. In principle, this means that a market already exists within the primary care sector, since the NHS can change the contracting arrangements and practices might be expected to compete for patients. Fears of privatisation of general practice, much voiced in doctors' magazines, seem overblown given this is close to the current situation. In practice, the market does not operate because the service has given greater priority to continuity than to patient choice, because of managerial inertia, because of lack of capacity, and because professionals have been highly successful at minimising the effects of competitive forces.

Strengths and weaknesses of the established model

Any policy changes must be targeted at the weaknesses and preserve the strengths of general practice.[2] We believe that general practice should be judged on the basis of its ability to deliver four key health policy objectives: equity, efficiency, clinical quality, and patient responsiveness. How has the current dominant model performed?

Equity—Compared with other healthcare systems the general practice orientation of the NHS ensures that the UK does well in respect of equity.[4 5] Healthcare systems that are oriented towards specialist care tend to reinforce inequalities, particularly in access.[6] The absence of financial barriers to primary care

contributes to equity and means that patients in the UK are less likely than those in other countries to report that they do not use services because of the cost of care.[7] However, there are problems for which general practice has some responsibility. In coronary heart disease, for example, we know that women receive worse care than men and that people from ethnic minorities receive worse care than white people.[8 9] We also know that although good access to primary care minimises the effects of health inequalities,[10] those areas that have the greatest need also have least access. These inequalities have shifted little over the past 25 years.[11]

Efficiency—International comparisons have shown that the UK has one of the most cost effective healthcare systems of the developed countries.[12] The emphasis on primary care, with its ability to deal with clinical uncertainty and manage access to expensive specialist services, is an important explanatory factor.[13] Indeed, health systems dominated by specialist care tend to have higher total healthcare costs as well as poorer outcomes.[12]

Quality—The quality of the clinical care provided in general practice may have been its Achilles' heel in the past,[14] and analyses of the processes of care, especially for chronic conditions, have shown wide variations, sometimes around an unacceptable mean level of quality.[15] However, big improvements have been made, and the quality of care now bears little relation to that provided even 10 years ago.[16] These improvements can be attributed to several initiatives over a long period, including the development of clinical audit, an acceptance of the role of evidence based practice, and the targeting of resources towards improving specific areas of practice.[17 18] Preliminary data derived from the new general practice contract seem to confirm these improvements,[19] although it is unlikely that the pockets of poor quality that are known to exist in some areas have yet been fully overcome.

Patient responsiveness—Evidence describing the patient responsiveness of general practice is mixed. On one hand, patient surveys indicate a high level of satisfaction with general practice and a high degree of trust in individual general practitioners.[20] On the other hand, more detailed analyses of specific patient experiences show several areas of concern. For example, despite most practices apparently meeting government access targets to see a general practitioner within 48 hours, patients are anxious about the abdication of out of hours services and are unhappy about being unable to gain quick access to a known general practitioner for routinely booked appointments.[21] In addition, UK patients rate their general practitioner less highly than patients in other countries, both in terms of overall satisfaction and in relation to specific issues such as communication skills.[7 22]

If equity, efficiency, clinical quality, and patient responsiveness are the policy outcomes by which general practice should be judged, what are the processes which lead to them? A combination of evidence and experience suggests three are important: coordination, continuity, and comprehensiveness. Coordination is becoming increasingly important as health systems become more complex, the population ages, and the prevalence of co-morbidity increases.[23] A list of registered patients is central to the service's ability to provide coordinated care.[12] Continuity is valued highly by both patients and doctors.[24] The opportunity for general practitioners and patients to get to know each other, and the sense of ongoing responsibility which this relationship engenders, are associated with improved compliance, fewer mistakes, and better health outcomes.[25 26] Comprehensiveness is also key, aided by the delivery of care by clinical generalists and by offering a comprehensive range of services from a single site close to patients' homes.[12]

In summary, the current model of general practice seems to perform very well on equity and efficiency, quite well on quality, but less well on patient responsiveness. If general practice is to be exposed to greater competition, the effect should therefore be judged on the potential to improve patient responsiveness and perhaps quality and not to damage equity or efficiency.

Other market based models

What are the alternatives to the current, relatively homogenous, model of general practice? The box gives five non-exclusive possibilities. The ways in which these models are experienced by patients will depend on the degree to which the providers tackle issues such as skill mix, practice mergers, collaboration between providers, and the development of new services. The commercial takeover and merger options might be indistinguishable to patients from their current practices. The population and condition specific services are likely to feel quite different, whereas the perception of a hospital based service will depend on whether it has a specialist or generalist approach.

What effect might these models have on the policy objectives for primary care? The literature describing the effect of markets and competition is not particularly helpful. Findings are conflicting and seem to be strongly influenced by the historical and organisational context and societal culture within which market interventions have been evaluated.[27] The only thing that we can say with some certainty is that advocates of competition are inclined to overplay the benefits and opponents to overplay the risks. We can also assume that competition is not a panacea, since at the same

Market based models for primary care

Commercial takeover—Comparatively large independent companies such as current or new independent sector providers, high street retailers, or pharmaceutical companies might buy up whole practices or establish new practices, employing all of the staff

Mergers of existing practices—Successful established practices might want to take over other practices and either merge them or manage them using a common executive team.

Hospital based service—The NHS hospital sector may decide to provide primary care services, either in hospital outpatient departments or by setting up new primary care clinics linked to hospitals. This model is likely to be particularly attractive to foundation hospitals, which have the ability and incentives to expand their capacity

Population specific service—General practice services targeted at specific populations (eg teenagers, elderly people, or commuters) could be established by any provider (moving away from comprehensive family practice)

Condition specific service—Discrete services targeted at conditions or procedures, such as hypertension clinics or investigative facilities, could be delivered by independent providers under contract to practices or primary care trusts

time as the UK is exploring market solutions, the United States and Germany are trying to regulate their markets. So, with unhelpful evidence to guide us, we start by considering the effect on patient responsiveness, which we believe should be the most important consideration.

Patient responsiveness—Competition between providers is likely to have a mixed effect on responsiveness. A general practice that has to compete for customers is more likely to respond to their demands by, for example, prolonging opening hours or providing a wider range of services. Those patients who want to trade personal care for accessible or technically efficient care might be better served than under the current arrangements. At the same time, if competition leads to fragmentation, patients who value personal, coordinated, and continuous care are less likely to receive it. The introduction of non-NHS providers may also affect the public's sense of responsibility for, and solidarity with, its local practice.[28]

Equity—Markets tend to favour those who are most able to play them, generally the wealthy, educated middle classes. Introducing unmanaged competition is likely to exacerbate current health inequalities. However, opening markets in deprived areas may offer choice for the first time to those who currently get the poorest service. It is unclear whether it is possible to manage markets to improve equity in the ways in which the government has suggested.[29]

Efficiency—Competition might be expected to drive down costs, but given the desire to increase capacity in order to offer greater choice and a contract which is effectively priced nationally, this may not be the case. Some evidence shows that increased transaction costs and the need to give private providers an incentive to enter a new market might result in increased costs, at least in the short term.[30] Supporters of general practice have argued that it is already highly cost effective and that new entrants to the market will be unable to compete with current providers. The recent large increase in spending on general practice services resulting from the new practice based contract may challenge this assertion.

Quality—Since there is some room for improvement, new providers may be able to compete with current providers on the basis of clinical quality for discrete conditions. However, policy makers need to consider the effect on patients who have multiple conditions or problems if they divide clinical primary care into disease or population based silos, as might happen in the population and disease specific options.

Conclusions

Exposing general practice to greater market forces is likely to result in some advantages and some risks for patient care. If the aim is to shake up general practice and make it more responsive to patients, the benefits of introducing an element of competition are likely to outweigh the risks. At the same time, however, market forces could exacerbate inequalities and reduce the quality of care for those with comorbidity. Overall, we think that the net effect of opening up the market to different models of general practice will be positive if integrated models (takeover and merger options) are introduced, but negative if packages of care are hived off to different providers (condition specific model) and the integrity of practice based provision is lost. The effects of the other two options are far more uncertain and represent a move into uncharted territory in the UK. Ultimately, we suspect that health system reform is best achieved using a judicious balance of market forces alongside educational approaches and performance management. Learning to get this balance right is likely to result in an uncomfortable ride for general practice.

Summary points

General practice in the United Kingdom is about to lose its near monopoly in the provision of primary care services

The established model of general practice is popular with patients and contributes to the quality, efficiency, and equity of the NHS

Its responsiveness to patients' expectations and preferences could be improved

Introducing greater competition may improve responsiveness but has the potential to exacerbate inequalities, increase costs, and reduce quality of care for people with multiple conditions

Adoption of integrated models will minimise this risk

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1 Roland M. Linking physicians' pay to the quality of care—a major experiment in the United Kingdom. *N Engl J Med* 2004;351:1448-54.
2 De Maeseneer J, Hjortdahl P, Starfield B. Fix what's wrong, not what's right, with general practice in Britain. *BMJ* 2000;320:1616-7.
3 Department of Health. *More GPs for under doctored areas*. Press release, 26 July 2005. www.dh.gov.uk (search for 2005/0267).
4 Blendon RJ, Schoen C, DesRoches CM, Osborn R, Scoles KL, Zapert K. Inequities in health care: a five-country survey. *Health Aff (Milwood)* 2002;21:182-91.
5 Morris S, Sutton M, Gravelle H. Inequity and inequality in the use of health care in England: an empirical investigation. *Soc Sci Med* 2005;60:1251-66.
6 Weiner JSB. Measurement and the primary care roles of office based physicians. *Am J Public Health* 1983;73:666-71.
7 Schoen C, Osborn R, Huynh P, Doty M, Davis K, Zapert K. Primary care and health system performance: adults' experiences in five countries. *Health Aff (Milwood)* 2004;(web suppl):w4-487-503.
8 Gatrell ALG, Chapple A, Horsley S, Smith M. Variations in use of tertiary cardiac services in part of north-west England. *Health Place* 2002;8:147-53.
9 Bowling A, Bond M, McKee D, McClay M, Banning AP, Dudley N, et al. Equity in access to exercise tolerance testing, coronary angiography, and coronary artery bypass grafting by age, sex and clinical indications. *Heart* 2001;85:680-6.
10 Shi L, Macinko J, Starfield B, Wulu J, Regan J, Politzer R. The relationship between primary care, income inequality, and mortality in US States. *J Am Board Fam Pract* 2003;16:412-22.
11 Hann M, Gravelle H. The maldistribution of general practitioners in England and Wales 1974-2003. *Br J Gen Pract* 2004;54:894-8.

12 Starfield B. *Primary care: balancing health needs, services and technology.* Oxford: Oxford University Press, 1998.
13 Haslam D. Schools and hospitals for education and health. *BMJ* 2003; 326:234-5.
14 Irvine D. The quiet revolution. William Pickles lecture 1975. *J R Coll Gen Pract* 1975;25:399-407.
15 Seddon ME, Marshall MN, Campbell SM, Roland M. Systematic review of studies of quality of clinical care in general practice in the United Kingdom, Australia and New Zealand. *Qual Health Care* 2001;10:152-8.
16 Baker R, Roland M. General practice: continuous quality improvement since 1948. *Br J Gen Pract* 2002;52(suppl):S2-3.
17 Campbell SM, Roland M, Middleton E, Reeves D. Improvements in the quality of clinical care in English general practice 1998-2003. *BMJ* (in press).
18 Sheaff R, Sibbald B, Campbell S, Roland M, Marshall MN, Pickard S, et al. Soft governance and attitudes to clinical quality in English general practice. *J Health Serv Res Policy* 2004;9:132-8.
19 Health and Social Care Information Centre. *Quality and outcomes framework information.* www.ic.nhs.uk/services/qof (accessed 21 Sep 2005).
20 Commission for Healthcare Improvement. *Local health services patient survey 2003.* http://www.healthcarecommission.org.uk/assetRoot/04/00/46/21/04004621.pdf (accessed 2 Nov 2005).
21 Bower P, Sheaff RS, Sibbald B, Campbell S, Roland M, Marshall MN, et al. Setting standards based on patients' views on access and continuity: secondary analysis of data from the general practice assessment survey. *BMJ* 2003;236:258-60.
22 Grol R, Wensing M, Mainz J, Jung H, Ferreira P, Hearnshaw H, et al. Patients in Europe evaluate general practice care: an international comparison. *Br J Gen Pract* 2000;50:882-7.
23 Watt G. The inverse care law today. *Lancet* 2002;360:252-4.
24 Freeman G, Hjortdahl P. What future for continuity of care in general practice? *BMJ* 1997;314:1870-3.
25 Manious A, Baker R, Love M, Pereira Gray DJ, Gill JM. Continuity of care and trust in one's physician: evidence from primary care in the US and UK. *Fam Med* 2001;33:22-7.
26 Dovey SM, Meyers DS, Phillips RL Jr, Green LA, Fryer GE, Galliher JM, et al. A preliminary taxonomy of medical errors in family practice. *Qual Saf Health Care* 2002;11:233-8.
27 Sheaff R, Schofield J, Mannion R, Dowling B, Marshall M, McNally R. *Organisational factors and performance: a review of the literature.* London: National Coordinating Centre for Service Delivery and Organisation, 2003. www.sdo.lshtm.ac.uk/pdf/studyinghealthcare_sheaff_report.pdf (accessed 2 Nov 2005).
28 Marshall M, Noble J, Davies H, Walshe K, Waterman H, Sheaff R, et al. *Producing information about general practice services that makes sense to patients and the public; final project report.* Manchester: National Primary Care Research and Development Centre, 2005.
29 Department of Health. *Building on the best; choice, responsiveness and equity in the NHS.* London: DoH, 2003.
30 Robinson J, Luft H. Competition, regulation and hospital costs, 1982 to 1986. *JAMA* 1988;260:2676-81.

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What do patients and the public want from primary care?

Angela Coulter

The government hopes that getting patients' views on their priorities for primary care will ensure support for its plans. It is likely to find patients care more about quality of care than structural or financial reform

The UK government has stated it wants the public to help shape the future of the health service. In the run-up to the planned publication of a white paper on care outside hospitals, Patricia Hewitt, secretary of state for health in England, is leading a big public engagement exercise to "genuinely involve patients, public and staff in designing family health and social care to meet the challenges of the 21st century."[1] The secretary of state's commitment to engaging directly with the public is commendable if it is a genuine attempt to listen and learn, but she should also take account of the extensive body of research evidence on what patients and the public want. Patients have diverse needs and expectations leading to different, and sometimes conflicting, views on priorities,[2] but it is possible to discern themes. What does the evidence show?

National Citizens summit organised to get patients' views on health care

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Structure of primary care

A distinction can be made between what patients want as individual healthcare users and what they hope for as citizens or taxpayers (box 1). In general, patients care more about the quality of their everyday interactions with health professionals than about how the service is organised. Furthermore, although there is scope for improvement in primary care, changes that seem to undermine the founding principles of the NHS are likely to be strongly resisted.

Interpersonal care

Patients want primary care professionals who are good communicators and have sound, up to date clinical knowledge and skills. They also want professionals who are interested and sympathetic, involve them in decisions, give them sufficient time and attention, and provide advice on health promotion and self care.[3] A systematic review of the literature on patients' priorities for general practice care, which examined 19 studies published between 1966 and 1995, found that the most important factor was "humaneness," which ranked highest in 86% of studies that included this aspect. This was followed by "competence/accuracy" (64%), "patients' involvement in decisions" (63%), and "time for care" (60%).[4]

Most patients who consult their general practitioner have specific expectations—for example, they want an explanation of their symptoms, treatment, or investigation. Many have their own ideas about what is wrong and what may have caused it, but they do not