

Primary Care 'market' launched

Ron Singer a London GP and President of the Medical Practitioners Union (MPU), a section of *Amicus*, writes on the reorganisation of Primary Care Trusts. Visit their web site at: <http://www.mpunion.org.uk/>

The term 'primary care' includes most health service provision outside hospital (and many definitions include Accident and Emergency departments which are a first port of call for people seeking immediate treatment). Working in primary care there are tens of thousands of nurses, doctors, physiotherapists occupational therapists and so on who provide care to patients in their own home, in general practices or health clinics.

Over 90% of NHS contacts with patients occur outside hospitals: but primary care and community services have been the traditional poor relation of the 'exciting' world of NHS hospitals.

In 2001 the government set up Primary Care Trusts in England (PCTs) to bring together all the NHS 'departments' that provided care outside hospitals. PCTs are responsible for GPs, dentists, opticians, local pharmacies, district and school nurses, health visitors, other community services - and as 'commissioners' of care, they are also responsible for payments for all hospital services used by their residents.

However in a dramatic, sudden and unexpected announcement in July this year PCTs are to be enlarged and stripped of their role in providing health care: they are to become commissioners of care only.

Government policy has for a while been to transfer as much work as possible from hospitals into GP surgeries and 'the community'. This is thought to be what patients want, will help to reduce the demand in hospitals and A&E departments, and be cost efficient, i.e. cheaper.

But as services are transferred from hospitals to the community it is rarely possible to identify the shift of resources to pay for the service in its new setting. In spite of the increase in NHS funding, many hospitals and PCTs are short of cash and desperately trying to save money.

Already care for asthma, blood pressure and diabetes takes place mainly within general practice, and the aim is to provide care in hospital only for patients who must receive this 'specialist' level of care.

In other words the services that PCTs now

provide are to be further increased at the same time as PCTs are to be forbidden to provide them themselves after 2008. The nature and status of the new providing bodies is currently (September 2005) a mystery. The assumption is that this is a huge opportunity for the private sector to take a big bite into the NHS outside of hospitals.

There are examples of gearing up NHS services in the community - increased resources for GPs (including the world's first national database for chronic diseases) and the creation of community matrons and nurse consultants, for example. But other services are still over-stretched - health visiting and services for the terminally ill (Macmillan Nurses) to name two and Britain will still be left with one of the lowest number of doctors and nurses per head of population in the developed world.

Other new initiatives such as NHS LIFT and Patient Choice (described below) both come with the sting of privatisation in their tail, and the high risk of fragmentation of care.

Meanwhile huge amounts of money are being spent on various NHS IT initiatives (see Choose and Book and Care Record Service) diverting money from patient services and putting the confidentiality of patient records at risk.

The Huge Role of the Private Sector

Few people are aware of the extent to which the government is actually forcing PCTs to pay the private sector to take over our health services in preference to the NHS. PCTs have been ordered to spend at least 10% of their (NHS) money in the private sector, for example via Independent Treatment Centres, and to build premises only via NHS LIFT (both described elsewhere on this site).

Whereas privatisation was mainly seen in hospital care, primary care is now to be privatised and to become another route for tax payers money destined for the NHS to end up as shareholders' dividends.

We say the money would be better used improving NHS facilities and raising quality in the NHS where care decisions are clinically not commercially based.

As you read through the following paragraphs you will see how the NHS is being privatised. A White Paper on 'Care outside hospitals' due in October is likely to further increase the role of the private

sector particularly now that PCTs are to be stripped of their role in providing NHS services to their community.

Choose and Book

When being referred to a hospital for an operation or consultant opinion, your GP must from the end of this year offer you a choice of 5 'providers', one of which must be in the private sector.

The government says offering 'choice' will introduce competition into the NHS which will drive up quality.

We say if the money had been invested in the NHS patients will not need 'choice', only faster access to hospital care. The IT system will allow instant booking of the operation or consultant appointment. Whilst the attractions of such a system are obvious, GPs say they are clinicians, not NHS travel agents and it is a huge waste of their clinical time if they have to personally explain five choices to each patient, and then book the appointment.

Asking GP staff to do this work is equally unrealistic, given the pressures under which they Work. Discussions are on-going!!

Care Record Service

Your GP and hospital notes are about to be placed on a national database, viewable by many thousands of NHS and private sector staff.

This has advantages in the rare circumstance of needing care away from home: but what about aspects of your personal history that you do not want shared across the system? How will confidentiality of your notes be protected?

If patients are offered the choice to opt in or opt out of this system it will be complicated and impossibly time consuming for both clinician and patient to make the choice at each consultation.

Alongside ID cards this additional national database of all our intimate details has to raise serious questions of civil liberties.

NHS LIFT

The Private Finance Initiative is described elsewhere on this site. The community variant is called LIFT (Local Investment Finance Trust) and operates in a similar way. It's the mechanism for the private sector to provide cash to build GP surgeries and community clinics, which are then

rented back to the NHS on 25 year leases. This is expensive and will not replace all poor premises before the cash runs out. LIFT also offers openings for sections of the private sector, such as pharmaceutical chains, to stake a long-term claim to involvement in health centres, and once a LIFT deal has been signed, every future development of primary care facilities must first go to the private sector for funding.

GP Services

From the time the NHS was formed all UK residents could register with a named GP, who had responsibility for their care every day and night of every year. This has all changed. You are now registered with a practice rather than a named GP; PCTs are responsible for care 'out of hours'. Any private organisation can now provide NHS GP services, and the government has changed the 'sale of goodwill' regulations to allow the trading of practices on the open market.

Since the compromise deal signed by Aneurin Bevan at the establishment of the NHS in 1948 GPs have always technically been 'private contractors' and never employees of the NHS: but GPs have always had a national contract with the NHS, pension and other rights that blurred the distinction between self employed and employees. GPs felt part of the NHS.

However as practices fall vacant private companies can now bid to PCTs to take them over and operate them on a for profit basis.

They are likely to gain a foot-hold in deprived areas where it is difficult to recruit GPs and then just like Spec-Savers (or Tescos) 'grow their market share'.

Overall there has been an expansion of primary care and community services. Further expansion is planned alongside ever greater opportunities for the private sector to bid for basic NHS care.

Much NHS money is already being directed into the private sector, and this undermines the integration and cohesion that has been the hallmark of quality NHS primary care.

The speed of the take over by the private sector is about to increase dramatically. Commercial companies may try and provide good care but only if this makes a profit. They compete rather than cooperate; they have commercial secrets rather than open accountability.

It is sad that at the same time as recognising the need to improve primary care government policies are fragmenting and undermining it. Just as other countries

are trying to build primary care into their own systems we are about to lose a national focus and identity for ours.

Frank Dobson, former health secretary, speaking to a meeting of the NHS consultants association recently said:

"The prime minister has said there is no limit to the amount of work to be farmed out to the private sector. That means they intend to dismantle the NHS."

He added that the whole basis of the NHS the "pooling of risk and of cost" was under threat as health corporations are invited to play an increasingly large role.

"The government is encouraging the private sector to cream off the most simple treatments, leaving the NHS to cope with the more complicated ones," he said.

"Tony Blair says that he wants this to be part of his legacy. Besides being the man who took us into Iraq, he seems to want to be the man who took us out of the NHS."

Government abandons blanket rules...but PCTs can chose to privatise

The government has backtracked on its blanket policy ordering primary care trusts to divest themselves of the bulk of services they provide.

Decisions to hand over provision of PCT-run services to other providers, including the independent and voluntary sectors and foundation trusts, will be a matter for individual PCTs, health secretary Patricia Hewitt told the Commons.

In a statement to parliament, she said: "Staff will continue to be employed by their PCT unless and until the PCT decides otherwise following full local public consultation." The statement contrasts with the government's original position, laid down in 'Commissioning a Patient-led NHS', published in July.

Then, NHS chief executive Sir Nigel Crisp said the future role for PCTs would see them "acting as provider of services only where it is not possible to have separate providers".

In the statement, Hewitt also stressed that



the terms and conditions of staff whose organisations are taken over by new organisations "will of course be protected".

Unison put forward a successful motion at the Labour Party conference opposing the increased use of the independent sector by

the NHS. Head of health Karen Jennings described this week's statement from Ms Hewitt as a "wholly unsatisfactory fudge".

She said that leaving decisions about the future of PCT-provided services to PCTs would "give staff no peace of mind" and she urged the government to "take a step back and consult people properly".

The Commons health select committee announced it will hold a two-session inquiry into changes to PCTs. Speaking in a personal capacity, chair and Labour MP Kevin Barron said the government's statement appeared to indicate what was "probably a more sensible approach". But he said "we need to look at this in some detail".

However, in PCTs there are plenty of gung-ho would-be entrepreneurs who will be keen to open up these services to private companies. The "step back" required is to abandon the very idea of a PCT 'market'.