PATIENTS NOT PROFIT

CONSULTATION

On a draft proposal for a bill to amend the primary Medical Services (Scotland) Act 2004 to prevent health boards from allowing private limited companies to run general practices.

CAROLYN LECKIE MSP

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Foreword

The founding principles of the NHS are under attack. It took one Act of parliament in 1948 to establish it. But, bit by bit, since the early 80’s, numerous bits of legislation have set about dismantling its public ethos and letting the interest of private profit dictate how our health service is run. That process has continued under devolution in Scotland.

In 2004 the Scottish Executive passed the ‘Primary Medical Services (Scotland) Act 2004’. This bill allowed general practice (primary care services) to be run by private companies for the first time. Prior to this change in the law primary care services could only be provided by a GP on their own or as part of a partnership of GPs. The law allows any corporation to bid for and run GP services. The only condition is that just one share in the company is owned by a medical practitioner. This massive economic, political and moral shift in the ethos and methods underpinning the delivery of health care occurred without any public consultation whatsoever.

The first instance of this actually taking place in Scotland was in 2006 when SERCO Healthcare Ltd bid to run a practice in Harthill (Lanarkshire) after the local GPs decided to go their separate ways. It quickly became apparent from the three public meetings and the petition signed by over 25% of the population of the area that there was a deep antipathy to private firms running GP surgeries. One woman put it succinctly, “We don’t want business people running our health centre, we just want doctors!” Following overwhelming public pressure NHS Lanarkshire awarded the contract to the local GP.

Despite the local GP retaining her practice NHS Lanarkshire has set a precedent for tendering GP surgeries to private companies. Harthill might be safe for now but any GP practice that dissolves in the future, anywhere in Scotland, is at risk of being taken over by companies like SERCO whose motivation, enshrined by law, is profit first and last, not patients. This process is much further on in England and indicates a direction of travel towards more and more privatisation of the NHS.

The purpose of this bill proposal is to prevent Health Boards from allowing private companies to run practices in Scotland in the future by amending the 2004 act. It will also be a vehicle for debate about the security of our public health care system and how best to protect it. The privatisation debate will benefit from this proposal to coalesce around. I am committed to do all I can to fight to retain the public sector ethos of the NHS. Time and again the public confirm their belief in an NHS where the provision of health care is carried out based on need, rather than at the whim of enterprise.

The Scottish Executive has repeatedly stated that they do not wish to privatise the NHS. If this is the case they will have no difficulty in supporting this bill proposal that will ensure that only GPs run primary care services and make it impossible for private companies, limited by share to take them over.

Carolyn Leckie MSP
1. Introduction

This bill intends to reverse the provisions introduced in 2004 that allows for primary care (general practice) to be provided by private companies. When this bill was introduced there was no public debate on the implications that it would have. It was only when the first tender to the private sector was issued by NHS Lanarkshire in 2006 that the public and health professions at large became aware of the implications of the changes. We are therefore proposing a bill that would once again restrict the provision of primary care services to health professionals and prevent private companies from tendering.

This bill is being introduced by Carolyn Leckie MSP. We are asking for views on this proposal to allow the bill to be refined into a form that will best serve the Scottish people.

Please send responses to:

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By 16th July 2007

This consultation is open to all, and we would therefore welcome responses from individuals, groups, communities, health boards, health professionals, academics and others.

If you wish your response to be kept confidential, please make that explicit in your response (otherwise it will be available for public inspection in accordance with the principles of transparency and freedom of information). Confidential responses will be included in any summary or statistical analysis but this will not reveal the identity of any respondent who has requested confidentiality.
2. Context of the Proposal

Current law

*Primary Care Contracts*

Since the inception of the NHS in 1948 primary care has been provided by GPs. They have retained their self-employed status but have all signed a nationally agreed contract that was agreed between the BMA and the government. This contract was to provide General Medical Services (GMS). Despite their contractor status, GPs are an integral part of the NHS as they have an open national contract, work closely with all other aspects of the NHS and belong to the NHS pension scheme.

In the past 10 years a minority of practices have gone from national contracts to local contracts which provide all the national contract provides with some extra work based on local need. These contracts are called Personal Medical Services (PMS) contracts. Until the new GP contract was introduced during 2004 all GP services had to be provided by GPs working in practices within the usual structures of the NHS in Scotland. If a Health Board wished to provide general practice to a population it was required to employ GPs within the constraints of national contracts and guidelines (either GMS or PMS).

The change in 2004 allowed a third option for Health Boards to enter into a general medical service contract with a company limited by shares. This means that the Health Board would work with a private company and there would be a commercial contract. A commercial contract would be very different from the current contracts which GPs hold. Commercial contracts have profits built into them and they cannot be accessed by the public as they are ‘protected’ by commercial sensitivity. In Scotland these are called HBPMS contracts (they are called APMS contracts in England and Wales).

The new GP contract in 2004 also changed the way in which GPs worked together in group practices. Up until 2004 each GP had a personal list of patients who were signed up to that specific doctor. Where several GPs worked together, they shared the workload, covering holidays and patients could see any doctor. However if the group of GPs separated the patients would follow the doctor on whose list they were. This protected the GPs income and allowed patients to follow the doctor of their choice. The new contract no longer recognises patients as being attached to a GP but to a practice. This means that if a group of GPs dissolve their practice, they do not share the patients. Instead all the patients move with the practice and are allocated as a practice by the Health Board. Since the change in the law in 2004 the Health Board can allocate all the patients to one or some of the partners from the original practice. However this new law also allows the Health Board to have a contract with private companies rather than just with GPs.
Opportunities to contract with private companies

The opportunity to change who provides GP contracts resulted from the Primary Medical Services (Scotland) Act 2004. This contains a clause allowing Health Boards to enter into contracts with private companies to provide primary care services. This was agreed with the BMA but was not discussed with any patient groups and did not undergo any wider public consultation. This raised the possibility of vast changes in how patients are cared for without asking them what they thought or felt about it.

The reason given originally for changing the law was to allow Health Boards to provide GPs in under-doctored areas. This reasoning confuses two separate issues. There are some areas with greater need for primary care than is currently provided but this is not a problem of the method of delivery (GP or private company) of services but instead a problem of resource allocation. Health Boards who wish to reallocate resources towards areas of greater need (under-doctored areas) have the option to directly employ GPs in these areas or provide other resources to existing GPs in these areas. There are significant numbers of fully qualified GPs in Scotland who are currently unable to get a job in primary care. This means that Health Boards would have little difficulty in filling directly salaried positions if they were created. Contracting with the private sector to solve problems resulting from an inequitable allocation of resources would not address this issue.

Many people believe that this reason was not the real reason for the change the law. 4% of English practices are now run by private firms and many of these are in areas which were not under-doctored. Some believe there is instead an ideological drive to get as much of the NHS as possible to be run by private companies for profit.

Background to the need for the Patients Not Profits Bill

The Primary Medical Services (Scotland) Act 2004 makes no mention of when the new powers to contract with the private sector may or may not be used.

Only one GP surgery at the time of this bill being proposed have been tendered to the private sector in Scotland and attracted a bid from a private company. This occurred in Harthill when the GP partnership dissolved. This did not result as a consequence of a shortage of GPs. In fact one of the GPs was keen to keep practising there along with a new partner and had the support of a majority of the patients. Despite clear public support the practice was put out to private tender. The GP won the practice but only after a period of uncertainty for the population of Harthill. Furthermore the doctor suffered a lot of stress and uncertainty over possibility of losing her livelihood as well as having to spend a large amount of time, effort and money bidding for the practice she had run and built up for many years.

The Primary Medical Services (Scotland) Act 2004 for the first time it allows health boards to contract with ‘a company limited by shares’ for the provision of primary care services. These companies are obliged by law to make their first priority the accrual of
profit for their shareholders. We believe that this is incompatible with the provision of a public service such as the NHS and will lead to a distortion of provision of health services which will create long-term problems for patients, staff, communities, health boards and government.

It has been argued by some that since GPs are contractors to the NHS there is no difference between them and private firms. We propose that this ignores several important differences:

- GMS contracts (between a health board and GPs) are open transparent documents that are publicly accessible. Contracts to private firms are not accountable in this way and can be shrouded in ‘commercial confidentiality’.
- GPs do not have shareholders to whom they are accountable. Instead they are accountable to the GMC professionally, to the health board and to their patients (who can transfer to another GP if they wish). This provides GPs with a strong incentive to provide high quality care for their patients.
- GMS contracts are between doctors (and occasionally members of their staff) as a partnership and (through the Health Board) their patients. In contracting to private firms this is lost and the contract becomes one between the Health Board and the company. In this way the patients are not offered a continuity of care that occurs with a GMS contract. It is well recognised that GPs working for a private company are less likely to stay for a long periods of time as there are few ties to a particular population.
- The public perceives that services provided by GPs and their staff are modelled on the values of public service. This is not the case with private companies whose first priority is the generation of profit.
- If Health Boards are concerned about the level of salary GPs receive from practice income they can directly employ GPs and set the salary level. This is not the case in contracts with the private sector.

GPs have been part of the NHS since its inception. They are independent contractors, which allows them the freedom to develop their practices individually, but they are an integral apart of the NHS. They work closely with all other parts of the NHS, only have a contract with the NHS and have been accepted by all as part of the NHS since 1948. It is only recently, when the spectre of private companies loom that, all of a sudden, it is policy to talk of GPs as not being part of the NHS. They have open nationally negotiated contracts and they don’t have shareholders to siphon off the profits. They are generally owned and run by the same doctors over many years. These doctors have a huge vested interest to ensure they provide high levels of care, they are in competition with other local GPs, and all the evidence shows that general practice in the UK is of the highest standard in the world. The fact that most GPs stay in the same practice for a long time provides continuity of care, a family doctor who looks after several generations of families and knows them and the community well. This knowledge, gained over many years, provides the NHS with a service it would be impossible to buy at any price and saves the NHS huge amounts of money in preventing unnecessary investigations and referrals. GPs owning their practice commits them to possession, pride and continuity which no private
company could provide. In short, GPs are not the same as multi-national private companies.

**Review of relevant report and papers**

The use of private companies to provide NHS primary care services in the UK is only a recent change and there are currently no private companies providing such services in Scotland. In England there is a very different situation resulting from a similar change in the 2003 Health and Social Care Act (resulting in 4% of primary care services now being provided by the private sector in England). These changes have led to a great deal of criticism.

Professor Graham Watt of the University of Glasgow wrote the following introduction to a paper in the British Journal of General Practice shortly after the only tender to the private sector in Scotland was issued:

"When a man walks into your office, sits down in front of your desk and tells you he is Napoleon Bonaparte, do not get drawn in a discussion of cavalry tactics at the battle of Austerlitz ... They conceal the central point. The thing is mad.

When private providers argue why they are good for UK primary care, we need to consider not only their ‘cavalry tactics’, but also the possibility that there is something inherently unsound about what they propose".1

Continuity of health care is one of the key strengths of primary care services in the NHS. Involvement of private providers in primary care commodifies the service into separate parts, thereby diluting the ability of the NHS to ensure this continuity.2

The Centre for International Public Health policy at the University of Edinburgh outlined its concerns at the provisions being made for privatisation of primary care in a written submission to the Westminster Health Select Committee.3 This submission contends that private provision leads to higher transaction and administration costs, fragmentation of services and risk pools, loss of mechanisms for fair distribution of resources, loss of accountability and increased likelihood of fraud.

The BMA has also expressed concerns about private provision.4 They reiterate concerns of the profit motivation of private companies, their lack of public service values, a likely restriction in patient access to doctors and ‘cream-skimming’ of the services most easily provided (thereby increasing the effect of the inverse care law (where those with the health care need and supply are inversely related) and health inequalities). They also note that patients preferences in who provides their services are often ignored when services are tendered in this way. They note that GPs are disadvantaged in the tendering process for services, and that this threatens continuity of care. The potential for conflict of interests to arise where a private provider is prescribing medications or referring patients to other private organisations, all of which could lead to fraudulent activity to profiteer from the funding of health care and at the expense of patients, is also described.
There is also a potential ‘race to the bottom’ in terms of the quality of health services provided in a privatised health care market. In essence, those companies using the least number of GPs per patient will be able to bid lowest and make the most attractive offer to health boards. This is not in the patients interest.

Private providers of primary care services have also been found to be inefficient and expensive across the world. Academics writing in Harvard who analysed the effect of increasing private sector involvement in the provision of health care services concluded the following:

“Privatisation results in a large net loss to society in terms of higher costs and lower quality, but some stand to gain. Privatization creates vast opportunities for powerful firms, and also redistributes income amongst health workers ... privatization takes money from the pockets of low-wage mostly female health workers and gives it to investors and highly paid managers ... investor-owned care embodies a new value system that severs the community roots and Samaritan traditions of hospitals, makes physicians and nurses into instruments of investors, and views patients as commodities. Investor ownership marks the triumph of greed”.

3. Detail of Proposal

What the proposal will do

The opportunity for health boards to contract general practice (primary care) services to private companies arises because of changes made in the ‘Primary Medical Services (Scotland) Act 2004’. In particular for the first time it allows health boards to contract with ‘a company limited by shares’. These companies are obliged by law to make their priority the accrual of profit for their shareholders.

We therefore propose to simply delete section 17L, subsection 1 (c), (of the Primary Medical Services (Scotland) Act 2004) which states that a health board can enter into a general medical services contract with a company limited by shares. We also propose to delete subsection 3 that describes these companies and which would therefore become redundant (Appendix 1 shows the current wording of section 17L).

Who will be affected

This change will affect Health Boards in Scotland who have an obligation to provide primary medical services for their populations. It will ensure that it remains the case that all primary medical services in Scotland are provided either directly by health boards, or directly by GPs and their staff.

It will also affect patients in Scotland if the GP (or partnership) with whom they are registered dissolves (or retires/ closes in the case of a single-handed GP). With the current legislation the health board responsible could choose to tender for primary medical services to the private sector, and so the provider of their primary care could become a private company. If this bill is passed then only another GP(s) could provide the service.

General practitioners, practice nurses, receptionists, practice managers and other primary care staff will also be affected by this bill. At present the dissolution of a practice (or the retirement/ closure of a practice in the case of single-handed GPs) could result in staff losing their employment or in them being transferred to a private company. This bill would mean that this situation could not result in them being transferred to a private company.

The private healthcare industry will also be affected by the passage of this bill. Private healthcare provision is currently an expanding market, with significant resource being channelled from individuals and government. This bill would restrict this expansion from primary medical services.

Difficulties with legislation
We perceive no difficulties with the proposal as it will simply return to the status quo prior to the 2004 Act. No practice has been privatised yet, so it will not be necessary to alter any existing contracts.

**Possible financial implications**

There are no negative financial implications. Changing the law will reduce the work a Health Board will have to do when allocating a practice, as well as for those applying for a vacant practice. It will save the NHS money as more of it will be spent on patient care and not on share-holder’s dividends

**Enforcement**

Health boards will return to the situation prior to 2004 and will be monitored by the Scottish Executive within the existing structures.
4. Questions

As part of the consultation process for this bill I am asking for all interested parties to consider the following questions in their response:

1. What do you believe is the best model for the provision of primary care services in Scotland?

2. This bill aims to prevent private companies from providing primary care services in Scotland by amending the Primary Medical Services (Scotland) bill 2004. What is your view of this proposal?

3. Are there other issues that this bill could address relating to the mechanisms health boards can adopt to provide primary care services for their populations?

If you have other comments that you feel should be considered in respect to this bill, please feel free to add these in your response.
5. **Glossary of terms**

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<tr>
<th>Term</th>
<th>Definition</th>
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<tr>
<td>Health Board</td>
<td>This is the entity of NHS Scotland which has responsibility for primary care services and which enters into contracts to provide such services.</td>
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<td>GPs</td>
<td>General Practitioners.</td>
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<td>GMS</td>
<td>General Medical Services contract.</td>
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<td>PMS</td>
<td>Personal Medical Services contract.</td>
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<td>HBPMS</td>
<td>Health Board Primary Medical Services contract.</td>
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**GP Partnership**

Partnership between a GP, GPs and/or other members of staff (such as practice managers and practice nurses) which can be informal (partnership at will) or formal (partnership agreement). This provides the entity for entering into a contract with a health board to provide primary care services.
Appendix: Section 17L of the *Primary Medical Services (Scotland) Act 2004*

Section 17L of the *Primary Medical Services (Scotland) Act 2004* dictates the possible contract arrangements that a Health Board can utilise to ensure provision of primary care services for its population. This is shown below:

**17L. Eligibility to be contractor under general medical services contract**

(1) A Health Board may, subject to such conditions as may be prescribed, enter into a general medical services contract with-

(a) a medical practitioner;
(b) a partnership, where the conditions mentioned in subsection (2) are satisfied; or
(c) a company limited by shares, where the conditions in subsection (3) are satisfied.

(2) The conditions referred to in subsection (1)(b) are that-

(a) all of the partners are individuals;
(b) at least one partner is a medical practitioner; and
(c) any partner who is not a medical practitioner is-
   (i) an NHS employee;
   (ii) a section 17C employee;
   (iii) a section 28C employee or an Article 15B employee;
   (iv) a health care professional who is engaged in the provision of services under this Act, the 1977 Act or the 1972 Order;
   (v) an individual who is providing primary medical services in accordance with a general medical services contract;
   (vi) an individual who is providing primary medical services in accordance with a section 28Q contract or general medical services in accordance with Article 56 of the 1972 Order;
   (vii) an individual who is providing primary medical services in accordance with section 17C arrangements or section 28C arrangements or personal medical services in accordance with Article 15B arrangements;
   (viii) an individual who is providing general dental services;
   (ix) an individual who is providing primary dental services in accordance with a section 28K contract or general dental services in accordance with Article 61 of the 1972 Order;
   (x) an individual who is providing personal dental services in accordance with section 17C arrangements; or
   (xi) an individual who is providing primary dental services in accordance with section 28C arrangements or personal dental services in accordance with Article 15B arrangements.

(3) The conditions referred to in subsection (1)(c) are that-
(a) at least one share in the company is legally and beneficially owned by a medical practitioner; and
(b) any share which is not so owned is legally and beneficially owned by an individual referred to in subsection (2)(c)(i) to (xi).

(4) Regulations may make provision as to the effect on a general medical services contract entered into with a partnership of a change in the membership of the partnership.

(5) In this section-

"health care professional" means a member of a profession regulated by a body mentioned (at the time the contract in question is entered into) in section 25(3) of the National Health Service Reform and Health Care Professions Act 2002 (c.17); "NHS employee" has the same meaning as it has in section 17D in relation to an agreement under which primary medical services are provided; "the 1972 Order", "the 1977 Act", "Article 15B arrangements", "Article 15B employee", "section 17C arrangements", "section 17C employee", "section 28C arrangements", "section 28C employee", "section 28K contract" and "section 28Q contract" each has the same meaning as in section 17D.

(6) The references in-

(a) subsection (2)(c)(iv) to a health care professional who is engaged in the provision of services include a health care professional who has been so engaged;
(b) subsection (2)(c)(v) to (xi) to a person or individual who is providing services include a person or individual who has provided the services, within such period as may be prescribed.
Bibliography


3 Memorandum submitted by the Centre for International Public Health Policy, University of Edinburgh (PCT 43) to the UK parliament health select committee, 10th November 2005.


