
RCN Policy Unit

Policy Briefing 03/2006

‘Registering choice: How primary care should change to meet patient needs

ABSTRACT

This briefing is a summary of a report that Prof Paul Corrigan produced for Social Market Foundation. The report *‘Registering choice: How primary care should change to meet patient needs’* predates Prof Corrigan’s appointment as a senior Government adviser on health and may provide a useful indicator of the contents of the white paper. Prof Corrigan’s report is available on the SMF website (<http://www.smf.co.uk/index.php?name=UpDownload&req=viewdownload&details&lid=149>)

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Introduction

The headings below loosely reflect the structure of Prof Corrigan's report, which is divided into three chapters. In the first chapter, Corrigan argues that primary care should be organised more effectively to meet patient demands. Second chapter focuses on how PCTs might fail in a system of patient choice. The second chapter outlines how the Government should deal with PCT failures in a patient choice system and, finally, the third chapter focuses on providing patients with information to help them make informed choices regarding Primary Care.

Report summary

Capacity and quality: Paul makes a compelling point that Primary care choice is dependent on increasing capacity and accepts that this has not been addressed in the past. But instead of arguing simply for more resources and in essence providing more of the same (or as he puts it leaving it to PCTs), he suggests that the solution lies in 'differentiation'. In other words, whilst two separate parts of the country may have the same general primary care needs; do both sets of needs need to be met in the same way? He suggests that 2 things need to happen at once – increased financial investment *which should lead to* "differentiated" primary care services to meet different needs. As long as the service meets both local (i.e. strategically planned but patient led) and national (i.e. qualitative, quantitative and financial) standards, why should all services look the same?

This process shouldn't be top down only as this would inevitably lead to more of the same, so the top down distribution of resources and provision needs to be supplemented by empowered patient choice.

Voice: Prof Corrigan simply states that the problem with implementing choice in Primary care is that there is little or no experience of effective voice in PC. The usual channel for patient voice – belonging to a GP practice and discussing individual needs with them – is inequitable and unevenly applied. In essence, the 'power' to register with a GP is of little use to whole sections of society who may not want to register locally; may not have a practice locally; or may not even want to register at all. (I wonder what this says about his confidence in Practice Based Commissioning as the solution to innovation in primary care service development.)

In order to provide new ways for the public to voice a need for services and prompt new provision of services, Paul calls for new democratic forums / routes of access & influence to establish the existence of need for new

service entry to markets. Patients should be able to petition the PCT to call for new services – perhaps a critical mass of queries could be used to stimulate a commissioning exercise for new services.

This isn't quite the same as our concern around the underdevelopment of voice in the NHS but it rings a similar tone. How can PC be patient led when there is no genuine voice to determine service provision? Latterly he states again that Choice is the main (but not the only) motivator for improvement - a fairly straightforward argument that fully informed and vocalised choice is the best way of determining local and diverse needs rather than setting up a bureaucracy which tries to "proxy that understanding" of need.

Models & market entry: Market entry (not privatisation!) should be made easier. This is about encouraging the entrepreneurial spirit (although Paul accepts that some are happy to provide services that simply "tick along"). In addition to the entrepreneur/private provider model, he lists a number of other potential provider models, none of which are startling - Co-operatives, FT (acute) providers, existing provider diversification (e.g. pharmacist's etc taking on new services) or a version of ISTCs.

Keeping the N in National Health Service: A small but important section. Here he responds to concerns about fragmentation and uneven distribution of services by arguing for new regulation and inspection of PC but not just on quality etc. Market entry and exit must also be regulated to ensure safe and equitable distribution of services.

Failure: Overall this process is facilitated by PCTs who retain responsibility for the distribution of services and market entry/exit. As 'failure' becomes apparent (and this may be qualitative failure; business failure or change in market need related failures such as demographic changes rendering a service obsolete), the PCT intervenes to support development and improvement.

Paul suggests that failing services *could* be 'bought out' by other providers or ultimately by the PCT but patients should be able to choose other providers in this event and not simply be registered by default to the new owner of the failed service. He only loosely mentions that providers may choose to leave the market - how this 'gap' is filled is unclear but one assumes that he would expect the PCT to encourage alternative provision.

He also makes some passing comments about the GMC becoming more accessible and transparent but it's hardly earth shattering in conclusion "...the process for exit for individual practitioners needs to be more accessible, more transparent and more independent." (p 42).

He does state however that patient choice in isolation will not determine what is best for collective interests hence the need for more effective legislation, regulation and inspection in primary care.

Information for choice: this is a key part of the publication and provides a useful description of some of the current challenges as well as best practice in existence. He points out as we did that information is classically asymmetrical and that every effort must be made to develop a range of solutions to this problem. In summary he states information may take the following forms

Convenience of access: where and when services are available and to whom.

Services on offer: descriptive information on the nature of services available from each provider

Quality, safety and reassurance: Here he suggests that patients would need to have data on the quality outputs or outcomes of the service on offer. He goes on to suggest that the lack of transparency surrounding primary care regulation and inspection and the fact that the Healthcare Commission cannot inspect GP practices is an “odd exception” and should change.

Communication and dissemination - In terms of providing technical information to the public he proposes the use of initiatives like the NHS Expert patients program, trained, non-medical leaders as educators or patient reviews of services (he uses ‘Amazon.co.uk’ as an example of how consumers can review the products on sale...). This has echoes of the patient stories initiative that proved to be such an influential part of the leadership program.

Information will be provided by Primary care organisations, partnerships between public and private interests, consumer groups and entrepreneurs who have identified a need for information. This process should be managed by Govt however to ensure that the data collected is accurate and appropriately published. He places this responsibility with the DH and the Healthcare Commission but I suspect another agency could be developed specifically to run this process.

In conclusion to this part he also identifies, as have we, that in order to address the inequity of information in this complex area, additional support will be needed. Here he resurrects the idea of Patient Choice Advisers, again refers to the use of expert patients or local councillors, and latterly mentions that NHS / PCT staff might have a role to play (!).

Conclusion

The main conclusions of the report are:

- A new PC framework needs to be developed to avoid hospital admission and deal with long term conditions
- More effective health improvement strategies
- Closer relationship between primary care and social care
- Providing more 'secondary care' in the primary care setting
- PC to play a stronger role in diminishing health inequalities

In essence this is all dependent on effective voice in choice – genuine consumer power to move between providers; a clear, transparent, failure regime which keeps a watching eye on quality, effectiveness, and distribution of services; and finally a wide range of mechanisms to distribute qualitative, quantitative and experiential evidence and information on the range of services provided.