The National Health Service (Primary Care) Bill [HL]

HL Bill 91 of 1996-97

Research Paper 97/16

5 February 1997

The *National Health Service (Primary Care) Bill* [HL Bill 91 of 1996-97] had its Third Reading in the House of Lords on 30 January 1997; no date for its Second Reading in the Commons has yet been set. The Bill is the result of a year-long consultation exercise over the future of primary care, and would permit GPs and dentists, with the consent of the Secretary of State, to establish pilot schemes which would enable primary care services to be delivered in a more flexible way than is currently possible. This paper gives a brief history of the consultation process and the series of discussion documents and White Papers issued in 1996 on primary care, and then goes on to examine the detail of the Bill and the responses to it. Members are also referred to Library Research Paper 97/17 which gives a separate account of the negotiations over dentists' remuneration and the effect of the Bill on NHS dentistry.

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I Introduction and summary: a "primary care-led NHS"

The term "a primary care-led NHS" has been heard increasingly in the past few years, especially since the publication of Department of Health guidance on the expansion of GP fundholding in 1994, *An accountability framework for GP fundholding: towards a primary care-led NHS*. The expression is used in two distinct, although related, ways: the first, as implied by the guidance, to refer to the increasing role of GPs in purchasing care for their patients and hence their greater control over hospital ("secondary") care; and the second to the shift of services from the secondary sector towards more community-based settings, often as a result of technological change. While the issue of GP fundholding has remained contentious since its inception, the concept of GPs, and other primary care professionals, having a greater input into the planning of services is one which has general support; the Labour party, for example, while opposing individual fundholding, has advocated locality-based commissioning which would invest considerable decision-making power in GPs.[1] It is also generally accepted that patients tend to prefer to be treated, wherever possible, in their own homes or in GP surgeries, rather than in large hospitals, and the introduction of new developments such as day-surgery, "hospital-at-home" schemes and minor surgery carried out by GPs has certainly increased the extent to which this is happening. Inevitably, this has resulted in fears that such developments may lead to work being shifted from one sector to another, without the appropriate injection of support and resources for those working in primary care, and there is a broad consensus that some form of change in current funding and administrative arrangements is necessary.

Part II of this Paper will describe the consultation process which has been taking place over the past year on what changes would be needed in today's health service to facilitate this shift in emphasis from hospital-based care to primary and community services, without simply overwhelming the latter. It summarises the Department of Health's discussion document *Primary care - the way ahead* which resulted from these consultations.

Part III discusses some of the practical implications of the discussion document: it sets out the current contractual arrangements for primary care practitioners (GPs, dentists, optometrists and pharmacists), discusses how these limit the possibilities of local flexibility, and considers what the effect of a more flexible framework for these services might be. These include the possibility of GP surgeries becoming "super-surgeries" offering services currently only available in hospital; it could also encourage multi-disciplinary health centres with the whole range of primary care services available under one roof.

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1 *A health service for a new century: Labour's proposals to replace the internal market in the NHS*, 3 December 1996

Part IV summarises the White Paper, *Choice and opportunity*,[2] which was published by the Department of Health, Welsh Office and Scottish Office in October 1996, setting out legislative proposals resulting from the discussions on *Primary care - the way ahead*. GPs and dentists are to be given the opportunity to set up pilot schemes so that different ways of providing and funding services can be evaluated: examples include practice-based contracts (as opposed to the current system where the Health Authority/Board contracts only with individual GPs or dentists); a salaried GP/dental service with NHS trusts or "other bodies" such as private sector companies as employers; single budgets for general medical services and hospital and community services, in effect an extended form of fundholding with freedom to switch funding between primary and secondary services; and greater local flexibility in the existing national contract. Such pilots would be voluntary, would be evaluated before they could be replicated elsewhere in the service, and patient charges, where currently applicable, would be precisely the same as under the national contract. Proposals for pharmacists include the possibility of Health Authorities and Boards contracting with them for extra services, over and above those currently provided for in the national contract.

Part V of the Paper summarises a further White Paper, this time published by the Department of Health alone, *Primary care: delivering the future*[3]. This sets out around 70 proposals for the development of primary care which do not need legislation: included are the extension of nurse prescribing, improvements to vocational training and continuing education for GPs, an increased emphasis on research in the primary sector, and the extension of the NHS pension scheme to staff employed by GPs.

Finally, Part VI describes the *Primary Care Bill* [HL Bill 18 of 1996-97] clause by clause and Part VII brings together the responses of opposition parties, health professions and patients' representatives to the proposals.

Members are also referred to Library Research Paper 97/17, *Dentists' pay and the National Health Service (Primary Care) Bill*, which describes the particular difficulties experienced with the current dental contract and dentists' remuneration, and discusses the possible effect of the Bill on NHS dentistry.

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2 Cm 3390, October 1996

3 Cm 3512, December 1996

II Consultation over developing primary care

Between October 1995 and March 1996, the Health Minister, Gerald Malone MP, initiated a nationwide "listening exercise" to find out both from health service professionals and patients how they envisaged the future of primary care and what legislative changes might be needed. Consultation took place at both the national and local level: Ministers and other senior officials met representatives of a wide range of organisations; Mr. Malone made a series of visits covering each NHS region; and health authorities co-ordinated local consultation exercises and surveys. The results of this exercise were published by the Department of Health in the document *Primary care: the future* in June 1996.[4] This was then followed by a further round of discussions with the professions and others to consider how the ideas in the document could be implemented in practice. Similar consultative processes have taken place in Wales, with the publication of the document *Primary care: the way forward in Wales*, and in Scotland with discussion based on the draft paper *Primary care - the way ahead*.

Primary care: the future set out a set of principles which should govern both primary care itself and access through primary care to secondary care. Primary health care should:

- provide continuity of care;
- be comprehensive;
- be properly co-ordinated so that professionals work together, if necessary in partnership with secondary care and other agencies, to meet a patient's needs;
- be the gatekeeper to secondary care, often, though not always, through general practice;
- address the health needs of local communities as well as of individuals.[5]

In addition, it was accepted that where appropriate, care should always be offered in a primary care setting, rather than in a hospital. This was based both on the premise that patients prefer primary settings where possible, and on the argument that in many cases primary care can offer better value for money.

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4 the listening exercise is summarised in Annex 1 of *Primary care: the future*

5 Dept of Health, *Primary care: the future*, June 1996 p.i

Five "touchstones" of primary care were also identified: quality, fairness, accessibility, responsiveness and efficiency. **Quality** included the need for professionals to be up to date and working co-operatively in teams; facilities should be up to standard; use of IT should be developed; and GP practices could be linked together to reduce professional isolation. **Fairness** emphasised the need for all patients to have access to high quality care, with a fair spread of resources both around the country and between primary and secondary care. **Accessibility** highlighted the need for patients to have reasonable access to services both in terms of the distance between their homes and services, and the times at which they are offered. Emergency primary care should continue to be available 24 hours a day. Services should also be equally accessible to all patients, regardless of their age, sex, ethnicity or health status. **Responsiveness** emphasised the importance of reflecting the needs both of individual patients and of local communities. Patients should be involved in their own care and able to exercise reasonable choice; at the same time it should be acknowledged that they have responsibilities as well as rights. Services should be flexible enough to respond to the needs of particular areas, and the regulations governing them should therefore be drafted in such a way as to allow for local diversity. **Efficiency** highlighted the need to make the best possible use both of financial and human resources. Staff should be encouraged to develop and use their skills to the full, and practice should be based wherever possible on scientific evidence.

Finally, the Department's analysis of the information gained during the listening exercise was set out in seven "themes":

- **Resources**: achieving a more equitable distribution, greater flexibility locally and an appropriate balance between secondary and primary care within the available resources

- **Partnerships in care**: developing team and collaborative working between professionals, between primary and secondary care and with authorities and other agencies and also increasing the role of non-medical staff in providing care

- **Developing professional knowledge**: through basic, post graduate and continuing education and training, research and clinical audit and with greater emphasis on multi-disciplinary approaches

- **Patient and carer information and involvement**: developing choice and information but also recognising patient responsibilities as well as rights

- **Securing the workforce and premises** (the basic building blocks of care): through action on GP recruitment, different approaches to contracts for GPs, pharmacists and optometrists to reflect changing workforce needs and to develop a multi-disciplinary approach; a more coherent approach to the primary care workforce and improving the standard and capacity of premises

- **Better organisation**: through linking practices together locally; better managerial support and organisation; reducing bureaucracy and developing the IT infrastructure and the opportunities it offers

- **Local flexibility**: by enabling different approaches to be taken to meet different local needs and circumstances. The time was thought to be right to review the way GPs, pharmacists and optometrists can be engaged to provide services to allow more flexibility and greater choice while keeping traditional strengths. A range of options have been put forward for GPs including a salaried option with GPs employed by, for example, community trusts, a definition of core GMS [General Medical Services] and practice based contracts including an extended version of fundholding that gave the practice a single budget for all services.[6]

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6 Dept of Health, *Primary care: the future*, June 1996 pp iv-v

III The practical implications

As the above summary suggests, the consultation paper did not put forward specific blueprints for change but remained very open-ended. However, developing these themes could lead to quite revolutionary changes in how primary health services are delivered. Currently the contracts governing all GPs and all dentists, pharmacists and optometrists providing NHS services in the community (as opposed to those employed in hospitals) are agreed nationally and set down in SIs. GPs, for example, are paid according to the *Statement of Fees and Allowances*, known as the "Red Book"[7]: their remuneration is made up both of allowances based on the size and characteristics of their patient list and on fees for specified items of service such as contraceptive services or health promotion programmes. This contract cannot be varied, even by mutual agreement between the GP and the relevant Health Authority; the only flexibility consists in the possibility of the Health Authority making extra payments for services not specified in the national contract and which are not classed as "general medical services" (in other words where GPs are providing services for which the Authority would otherwise contract with an NHS trust or other body). There is currently therefore no clear mechanism for funding GPs to provide additional general medical services, such as enhanced health promotion programmes or extra time devoted to chronic disease management, even if both the Health Authority and the GP agree that this would be desirable.

The situation is further complicated by a lack of consensus over what should be included in the definition of "general medical services". The British Medical Association has recently published a document *Core services: taking the initiative*[8], which attempts to define which services currently performed by GPs are actually required by their national contract and which are "non-core"; it then proposes that GPs should negotiate extra payments for these non-core services. Where services defined as "non-core" are clearly services which might otherwise be provided by NHS trusts or other bodies, this should be relatively straightforward, as Health Authorities can pay GPs for them in the same way as they would pay a trust. However, if there is any doubt as to whether the services in question could be classified as "general medical services", the position concerning payments is very unclear.[9]

A second problem with the current situation is that the nature of GPs', dentists', pharmacists' and optometrists' contracts does not encourage them to work together as a primary care team. For example, pharmacists' terms and conditions of service[10] require at least one qualified pharmacist to be on the pharmacy premises while prescriptions are being dispensed. Where

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7 prepared under regulation 34 of the *National Health Service (General Medical Services) Regulations 1992* SI 1992/635

8 BMA, 1996

9 examples of GPs receiving extra payments for services such as nursing home work, HRT implants and endoscopies are given in "Core services contract wins support from local health authority chiefs", *BMA News Review*, 27 November 1996 p.15

10 Schedule 2 of *The National Health Service (Pharmaceutical Services) Regulations 1992*, SI 1992/662, as amended

only one pharmacist works on the premises, this effectively prevents pharmacists from carrying out other functions such as advising local GPs on their prescribing practice or carrying out home visits. Even in cases where pharmacists are able to become involved with other primary care professionals in this way, they will still receive no specific payment for this work, as there is no provision for this in the regulations. Indeed, as pharmacists' pay is linked with the number of prescriptions they dispense, a pharmacist could actually suffer financially if, as a result of such advice, local GPs reduced the number of prescriptions they issued. The current GP contract also hinders practice nurses from taking over GP work where this is appropriate: if a GP practice were to decide to replace a GP with a nurse, it would lose out financially, as nurses cannot contract with the Health Authority/Board and be remunerated in the same way as a GP. Nurses may also be disinclined to transfer from the hospital sector to primary care because they are currently unable to remain in the NHS pension scheme if employed by a GP practice.

A further impediment to co-operation is the difference in the way GPs, dentists, pharmacists and optometrists are reimbursed for the costs of their premises: GPs are directly reimbursed for their rent (or notional rent where they own their own surgeries), while other primary practitioners must meet the cost of their premises out of their general remuneration. This distinction has not made it easy to date for different practitioners (for example a pharmacist and a GP) to share premises, however convenient such an arrangement might be for patients.

Greater flexibility in primary practitioners' contracts could thus lead to a considerable change in the way primary care services are delivered. One example cited in the consultation paper, which was particularly picked up in the press, was the development of GP surgeries into a form of cottage hospital, providing a far wider range of services than is usually found in a surgery. Such a development could include a widening of services offered by GPs themselves (eg a wider range of minor surgery than is currently available in primary care), an increase in the variety of services offered by different health professionals on the same site, and a more independent role for clinicians such as nurses and pharmacists. Other possible developments could be the introduction of salaried GPs employed by NHS trusts to provide general medical services; this could be particularly valuable in inner city areas where GPs might hesitate to accept the long-term financial commitment of becoming a partner in a practice, but where they might be willing to spend a number of years. Currently GPs can only be paid on a salaried basis, rather than as self-employed contractors, in cases where services are inadequate and the Secretary of State has explicitly authorised the Health Authority to make special arrangements.[11]

Clearly, not all the areas for change identified in the discussion document will require changes in legislation, although many may be helped by greater flexibility in practitioners' contracts and remuneration. In the area of developing partnerships in care, for example, it would be possible for closer links to be established between professionals through a greater emphasis

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[11] see sections 29(4) and 56 of the *National Health Service Act 1977*

on collaboration and the development of local mutually agreed working practices. A recent document published by the Department of Health's Standing Medical and Nursing & Midwifery Advisory Committees[12] made a number of recommendations on precisely this point: professionals are encouraged to adopt a collaborative approach across organisational boundaries, agree information-sharing procedures with other professionals from different agencies and put further work into clinical audit; managers should be committed to inter-agency co-operation and should ensure that services are co-ordinated by a named professional; and commissioners of service should ensure that standards for collaborative working are built into contracts. At the same time, changes in contractual arrangements could assist these developments by removing some of the institutional bars to co-operation discussed above.

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[12] Department of Health, *In the patient's interest*, October 1996

IV Legislative changes

A White Paper, *Choice and Opportunity*,[13] was published by the Health Departments of England, Wales and Scotland on 15 October 1996, giving details of the proposed legislative changes resulting from the consultation over *Primary care: the future*. These proposals are summarised below, first looking at possible changes for GPs, and then other health service practitioners. The proposals for changes in dentists' contracts are covered in another Paper[14], as the issue of NHS dentistry services has been the subject of a separate review over a number of years. References to Health Authorities in England and Wales should also be taken to refer to Health Boards in Scotland.

A. GPs

1. Pilot projects

The White Paper proposes legislation to enable a variety of contractual options for GPs to be piloted. Possible forms of contract suggested in the Paper include:

- GPs being employed directly by NHS trusts, or by "other bodies" such as private sector companies. This might be appropriate in areas where GPs are unwilling to commit themselves to the long-term financial responsibility of becoming a partner in a practice; it could also appeal to doctors who wish to be freed from the business side of practice and are willing to give up their "independent contractor" status, or to those needing more flexible working arrangements. However, direct employment by Health Authorities would still be forbidden, except in exceptional circumstances (as now), in order to retain the clear "purchaser" role of Health Authorities.

- contracts being agreed between Health Authorities and whole GP practices. This contrasts with the current system where the contract is always with the individual GP and could, for example, allow a practice nurse to be employed in place of a GP without the practice suffering financially.

- single budgets for both general medical services and for hospital and community services. This would be an extended form of fundholding, where the GP practice would be responsible both for providing services itself and for purchasing others

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[13] Cm 3390, 15 October 1996

[14] Library Research Paper 97/17

elsewhere where most appropriate, with freedom to switch funding between services in the best interests of patients. Currently, GP fundholders' budgets for hospital and community services are quite separate from the funding they receive for providing "general medical" (that is traditional GP) services.

- local flexibility in the existing contract. Where GPs prefer to retain the existing contract, it should still be possible for them to agree *extra* contracts with their local Health Authority for enhanced general medical services, for example developing services for particular groups of patients such as those with chronic diseases or mental illness.

The legislation would essentially be *enabling* legislation: it would remove the current bars to such financial arrangements, without requiring any practice to follow any particular route. The White Paper puts great emphasis on the fact that any such innovations would be completely voluntary. They would also be in the form of pilot schemes. Every pilot scheme proposed by a Health Authority and GP practice would initially need to be approved by the Secretary of State, and would run only for the time specified in the proposal; it would then be evaluated against criteria agreed at the beginning of the project. Only after a number of pilots had been evaluated and shown to be successful might it be possible for similar arrangements to go ahead without central approval; for this stage to be reached, further Parliamentary approval of the necessary regulations would be needed. According to the White Paper, the easiest way of achieving change in NHS legislation to permit such pilot projects would be through giving Health Authorities the same powers to agree contracts with primary care practitioners as they currently have with secondary (that is, hospital and community) services.

One way identified in the White Paper of achieving this would be to bring general medical (and also dental) services within the scope of Part I of the *National Health Service Act 1977* and the *National Health Service (Scotland) Act 1978*. Part I of these Acts gives the Secretary of State the very general duty of promoting a comprehensive health service and the power to do whatever is necessary to facilitate this duty; many of these functions are then delegated to Health Authorities to carry out on behalf of the Secretary of State. These very wide powers leave a great deal of latitude as to *how* precisely the duty of promoting a health service should be carried out. However, Part II of the 1977 and 1978 Acts, which currently covers general medical, dental, ophthalmic and pharmaceutical services, is much more tightly drafted, giving Health Authorities the duty of arranging these services "in accordance with regulations". As discussed above, Health Authorities are therefore currently very restricted in the ways they contract for primary care services. Bringing general medical and dental services within the scope of Part I of the Act would give the Secretary of State the flexibility necessary for the suggested pilot projects.

Although the key point of these proposals is to permit local flexibility, the White Paper sets out a number of principles which must apply nationally:

- patients must continue to have the right to be registered with a GP
- the legislation should ensure there are national safeguards for both patients and practitioners
- there must be public accountability for the use of funds
- if pilots are unsuccessful, it must be possible to revert to the previous arrangements

2. NHS contracts or "ordinary" contracts?

Currently contracts between Health Authorities and primary care practitioners are "ordinary" contracts; that is, they are enforceable in law. Contracts between Health Authorities and NHS trusts, on the other hand, are "NHS contracts": these are not enforceable by law, although they are subject to binding arbitration by the Secretary of State, and tend to be simpler. The White Paper leaves open whether the new pilot contracts between GPs or GP practices and Health Authorities should be NHS or ordinary, although leaning towards the use of NHS contracts. Any contracts with non-NHS bodies (for example with a commercial organisation employing GPs in the same way as commercial pharmacies currently employ pharmacists) would be ordinary contracts.

3. Appointments of GPs

At present, Health Authorities, who are responsible for selecting GPs for practice vacancies, are required to make an appointment after the post has been readvertised three times, even if they are not satisfied that the applicant is suitable and even where the GP will be working single-handed, rather than in a group practice.[15] In 1995, a Department of Health working party report, *Maintaining medical excellence*,[16] recommended that the legislation should be changed at the first possible opportunity to ensure that appointments to single-handed practices are only made when at least one of the candidates meets the required standard. The White Paper states that the Government shares this view and that the Bill will include such an amendment. Even though the current maximum of three readvertisements is set down in secondary, not primary legislation, amendments to primary legislation are needed to enable Health Authorities *not* to make an appointment where there is no suitable candidate.

The White Paper also makes two further proposals. At present, the legislation makes no distinction between single-handed practices and group practices: in both cases Health Authorities are responsible for making appointments to vacancies. Describing this as "clearly illogical", the White Paper proposes that the responsibility for recruiting a new member to a group practice should rest with the existing partners, while the Health Authority would retain

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15 *The National Health Service (General Medical Services) Amendment Regulations 1994* SI 19942/633, amending SI 1992/635

16 Dept of Health, 1995

the overall responsibility of ensuring there was an adequate provision of services for its residents. The second proposal concerns the Medical Practices Committee (MPC)[17] which is responsible for considering whether there is a vacancy for a new GP, or whether the area is already adequately provided for. Once the MPC has declared there *is* a vacancy, the Health Authority or Board recruits for the post, but the MPC is then required formally to admit the GP to the Authority's Medical List. As this second "approval" stage is purely a formality, it is proposed that the Authority could take over the role of admitting the GP to their Medical List.

B. Pharmacists

The White Paper identifies a number of problems with the existing regulations governing community pharmacy services, primarily relating to lack of flexibility. Currently there is no provision for Health Authorities to pay pharmacists for providing services above the minimum level required by the regulations; they are also unable to contract with a pharmacy outside the boundaries of the Health Authority, even if this would provide a more convenient service for patients living near a boundary (although this does not prevent patients from taking their prescriptions to any pharmacy they wish). Under the proposed legislation, Health Authorities would be able to purchase additional community pharmacy services on top of the existing provision; a list of possible services, such as providing counselling services for specific groups of patients and acting as an adviser to other health care professionals, would be set down by the Secretary of State in directions, and it would then be up to the local Health Authority to decide which of these services to purchase and from whom. Pharmacists would be able to apply to provide pharmaceutical services from premises other than pharmacies, thus enabling community pharmacy services to be provided from locations such as residential homes. Pharmacies would also be able to apply to provide services both to their local Health Authority, and to a neighbouring one.

Under Part I of the *National Health Service Act 1977* and the *National Health Service (Scotland) Act 1978*, Health Authorities and Boards have very general powers to purchase "health services", and under these provisions many have purchased services associated with community pharmacies such as needle exchange schemes. Such contracts between Health Authorities and service providers are legally enforceable contracts, as opposed to the "NHS contracts" used for contracting between Health Authorities, GP fundholders and NHS trusts. The White Paper suggests that the necessity of using ordinary contracts may have discouraged Health Authorities from approaching NHS contractors such as pharmacists to provide these services; it therefore suggests that NHS contracts should be used, thus encouraging Health Authorities to consider pharmacists for a wider range of services.

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[17] Scottish Medical Practices Committee in Scotland

C. Optometrists

Most of the points about optometry services made in the discussion document related to closer working relationships between optometrists and other health care professionals, in particular GPs and hospital consultants. It was suggested both that optometrists should be able to refer directly to hospital consultants (at present this must be done via the patient's GP), and that optometrists should develop their role to include detecting and monitoring eye diseases such as glaucoma, providing continuing care to children with visual problems and providing low vision aids and advice to partially-sighted people. The White Paper commented that many of these proposals could be implemented within current legislation and that consultation was already underway. However, it went on to suggest that the use of NHS contracts, rather than ordinary contracts, by Health Authorities and Boards when purchasing services under Part I of the *NHS Act 1977/NHS (Scotland) Act 1978* would benefit optometrists in the same way as pharmacists: Authorities would then be more likely to consider them as potential providers of services such as shared care optometry schemes. No reference was made in the White Paper to the question of optometrists' referring directly to hospital specialists; although changes in the regulatory framework would be necessary for this to be introduced, this could be done through secondary legislation with no need for amendments to primary legislation.

V Changes which do not need legislation

On the 17 December 1996, the Department of Health published a further White Paper on primary care, *Primary care: delivering the future*.[18] This Paper sets out the future changes to primary care suggested in the earlier consultation exercises which can be implemented without legislation. Around 70 proposals are listed, including measures to develop partnerships between primary care workers, improving professional development, involving patients and carers, adjusting the distribution of resources, and improving primary care premises. The Department summarised the proposals as follows:

> "**Developing partnerships in care**
>
> The White Paper will enable all those who work in primary care to make full use of their skills and ensure there are no service gaps through greater support for team-working, extended roles for professionals and removal of obstacles to collaboration. The proposals include:
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> - Extend the existing nurse prescribing pilot scheme from April 1997 with a view to full implementation from April 1998. 500 GP practices and 1,500 nurses will be involved in piloting the new arrangements
>
> - Review of the prescribing and supply of medicines to consider the scope for professionals other than doctors to take on new roles
>
> - Support for wider role for community pharmacists, for example to ensure patients take the right medication at the right time
>
> - A Green Paper on mental health services setting out options for consultation on how health and social services can better combine to deliver a seamless service.
>
> **Developing professional knowledge**
>
> Patients should be confident that those working in primary care have the right knowledge and skills to do their job properly. The White Paper sets out proposals to ensure that professionals have access to education and training which matches the needs of their patients. It responds to calls for more opportunities for multi-disciplinary learning, for better continuous education, for more training outside hospitals and for improved R&D and clinical audit in primary care. The proposals include:

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[18] Cm 3512

Quality in Nursing

- Aim to bring practice nurses within the arrangements for educating and training all other non-medical staff from April 1998 so that their needs can be properly considered alongside those of all other nurses.

Quality in General Practice

- A review of continuing professional development in general practice to be led by the Chief Medical Officer so as to meet the needs of individual professionals, get the best out of existing arrangements and improve the links between education, R&D and audit

- Improvements to GP vocational training, including: a new requirement to be introduced by September 1997 to ensure that all those undertaking vocational training meet minimum standards; GPs to be allowed to spend a greater proportion of training time in general practice from April 1998; funding for GP vocational training to be brought under the Medical and Dental Levy so it can be better integrated with other training for doctors and tailored to meet individual needs

- A review of accreditation to the subsidiary medical lists, for example for minor surgery and child health surveillance, to ensure national criteria are adopted more consistently and that those on the lists remain up-to-date.

Quality in Dentistry

- Development of General Professional Training for all dentists after graduation and development of specialist dental practices.

Research

- Proportion of NHS R&D spending relevant to primary care to be doubled from 6-7% (£25 million) to 14-15% (£50 million) over next 5 years

- Commitment to ensure that by 1998 general practices in every NHS region are able to work together in research networks on projects relevant to patients' needs.

Patient and carer involvement and choice

The objectives are to provide patients and carers with the information about health, NHS services and how to use them appropriately. Among the proposals are:

- £30,000 to be included in each Health Authority's allocation for local public education campaigns in 1997/98

- Follow up the Chief Medical Officer's Review of Emergency Care Outside Hospital to provide people, especially children, with basic health care and first-aid knowledge

- An examination of the provision of information within the NHS, including information to the public, as part of the work programme for *A service with ambitions* [the White Paper on the future development of the NHS in England, published in November 1996].

Distribution and use of resources

The objectives are a fairer distribution of resources, more effective use of resources, and the right balance between primary and secondary care. Among the proposals are:

- A more equitable distribution of cash-limited funds for General Medical Services and community health services in 1997/98

- Pilots of General Medical Services effectiveness indicators at Health Authority level in 1997/98 with view to wider implementation in 1998/99

- Funds to Health Authorities in 1997/98 for selected schemes to improve the availability of General Dental Services

- Extra £32 million new money for Health Authorities in 1997/98, specifically targeted at services for elderly and mentally ill people and drug misuse services.

Workforce and premises

Workforce

The objectives are to make primary care an attractive and professionally satisfying place in which to work and to offer new opportunities to meet the needs of the changing workforce.

The proposals for 1997/98 include:

- An improved GP retainer scheme to be introduced to allow GPs who take career breaks, for example to raise families, to keep in touch with practice and maintain their skills

- A new salaried doctors scheme (in addition to the opportunities offered by the NHS (Primary Care) Bill) to provide different and more flexible employment arrangements

- NHS pension scheme open to GP practice staff from September 1997.

Premises

The objectives are better premises resulting in wider range of better services. Proposals to increase the options available next year include:

- The 1970s cost-rent schedules to be up-dated to allow funding for a wider range and size of premises to meet the needs of modern primary care

- Loans and grants to help GPs buy themselves out of leases on sub-standard premises, thus saving NHS funds in up-keep of poor premises
- New funding arrangements from April 1997 for health centres occupied by GPs to encourage better maintenance and repair

- Further private sector investment in GP premises through the Private Finance Initiative

- Better arrangements for the use of GP fundholder savings for premises development.

Better organisation

The objectives are better organisation to reduce the burdens on professionals and give better services to patients. Proposals include:

- GP out-of-hours development fund made permanent

- Establishment of GP locality pilots to manage overall levels of resources including prescribing

- £2 million primary care development challenge fund to help Health Authorities, Trusts and GPs locally take forward the White Paper proposals

- A clear link between reimbursement and accredited GP computing systems to ensure national standards and better value for money

- Incentives for GP practices to link to the NHS Network."[19]

The proposals in the White Paper have received a broad welcome from professional bodies such as the BMA, the RCN and the National Association of Health Authorities and Trusts (NAHAT). The Labour Party described the package as "timid and lacking vision" but "welcomed the Government's belated adoption of Labour's proposals for GP commissioning".[20]

These proposals at present relate only to England. However, the Scottish Office is bringing out a White Paper on health in the next few months, which will include a chapter on primary care, while the Welsh Office is expecting to make similar proposals to those in the English White Paper in due course.

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[19] Department of Health, *Primary care: delivering the future: summary of the White Paper published 17 December 1996*

[20] Labour party press notice, *Health White Paper too timid on primary care - Labour*, 17 December 1996

VI The Bill

The *National Health Service (Primary Care) Bill*[21] had its First Reading in the Lords on 19 November 1996, its Second Reading on 3 December, its Committee Stage on 17 December, its Report Stage on 23 January 1997 and its Third Reading on 30 January 1997. At the time of writing, no date has yet been set for its Second Reading in the Commons. Part I of the Bill makes provision for pilot schemes for general medical and dental services, while Part II covers the permanent arrangements which could result from the pilots, in addition to other amendments to primary health services. Amendments made during the Lords stages are marked in bold.

Part I Pilot schemes

Clause 1 defines a pilot scheme as one or more agreements made by a Health Authority or Board under which personal medical or personal dental services may be provided. Medical and dental services may not be provided in the same scheme, and nor may Health Authorities or Boards provide services directly themselves. "Personal medical and dental services" are defined as the services currently provided by GPs and dentists under Part II of the *NHS Act 1977* and *NHS (Scotland) Act 1978*; in addition pilot schemes may also provide services under Part I of these Acts (that is health services other than general medical, dental, pharmaceutical and ophthalmic services). In other words, a GP pilot scheme could provide both standard GP services and "secondary" services currently provided by hospitals or community services.

Clause 2 makes provision for proposals for pilot schemes. Before a scheme may go ahead, it must be approved by the Secretary of State; Health Authorities and Boards are required to submit proposals to the Secretary of State if asked to do so by an NHS trust, a GP or a GDP (general dental practitioner); and the Secretary of State is empowered to issue directions as to how proposals should be submitted and what consultation should take place. **Clause 3** empowers the Secretary of State to approve a scheme as submitted, reject it, or approve it with modifications. S/he may not approve a scheme unless satisfied that it would be possible for **any participant other than the Health Authority** to withdraw from the scheme should they wish to do so. Once a scheme has been approved, then under **clause 4** the Health Authority must implement the proposals; variations from the proposal are only possible if the Secretary of State specifically approves, or has given directions authorising variations of that particular description. As soon as is practicable after the scheme has been implemented, details must be published by the Authority to ensure that the "scope and nature of pilot schemes are a matter of public knowledge and record".[22] The proposed provider of services under the scheme, but not the Health Authority concerned, may withdraw from it at any point.

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21 HL Bill 91 of 1996-97

22 *National Health Service (Primary Care Bill): notes on clauses: House of Lords*, November 1996 p.13

Clause 5 requires the Secretary of State to carry out at least one review of each pilot scheme, while **clause 6** empowers the Secretary of State to issue directions varying or terminating schemes. The Secretary of State is also given the power to make directions authorising Health Authorities to vary schemes in specified circumstances.

Clauses 7 & 8 provide that the provisions of the *NHS Act 1977* and the *NHS (Scotland) Act 1978* apply to the Secretary of State's functions under Part I of this Bill in the same way as they do to his functions under Part I of the 1977 and 1978 Acts. This means that the legal framework governing pilot schemes parallels the framework for the delivery of services under Part I of the 1977 and 1978 Acts. The one exception is the Secretary of State's power under section 13 of the 1977 Act to devolve functions to Health Authorities; this will *not* apply to this Bill, with the result that the Secretary of State will not be able to devolve his new powers such as approving pilot schemes to Health Authorities. Health Authority functions in relation to pilot schemes are defined as "primary functions" for the purposes of the *NHS and Community Care Act 1990* which allows NHS contracts (as opposed to ordinary, legally enforceable contracts) to be used between Health Authorities and providers of piloted services.

Clause 9 requires any doctor providing services in a pilot scheme to have the same qualifications as those required for a GP providing services under the current national contract. **Clause 10** prevents a GP providing GP services under a pilot scheme from also providing them under the current contract, except in circumstances specifically provided for by regulations. This means that a GP participating in a pilot scheme will have to have their name taken off their Health Authority's "Medical List" (the list of GPs contracting with the Health Authority under national conditions). However, **clause 11** and **Schedule 1** then allow the Secretary of State to give preferential treatment to any doctor in a pilot scheme, so that a doctor wishing to leave the scheme and go back on to the Medical List is able to do so without the need for the Medical Practices Committee to declare that a GP vacancy exists in the area. This should prevent a GP deciding to provide services under a pilot scheme, and then being unable to revert to providing standard GP services under the national contract, should the pilot scheme be terminated or the doctor in question decide to leave. This decision as to whether or not a GP will get preferential treatment in the future must be made **before the pilot scheme is approved**, and the criteria on which the decision is based must be published. Schedule 1 also includes the safeguard that this right of return to the Medical List could be over-ridden if the NHS Tribunal (which investigates allegations that GPs and other primary care contractors are incompetent or negligent) declares that the practitioner is not fit to provide such services.

Clause 12, introduced by the Government at Third Reading, makes provision for GP fundholders who may wish to become involved with pilot projects. The Secretary of State is required to make regulations enabling such GPs to re-gain their fundholding status immediately if they wish to do so, as long as they meet the conditions for fundholding status prevailing at the time. Clause 13 empowers the Secretary of State to make regulations governing the respective rights and liabilities of GPs working in pilot schemes and those

working under the national contract if they deputise for each other, for example through out-of-hours rotas. The intention stated in *Notes on Clauses*[23] is that each kind of GP should be fully responsible for their own actions when deputising for the other. **Clause 14** permits the Secretary of State to designate providers of personal medical or dental services as "NHS bodies" so that contracts between these bodies and the Health Authority may be NHS contracts rather than ordinary contracts[24]. This could apply both to existing primary care practitioners (who are not currently defined as health service "bodies") and to potential non-NHS providers of primary care services. As an NHS contract, any disputes would be settled by the Secretary of State rather than through the courts; however where the Secretary of State directed that payment should be made, this payment could if necessary be recovered through the courts as a civil debt. The Secretary of State is empowered to make regulations as to how applications to be designated a health service body should be made and how such the designation may be removed; s/he must also publish an up-to-date list of health services bodies designated under this section.

Clause 15, introduced by the Government at Report Stage, enables the Secretary of State to confer powers on the Dental Practice Board in relation to pilot dental schemes. This would allow the Dental Practice Board to carry out similar functions in relation to pilot schemes as it currently does for general dental services, including monitoring the quality of NHS dental treatment through the Dental Reference Service.

Clause 16 allows the Secretary of State to make regulations providing for financial assistance for "preparatory work" for pilot projects: this includes both preparing proposals for a pilot scheme and preparing to provide the actual services. Such regulations may, in particular, impose limits on the overall amount paid by any one Health Authority in any one financial year, or on the amount received by one person or pilot scheme; they may also require the person receiving the assistance to repay it if they do not comply with specified requirements. **Clause 17** enables doctors working in a pilot project to apply for fundholding status, but with the exclusion of doctors "employed by another person". This would exclude doctors employed by NHS trusts, or by private companies. **Clause 18** allows the Secretary of State to make regulations governing charges for dental treatment provided by pilot schemes; the regulations must ensure that the same charge is made for treatment, regardless of whether it is provided in a pilot scheme or under current arrangements.

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23 *ibid* p.28

24 see above p.15

Part II Primary care

Permanent arrangements

Clause 19 sets out the legal framework which will apply if the pilot projects lead on to permanent arrangements. **Clause 19(1)** inserts a new section 28C into the *National Health Service Act 1977* in order to bring personal medical and dental services into Part I of the 1977 Act[25]. This then enables Health Authorities to make contracts for these services in the same way as it contracts with NHS trusts and other bodies for hospital and community health services. Such contracts may not include both dental and medical services (in the same way as the individual pilot projects may not combine dental and medical services), but may include other "Part I" services. This means that a Health Authority could, for example, contract with a practice to provide both standard "GP" services and services such as community nursing which would currently be provided by a NHS trust. Although these functions are conferred directly on health authorities (unlike the existing functions of contracting with hospitals and other providers, which are delegated from the Secretary of State on to Health Authorities), the Secretary of State is given the power to direct how they should be carried out. **Clause 19(2)** makes parallel provision for Scotland, inserting a new section 17C into the *National Health Service (Scotland) Act 1978*. **Clause 19(3)** prevents the Secretary of State from bringing this whole section into force unless s/he is satisfied that it would be in the interests of any part of the health service to do so.

Clause 20 permits the Secretary of State to make regulations governing how services should be provided under the new permanent arrangements (known as "section 28C arrangements" and "section 17C arrangements" in England/Wales and Scotland respectively). **Clause 20(1)** inserts a new section 28D into the *National Health Service Act 1977* and **clause 20(2)** inserts a new section 17D into the *National Health Service (Scotland) Act 1978*. This clause therefore enables regulations to be made so that Health Authorities can enter into contracts without express permission from the Secretary of State, but ensures that only contracts of a form acceptable to the Secretary of State will develop from pilot to permanent status. Such regulations must ensure that participants in pilot projects **other than Health Authorities** may withdraw if they wish, must set down conditions as to participants' qualifications and experience and **must ensure that those giving up fundholding status in order to enter pilot projects are subsequently able to regain it**; they may also set down other requirements such as limiting section 28C/17C arrangements to prescribed circumstances or areas.

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[25] see above p.14

Right to choose GP and dentist

Clause 21 requires the Secretary of State to make regulations setting out a patient's right to choose their GP, subject to the consent of the GP concerned and any limits imposed on the number of patients to be accepted by any one practitioner. Currently this right is set out in Part II of the 1977 and 1978 Acts; this clause extends the right to anyone seeking services from a GP operating under the new "section 28C" arrangements. The legal mechanism is, again, new sections (28E and 17E) inserted into the 1977 and 1978 Acts respectively. **Clause 22**, similarly, requires the Secretary of State to make regulations giving patients the right to choose their dentist, subject to the consent of the dentist concerned.

Deputising arrangements

Clause 23 allows the Secretary of State to make regulations governing the liabilities of GPs when an "ordinary" GP deputises for a GP providing services under section 28C arrangements, or vice-versa. The intention of this clause, according to *Notes on Clauses*[26] is to ensure that GPs of either description will take full responsibility for their actions when deputising for each other.

Dental charges

Clause 24 allows the Secretary of State to make regulations governing dental charges; such charges must be identical to those paid by patients treated by an "ordinary" dentist.

Pharmaceutical services

Clauses 25 & 26 insert new sections 41A & 41B and 27A & 27B into the 1977 and 1978 Acts respectively. Under **clause 25**, the Secretary of State is empowered to give directions either requiring or permitting Health Authorities to arrange additional pharmaceutical services for their local area. The directions may specify what may count as "additional pharmaceutical services", but services already provided by pharmacists under Part II of the 1977/1978 Acts may not be included. **Clause 26** then specifies that any services provided in this way may only be provided by a pharmacist on a pharmaceutical list (ie already contracted to a Health Authority to provide NHS pharmaceutical services) and that the directions may set down the terms and conditions on which the services are to be provided. However, Health Authorities are given the flexibility to make different arrangements with different pharmacists, or with the same pharmacist in differing circumstances. **Clause 27** requires the Secretary of State to make

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[26] *National Health Service (Primary Care Bill): notes on clauses: House of Lords*, November 1996 p.53

regulations obliging Health Authorities to publish lists of dispensing doctors; at present, although Health Authorities must maintain lists of pharmacists providing NHS pharmaceutical services, they are not required to keep comparable lists of GPs providing a dispensing service. The intended effect is to ensure that the NHS Tribunal (which investigates allegations that GPs and other primary care contractors are incompetent or negligent and may remove them from Health Authority lists) has full jurisdiction over GPs' dispensing activities.

NHS contracts

Clause 28 inserts new sections 4A and 17AA into the *NHS and Community Care Act 1990* to ensure that any contracts entered into by Health Authorities with optometrists or pharmacists under Part I of the 1977/78 Acts are NHS contracts. This means that any disputes over such contracts may be settled by the Secretary of State, without the need for intervention by the courts. This does not apply to the standard pharmaceutical and ophthalmic services provided under Part II of the Acts, but only to cases where Health Authorities are purchasing goods and services in connection with their general powers under Part I.[27]

Medical lists and vacancies

Clause 29 inserts new sections 29A and 29B into the 1977 Act, repeals section 30 and replaces section 31(1), in order to amend the way medical vacancies are filled in England and Wales. GPs may only be appointed to a vacancy and included on the Health Authority's Medical List if they are under retirement age for GPs, not disqualified by the NHS Tribunal, and have been nominated or approved for appointment. The Secretary of State is then given the power to make regulations governing how Health Authorities should nominate (for single-handed vacancies) or approve (for vacancies in group practices) appointments. The detailed appointment procedures are therefore not on the face of the Bill but *Notes on Clauses*[28] states the Department's intentions as follows:

> "Thus the process of recruitment will in future follow a series of steps: application to the MPC by the health authority to ascertain that a vacancy exists; decisions by the health authority about what type it is; advertisement by the health authority for a single-handed vacancy or by partner(s) in a practice in the case of a vacancy within that practice; selection by the health authority or the partner(s) concerned; admission to the list by the health authority, which will follow health authority approval of the selection in the case of partnership appointments."

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[27] see above pp 16-17

[28] *National Health Service (Primary Care Bill): notes on clauses: House of Lords*, November 1996 p.66

This new power to make regulations, and the repeal of section 30 of the 1977 Act (which gave the Medical Practices Committee the duty of formally admitting GPs to Medical Lists held by Health Authorities) should implement the intentions set out in the White Paper[29] of streamlining procedures and ensuring only satisfactory candidates are appointed. **Clause 30** makes parallel provision for Scotland, inserting new sections 19A and 19B, repealing section 20 and replacing section 21(1) into the 1978 Act.

Sale of goodwill of medical practices

Clause 31 extends the ban on the sale of goodwill of medical practices (which has been in place since the founding of the NHS) to doctors providing services under the new "section 28C" arrangements. This means that doctors providing services under the new arrangements are treated in the same way as "ordinary" GPs as far as the ban on the sale of goodwill is concerned. The legal mechanism is the substitution of a new section 54 in the 1977 Act and new section 35 in the 1978 Act.

Financial allocations

Clause 32 amends section 97 of the 1977 Act to simplify how financial allocations are made to Health Authorities. Since the passing of the *Health Authorities Act 1995*, Authorities have received two separate cash-limited allocations. According to *Notes on Clauses*[30] this has led to unnecessary bureaucracy and the need for the Secretary of State to approve transfers between cash allotments. Under clause 32, Health Authorities will receive just one cash-limited allocation; the Secretary of State will also continue, as before, to have the duty of meeting Health Authorities' non-cash-limited spending (that is, for remuneration of primary care practitioners providing services under Part II of the 1977 Act). Health Authorities will also be authorised to use cash-limited funds for additional pharmaceutical services (as defined in clause 25) and for remuneration for ordinary GPs' providing "designated" services. This last provision would enable Health Authorities to make extra payments to ordinary GPs, for example to provide services in specific ways to suit local circumstances. Although GPs' remuneration under current arrangements is met from non-cash-limited funds, payments made to GPs under the new section 28C arrangements or pilot projects will be met from cash-limited expenditure; in future there will therefore need to be a transfer of funds from non-cash-limited to cash-limited budgets when resources are allocated to Authorities. **Clause 33, introduced at Report Stage by the Government, makes similar provision for Scotland regarding payments for additional pharmaceutical services and for "designated" GP services.**

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29 see pp 15-16

30 *National Health Service (Primary Care Bill): notes on clauses: House of Lords*, November 1996 p.74

Miscellaneous

Clause 34 provides that an Order in Council making parallel provision for Northern Ireland would be subject to the negative resolution procedure. Sections 29-31, however, will not be applied to Northern Ireland. **Clause 35** provides that any power under the Act to make regulations is exercisable by the Secretary of State and must be in the form of a statutory instrument, subject to the negative resolution procedure. Where the Secretary of State is given the power to make directions, these must be in writing. **Clause 36** defines the terms used in the Bill and **clause 37** gives the short title, commencement and extent. Sections 34-36 will come into force as soon as the Act is passed; the remainder of the Act will be brought into force by commencement orders, with the possibility of different sections being brought into force at different times. During the Second Reading in the Lords, the Government spokesperson in the Lords, Baroness Cumberlege, stated that the aim was for the first pilot schemes to come into operation on 1 April 1998.[31] **Clause 37** also brings into force **Schedule 2**, which makes minor and consequential amendments, and **Schedule 3** which lists repeals and revocations.

Financial effect of the Bill

According to the Bill's *Explanatory and Financial Memorandum*, £6 million has provisionally been allowed for the financial year 1997-98 to meet the additional costs of preparing, managing, monitoring and evaluating the new schemes. No estimate is given for the amounts which will have to be transferred between cash-limited and non-cash-limited allocations to enable Health Authorities to fund the new schemes from their cash-limited budgets.

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[31] HL Deb 3 December 1996 c.592

VII Responses

A. General responses

The general principle behind the Bill, that of allowing greater flexibility in primary care arrangements, has on the whole been well received, both within the health service and by the opposition parties. The emphasis on the voluntary nature of the changes, together with the use of pilot schemes and evaluation, has been universally welcomed, as have the changes in the way GPs are appointed to single-handed practices; other positive points highlighted by commentators include the possibility of more conveniently-located services for patients, the development of "super-surgeries", greater possibilities for professional development, and enhanced relationships and co-operation between professions.

The Royal College of Nursing "warmly welcomed" the proposals, commenting that they could have far-reaching implications for nurses, for example by enabling nurses to take on a more equal role in primary care. It was also enthusiastic about the possibility of primary care services being available in a wider range of settings than is currently the case.[32] The British Medical Association also "welcome[d] the Government's emphasis on primary care",[33] and stated that "the concepts of greater choice and flexibility for both patients and GPs, where desired, are to be applauded".[34] In the Second Reading debate in the Lords, Baroness Jay, speaking for the Labour Party said that she "welcome[d] the principle of seeking to improve these frontline services"[35] and Baroness Robson of Kiddington for the Liberal Democrats suggested that "the Bill has the potential to be a step forward in the provision of community care".[36] The National Association of Health Authorities and Trusts (NAHAT) suggested that the legislation could "mean wider choices for patients, better targeted services, and improved value for money".[37] Rather less enthusiastic was the response of the Association of Community Health Councils of England and Wales (ACHCEW): while welcoming the general debate on the future of primary health care, the association doubted the value of changing the current GP contract, and expressed concern that "flexibility" could lead to greater geographical inequity and a lessening in accountability.[38]

Despite this general approval of the broad principles of the Bill, both the opposition parties in Parliament and representatives of health professionals and patients have raised a number of specific concerns about the Bill. Perhaps the most fundamental of these relates to the

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32 RCN Parliamentary Briefing, 23 October 1996
33 BMA Parliamentary Brief, October 1996
34 BMA Parliamentary Brief, November 1996
35 HL Deb 3 December 1996 c.596
36 HL Deb 3 December 1996 c.604
37 NAHAT press notice, 15 October 1996
38 ACHCEW, response to *Primary care: the future* and ACHCEW, *Health Perspectives*, December 1996

position of private companies, such as pharmaceutical companies, while others relate to matters such as finance and quality. Below are summarised the particular aspects of the Bill which have become points of contention.

B. Detailed critiques

1. The role of the private sector

Probably the most contentious part of the proposals is the possible future role they could give to the private sector. The White Paper, *Choice and Opportunity*,[39] made reference to the possibility of GPs being employed by "other bodies, such as NHS trusts", and the possibility of "other bodies" being private companies has been taken up both by the opposition parties and by the British Medical Association. In his response to Stephen Dorrell's statement on primary care on 15 October, Chris Smith, the Labour health spokesman, stated that "one proposal in the document fills Opposition Members with particular alarm", going on to say:

> "Does that not reveal that the Government's real agenda is allowing primary care GP services to be provided by private commercial companies? Would not the proposal tear at the very roots of the public service ethos of general practice? The GP service, with its fierce independent professionalism, has been the foundation stone of the NHS for 50 years. The relationship between GP and patient has been uniquely important for the British health system, but that relationship will be fundamentally undermined if GPs are employed and their services provided by private sector companies ranging from pharmaceuticals to supermarkets. The professional integrity of the GP must be sustained and the Government's proposal puts it as risk."[40]

This argument was immediately attacked by Mr. Dorrell, who pointed out that GPs have always been private contractors, and that, ironically, the Bill would allow them, for the first time, to be employed by NHS trusts. Describing Labour's concerns as "the Aunt Sally of privatisation", he emphasised that any new ways of providing primary care would ensure parity for patients: GP services would continue to be free at point of delivery, regardless of who was providing them, while dental services would be subject to the same charging regime as exists currently. Nevertheless, the issue has not gone away. In the Second Reading debate in the Lords, the Labour spokesperson, Baroness Jay stated that "over the past few days I have spoken to GPs in London who have already been approached by private companies with an interest in pursuing new contracts through them"[41]; such examples have also been cited in the press. UniChem are reported to be considering applying to set up "one-stop health shops",

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39 Cm 3390, October 1996

40 HC Deb 15 October 1996 c.591

41 HL Deb 3 December 1996 c.599

combining GP services, minor surgery, chiropody, dental services and a pharmacy in one premises, while Tesco, Asda and Boots are also understood to be interested in exploring such developments.[42] On the one hand, it could be argued that, from the patient's point of view, there is no difference between a self-employed GP and one employed by a pharmaceutical company: assurances have been given on charging (ie the patient would remain within the NHS), and patients could benefit from services being available in more convenient locations such as supermarkets. Different professionals working closely together on the model apparently being considered by UniChem could also be of clinical benefit. On the other hand, there is anxiety about the possibility of GPs employed in this way being subject to pressures by their employers, especially if that employer is a pharmaceutical company with obvious interests in promoting particular drugs.

The BMA have come out firmly against any private sector involvement, with the BMA Council passing a resolution on 9 January 1997 that "This Association believes that general medical services must remain fully within the NHS and not be open to direct or indirect privatisation". Dr. Ian Bogle, Chair of the BMA's GPs' Committee, expanded on this resolution, stating that:

> "The GP must be free to be the advocate of the patient and to exercise independent clinical judgement. Staff working in the NHS share common objectives such as the Health of the Nation targets. Commercial organisations inevitably have other priorities such as the needs of their shareholders and the requirement for profit.
>
> There is no room for a third party in the doctor's consulting room. I fear that commercial organisations could impose contracts which would compromise the independence of the GP."[43]

Simon Hughes, for the Liberal Democrats, expressed similar concerns in his response to Stephen Dorrell's statement on the White Paper, asking for assurances that "the new primary care system will be free from commercial profit-making at the expense of the health service" and that "companies, whether Tesco or Asda, Tarmac or Wimpey, will not be able to employ people in the health service and make profits for the private sector at the expense of patients".[44] The Royal College of Nursing has not expressed opposition, but its general secretary Christine Hancock, writing in the *Health Service Journal*, emphasised the need to guarantee the independence of any primary care professionals employed by commercial companies and the need for clear guidance, based on public consultation.[45] Concerns have also been expressed about equity, with the suggestion that commercial companies are far more

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42 "UniChem in plan to run doctor services for NHS", *Financial Times*, 9 December 1996 p.1 & "Shopping for a doctor's surgery", *Financial Times*, 10 December 1996 p.14

43 BMA press notice, 9 January 1997

44 HC Deb 15 October 1996 c.594

45 "What's in it for nurses?", *Health Service Journal*, 7 November 1996 p.21

likely to express interest in prosperous suburban areas than in deprived inner city or remote rural areas.[46]

An amendment explicitly excluding the involvement in pilot schemes of companies with the power to pay dividends was introduced at the Lords Committee Stage by the Labour and Liberal Democrat parties.[47] It was rejected by Baroness Cumberlege (the Department of Health's spokesperson in the Lords) on the grounds that it was unnecessary and damaging: talk of commercialisation was "a nonsense", all new services would be subject to NHS rules and standards, and it would be foolish to rule out any sensible opportunities for pilot schemes, "including a GP being employed by a commercial organisation".[48] Baroness Cumberlege further assured the House that the Secretary of State would only countenance new arrangements "if there are obvious gains attached to them" and that particular attention would be paid to the danger of conflicts of interest. The amendment was put to the vote, but was rejected by the Committee.

The House returned to the issue of commercialisation on Third Reading, when Labour and the Liberal Democrats tabled further amendments aiming to limit private sector involvement in pilot schemes.[49] These were defeated. However, Baroness Cumberlege stated that the Government was "looking again at these provisions", discussions were taking place between the Department of Health and the BMA, and that "a degree of precision" would be introduced over the next few weeks. The precise nature of the discussions with the BMA was not made clear, but Baroness Cumberlege said that the Department was "at one with the BMA on our shared objectives".[50] It seems likely that amendments of some form will be tabled by the Government on this issue during the Bill's passage through the Commons.

2. Salaried GPs

As well as the possibility of GPs being employed by commercial organisations, the Bill would allow pilot projects where they were employed by NHS trusts. As a general principle, this possibility has not been met with any opposition, especially given the voluntary nature of the pilot schemes: hope has been expressed that such a possibility may help tackle GP shortages in areas such as deprived inner cities where GPs are unwilling to buy into a partnership under the existing contract. The Labour Party explicitly welcomed the idea of GPs being employed by *community* trusts in the Third Day debate on the Queen's Speech[51]. However, the Labour spokesman, Chris Smith, went on to express concern about the idea of *acute* trusts (ie those providing hospital, rather than community-based services) employing GPs, on the grounds that

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46 HL Deb 17 December 1996 c.1398
47 HL Deb 17 December 1996 c.1396
48 HL Deb 17 December 1996 c.1403
49 HL Deb 30 January 1997 cc 1253ff
50 HL Deb 30 January 1997 c.1253 & c. 1263
51 HC Deb 25 October 1996 c.248

a GP could end up ordering care for their patient from the same hospital, thus breaking down the purchaser/provider split. The same concern was raised by commentators in the *Health Service Journal*.[52] Given many NHS trusts provide both acute and community services, Mr. Smith suggested that a better solution would be GPs' being employed by the Health Authority, which has been explicitly ruled out in the Bill. The idea of direct employment of GPs by Health Authorities was put forward at Committee Stage in the Lords by Labour, but rejected on the grounds that clearer lines of management and accountability would be preserved if Health Authorities, as now, were only allowed to employ GPs in exceptional circumstances.[53]

The way in which the relationship between GPs and the rest of the NHS might change as a result of a salaried service has also been raised. A former NHS trust chair Roy Lilley recently suggested in *The Health Summary*[54] that a salaried service would lead to more compliant GPs: they could be *required* to act in accordance with clinical protocols, prescribe generically and measure the outcomes of the treatment they provide, while at present they can only be required to do what is laid down in their national contract. The Association of Community Health Councils of England and Wales (ACHCEW) cited the less favourable aspects of loss of independence: that giving GPs employee status could make it difficult for them to speak out against perceived inadequacies in NHS services or could make them "subject to management-led programmes to reduce costs".[55] (The same arguments could presumably also be used against the idea of GPs being employed by commercial organisations on the grounds that it illustrates how employees can be influenced in a way which independent contractors cannot.)

3. Workforce planning

One of the BMA's major concerns about the Bill relates to workforce planning. Currently, the Medical Practices Committee is responsible for deciding whether vacancies exist for GPs in any particular area[56], but under the proposed new system there would be two mechanisms for controlling entrance to general practice: the Medical Practices Committee for "standard" general practice, and applications to the Secretary of State for GPs wishing to enter pilot schemes. The BMA has expressed concern about this for a number of reasons:

- it appears that there will be no single body planning or controlling the GP workforce; this could lead to "over-doctoring" in some areas with "under-doctoring" in others;

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52 "He who pays the piper", *Health Service Journal*, 31 October 1996 p.18

53 HL Deb 17 December 1996 c.1469

54 "Ticking away", *THS*, December 1996 p.1

55 ACHCEW, *Health Perspectives*, December 1996

56 see above pp 15-16

- the MPC's expertise in checking new GPs' qualifications will no longer be used (except when recruiting to single-handed practices under the national contract) with a consequent duplication of activity by every Health Authority;

- existing GP practices might be disadvantaged because of the presence of new GPs in a pilot in the area; the MPC could turn down a request for a replacement partner on the grounds that there are already adequate GP services in the area.[57]

Similar points were made by Labour and Liberal Democrat spokespersons in the Lords Second Reading debate[58] and amendments were put forward at Committee Stage, Report Stage and Third Reading, proposing a role for the MPC in assessing proposals for pilot schemes and subsequent permanent arrangements.[59] Particular concern was expressed about the possibility of the NHS becoming fragmented because of a lack of national oversight. In response to comments made at Committee Stage,[60] Baroness Cumberlege emphasised that pilot schemes would include a far wider range of services than just GP services and that it was for Health Authorities, not the MPC, to judge the health needs of their populations and decide what services would best meet their needs. On the issue of equity of access to services, she reiterated the Government's commitment to fairness and suggested that the Bill as it stood should lead to improved equity: the MPC is not able to require GPs to work in under-doctored areas (it may only prevent them from entering areas already adequately served), while under the pilot scheme system Health Authorities and service providers would be able to work together to find new ways of serving their populations. Nevertheless, she assured the Committee that talks were currently taking place between the Department of Health and the MPC on how fairness of distribution could best be delivered.

At Third Reading, Baroness Miller, speaking for the Government, informed the House that "good progress" had been made on these talks. Agreement had been reached that there should be greater scope for local people to decide on the distribution of GPs *within* a Health Authority area, but that this should be accompanied by a "robust national overview" of the workforce to ensure fair distribution *between* Health Authorities. The Medical Practices Committee and the NHS Executive's advisory group on resource allocation (which has expertise in assessing the need for different services in different areas) would work together to "formulate a national view of GP distribution which can be applied both to the existing arrangements and to the new ones provided for in the Bill."[61] Baroness Miller went on to state that the Government would be considering amendments to be brought forward in the Commons in the light of these discussions.

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57 BMA Parliamentary Brief, November 1996

58 HL Deb 3 December 1996 c.601 & c.603

59 HL Deb 17 December 1996 cc 1431ff; HL Deb 23 January 1997 cc 836ff; & HL Deb 30 January 1997 cc 1270ff

60 HL Deb 17 December 1996 cc 1435ff

61 HL Deb 30 January 1997 c.1272

4. Funding and the effect on the hospital sector

The issue of how the development of primary care will be resourced, and the possible impact on funding for secondary care services, has been raised by virtually all commentators. Both Labour and Liberal Democrat spokespersons in the Lords raised "the usual vexed question of resources"; Baroness Jay for Labour expressed doubt that the £6 million mentioned in the Bill's *Financial Memorandum* would be adequate for the preparation, management and evaluation of pilot projects in 1997-98,[62] while Baroness Robson raised the issue of the possible funding shift from secondary to primary care:

> "I also feel that the further development of primary care will inevitably demand greater resources. We are concerned that changes flowing from the Bill must not be at the expense of the secondary sector, which already suffers from a shortage of resources."[63]

In its response to the Department of Health's discussion document, *Primary care: the future*[64], NAHAT placed very great emphasis on the role of finance, stating that "achieving [a primary-care led NHS] poses possibly the biggest challenge yet for the Service and cannot be achieved without additional and a more equitable distribution of resources".[65] The British Medical Association also made a plea for additional funding:

> "Whilst acknowledging the need to distribute finite resources in a fair, balanced and flexible way, the BMA does not accept that the present level of NHS resourcing is capable of delivering the level and quality of primary and secondary care to which the population and the Government aspire. In particular, we do not accept that developments in the delivery of secondary care nearer to the patient can be funded solely from corresponding economies in the secondary care sector."

The arguments supporting the appeal for additional funding are two-fold: that current resources are inadequate to maintain the level of service patients expect, and that certain aspects of the development of primary care represent a new service, rather than merely the shift of particular procedures from the hospital setting to the GP surgery. NAHAT, for example, suggests that:

> "Many commentators believe that much of the increased workload in the primary sector is "new treatment" rather than "transferred treatment" and needs to be appropriately financed."

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62 HL Deb 3 December 1996 c.601
63 HL Deb 3 December 1996 c.602
64 Dept of Health, June 1996
65 NAHAT press notice, 10 October 1996

Likewise, it has been argued (particularly in the context of the inexorable rise in admissions to hospital) that improving primary care services actually *increases* use of secondary care services, presumably because previously unmet need is being picked up.[66] If this were to prove to be the case, then it could be argued not only that resources should not be transferred from secondary to primary services, but that secondary, as well as primary services, would need *extra* funding.

A separate point relates to the way funding is allocated for primary care services between Health Authorities. In its latest White Paper, *Primary care: delivering the future*, the Department of Health stated that:

> "Funds for some aspects of primary care are distributed less fairly than for other health budgets. In General Medical Services (GMS), resources have tended to follow GPs and GPs themselves are not distributed entirely equitably in relation to population needs. Distribution of funding of community health services has also taken less account of need than for hospital services and has not kept pace with shifts in workload as ways of delivering services have changed - particularly in relation to people with long term health needs."[67]

Both ACHCEW and NAHAT emphasise the need for a "more refined approach" to allocating primary and community care resources[68] and *Primary care: delivering the future* cites a number of ways in which the Government is attempting to achieve this, including basing Health Authorities' cash-limited funds in 1997/98 for general medical and community health services on "new improved indices of need". The changes, however, will be phased in over a number of years, to prevent radical funding shifts over a short time period.

5. Piloting, evaluation and consultation

The use of voluntary pilot schemes has received a general welcome. Both Labour and Liberal Democrat spokespersons in the Lords Second Reading debate expressed satisfaction that an incremental approach was being adopted, along with references to the lack of such an approach in earlier NHS reforms.[69] Likewise, the BMA commented that "the voluntary nature of the proposals is a welcome change from the Government's previous dogmatic initiatives which were imposed on an unwilling profession".[70] A number of points, however, have been made about the way pilot schemes should be evaluated. Baroness Robson, for the Liberal Democrats, emphasised her belief in the importance of evaluation being thoroughly completed before schemes are made permanent, stating: "We must not have a repetition of the speed at

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66 eg, "In the fast lane", *Health Service Journal*, 8 December 1994 pp 31-32

67 Cm 3512, December 1996 p.34

68 NAHAT's and ACHCEW's responses to *Primary care: the future*

69 HL Deb 3 December 1996 c.598 &c. 602

70 BMA Parliamentary Brief, November 1996

which the nursery voucher scheme was given the go-ahead, even before the pilot scheme was finished".[71] The BMA made a number of proposals as to how evaluation should be carried out: it should be "profession-led", of suitable duration and include both local and national elements: the local element should include those participating in the pilot, patients and patient interest groups, local GP representative bodies and academic bodies, while the national element should take into account both workforce planning and the training needs of GPs. The BMA also emphasised that funding will be needed to carry out such evaluations effectively.[72] Emphasis on the importance of considering patients' views in the evaluation, together with equity and quality issues, was also given by ACHCEW.[73]

At the Lords Committee stage, and again at Report, Baroness Robson proposed that evaluation should take place no less than 18 months and no more than three years after the start of the pilot.[74] While agreeing that the vast majority of pilot schemes would be evaluated within this timescale, Baroness Cumberlege initially rejected this amendment on the grounds that it was too inflexible: there could be exceptional cases where evaluation after longer or shorter periods was appropriate. However, at Third Reading, she stated that, after further consideration, it had been agreed that a maximum timespan of three years would be appropriate, and that an amendment to this effect would be introduced in the Commons.[75]

As well as commenting on the importance of wide involvement in evaluating the pilots, a number of bodies have raised the issue of the consultation procedure before a pilot is set up in the first place. ACHCEW stated that it expects Community Health Councils, along with other representatives of patients and the local population, to be consulted and expressed the hope that this consultation would be "genuine", stating that "the 'consultation' which took place when NHS trusts were being set up would not be a good model."[76] The British Medical Association has proposed that Local Medical Committees should be consulted both on the establishment and evaluation of pilots.[77]

Both ACHCEW's and the BMA's concerns were taken up at Committee Stage where a series of amendments were debated on consultation procedures.[78] These included consultation:

- with relevant patients' organisations, the professions and local authorities on proposals to set up pilot schemes;
- with relevant patient organisations and the professions on reviews of pilot schemes;

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71 HL Deb 3 December 1996 c.602
72 BMA Parliamentary Brief, November 1996
73 ACHCEW, *Health Perspectives*, December 1996
74 HL Deb 17 December 1996 c.1450 & HL Deb 23 January 1997 c.827
75 HL Deb 30 January 1997 c.1267
76 ACHCEW, *Health Perspectives*, December 1996
77 BMA Parliamentary Brief, November 1996
78 HL Deb 17 December 1996 cc 1419ff

- with relevant patient organisations and the professions on setting up permanent arrangements; and

- with representatives of pharmacists (both nationally and locally) on the possibility of purchasing additional pharmaceutical services.

Baroness Cumberlege welcomed the aims behind the amendments, but felt that "the legislation and the arrangements to enable us to achieve this co-operative approach are already in place".[79] She pointed out that, under the existing terms of the Bill, the Secretary of State is empowered to require appropriate local consultation on proposals for pilot schemes, and that Community Health Councils and the professions' local representative committees already had considerable rights of consultation under existing legislation. However the issue was raised again both at Report and Third Reading, and on this last occasion, Baroness Cumberlege said that the Government "was not indifferent to the strength of feeling expressed by many of Your Lordships" and that in the light of this they would "consider whether some of the undertakings we have given might be given greater force on the face of the Bill". "If appropriate" amendments would be brought forward during the Commons' stages.[80]

Further points raised at Committee stage related to parliamentary involvement. Labour proposed that an annual report should be made to Parliament on all decisions made regarding pilot schemes in order to keep a national overview of the many different schemes expected over the country.[81] Both Labour and the Liberal Democrats also supported another amendment requiring the affirmative rather than negative procedures to be applied to regulations enabling pilot schemes to become permanent arrangements, thus ensuring further parliamentary debate before permanent changes could be made.[82] Baroness Cumberlege, however, did not feel able to accept either amendment: she felt that an annual report to Parliament would involve Parliament in the detail of NHS operations "in an unprecedented way", and rejected the use of the affirmative procedure on the grounds that there were already sufficient safeguards in the Bill, in particular the requirement that the Secretary of State be satisfied that the introduction of permanent arrangements would be in the interests of the NHS. When the issue of an annual report was discussed further at Report, she suggested that similar information could be called for by a Select Committee or through parliamentary questions, and that these would be more suitable means of providing information than through a formal report to Parliament.[83]

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79 HL Deb 17 December 1996 c.1425
80 HL Deb 30 January 1997 c.1267
81 HL Deb 17 December 1996 c.1421
82 HL Deb 17 December 1996 c.1456
83 HL Deb 23 January 1997 c.831

6. Quality

The issue of standards and equity of access to services has been raised by a number of commentators. Baroness Jay, in her Second Reading speech for Labour, commented that there was not a great deal in the Bill specifically addressing the question of quality and made the point that:

> "Deregulation in the form the Bill proposes may well lead to greater variety and flexibility in meeting different patients' needs. But it will only be of real benefit to those patients if different forms of care and service provision are of equally high standard. This can best be achieved in a national framework of accountability and standard setting."[84]

ACHCEW expressed the fear that "purchasers" of primary health care (ie the Health Authorities contracting with the pilots) may lack the information to set down specific quality targets and ensure that they are met, suggesting that "there is a risk that in some respects the quality of services could fall, whether by accident or design".[85]

Amendments were tabled at the Lords Committee stage by Labour and the Liberal Democrats, proposing that national quality criteria should be agreed which pilot schemes would have to meet.[86] While unwilling to write such a requirement on to the face of the Bill, given the difficulties there might be in defining such criteria, Baroness Cumberlege stated that a national representative group of the professions, academics, patients and Health Authorities was being set up by the Department of Health to discuss how such standards could be identified.[87] Were it to be possible to identify appropriate criteria, these could be used in both assessing proposals for schemes and evaluating the success of projects. Returning to this issue at Report, Baroness Jay proposed that pilot schemes should only be acceptable if quality standards set by such a national group were met. The amendment was again rejected on the grounds that it was unnecessary to include it on the face of the Bill; there were a great many groups advising the Department of Health and there was no need to enshrine their work in legislation.[88]

A separate amendment on the quality of additional pharmaceutical services was tabled by Labour's spokesperson, Baroness Jay, reflecting concerns from the Royal Pharmaceutical Society that the current statutory requirement for pharmacists to conform with professional standards of practice might not apply to the additional pharmaceutical services envisaged in

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84 HL Deb 3 December 1996 c.599
85 ACHCEW, *Health Perspectives*, December 1996
86 HL Deb 17 December 1996 cc 1441ff
87 HL Deb 17 December 1996 c.1445
88 HL Deb 23 January 1997 cc 813ff & c.824

the Bill.[89] While rejecting the amendment, Baroness Miller, speaking for the Government, assured the Committee that the Secretary of State would certainly consider professional standards, such as those laid down by the Royal Pharmaceutical Society, when issuing directions for additional pharmaceutical services.

7. Role of non-medical professions

A number of points have been made about the relative roles of the various health professions in primary care pilots. ACHCEW expressed concern at "the level of influence which it is suggested that general practice should have over primary care"; these concerns relate both to the issue of accountability to the local population and to the possibility of the GP's medical perspective "crowding out" other professions' perspectives, such as the public health concerns of health visitors.[90] This last point was taken up by the Royal College of Nursing, who suggested that "focusing all primary health care around a general practice base may reduce the ability of the NHS to address wider community needs, particularly in relation to public health issues".[91]

The RCN also commented on the lack of direct references to nurses in the White Paper, *Choice and opportunity*, but suggested that in fact the legislative changes could have an enormous impact on nursing, given the possibility of practice-based contracts and nurses entering into full partnership with GPs. The flexibility inherent in the legislation would also allow community nurses to be directly employed by GPs (currently only practice nurses are employed in this way, while community nurses are employed by trusts). If this were to happen, the RCN emphasised the need for appropriate clinical supervision arrangements to ensure that the scenario of "one profession [ie doctors] acting as the gatekeeper to the development of another" did not arise. The RCN suggested that the most appropriate way of addressing this issue would be for GPs to take a senior nurse into partnership if nurses are directly employed by the practice.[92] Other points on nursing made by the RCN included the need to extend nursing prescribing and ensure that practice nurses had access to the NHS pension scheme; both points have subsequently been addressed by the later Department of Health White Paper, *Primary care: delivering the future*, although it has still been suggested that it would be helpful to include access to the pension scheme on the face of the Bill and, in particular, to ensure that practice nurses may join the scheme whether their GP employer wishes them to do so or not.[93] Finally, the RCN queried the rationale behind the ban in the Bill on pilot projects including both medical and dental services.

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89 HL Deb 17 December 1996 c.1461

90 ACHCEW's response to *Primary care: the future* & *Health Perspectives*, December 1996

91 RCN Parliamentary Briefing, 28 November 1996

92 "What's in it for nurses?", *Health Service Journal*, 7 November 1996 p.21 & RCN Parliamentary Briefing, 28 November 1996

93 HL Deb 17 December 1996 c.1429ff & HL Deb 23 January 1997 cc 816-7

This last point was taken up by Lord Rea at Committee and Report Stages: in response, Baroness Cumberlege assured the House that doctors and dentists would be encouraged to work together, including the possibility of their sharing premises, but cited the different ways that GPs and dentists work (in particular the way most dentists combine private and NHS work) as a reason for insisting on separate pilot schemes.[94] She also felt that keeping separate contracts for the two services would help ensure that funding for dentistry was spent on dentistry.[95]

The role of nurses and other health professionals was also addressed at length at Committee and Report stages. The Crossbencher, Baroness McFarlane of Llandaff, supported by Labour and the Liberal Democrats, put forward amendments which would broaden the definition of pilot schemes, enabling the development of nursing and other services independently of personal medical or dental services. It was also proposed that nurses, as well as GPs, dentists and NHS trusts, should have the right to put forward proposals for pilot schemes to the Secretary of State.[96] Suggested services to be provided in such nurse-led pilot schemes included health education, screening programmes and twenty-four hour emergency mental health services; Baroness Jay also highlighted the possible role of other health professions such as occupational therapists, clinical psychologists and midwives. The amendments, however, were rejected by Baroness Cumberlege on the grounds that the Bill already provided sufficient opportunities for nurses to develop their skills through their membership of the primary care team or by taking on more significant roles in NHS trusts providing primary care services.[97] When the issue returned at Report, she also pointed out that under current legislation there was nothing to prevent Health Authorities from contracting with nurses to provide the sort of services described; the point of the Bill was to bring greater flexibility to general medical and dental services where such flexibility currently did not exist.[98]

8. Future questions

Clearly, the precise impact on the NHS of this legislation will depend on the kind of pilot schemes put forward by primary care practitioners, NHS trusts and Health Authorities. In an article written shortly after the publication of the first White Paper, *Choice and opportunity*, health policy academics, Geoff Meads and David Wilkin, posed the following series of questions on future development:

> "Key questions now need to be answered. What is the NHS Executive's role in leading and facilitating the move to a primary care-centred system? Where, for example, is the development capacity at regional level? How will

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94 HL Deb 17 December 1996 cc 1418-9
95 HL Deb 23 January 1997 c.812
96 HL Deb 17 December 1996 c.1408 & HL Deb 23 January 1997 cc 804ff
97 HL Deb 17 December 1996 c.1414
98 HL Deb 23 January 1997 c.808

> HA/primary care relationships need to change to develop the regulatory mechanisms for a hybrid purchaser-provider dealing with public and private sector agencies? What should be the future service boundaries of trusts as they encompass 'outreach' services, develop internal contracting and their own gatekeeping mechanisms? What will non-statutory organisations contribute, particularly as potential hosts of integrated health and social services in primary care? What will be the future of general practice, as a clinical discipline and as a unit of organisation? Do the two still belong together and does either still offer the best value for money in primary care contracts?
>
> The list could go on. Its issues reach to the heart of the NHS and the white paper's importance can scarcely be over-stated. The same applies to the need for care and attention in its implementation. The opportunities are considerable, but we must ensure they generate structured diversity and improvements for all primary care patients, not increased inequalities and chaos."[99]

The Bill is primarily an enabling, not a prescriptive, measure. However, as Meads and Wilkin suggest, its potential impact on the future shape of the NHS, and on the way services will be delivered to patients, is considerable.

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[99] "Legislation of primary importance", *Health Service Journal,* 24 October 1996 p.19

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