

The Supply Side

Health Policy Consensus Group

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The Group Members:

Professor Nick Bosanquet, Imperial College.

Anthony Browne, former health editor of the *Observer*, now environment editor, *The Times*.

Dr. Adrian Bull, Carillion Health.

Geraint Day, Co-operative Party and Institute of Directors.

Professor, Lord Meghnad Desai, London School of Economics.

Helen Disney, Civitas.

Dr. David G. Green, Civitas.

Benedict Irvine, Civitas.

Ruth Lea, Institute of Directors.

Dr. Christoph Lees, NHS Consultant, Addenbrooke's Hospital.

Andrew Neil, Press Holdings.

Paul Ormerod, Volterra Consulting.

Stephen Pollard, Centre for the New Europe.

Professor Stephen Smith, NHS Consultant and University of Cambridge.

Matthew Young, Adam Smith Institute.

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Summary of Recommendations for Hospitals:

In order to ensure adequate supply of health services, and to allow a genuine ethos of local public service, independent of politics, to emerge, the following measures are proposed:

1. The Government should not own hospitals and all such institutions currently in the public sector should become independent at the earliest possible date. The simplest method would be to make them all foundation hospitals, whilst ensuring that their assets must be permanently used to provide health care. Existing NHS hospitals should not be transferred to the ownership of for-profit institutions.
2. However, foundation hospitals as currently proposed are only a small step in the right direction. Hospitals should have complete autonomy from Whitehall. In particular, there should be no specific restrictions (beyond those that apply to all workplaces) on the ability of hospitals to recruit staff or to determine the conditions of their employment.
3. The Government has an important role in ensuring that hospital accident and emergency infrastructure is universally available. In the rare event of a hospital being in financial difficulty, the Government must be able to take appropriate action.
4. There should be no restrictions on the establishment of new hospitals, whether they are for-profit or not, as at present.
5. The Government should not impose restrictions on the training of doctors, nurses or other medical staff.
6. Foundation hospitals should be free to raise funds in capital markets which are not counted as part of public borrowing, but to avoid the perception that the taxpayer is the ultimate guarantor of loans, all individuals and institutions making such loans must legally renounce any future claim on public funds.

Introduction

Where We Are Now: UK Health Care in 2003

The UK government has a near monopoly over the funding and provision of health care. After decades of political control, our healthcare spending is comparatively low, but is set to rise to something approaching the EU average over the next few years. Our healthcare outcomes are comparatively poor.

The 28 English strategic health authorities supervise 304 Primary Care Trusts (PCTs)² which are to be the main buyers of services from NHS hospital trusts which were designed to be independent, under a system of earned autonomy, are subject to a rigorous regime of inspections and monitoring by central government and semi-autonomous agencies. From April 2003, over 75% of the NHS budget will be controlled by local PCTs, with allocations being made for three years rather than one. On 11 December 2002, Alan Milburn announced the allocation of £148.3 billion to PCTs over the next three years.³ Labour's purchaser-provider split is a development rather than a reversal of the Tories' internal market.

With some minor recent exceptions, patients have no choice among doctors and hospitals.⁴ UK politicians through targets, departmental circulars and arms-length rationing under the 'scientific' guise of the National Institute of Clinical Excellence, interfere with clinical autonomy or the professional duty of clinicians to act in the interests of patients.

There has been much criticism of the Government's plans to increase the role of the private sector, but it already provides much mental health and residential care. The central issue is the degree of competition rather than the public-private split. Perhaps with this in mind, the Government has launched a policy designed to increase hospital autonomy, by creating 'NHS Foundation Trusts' discussed in more detail below.^{5 a}

^a **NOTE on terminology:** The HPCG hopes that NHS Trusts will become not-for-profit Community Trusts. The phrase Foundation Trust is used in this paper when citing other authors, and referring to Government policy.

Options for Reform Template

Coupled with funding reforms outlined in our earlier paper *Step by Step Reform*, over the next decade, we envisage moving to a diverse health economy that is independent of party political processes, thereby strengthening the ethos of public service, but doing so outside political control.

We have used the following criteria and options to guide our thinking while considering options for concrete reform of supply-side organisations.

Options for Reform Template

Criteria	Options for Reform, questions and examples
<p>Ownership</p> <ul style="list-style-type: none"> - Transfer / disposal of assets - Legal form 	<p>Publicly owned, privately (for-profit or not-for-profit) owned.</p> <ul style="list-style-type: none"> - Is there a lock on assets, to prevent sales of assets providing a public service? Or do organisations have the power to disperse. - Do existing legal forms (under company, charity law) allow sufficient freedom and protection of public assets? Or should a new form be created?
<p>Management</p> <p><i>Who appoints the board?</i></p> <ul style="list-style-type: none"> - Composition of the board - Role of board <p><i>Autonomy of financial management</i></p> <ul style="list-style-type: none"> - Ability to access a range of appropriate finance⁶ <p><i>Employment regime</i></p> <p><i>Funding capital programmes</i></p> <p><i>Donations</i></p>	<p>Are management methods determined nationally or locally? Nature of relationship with board.</p> <ul style="list-style-type: none"> - Secretary of State for Health. Local community stakeholders and or staff through democratic election. Issue: are boards publicly accountable; are they independent of party politics? - Cross-section of local community; the local 'great and good'. What happens if agreement cannot be reached - are decisions then made by Chief Executive? - Do boards have real power (either day-to-day, or in setting organisational strategy)? <p>Ability to retain surpluses, or to make profits. Can organisations outsource to for profit companies for some or all service provision?</p> <ul style="list-style-type: none"> - Freedom to borrow against assets on capital markets. - Should borrowing be restricted by government <p>Is there a system of national pay bargaining? Or do providers have freedom to set employment terms and conditions locally?</p> <p>Funded by national, regional, or local government.</p> <p>Are donations subject to or exempt from taxation.</p>
<p>Regulation and accountability</p>	<p>Level of centralised monitoring. Number of regulatory bodies.⁷ Degree of independence. Accountability to patients, and local community. Exit and voice.</p>

The Options for Acute Care - Public Service Not Public Sector: Combining Social Solidarity with Consumer Choice.

- **Ownership**
 - Lock on asset distribution and on asset use.
 - Do we need a new legal form?
- **Management**
 - Who appoints the board?
 - Autonomy of financial management (raising revenue, ability to access a range of appropriate finance⁸)
 - Employment regime
 - Capital programmes; Donations
- **Regulation and accountability**

Hospital Ownership

We do not think the government should be involved in the provision of acute care, and so the first step should be to allow the transfer of hospitals to not-for-profit community trusts. We need to create a mechanism to decide whether to transfer assets free of charge (which might be seen as the government giving away property that belongs to citizens), or to sell them at an agreed price (which would be deeply unpopular and dubbed privatisation).⁹ This is fundamentally a presentational problem; we must emphasise that what patients pay will not be affected by hospital ownership.

Community trusts should be entirely independent of the government and free to serve consumers as they believe best. They should be obliged to preserve their non-commercial status, although there should be no restrictions on the freedom of new hospitals to emerge as commercial enterprises.

Locks on asset distribution and on asset use.

While the idea of a public service should not be conflated with that of a state service¹⁰, we consider that former NHS organisations with greater independence and financial freedoms must not be able to be broken up or sold off for private gain. When NHS Trusts become community trusts, it is desirable that those assets cannot be transferred to private persons or profit making companies and

thus permanently lost to the public good. To this we may need to have a lock on public asset distribution. Of course, the simplest example is the case of dissolution. ‘As in the case of registered charities, this would mean that where a [...community] trust is dissolved, the assets should not be distributed to private individuals but held for the public purpose provided (for example by distribution to another [...community] trust or back to the state).¹¹ In Spain for example the dissolution clauses found in the statutes of *consortia* clearly detail what happens to the assets.¹²

Locks on *asset use* would be an even more stringent controlling factor; it is important to draw the distinction between privatising the asset and privatising the service. So long as we protect consumers by guaranteeing an adequate supply of readily accessible diagnostic and healthcare treatment services to all, the ownership of a hospital is irrelevant. And as Mayo and Lea point out, ‘A ‘lock on asset distribution’ would not deny a [community] trust in the pursuit of its public purpose mission the freedom, subject to prudential regulation, to dispose of assets on commercial terms or to enter into joint ventures using its assets as security.’¹³

Do we need a new legal form?

We need to determine whether such locks on assets and or asset use can be provided for within existing legal forms. The company articles of association could set out the nature of activities undertaken by the organisation, alongside prescriptions against their fundamental change (which would amount to acting *ultra vires*) without referral to an appropriate regulator.¹⁴

Community trusts require a number of other legal characteristics: such as the ability to trade on a not-for-profit basis; non-profit distribution; an effective and inclusive governance structure; the power to borrow; and stakeholder ownership with the benefits of limited liability.¹⁵

What legal form should community trusts take? Several structures are already available: companies limited by shares, charities, companies limited by guarantee, co-operatives and organisations founded by royal charter.

We consider that there are four viable solutions (not mutually exclusive) that would not require the creation of a new legal form:

- *Royal Charter model*
- *Mutual model*
- *For profit privatisation*
- *Lease model*

Royal Charter model

One option would be to give hospitals royal charters, like universities and many voluntary hospitals before nationalisation. Universities have the powers given them by the royal charter and cannot change their constitution without the approval of the Privy Council. Like a charity, the assets cannot be privatised and must permanently be used for the public purpose stipulated in the royal charter – thereby protecting asset use. An independent regulator (such as the FSA or OfCom) would monitor providers' health service activities, in particular focussing on asset use.

Mutual model (+ asset use lock)

Alternatively there could either be a free transfer or sale of assets to newly founded mutual organisations. Mutuals are not explicitly defined in UK statute; rather, the Industrial and Provident Societies Acts and Companies Act regulate them. They come in two main forms. Usually they are run for the benefit of members (such as a co-operative of farmers or workers), but they can also be run for the benefit of the community. In both cases any surplus is employed by the organisation to provide more and/or better quality services and facilities.¹⁶ Friendly societies are similar but have separate legislation and may also be run for the members or for the benefit of other people. Though in theory the assets of an industrial and provident society (I&PS) must be transferred to a body with a similar purpose on dissolution, an I&PS can always convert to a company, be sold and distribute

the assets to its members, (Mayo and Lea, p20-22), as happened to the Halifax and Northern Rock to name but two.¹⁷ To avoid a repetition, a lock on assets would be essential.¹⁸

For profit privatisation

Companies limited by shares are clearly not appropriate for community trust hospitals, as those organisations (or at least their managers) have a fiduciary duty to private and external shareholder who are the owners of the company and have a right to all profits. It is (at least politically) unthinkable that public hospitals would be converted into companies limited by shares.

Though politically difficult for any party, owing to public fears of spiralling healthcare costs and the prospect of being turned away from the hospital door, it would be theoretically possible to sell NHS Trust assets along with a lock on the future use of those assets, which would be subject to stringent scrutiny by a regulator. As mentioned above, it is vital to draw the distinction between privatising the asset and privatising the service. If consumers are protected by the guarantee an adequate supply of readily accessible diagnostic and healthcare treatment services to all, then the ownership of a hospital is irrelevant.

Lease model

Though possible in theory to sell NHS Trust assets to private for profit companies, it would be a massive ideological Rubicon to cross. We think it might be better to rent hospitals to private (for-profit and not-for-profit) organisations – perhaps by establishing a government property agency to handle letting. Organisations could buy a 99-year lease, with the government remaining as the asset owner. Again, providers' use of leased assets would be subject to scrutiny by the independent regulator.

We expect that hospitals will be in the main transferred to mutuals, but in some cases the government may allow the transfer of the management of assets to private organisations that will make profits from their public service activities, as occurs in many German public hospitals.¹⁹

Public Interest Companies

Over the past 15 years Spain has created new many new legal forms,²⁰ including consortia and foundations, to enable reform of the health system.²¹ In the UK, there has been much recent interest in creating a new structure, called a public interest company (PIC), an idea that draws partly on the American tradition of ‘public benefit corporations’. The Public Management Foundation produced a report in June 2001 setting out the case for PICs.²² One of its authors, Paul Corrigan, subsequently became Mr Milburn’s special adviser. The idea is to create a new kind of trading organisation whose character cannot be changed by simple resolution of shareholders, directors or members. Like a charity, it will be unable to alter its objects without permission from an independent regulator, but it will not have the tax breaks enjoyed by charities. Shareholders would hold only preference shares redeemable at face value. Trading surpluses would have to be ploughed back for the benefit of the public and not distributed to shareholders or anyone else. PICs would resemble mutual structures for the benefit of the community (currently registered under the Industrial and Provident Societies Acts) but would not be able to privatise the assets. They ‘combine the appeal of the best of the public, private and voluntary sector models into a single entity specifically designed to deliver public services while remaining independent of direct management by the public sector.’²³ As such, PICs ‘offer a middle ground within public services between state-run public and shareholder-led private structures.’²⁴

The Government has announced plans for foundation hospitals, based on PICs, although their exact form has yet to be agreed.²⁵ This uncertainty makes it difficult to determine the exact

starting point for any future policy. However, we propose that the future of the NHS lies in extending the Government's proposals for Foundation Trusts beyond their current scope.

Of course the legal framework for providers is only that – a framework. It does not determine how organisations are run.

Hospital Management

Hospital Board

Management boards play vital role in ensuring that public and non-profit organisations are publicly accountable and perform well.²⁶ The ability of a board effectively to hold day-to-day management to account and to set and steer organisational strategy depends on a number of factors, including the means of appointment, frequency of meetings, and the experience of board members.²⁷

Board Membership and Appointment: The selection of board members is a potential stumbling block, the main problem being who should decide. The secretary of state for health should not appoint board members; doing so does not guarantee local public accountability. However, we do not want to be too prescriptive about board structures, but instead, suggest that patterns are allowed to emerge, so long as good corporate governance applies. Board members could be elected, but those putting their names forward may not be representative of a local community. Appointed boards of the local great and the good can work pretty well, but there is a danger that they would not be radically different from the current system; filled by those also seeking to be magistrates and school governors.

It is common to draw a distinction between consumer mutuals and those owned and controlled by staff – producer mutuals. Both consumer and producer mutuals have positive sides in relation to healthcare provision – by actively involving either patients or staff. However, there is always a danger of one set of interests being dominant over others. That is to say, in a clinician or

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healthcare professional dominated board there would be a danger that the hospital would be run to serve the interests of those healthcare professionals. Similarly, in a consumer led board the important input of healthcare professionals may be unheard. For this reason it may be better to have a mutual board whereby a genuine balance of interests (patients, medical staff, local health professionals, local politicians), is represented. But there would be a danger of factional stalemate in such a board. Community trusts should also embrace comprehensive citizen participation, helping to enable people to take greater responsibility for their own health.²⁸

Operation of the boards: The board must function as a board and must act in the best interest of patients. With many interests represented there is a potential problem of lack of agreement, in which case boards might be rendered very weak; decision-making power might go to the chief executive, or to lower-level staff.

Autonomy of Financial Management (Ability to access a range of appropriate finance, Raising Revenue, Setting employment terms and conditions)

Financial management freedom or otherwise will be the acid test of community trusts; without ‘full financial management powers, the management of the health system operates within a straight jacket.’²⁹ The Government’s current plan is that Foundation Hospital Trusts will be public organisations with freedom to borrow, though such borrowing will be included in national accounts. There are precedents for such financial independence; Swedish foundation hospital directors can borrow money on the open markets to finance capital projects. Danish hospital corporations can borrow private finance, provided the loan is approved by the Government.³⁰

According to the Government’s plans, Foundation Hospitals will have seven-years of guaranteed income stream – in order to be able to finance debt. Freedom to borrow does not necessarily mean untrammelled freedom – there is no reason that Foundation Hospitals can’t be

allowed to borrow subject to some constraints.³¹ A regulatory body will oversee borrowing to ensure that it is prudent and does not create excessive risk to core services or facilities. Some fear that granting the power to borrow will lead to irresponsible borrowing creating unmanageable levels of debt and perhaps insolvency.³² However, it should be noted that there are a number of organisations which operate entirely in the private sector which the public sector will not allow to become insolvent. Clearing banks are an example of a private, regulated, organisation which it would be impossible for the government to allow to go bankrupt in practice.³³

Secondly, community trusts may also be able to attract more revenue by increasing throughput.

A third element of financial management independence is the ability to set work conditions and pay levels. These elements have formed an important part of hospital reforms in Spain, Denmark and Sweden.³⁴

Capital Programmes

At present capital programmes are authorised by the Strategic Health Authorities. It has been suggested that HRG prices be pitched so there will be a possibility of a surplus, which could be spent on capital projects.

Donations

Community trusts should be able to receive tax-exempt donations.

Freedom to set employment terms and conditions

Employment terms, conditions and pay should be outside national control. We are against uniformity and do not believe there should be artificial restrictions on the labour market.³⁵

Community trusts must be flexible organisations which have power to make their own decisions and respond to disparate markets. They must be able to set salary levels and other

conditions for staff. Given that there is already a minimum wage in the UK, we do not think there should be any national minimum pay levels for healthcare professionals. Local trusts should negotiate staff contracts and subsequent pay awards. They must recruit personnel based on hospital, that is local community, needs; and if needs change, a community trust must be able to change its organisational structure as necessary. The move from public law (i.e. civil service) contracts to private labour law contracts in many Spanish hospitals has been very important; giving hospitals greater autonomy has allowed them to pay their staff better.³⁶ Freedom to set pay and conditions is also a feature of hospitals in Denmark and Sweden.³⁷

Though unable to set pay, UK hospitals already offer employment encouragements through terms and conditions. For example, hospitals might appoint at the top of the consultants' pay scale, including a number of 'discretionary points', also extra payments may be given to recruit and retain nurses.³⁸ We think such incentives should go a step further. Of course the threat of changes to pay in the UK public sector is always a sensitive issue. The spectre of a two-tier health system, with one hospital poaching another's staff is frequently raised; indeed, the same arguments have been rehearsed in Spain and Sweden. While it is not possible to guarantee that some hospitals will not lose valued staff to competitors, the benefits of local pay setting will surely outweigh the disbenefits.³⁹

The free market for labour is further constrained by training quotas. We think the government should abolish all medical training quotas.

Regulation and accountability

The extent and origin (national, or regional) of regulation has a direct impact on an organisation's freedom to make decisions according to local need and adjust provision accordingly. With NHS Trusts potentially subject to monitoring by 40 bodies,⁴⁰ the level of centralised monitoring is currently too high and looks set to increase as hospitals earn further autonomy. This pattern of

simultaneous centralisation (of targets and inspection) and decentralisation (of day-to-day management) is not peculiar to the UK, but current debate on hospital reform does provide a very clear example.

We are not arguing against regulation *per se*, but consider that most of the benefits of greater independence will be negated by regulation. Regulators should be accountable to the Health Minister and to Parliament. Ruth Lea has argued that the NHS could fulfil this role – being both the regulator and funder – but not the provider of health care.⁴¹

Accountability to patients: Community trusts must primarily be accountable to the local community. Ideally local residents would have both an exit mechanism, that is access to another acute hospital providing the same services, and a voice mechanism - a clear and user friendly complaints procedure.

Local social service funding and provision.

The major problem of acute hospital bed blocking by the elderly, which has knock-on effects throughout the health service, is a problem of coordination between local health services and local social services.

Options for Reform of Accident and Emergency

If all acute care hospitals were de-politicised, what would happen to the accident and emergency services – those services that fall most clearly into the category of public goods? Many people accept that it is a legitimate function of government to ensure that there is an accident and emergency service throughout the country, but the government does not need to own or run hospitals to do so. Nor does it need to pay for accident and emergency services from taxation – insurance policies can provide cover as they do elsewhere.⁴² However, there may be a role for the government in providing investment in the infrastructure in less densely populated areas.

Options for Reform of Primary Care

In an attempt to control healthcare expenditure, European countries have seen a shift from hospital-based care to primary care over the past two decades.⁴³ In most countries GPs work either single-handed or in small groups. In Switzerland, they have also established physician-led health maintenance organisations.⁴⁴ They are paid on a fee-for-service basis, by capitation or a combination of the two. They may function solely as generalists or offer additional specialist services. Some offer diagnostic services and minor treatment; others do not. GPs may or may not act as gatekeepers to specialist and hospital services. GPs may be free to set up and practice wherever they wish; alternatively they may be subject to a variety of restrictions. It is very difficult to point to the ideal model and, perhaps, the best policy would be to have no policy at all, so that general practice can evolve as events unfold.

The government has already started to introduce some flexibility into primary services; a GP flexible working contracts scheme ‘PMS pilots’ is a key element in the modernisation programme of the NHS, improving patient access to the NHS by opening up new, more flexible ways of offering primary care services.⁴⁵ The success of PMS has been demonstrated by its rapid expansion.⁴⁶ Over 30% of GPs are now working under the new contract, whereas when the NHS

Plan was published in July 2000, only four per cent of GPs were working to PMS agreements. John Hutton has now said that "This expansion is good news for patients and the profession," and that "PMS is here to stay."⁴⁷

The New GP Contract: further flexibility.

A radical new contract negotiated between the BMA's General Practitioners Committee, the NHS Confederation and the four UK health departments was published in February 2003. Aiming to improve the quality of primary care provided by the UK's 42,000 GPs, it has been hailed as the boldest such proposal on this scale ever attempted anywhere in the world.⁴⁸ 'The proposal [on which members of the BMA will be balloted⁴⁹] spells out 76 quality indicators in 10 clinical domains of care, 56 in organisational areas, four assessing patients' experience, and a number of indicators for additional services. The proposal furthermore sets targets for performance that will be accompanied by increased payments to providers.' Spending on general practice will rise by 33% from £6.1 billion per year to £8 billion by April 2006.⁵⁰ The contract's key points are as follows:⁵¹

Benefits for patients

- "33% increase in resources for general practice over the next three years from April 2003
- Fairer resource allocation, based on the needs of patients
- New contract is designed to encourage good quality care
- GPs will have extra money to expand their services
- Extra investment in information technology will improve care and record keeping
- Better surgery premises
- No services will be cut, although they may be offered by different practices or other providers within a locality
- Greater flexibility should improve recruitment and help fill vacancies
- The practice-based contract means patients register with a practice but can still express their choice of GP."

Benefits for GPs

- "33% increase in resources for general practice over the next three years 2003 –2005
- Fairer resource allocation
- Increased investment in practice infrastructure
- GPs' own incomes may rise substantially
- All NHS work will be pensionable
- A practice-based contract where money follows the patient and practices have the power to decide their staffing mix
- Extra rewards for improved quality on a points system
- Extra resources available for offering extra services
- Controls over workload
- The right to opt out of 24 hour responsibility
- Improved seniority payments for all GPs
- Salaried option available"

We welcome extra investment in general medical services, and the practice-based nature of the contract, but are wary of the effects of tying extra resources to extra regulation through quality indicators and performance targets.

Ownership and Control

There is a serious risk that the new regime will diminish the capacity of GPs to serve as the champion of their patients within the NHS. They will face increased pressure to comply with central directions, whereas their patients will continue to have very limited means of making their wishes felt. Unless patients can inflict economic pain on their doctors, the service will continue to be unresponsive and inferior to continental Europe.

Primary care trusts could be mutualised. Many, including Mayo and Lea recommend that Foundation, or community trust status, subject to governance by a board of multiple stakeholders, should also apply to Primary Care Trusts.⁵² This would enable PCTs to be more accountable to the local community. Although NHS Trust hospitals tend to have a higher profile in a community, the very nature of primary care, being lower-tech and usually involving longer-term relationships, is in many respects better suited to active and meaningful patient involvement.⁵³

GLOSSARY

Foundation Trusts⁵⁴ It is intended that NHS Foundation Trusts will have the following freedoms:

- Freedom from Whitehall and Secretary of State powers of direction, enabling those who deliver care to develop services in ways that suit patient needs best.
- Freedom to develop ways of working that reflect local needs and priorities.
- Freedom to recruit and employ their own staff.
- Freedom to innovate in asset use, retaining surpluses to invest in developing new services.
- Freedom to access capital funding - to borrow.

Mutual⁵⁵ (Mutuals, mutuality, mutualised). There is no exclusive definition of mutuality. Put simply, mutuality is an institutionalised, value-based model of reciprocity. But a mutual is not a single legal form.

- A mutual is an enterprise owned by its members, which provides a variety of services to its members for their benefit.
- The word ‘Mutuality’ may refer to mutual models of ownership or decision-making, mutual methods of doing business or simply a mutual ethos.
- Historian Bob James describes mutuality as “ a contractual arrangement, which may be unspoken, between a group of people, as few as two, wherein it is understood that no member of the group stands in a superior position to any other in terms of voting power, ownership rights or accrued benefits.”⁵⁶
- Examples of mutual include agricultural co-operatives, building societies, banking mutuals and credit unions, communications co-operatives and co-operative Internet service providers, consumer co-operatives, energy co-operatives, fishing co-operatives, health provision and insurance mutuals, housing co-operatives, mutual insurers, tourism, and worker co-operatives.⁵⁷

PIC Public Interest Company. Developed by the Public Management Foundation, PICs have the following nine characteristics (from Brecher, C (2001)):

- *They are organizations for specific public benefit.* The goal of the organization is to benefit the broad public rather than individual shareholders, and the nature of the intended benefits is clearly specified.
- *The benefit is guaranteed over time.* The goal and assets are ‘locked’; the organization cannot change its goal or transfer its assets to any other parties.

- *They are trading organizations.* Income and resources are earned by trading for the delivery of services.
- *PICs are cost-efficient.* The organization is subject to incentives for efficiency.
- *PICs are entrepreneurial.* The organization is capable of and has incentives to develop new ways of accomplishing its goals and delivering its services.
- They are secure not-for-profit organizations. Surpluses must be re-invested, and no distribution of profit is made to people outside the organization.
- *They can raise capital from the money markets.* The source of capital would be public borrowings in the bond market, not equity issues.
- *PICs are accountable.* Accountability is to multiple stakeholders including staff, clients, bond-holders and the general public.
- *They are independent of direct political control.* The governing body is not made up exclusively or primarily of elected officials or their appointees.⁵⁸

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Notes

¹ Mayo, E., Lea, R., 2002. [p20-22]

² In addition, there are five 'Care Trusts', two of which are based on Mental Health Trusts, and three of which are based on PCTs (source – NatPaCT – the National Primary and Care Trust Development Programme, November 2002).

³ Department of Health, 'Power and resources shift to NHS Frontline', *Press Release: reference 2002/0520*, Department of Health, 11 December 2002.

⁴ On July 1 2002, almost 2000 heart patients who had been waiting six months for an operation became eligible to choose to be treated elsewhere in the NHS or in the private sector. As part of a pilot, the same choice has been extended to Londoners waiting more than six months for cataract surgery. By early 2003 Londoners waiting for orthopaedic operations, ear, nose and throat treatment, general surgery and other specialities were able to exercise similar choice. On 3 October 2002, Alan Milburn said that if these pilots are successful, choice will be extended to other parts of the country." In a speech on 23 January 2003, the Prime Minister confirmed Alan Milburn's statement saying 'I can announce today that from this summer, we will extend this scheme to cover almost all elective surgery in London. And from summer next year these choices will be offered to all elective surgery patients nationwide.'" Note, patients will continue to have very limited choice of GP.

⁵ See Department of Health, *A Guide to NHS Foundation Trusts*, Department of Health, 2002.

⁶ Mayo, E., Lea, R., 2002. [p20-22]

⁷ Each existing NHS Trust may be accountable to 40 different bodies (Mayo, E., Lea, R., *The Mutual Health Service*, NEF, 2002. [p4-5])

⁸ Mayo, E., Lea, R., 2002. [p20-22]

⁹ The creation of such a mechanism would keep options open.

¹⁰ Mayo, E., Lea, R., *The Mutual Health Service*, NEF, 2002. [p14]

¹¹ Mayo, E., Lea, R., 2002. [p18]

¹² Civitas research.

¹³ Mayo, E., Lea, R., 2002. [p18-19]

¹⁴ Mayo, E., Lea, R., 2002. [p18-19]

¹⁵ Mayo, E., Lea, R., 2002. [p18-19]

¹⁶ Mayo and Lea argue that Foundation Trusts should go beyond autonomous non-profit agency status and become full, self-governing mutuals, operating in a co-operative network of healthcare and related public services. According to Mayo and Lea (p8-9), 'the idea that social enterprises might run public services – either as employee mutuals or stakeholder mutuals – goes back to 1979, when social services in Ealing Borough Council were deciding how to organize transport for clients.'

¹⁷ Politicians and expert commentators from a wide range of political perspectives have argued the case for increased mutuality in health care. There is an unusual consensus on the solution. For example: Ruth Lea (Institute of Directors), Ed Mayo (New Economics Foundation), Chris Ham (of the Strategy Unit, Department of Health), Tony Blair, Anthony Giddens (in Giddens, A., *Where Now for New Labour*, Fabian Society, 2002), The Independent Healthcare Association, the Adam Smith Institute, the Public Management Foundation (see note 18), the Public Services Commission of the Liberal Democrats, and Liam Fox MP.

¹⁸ Charities are run by trustees who can not benefit financially from the work of the charity. All assets must be used exclusively for charitable purposes and if the objects of the charity change, or it is wound up, then all such assets must be used for a similar 'public' purpose. All changes require the permission of the Charity Commission. Unlike mutual organisations, there is no possibility of privatising the assets.

¹⁹ Busse, van der Grinten and Svensson (2002, pp.132-4), report on the increasing trend in contracting out the management of public hospitals to private companies. "For example, the Sana Kliniken-Gesellschaft (owned by 33 private health insurance companies) manages 25 small to large-size hospitals, among them two large teaching hospitals in Stuttgart."

²⁰ Spain has recently seen a considerable variety of new forms of hospital autonomy, as various regions have created different versions (derived from Busse R., *et al*, 2002 (p130-1) unless otherwise indicated).

- In 1990, Catalonia was the first region to formalise a purchaser-provider split and invented 'consortia' as a legal form, both allowing minority private participation as well as contracting out management or other functions to the private sector. Consortia are governed by a mixture of public and private law, the best-known example being the Consortium of the Hospitals of Barcelona.
- Andalucia established the status of an 'entity of public law' for the new Costa de Sol Hospital (near Marbella) in 1992. The hospital is governed by private law but is owned by the regional government.
- Galicia was the first to give its new Hospital Verin the status of a 'foundation', while others invented 'mercantile societies' in which the regional government is the shareholder.

- The Basque Country transformed its whole regional health service into a 'public entity under private law'; that is, individual hospitals form only part of the corporatised unit.
- The central government, which still controls health services in ten regions through INSALUD, followed the Galician example and transformed two new hospitals into 'foundations'. Owing to labour contracts, however, the transformation of existing hospitals proved to be difficult.
- Late in 1998, a new variant – 'public health care foundation' – was therefore created to enable the transfer of personnel (from Busse R., *et al*, 2002 (p130-1)).
- In 1997, the Law 15/1997 on new forms of management of the health service paved the way to offer a wider scope for the private participation in the public health system. This law became effective on January 14th 2000 with a Royal Decree (29/2000) on new forms of management in the National Health Institute. It creates four legal instances: Foundation, Public Administered Society, Consortia, and Public Health Foundation. These legal offices will in particular, allow new forms of management of personnel and economic resources (CIREM Foundation, Barcelona: "Consolidation and modernisation of the National Health System". Third reform report for the International Reform Monitor, July 2000. Online-publication. URL: [*http://www.reformmonitor.org/index.php3?mode=reform*](http://www.reformmonitor.org/index.php3?mode=reform), Spain, Health Care).
- The introduction of flexible organisational forms in hospitals (public foundations) was included within the 1999 Budgetary law, and further reinforced through a royal decree passed in January 2001, but was paralysed following a series of demonstrations against – as it was perceived as a first step towards the privatisation of hospitals (European Observatory on Health Care Systems, *Living HiT for Spain*, http://www.who.dk/observatory/Hits/20020525_4 (Exactly the same arguments are put by certain British Trades unions and former Health Minister Frank Dobson). Spanish left-wing parties are critical of new management forms, thinking for example, that public foundations can escape from public control (Bertelsmann Stiftung, *International Reform Monitor*, Social Policy, Labour Market policy and Industrial Relations, 2002).

²¹ Alan Milburn and Liam Fox, have both voiced real interest in Spanish style foundation hospitals. After visiting Spain and holding meetings with experts from Denmark, Sweden and Spain, where foundation hospitals already exist, the Minister for Health Alan Milburn laid out his plans for Foundation Hospitals in speeches on 22nd May and 5 June 2002. He is thought to have been impressed by his visit to Alcorcon, a foundation-style hospital in Madrid that is owned by the state but run by private management. He believes that independence from central control has allowed it to cut waiting times and improve patient outcomes despite dealing with a more severe case mix than comparable state run hospitals (The Source).

²² Corrigan, P., Steele, J., Parston, G., *'The Case for the Public Interest Company: a new form of enterprise for public service delivery'*, Public Management Foundation discussion paper, 2001. Also see the follow-up publication which suggests reorganisation of London Underground and NHS trusts; Brecher, C., *The Public Interest Company as a Mechanism to Improve Service Delivery*, Public Management Foundation, London, 2002.

²³ Brecher, C., *The Public Interest Company as a Mechanism to Improve Service Delivery*, Public Management Foundation, London, 2002

²⁴ From a speech on 5 June 2002, by Rt. Hon. Alan Milburn MP, published in The Source <http://www.sourceuk.net/portfolio/>).

²⁵ See Department of Health, *A Guide to NHS Foundation Trusts*, Department of Health, 2002.

Alan Milburn intends to establish NHS Foundation Trusts (NHSFTs) as free-standing legal entities which free from direction by the Secretary of State – but unlike Alcorcon, in the UK – after much protest, they will be publicly, not privately managed. Having explored a number of options about how best to establish NHS Foundation Trusts in law, it has been decided that the concept of the **Public Interest Company** (PIC), a direct descendent of the US public service structure the **Public Benefit Corporation** (PBC), will be used. Organisations as diverse as the Co-operative Movement and the Institute of Directors have made the case for such organisations on the basis that they have a clear public service ethos and are not for profit. PICs are based firmly within the public service with their assets remaining within public ownership and being protected against takeover by the private sector. They are toughly regulated but not externally controlled. They open up more potential for both staff and public involvement' (From a speech on 5 June 2002, by Rt. Hon. Alan Milburn MP, published in The Source <http://www.sourceuk.net/portfolio/>).

Like other examples in Spain, Denmark and Sweden, NHSFTs will be able to use the flexibilities of the new pay system that is currently being negotiated to modernise the workforce including developing additional rewards for those staff who are contributing most. Exercising these freedoms will give NHS Foundation Trusts precisely the sort of autonomy that is commonplace for hospitals elsewhere in Europe.

The Treasury had initially opposed plans which would have allowed the hospitals - which will remain within the NHS but will be independently run - to borrow money on the open-market. Gordon Brown was concerned that "off balance sheet" borrowing would leave public debts spiralling out of his control.

After a meeting on 9 October 2002, a Downing Street spokesman said: "The Government is moving ahead with these plans to devolve greater power and resources to the NHS." The move was said to give communities more say over how their local health services were delivered (10 Downing Street Press Release, October 9, 2002.

<http://www.pm.gov.uk/output/page6252.asp> Also see <http://www.labour.org.uk/foundationhospitals>). Depending on the speed of legislation, the first hospitals are expected to open in April 2004.

The news comes after an agreement was reached between the Treasury and the Department of Health over what borrowing powers the new wave of semi-autonomous hospitals should have; The Chancellor has set a rule of borrowing only to invest and he argued that giving freedom to foundation hospitals risked upsetting the balance of public finances.

The differences between Foundation Trusts (FTs) and existing NHS Trusts have been the subject of much recent discussion. FTs will have: greater freedom over human resources; management freedoms; enhanced private finance rights, ability to keep the receipts from land sales; reduced central regulation and monitoring. Alan Milburn has announced that they will also have / give: a clear public service ethos and not-for-profit basis; greater control to patients and services users and opening up options for greater accountability to local communities; more active involvement and control for staff and management; freedom from 'top-down' management from Whitehall; and finally, immunity to take-over from organisations which will not provide such benefits (speech by Alan Milburn, 2002).

Critics raise three arguments against such reforms: It is tantamount to privatisation / is privatisation by stealth; that it is a return to pre 1945 health care; that it will lead to variation in standards, between . This is the "two-tier" argument. These points of view are not peculiar to the UK, but rather have been rehearsed in Spain, Sweden and Denmark. The *Financial Times* published a survey of half the 2002 Three Star NHS hospitals. Most of those surveyed intended to apply for foundation status (Timmins, N., 'NHS Trusts keen to form foundation hospitals', *The Financial Times*, 9 November 2002).

²⁶ Cornforth, C., *The governance of public and non-profit organisations: What do boards do?*, Routledge, 2002.

²⁷ Cornforth, C., *The governance of public and non-profit organisations: What do boards do?*, Routledge, 2002.

²⁸ Mayo, E., Lea, R., 2002. [p1]

²⁹ Mayo, E., Lea, R., 2002. [p24]

³⁰ This is taken from a summary of a meeting on Foundation Hospitals is reproduced from the Department of Health's website: <http://www.doh.gov.uk/conferences/foundtrustsmay02lxeccs4.htm>

³¹ Chris Huhne MEP, 2002.

³² Here is the text of a note by Chris Huhne MEP on borrowing powers and liquidation of Public Benefit Organisations (PBO) (from Liberal Democrats, 'Brown Victory On Foundation Hospitals – Taylor' Liberal Democrats, Press Release, 09/10/2002):

"The Treasury is concerned that PBOs that fail will nevertheless have to have their debt paid by the government, since they will often provide an essential public service that cannot be allowed to stop (eg Foundation Hospital, Railtrack). This in turn may encourage excessive borrowing and investment ('moral hazard'). The Treasury argues that it is an illusion to imagine that these are free-standing businesses able to borrow off the Government's balance sheet."

Responses :

"Many companies are heavily reliant on government without it being assumed that the Government will take on their liabilities (for example, BAE systems, many small medical suppliers and several building contractors). Moreover, the Government has offered substantial guarantees (eg high speed rail link) without booking them as liabilities on the grounds that the contingency of the guarantee being called is too slim. The difference arguably arises where a service is essential and must continue even if the PBO fails (eg a district hospital, Railtrack). But this again is little different to an administration of a going concern in the private sector.

"The only difference might occur if the PBO had offered assets - such as a hospital scanner - as particular collateral on a securitised borrowing, but this should be forbidden unless they are inessential. It would have to be made clear as a condition of the PBO's borrowing that all the assets essential to the performance of its contractual role in providing services to a public sector commissioner could not be taken as individual security. They would be treated as a collective pool, and would be sold only to another PBO at the book cost minus normal depreciation. Fully depreciated assets within the pool would be independently valued. The PBOs would still be able to borrow from the private capital markets since they would be able to show a reasonable cash flow over time.

"Free cash flow is the most important element of creditworthiness given that liquidation occurs only in extreme circumstances, and two of the three rating agencies stress timeliness of payment in their rating criteria rather than allowing any explicit element for break-up value. Moreover, the PBO's assets would return cash to lenders in the event of a liquidation, albeit with a delay and possibly at a lower total value than would be the case if they could be sold separately.

“A PBO taking over the assets from another failed PBO would be able to borrow from the market to do so, and would be paying less than the borrowings of the failed PBO. This is because the sale price of the assets would be likely to be lower than the price at which they were bought. In normal circumstances, no government finance would be required in this failure. If the other PBO were not able to borrow from the market (because the revenue flows were not adequate for example), then the Government might in extremis have to supply bridging finance.

“It is possible that the Government could arrange insurance against this contingency. However, this is highly unlikely to occur. First, managers do not want to fail because of their personal reputations: this is what stops them undertaking imprudent investment and borrowing. Secondly, another PBO with recourse to the capital markets could step in the event of failure.

³³ Chris Huhne, M.E.P., 2002.

³⁴ Civitas research. At a meeting in London Luis Carretero (chief executive of the Son Dureta Hospital, Palma de Mallorca, Spain - a publicly owned 'foundation' hospital which has some financial freedoms and is run with the co-operation of private companies), explained that the autonomous system offers flexibility and management based on results, giving the hospital the ability to: Recruit personnel based on hospital needs; and to set salaries levels and other conditions for staff. For further details see the Department of Health's website:

<http://www.doh.gov.uk/conferences/foundtrustsmay02lxecs3.htm>

³⁵ One such artificial restriction is the tendency for and belief that all pay should rise.

³⁶ From a summary of a speech on Foundation Trusts, October 22, 2001, by Josef Bonet,

<http://www.doh.gov.uk/conferences/foundtrustsmay02lxecs2.htm>). Josef Bonet was the director general of INSALUD, based in Malaga, Spain, where he had responsibility for publicly owned, not-for-profit 'foundation' hospitals across Spain at: Hospital Alcorcón (Madrid), Hospital Manacor (Mallorca), Hospital Calahorra (La Rioja), Hospital Son Llatzer (Mallorca). Bonet explained these hospitals have the freedom to establish their own recruitment strategies and buy in the latest technologies.

³⁷ The Danderyd 'foundation' hospital in Stockholm is a publicly owned corporation which operates on a not-for-profit basis, it has full responsibility for pay levels and staff contracts.

³⁸ Source: private information from hospital specialists.

³⁹ Rebutting the suggestion (supported by 111 Labour MPs who signed a motion voicing their opposition), that FTs would lead to a two-tier service, in a Commons debate on 4 March 2003, Alan Milburn said he expects all hospitals to become FTs in the next four to five years. The NHS Confederation, now in favour of FTs, accepts that they will spread out to all other hospitals in time. However, potential leader of the T&G union, Jack Dromey warned that this was thin end of the wedge: “Foundation Trusts today, charging tomorrow”. David Hinchcliffe MP, chairman of the Health Select Committee has said the government's proposals are “unlikely to survive second reading in the Commons”. Ian Gibson MP, chairman of the Science and Technology Select Committee expressed concerns about the rise of selection in public services and argued that FT status should apply to all hospitals or to none.

The Government has attempted to deal with this issue. Proposals for NHS Foundation Trusts (see *A Guide to NHS Foundation Trusts*, DoH, 2002) allow increased freedom to set pay conditions within the new NHS national pay system. In the *Guide to NHS Foundation Trusts*, the DoH states that ‘NHS Foundation Trusts will have the local flexibility to deal with [...different recruitment and retention problems] in a way that is consistent with the needs of other local NHS organizations.’ Clearly, the interpretation of this phrase is important. How much flexibility will there be?

⁴⁰ Mayo, E., Lea, R., 2002.

⁴¹ Lea, R., *Health Care in the UK: The Need for Reform*. Institute of Directors, Policy Paper, 2001.

⁴² For example, in the US, emergency room treatments are covered by an individual's private health insurance policy. Note that those without insurance are also entitled receive medical care through hospital emergency rooms, partially subsidized by government payments (Arnett, GM, *A Profile of the US Healthcare Sector*, Seminar presentation to Civitas, London, 2001).

⁴³ This trend has had three facets: a cut in the number of hospital beds; a shortening of the length of in-patient stays; and thirdly a de-hospitalisation of certain procedures (Mossialos and Le Grand 1999).

⁴⁴ For details see Etter Jean-Francois, Perneger Thomas.V., Introducing managed care in Switzerland: impact on self-reported use of health services. *Public Health* 1997; 641:417-22.. 1997. Also see Zweifel, Managed Care in Germany and Switzerland: two approaches to a Common Problem. *Pharmacoeconomics*. 1998; 14 Suppl. 1: 1-8

⁴⁵ GPs, as independent, self-employed professionals contract with the NHS to provide general medical services (GMS). Contract terms are negotiated annually between the GMS Committee (the GPs representation within the British Medical Association (BMA) and the Department of Health (DoH). There is a standard contract – called the ‘Red Book’. The payment system is set out in the national contract, and includes a mix of fixed allowances, capitation fees and, health promotion payments and fees for certain specific services – such as contraception. A new GP contract (more flexible to local needs is to be concluded shortly.

Since 1998 an increasing number of GPs have been working to a different type of contract – the Personal Medical Services (PMS) contract – instead of working to a standard national contract. PMS pays a GP on the basis of

meeting set quality standards and the particular needs of their local population. For example if an area had a particularly high level of heart disease the PMS contract could set targets for ensuring that local people at risk were identified and prescribed appropriate treatment. So, there are four types of GP: *GMS Partners* – GPs who work in a General Practice partnership and (was) in a contract with a health authority to provide GMS to a list of patients; *GMS Singlehandlers* – GPs who work in a General Practice with no partners and (was) in a contract with a health authority to provide GMS to a list of patients; *PMS Contracted GPs* – doctors in contract with a HA to provide the full range of services to a list of patients through the Personal Medical Services pilot contract; *PMS Salaried GPs* – doctors employed to work in a Personal Medical Services pilot either by a PMS Contractor or by the PMS Contracted doctor. They provide the full range of services and have a list of registered patients. The 2000 National Plan also expects up to 1000 *specialist GPs* to be practising by 2004.

The NHS (Primary Care) Act 1997 allowed for the introduction of 'PMS pilots'. The term 'personal medical services (PMS)' refers to the same type of services as General Medical Services, but it differentiates the services as being delivered under a pilot scheme. PMS pilot schemes are voluntary and are intended to give Primary Care Trusts, Strategic Health Authorities and providers - particularly GPs, nurses - the flexibility and opportunity to innovate by offering different options for addressing primary care needs. Doctors, nurses and PCTs that become PMS pilots, are able to negotiate directly with their commissioner to provide the services patients want, for example, varying surgery times to meet the needs of the local population, including addressing the needs of particular groups, e.g the homeless (Source Department of Health).

The aims of PMS pilots are to:

- shape the primary and community health care services in their locality in partnership with PCTs, GPs, nurses, patients, Local Authorities and other voluntary organisations;
- address the problems of recruitment and retention of GPs, attracting more GPs to an area by offering GPs the opportunity of salaried employment. This could lead to the provision of a wider range of services which are more readily accessible to patients;
- encourage GPs and nurses to work more closely together, using the best of the skills available
- create more integrated services for patients;
- work to tackle health inequalities and the health problems of deprivation in parts of the country ;and
- give doctors and nurses new flexibility in the way they provide care. (Source Department of Health)

A pilot holds its new contract with the PCT or, where the PCT itself is the PMS pilot, the Strategic Health Authority. Having identified the needs of the practice population healthcare professionals can take advantage of the flexibility of PMS, by negotiating a contract that best serves the needs of the local population, by plugging gaps, and ironing out delivery inadequacies of existing services, and reforming inaccessible or inappropriate provision (Source Department of Health).

⁴⁶ A fifth wave of PMS Pilots was announced on 23 September 2002. The system now covers over 9300 GPs (c 30%) in almost 2500 schemes around the country (*Take up for GP flexible work contracts hits 30 per cent*, 10 Downing Street press release, 4 December 2002.) When the NHS Plan was published in July 2000 (Department of Health, *The NHS Plan, A plan for investment. A plan for reform*, Department of Health, 2000), only four per cent of GPs were working to PMS Agreements.

⁴⁷ From Department of Health website (<http://www.doh.gov.uk/pricare/pca.htm>) accessed on 5 December 2002.

⁴⁸ Paul Shekelle, 'New contract for general practitioners', *BMJ* 2003;326:457-458 (1 March)

⁴⁹ The ballot was originally scheduled for March 2003, but was postponed when many 'practices expressed serious concerns that the introduction of the global sum payments will lead to a reduction in the basic income of a practice and threaten practices' viability' (GPC and NHS Confederation, Joint letter on the minimum practice income guarantee, 17 April 2003).

⁵⁰ BMA, *New GP contract heralds historic new investment for NHS general practice*, Press Release, BMA London, Friday, 21 Feb 2003.

⁵¹ From: BMA, *New GMS Contract: investing in general practice*, BMA, Feb 2003.

⁵² Mayo, E., Lea, R., 2002. [p1]

⁵³ Mayo, E., Lea, R., 2002. [p11]

⁵⁴ Source DoH a Guide to NHS Foundation Trusts, December 2002.

⁵⁵ This definition is from Mayo, E., Lea, R., 2002. [p8]

⁵⁶ James, B., “Mutuality”, presentation to the Australian Friendly Society Association’s annual conference, May 2000, at www.takver.com/history/mutual.htm (accessed on 5 December 2002)

⁵⁷ This definition is from Mayo, E., Lea, R., 2002. [p8]

⁵⁸ From Brecher, C, *The PIC as a mechanism to improve public services delivery*, Public Management Foundation, 2001 (p1-2).