English general practice: once, twice, three times a hybrid

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The English National Health Service (NHS) is traditionally conceptualised and indeed often celebrated as a public entity. This is largely true, as most of its funding (principally from general taxation), most of its service delivery (through NHS foundation trusts and NHS trusts) and all of its governance lies within public sector control. This 'complete publicness' of the NHS is not, however, quite what it seems.[1] This is particularly the case for primary care and general practice services that have sought from the outset to retain a degree of autonomy and hence straddle the public–private sector interface. In this paper, an analysis is made of the degree and nature of hybridity in the English NHS, the risks and opportunities presented by such hybridity, and conclusions drawn about what this means for general medical practice.

Since its establishment in 1948, the NHS has engaged with both private and public sectors in the delivery of healthcare services; for example, allowing its medical specialists to undertake private practice alongside their NHS duties. In recent years, this diversity of supply options has been actively promoted by both Labour and Coalition/Conservative governments through encouraging competition for NHS clinical service contracts in hospital and community health services (eg elective surgery, community health care, musculo-skeletal care pathways), encouraging private, public and third sector suppliers to move into new areas of provision (eg community and adolescent mental health services, out-of-hours general practice), and patients having mandated choice of both public and private providers for certain NHS-funded elective procedures.[2–4]

There have also been attempts to foster greater hybridisation in organisational form. This includes NHS foundation trusts, whose governance incorporates elements of mutualisation, and which have greater financial freedoms to generate income from private sources.[5] Organisational hybridisation has also been encouraged through social enterprise – businesses that seek to not only generate profit but also achieve social impact.[6] These have been promoted in English NHS policy as combining the best of private (efficiency, responsiveness and entrepreneurship) and voluntary (values-driven, community-orientated, employee diversity) organisations.[7]

NHS primary care is part of this mix of traditional and contemporary diversity and hybridisation, in both its form and its service delivery. For example, community pharmacy is largely provided by small independent business practitioners or large corporate companies operating under contracts with the NHS. Dentists are likewise mostly self-employed or salaried by corporate providers, and 10% of community health services (eg community nursing and allied health professionals) have been 'spun-out' into social enterprises. Taking a wider view of primary care provision, long-term care of older people and people with disabilities in England is almost entirely the remit of private and voluntary providers working under contract to local government.

General medical practice is arguably the original NHS hybrid through its combination of public sector funding with private ownership and personal profit. Due to the independent status of general practitioners, politicians have had to rely largely on contractual mechanisms when seeking to influence the direction and development of primary care. Most notably, the general medical services contract introduced in 2004 specifies the core services to be delivered, sets out enhanced service payments to reward additional activities required to meet national health priorities, and has an extensive quality and outcomes performance framework. These seek to ensure consistency and development of standards of care.[8,9] There is also an increasing proportion of general practices that choose to adopt locally agreed Personal Medical Services contractual options.[10]

J PRIM HEALTH CARE
2017;9(3):204–207.
doi:10.1071/HC17039
Published online 12 September 2017

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These local contracts are seen by some as being less bureaucratic and enable more flexible responses to meet the needs of particular population groups.

The negotiation of such national general practice contractual arrangements has often proved tortuous and time-consuming. The relative political power of the medical profession is such that the government has not always secured the service delivery deal that it would have ideally sought for the investment made. For example, British Medical Association negotiators for the general practice contract agreed in 2004 are on record as saying they were 'stunned' at the generous financial deal that they were offered at that time.[11] However, this might also have been the case if general practitioners had been employed directly by the state. Hospital consultants are also strong negotiators who enjoy considerable flexibility in their patterns of work, with opportunities to generate additional personal income.

The national negotiation process for primary care contracts means that general practitioners are largely protected from the challenges that small business owners would typically face with a single dominant purchaser. Combined with the lack of effective competition or a functioning market for general practice as such – and the common problem being too great rather than too little demand for GPs' service – hybridisation gives English general practitioners an enviable position as business people. That is not to detract from the many demands of running such an enterprise – especially in a time of significant constraints to public finances – and combining the roles of clinician and owner, but it does highlight that some challenges of hybridity are perhaps less than might be expected.

Alongside these *role* (business–clinical) and *organisational* (private–public) aspects of hybridity, there has been sustained policy interest for over 25 years in English general practitioners being both purchasers and providers of services.[12,13] In many industries and other aspects of the English public sector, being responsible for a 'make or buy' scenario is common. For example, local authorities in England still provide elements of social care while purchasing the majority of services from the independent or third sector. In the English NHS, however, the functional and indeed organisational separation of those *who fund* and those *who deliver* clinical services has been seen as a key enabler of developing a more market-based system of governance.

General practitioner purchasers were the exception to this rule regarding the separation of purchaser and provider. Successive policies have instead encouraged, and indeed currently mandate general practitioners to be involved in the purchasing (or in English terminology, commissioning) function. The rationale for this included: general practitioners were deemed to have unique insights into the health needs of their registered population; they brought clinical credibility to the wider planning and funding system; and are familiar with financial incentives through their own experience of working within contractual arrangements. Furthermore, as key referrers to acute and other care, and being potential providers of enhanced primary care, their commitment to such reform was seen as crucial. Put bluntly, they were seen as both enablers and barriers to be managed as part of a wider concern to increase the influence and scope of primary care.

Such *functional* hybridity was built on the clinical and small business expertise of general practice, but it also required additional competences. These included working as part of a larger network or organisation, contributing to and accounting for population-level strategic decisions, and using leadership skills to exert influence across wider health and care systems. Despite significant enthusiasm for primary care-led commissioning over many years, and evidence of change being made to community and primary care services in particular,[13] the engagement from general practitioners in commissioning appears to have declined over time, possibly as a result of the function becoming compulsory and less GP-owned.[14,15] This could also perhaps be attributed to the realities of running a practice in the face of rising demand and constrained resources, alongside a demanding strategic commissioning role, and with increasing scepticism that the effort will actually result in sufficiently significant change to local services.

General practitioners in England can be considered hybrids in *role, organisation* and *function*. Hybridity has generated both demands and opportunity for these clinicians and required a bespoke approach to their funding and governance by central government. Determining if this hybridity has been worth the effort is a challenging undertaking. Patient satisfaction with general practice has historically been high and largely remains so, although there is a growing frustration regarding ease of access.[9,16,17] English general practice also performs well when compared internationally on key measures of quality, including care co-ordination.[18,19] However, its public health function remains relatively underdeveloped, and clinically led commissioning is no longer seen as being able to drive through fundamental service change.[20] To what degree these various strengths and weaknesses are related to one or more of the forms of hybridity is uncertain. Wider issues such as the level of government investment, NHS restructuring, lifestyle choices made by a new generation of GPs, and political mood swings may be more crucial in practice.

Changing demographics, increases in the number of people with complex and multiple conditions, and the need to divert activity from acute settings are now questioning the small-scale general practice model.[21] There is therefore interest in 'primary care at scale' in which practices come together through federated networks or mergers in order to increase their capacity to provide a greater depth and breadth of services.[22] This requires a new set of management skills as general practitioners negotiate how they want to work with other practices, consider the additional business risks or opportunities that are available to them, and compete or collaborate with other providers for available funding. New contractual forms are also being explored in which groups of providers, including general practice, are allocated capitated budgets to meet the needs of a designated population. Based loosely on Accountable Care Organisation models from the US, Multispeciality Community Provider contracts will require partnerships of organisations under the direction of lead-providers or contractors.[23] In relation to hybridity, such developments emphasise the business aspects of general practice, although they will potentially also increase the opportunities for salaried positions. This has been a growing trend and removes such employed clinicians from their *role* and *functional* hybridity.[16]

General practice hybridity in terms of role and organisation were designed into the NHS from the outset. Hybridity has its boundaries, however, and it is striking that most of general practice in England is still owned by general practitioners rather than by or with other professionals. Community governance models are rarely evident despite this being common in other comparable systems including in New Zealand. There are examples of general practice organisations diversifying into other income streams, but on the whole, the scope of their businesses remains limited. There is, therefore a case to be made for further forms of hybridity to facilitate greater engagement with communities, diversity of professional influence, social entrepreneurship, and deployment of technological innovation. General practice is a highly recognised and trusted service. Perhaps now is the time to consider how greater hybridity can enable more imaginative design and partnerships, which can liberate the further potential that it contains and which people and their communities so pressingly need.

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COMPETING INTERESTS
Author declares that there is no conflicts of interest.