

# Patient Choice and Primary Care

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## **Abstract**

Primary care plays a strategic role in the British National Health Service. It has been a target for health care reforms in recent years: the concept of general practitioner (GP) fundholding was introduced in 1991 as part of the 'purchaser-provider split' required for the operation of the 'internal market', only to be abolished in 1999 with the reorganisation of practices in Primary Care Groups (PCGs). Patient choice is the key to patient empowerment in the health care arena. This paper argues that recent reforms at the primary care level have reduced patient choice, and that this may impact on quality of care.

JEL classification: *I1*

Key Words: primary care, patient choice, NHS reform.

## **Introduction**

Primary care plays a strategic role in the British National Health Service (NHS). Since patients seeking care are required (except in emergencies) to call initially on the general practitioner (GP) with whom they are registered, over 90% of health care episodes begin in the primary sector, and some 90% of these are contained therein. Although primary care accounts for about 25% of the NHS resources, GPs are ‘gatekeepers’ to the more expensive hospital sector that absorbs the vast majority of the rest of NHS expenditure.

The importance of the primary sector has made it a target for health care reforms in recent years. Most notable was the concept of “GP fundholding” which was introduced in 1991 as part of the “purchaser-provider split” required for the operation of the “internal market”. This allowed eligible and willing groups of GPs to control a proportion of their own budgets. The twin objectives were to raise cost-consciousness amongst GPs by making them responsible for some of their prescribing and referral costs, and to make them more aware of, and responsive to, patient demands.<sup>1</sup> Over a period of seven annual waves of fundholding, about 55% of practices opted to become fundholding, thereby controlling over 20% of primary care expenditure.

Fundholding has proved to be a controversial reform. Evidence suggests that it resulted in some savings in prescribing and referral costs, and also that competition between hospitals for GP contracts had a positive effect on the quality of secondary services. Additionally, fundholders may have invested more heavily in their

practices, although there is no evidence about how patient outcomes have been affected, and there is widespread agreement that fundholding has greatly inflated managerial costs.<sup>2</sup> Furthermore, a 'two-tier' primary care structure emerged, in which patients of fundholders obtained secondary care quicker than these of non fundholding GPs.<sup>3</sup>

With these concerns in mind, the Labour Party committed itself to replacing the internal market if it came to power, and on gaining office in 1997 announced an organisational restructuring of primary care, effective April 1999, in which all general practices would be required to come together in geographically defined groups of some 50 practitioners (about 100,000 people) beneath the administrative structure of a Primary Care Group (PCG).<sup>4</sup> Interestingly, these proposals do not seek to remove budgetary autonomy from GPs; in fact, a significant further delegation of financial decision making is envisaged. Most primary care expenditure within a PCG's locality will, in stages, be transferred from the relevant Health Authority to the PCG in the form of a 'unified budget'.<sup>5</sup> Although constituent practices will retain their individual identities, a number of key strategic decisions, from IT to health care purchasing, will take place at the 'supra-practice', PCG level. At the time of writing (April 1999), it is not clear exactly how much budgetary and administrative centralisation will take place within PCGs, and this may vary between groups. These changes may reduce competition on the purchasing side, but they do not signal an end to the internal market.

Such reform raises a number of interesting questions. In this paper, we are interested in just one: the potential impact of PCGs on patient choice. In broad terms, patient choice is a key to patient empowerment in the health care arena. In this regard, a typical focus is on the extent of patient discretion in decisions about the treatment they receive, and empowering patients for this task by making information available about health care alternatives.<sup>6</sup> Our own orientation is different: we are interested in patient choice of the GP they consult, and by inference, of the practice and PCG to which they belong.

In contrast to some health care delivery systems in the developed world, the institutional arrangements in the British NHS restrict individual choice of practitioners at all levels. For reasons of cost containment, patients cannot ‘doctor shop’ and must normally seek care through the GP on whose ‘list’ they are registered. The Patient’s Charter states that patients have the right to change the GP with whom they are registered quickly and easily,<sup>7</sup> (and the 1991 reforms purported to reduce the transactions costs for patients in this process), but in reality it may be difficult for patients to register with the GP of their choice due to supply-side and informational constraints. In addition, GPs have the right to refuse new patients and are known to sometimes remove unwanted patients from their lists for unjustifiable reasons.<sup>8</sup> Patients have no right to a second opinion at the primary care level.

The basic NHS objective of equality of access and uniformity of standards means that no choice of health care plan is available to British residents. Private practice is very limited at the primary care level. It is offered on a fee-for-service basis because available insurance schemes use GPs as ‘gatekeepers’ to specialist services

in much the same way as the NHS does.<sup>9</sup> Since extra contractual referrals were not easy to obtain, fundholding limited, in most instances, the range of secondary care available to NHS patients. Whilst it is generally accepted that patients rarely get choice or continuity of practitioner within a secondary care team, fundholding created an additional problem for some patients whose programme of care was disrupted or delayed when their GPs changed their contracting arrangements.<sup>10</sup> Although the internal market moved the balance of power from hospital specialists to primary care, there is limited evidence that GPs consult their patients when negotiating secondary care contracts on their behalf.<sup>11</sup> Although the NHS became purchaser driven, patients had little power to regulate the activities of GPs.

Whilst the fundholding scheme theoretically gave patients a choice of registering with a fundholding or a non-fundholding practice, this option is removed by the introduction of PCGs. Being monopoly providers of primary care in their catchment areas, and purchasers of secondary care in a highly concentrated market, it is uncertain at this early stage how much choice of secondary care patients will experience. To accommodate the patient perspective a variety of political and administrative measures have been advanced recently by the government, which provide for patient participation at various levels.<sup>12</sup> Community Health Councils have acted as a watchdog for patient interests since 1977, and the Patient's Charter sets out the rights and basic standards that patients may expect from their health service. The extent to which such mechanisms affect decision making about service delivery and substitute for the individual choice is debatable.<sup>13</sup> It has been argued that they are largely symbolic gestures.<sup>14</sup>

This paper is organised as follows. The next section addresses the question, ‘Does choice of GP matter?’ This is followed in Section 3 by a review of available evidence on the extent to which patients currently exercise choice at the primary care level. A final section concludes by discussing the potential effect that the introduction of PCGs will have on patient choice. Reference is made to international experiences with respect to patient choice of primary care: we argue that, although this issue has received little attention in the UK context, patient choice of health care provider (as well as health care plan), is a prominent feature of health care systems in other countries, and that patient choice is not necessarily incompatible with a national health service.

## 1. The importance of patient choice

GPs play a crucial role in mediating imperfections in the market for health care. The nature of health and illness is such that prospective patients will not always know the causes of their problem, what types of treatment they need, and how best to access it. This information deficit means that their demand for health care will be poorly defined, that the signalling role that markets are generally expected to fulfil will malfunction, and that resource allocation may be inefficient. In such circumstances, patients (who can be thought of as ‘principals’) approach GPs to be *their* agents in the market for health care. By filling the information gap, and in the absence of externalities, GPs enhance efficiency by effectively representing patient preferences.

While this model has a lot to commend it, it should not be taken (naively) to imply that patients are ill-informed, passive ‘consumers’ of health care, who are unable to make any input into the care they receive. Instead, it should be realised that patients have valuable knowledge about their symptoms and circumstances, and preferences about the treatment they receive, that need to be given full recognition in the management decision. They may also have a desire to learn more about their condition and its treatment, which if fulfilled may contribute to self-care and recovery. Generally, however, we do not yet know how much information people want to have, or to what extent they prefer to leave treatment decisions to their doctor.<sup>15</sup> With third party payers, the doctor’s role is further complicated by the need to reconcile patient preferences with payer-imposed resource constraints and their own professional standards.

With the principal-agent relationships at the core of health care delivery, patient choice of agent assumes great significance. Indeed, evidence shows that the nature and quality of the doctor-patient relationship impacts not only on the satisfaction ratings of both parties, but also on patients' self-care and health outcomes.<sup>16</sup> Mediating factors are information exchange, and the 'chemistry' of the interaction. Since individuals respond differently to different consultation styles, limitations on the ability of patients to choose and to change their doctors could reduce the therapeutic value of consultations.

Effective patient choice enhances patient power and creates greater equity in the exchange relationship. Furthermore the ability of patients to exit and enter a relationship is an important competitive pressure that provides GPs with incentives to improve customer care and quality of service provision. A crucial implication of these arguments is that, wherever possible, competition for patients between GPs by facilitating patient choice should be encouraged: to accommodate differences in patient preferences for GP practice styles, to capitalise on the associated potential outcome gains, to enable the provision of differing service packages in response to differing customer wishes and needs, and to prevent the inefficiencies associated with monopoly supply.

Unrestrained 'doctor shopping' has never been permitted in the British NHS because it is argued that registration with one GP confers significant benefits: the doctor accumulates over time a knowledge and understanding of the patient's medical and broader socio-economic circumstances and can provide informed and continuous care in a way that 'walk in' transactions never do. Furthermore, there is



concern that NHS costs would escalate. With treatment free at the point of delivery, it is feared that patients would take persisting health problems from doctor to doctor in search of a more effective treatment. This argument, however, ignores the transaction costs and uncertainties of switching doctor, and discounts the possibility that many individuals, realising the benefits of a long-term relationship with their health care practitioner, would responsibly ‘doctor shop’.<sup>17</sup> National insurance experience in New Zealand and Canada bears out this view. New Zealand is a low expenditure health care system without rostering. Although Canadian health care expenditure is relatively high, this is largely attributable to the fee-for-service nature of physician remuneration, rather than to patients’ unrestricted choice of doctor. Recent proposals to introduce rostering of patients and capitation payments in Canada met with concern from several quarters about the impact on quality and outcomes of reducing choice and competition.<sup>18</sup>

In any case the reality of British general practice is such that patients often do not see the GP with whom they are registered, but another partner or a temporary locum instead. In these circumstances the continuity-of-care case for attaching patients to a GP list is weakened. Indeed doctors might feel greater responsibility and commitment toward individual patients, and a stronger doctor-patient relationship might be encouraged, by a system that encouraged patient choice and mobility.

Just as choice between treatment options requires outcomes information, rational choice of who to consult and where to go for primary care requires knowledge of provider attributes. There are many features of primary care that patients can monitor and compare when considering their choice of GP and practice. A recent

Europe-wide survey showed consistently that the most important features of primary care for patients were: the length of consultation, the speed with which appointments could be made, GPs' ability to listen to and discuss problems, GPs' willingness to keep up-to-date and confidentiality. Of relatively low significance was the décor and surroundings of the GPs surgery.<sup>19</sup>

Traditionally, patients have collected information about doctors and practice characteristics by observation and learning from one another through reputation effects.<sup>20</sup> Although the Patient's Charter stipulates that patients have the right to detailed information about local GP services, a recent survey found this was not always easily obtainable.<sup>21</sup> Performance indicators for primary care are being discussed in the NHS and modelled on similar devices in other public services such as education where they are used to name and shame failing institutions. In the competitive US health care market a wide range of ratings ('report cards') are routinely collected and published (including on the internet) to inform consumers' choice of health plan and physician and to provide an indication of standards of service that they might legitimately expect.<sup>22</sup>

## **2. Evidence of patient choice**

The notion of patient choice is difficult to capture empirically.<sup>23</sup> One approach is to look at the concentration of GP practices within a locality, concluding that patients living in areas with more practices have more choice. This measure equates choice with ‘ease of access’, and assumes no capacity constraints. It also misses another important aspect of choice, namely the differentiated nature of the ‘products’, and demand-side perceptions of these alternative bundles of attributes.

Instead of focusing on the services available, we might use voluntary patient mobility between suppliers as a proxy measure of the degree of choice. (This measure excludes people who are forced to change GP because they have relocated to a different area, their GP has de-registered them, or the GP has resigned, retired or died). A more complete picture of the opportunities for choice would be obtained if we had evidence of frustrated mobility: the extent of and reasons for patients being unable to exercise a choice to change.

Evidence of voluntary patient mobility between practices in England suggests that this is in the order of 1-1½% of patients p.a.<sup>24</sup> This contrasts with data from the US that suggests that some of the 4-4½% of enrollees voluntarily change health care plans each year.<sup>25</sup> Although the UK and US studies are not directly comparable because the NHS offers no choice or variation in health plan (benefits packages), the British study did find some systematic factors affecting mobility. (Transfers into practices were associated with fundholding, older average age of GPs, larger groups, and proximity to home). Interestingly, the American study found a strong

positive correlation between the degree of choice of plan and patient satisfaction with health care. Subsequent American evidence showed that the opportunity to select one's personal physician was the single predictor most strongly related to overall satisfaction.<sup>26</sup>

It is difficult to know precisely what these figures say about the extent of patient choice in the NHS. Seemingly few patients change practice though this need not imply that they are content with their current position.<sup>27</sup> Patients will move if the expected benefits exceed the costs. But patients have incomplete information about available alternatives such that their attitudes to risk will also affect whether or not patients decide to move. Although the provision of formal information about the services offered by GPs is set to improve in the near future, there are many important subjective factors in choice of doctor that will never be captured in this way. With GPs unwilling to be interviewed,<sup>28</sup> it is impossible for prospective patients to get ex ante information about important dimensions of the doctor-patient relationship. Risk averse individuals may, therefore, stay with their existing GP, to avoid jumping from the frying pan into the fire.

There are reasons to believe that the costs of moving are not insignificant. Possibly the most important of these are search costs (time, effort and expenditure associated with gathering information from various sources about alternatives), although psychic costs (fear of being labelled troublesome, and concern over continuity of care) should not be discounted.

The overriding factor however, is likely to be supply side availability. With strict local controls on GP/population ratios, many established GPs have reached their maximum list sizes, and for financial and work load reasons are unwilling to accept new patients. Patients selecting a new GP on the basis of carefully gathered information may therefore find the GPs list closed. The patient may be able to join the list of another doctor in the same practice, and may choose to do this if it is practice-specific characteristics rather than doctor-specific characteristics that influenced the choice in the first instance. Without surplus capacity in the system there cannot be free choice and mobility, and the quality incentives of supply side competition are lost.

We have found no direct evidence on the number of would-be movers, although such measures are a potentially important indicator of constraints on patient choice. An imperfect proxy for this is patient complaints: patients turn to voice when exit is barred. Community Health Councils deal with complaints on a daily basis, and estimated nationally that some 5000 were registered against GPs in 1995.<sup>29</sup> This figure could be higher now: medical litigations is rising at some 15% p.a.<sup>30</sup> Even so registered complaints are likely to understate the extent of dissatisfaction experienced by patients. The new NHS complaints procedure introduced in 1996 is unknown to many and will deter others from proceeding. The first stage (local resolution) involves confronting the doctor about the complaint, which many patients may find inhibiting. There is no automatic right to an independent review, which is the second stage of the process. The costly and complex nature of the legal route is prohibitive for most.<sup>31</sup>

There is evidence that patients with minor ailments are relying increasingly on the available 'safety valves' in the system, particularly pharmacists, NHS Direct, A and E departments and walk-in clinics at stations and large stores. Although this trend reflects increased awareness of these facilities, it is also a symptom of the fact that patients are for some reason unable to get the service they want from their GP. Similarly the growth in use of complementary therapists suggests that patients take opportunities to shop for advice outside the NHS where these exist.<sup>32</sup>

### **3. Conclusion: the potential impact of PCGs on choice**

Despite a rhetoric of patient choice in the NHS, the institutional arrangements to date have not facilitated this. In reality patients are restricted in their selection of practitioner, even though health care is a highly personal service, and choice is important for both health outcomes and to encourage quality improvements. Will the new primary care arrangements centred on PCGs alter this situation?

PCGs were introduced for a variety of reasons. In particular the government hopes to establish ‘co-operation, not competition’ and to improve equity by the removal of the ‘two tier’ distinction between fundholders and non fundholders.<sup>33</sup> It also believes that PCGs will make savings on contract administration, allow smaller practices to participate by enhancing risk-spreading, and improve primary care bargaining power when negotiating contracts. In principle, if the savings associated with these are realised, and if they are retained at the PCG level (or, indeed, given to constituent practices), then some of the arguments we make below might be mitigated. Indeed, some authors take the view that PCGs will be beneficial for patients.<sup>34</sup> However, it is an empirical question whether this will happen, and it is not clear whether PCGs, as monopolists with a captured population defined by area of residence, will have appropriate incentives to keep administrative costs down, make effective purchases, introduce quality of care improvements and satisfy patients’ preferences. Furthermore their orientation may be toward population health objectives, rather than the individual patient perspective. Our purpose here is not to make clear predictions, but to comment on the possible effects of PCGs on patient choice.

PCGs will be unlikely to directly influence patient choice of doctor because there appear to be no government proposals to alter the basis of registration for GP lists. Since, as we argued above, current registration rules limit patient mobility, we cannot expect the introduction of PCGs to improve patients' ability to express their preferences.

On top of this, there appear to be no new funds available for relaxing the binding constraints on the number of GPs that create a severe restriction on patient choice. In Sweden, reforms put in place in 1993/4 allowed patients to enrol with private sector doctors for the first time. Sufficient demand existed that the physician/patient ratio increased across a variety of County Councils, with some exhibiting a private sector market share of 30-40% within a year.<sup>35</sup>

Unified budgets may have an important role to play, however, depending on how they are distributed within the PCG. If centrally managed they may create homogeneity within the PCG and restrict the menu of choice available to patients seeking to choose between services offered by GPs. Indeed it has been argued that one of the key factors behind the introduction of unified budgets is a desire to reduce variations between practices.<sup>36</sup> To this end it is possible that restrictions will be placed on practice level contracting in order to remove costs and diversity, so blunting the ability of individual practices to compete for patients via contracts as well as through service delivery. Consequences of this might be a less flexible service for patients who would become more remote from the decisions affecting them and who would have little opportunity to express individual preferences. A logical extension of such a process could be the removal of the separate identity of



individual practices, and eventually the vertical integration of service delivery in each area, which would remove the purchaser – provider divide. The alternative is devolved budgets and practice level incentives: the ability to retain a measure of surplus, for example, would maintain a degree of practice discretion over service provision and contracting. But little guidance on this is available,<sup>37</sup> so we shall have to wait and see how different PCGs evolve.

There are many dimensions to choice. Whilst few would contest the objective of achieving uniformity of best medical practice, we have argued a case for patient choice on how this is delivered and with respect to the process aspects of care. Variety in features such as access hours, auxiliary services and the nature of doctor-patient relations not only accommodate differences in patient preferences but also stimulate quality of care and outcome improvements. The realisation of such benefits might be facilitated if PCGs were comprised of voluntary groupings of like-minded GPs, rather than being geographically determined.

Ultimately PCGs are constrained by the centrally imposed regulations of the NHS. Whilst these continue to reflect political objectives of cost containment and uniformity, real choices for informed consumers between differentiated service providers will not be achieved. Without such choice, however, natural safeguards against poor quality and non-responsiveness to patients are lost, only to be replaced by a battery of regulatory alternatives.<sup>38</sup> It is not surprising, therefore, that patients in the US, Canada, Sweden, France and Germany are strongly resisting policy suggestions that would reduce their choice and autonomy along UK lines.

In summary, regardless of the system, patients are unlikely to be empowered until administrative restrictions, capacity constraints and information deficits are removed and until GPs have appropriate incentives to internalise information about patient preferences. Whatever their other strengths may be, it is not obvious that PCGs deal with the first three of these issues any better than fundholding, and they may worsen the situation with regards the last one.

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- <sup>1</sup> For accounts of the internal market and fundholding see:  
 Glennerster, H, et al. (1994). *Implementing GP Fundholding: Wild Card or Winning Hand?* Open University Press, Buckingham.  
 Ham, C. Editor. (1997). *Management and Competition in the NHS*. Radcliff Medical Press, Abingdon. 2<sup>nd</sup> edition.
- <sup>2</sup> Useful reviews of the impact of fundholding include:  
 Gosden, T and Torgenson, D. (1997). The effect of fundholding on prescribing and referral costs: a review of the evidence. *Health Policy*, 40, 2, 103-114  
 Robinson, R. (1996). The impact of NHS reforms 1991-5: a review of research evidence. *Journal of Public Health Medicine*, 18, 3, 337-343  
 Smith, R and Wilton, P. (1998). General practice fundholding: progress to date. *British Journal of General Practice*, 48, 1253-1257
- <sup>3</sup> Department of Health. *Fairness and Equity for Hospital Treatment*. Press release. 16 July, 1997.
- <sup>4</sup> Department of Health. (1997). *The New NHS: Modern and Dependable*. PCGs are not an entirely new concept: they are preceded, under fundholding, by total purchasing units, and by the 42 commissioning pilots set up in 1997.
- <sup>5</sup> Azeem, M and Lawrence, M. (1999). Unified budgets for primary care groups. *British Medical Journal*, 318, 772-776. Four levels of PCG are planned, distinguished by the degree of budgetary autonomy they enjoy.
- <sup>6</sup> Coulter, A, et al. (1999). Sharing decisions with patients: is the information good enough? *British Medical Journal*, 318, 318-323.
- <sup>7</sup> Department of Health (1995). *Patient's Charter*
- <sup>8</sup> Association of Community Health Councils of England and Wales. (1998). Removals from GP's lists. *Health Perspectives*, September..
- <sup>9</sup> The notion of 'gatekeeping' implies access restrictions. For an interesting discussion of this see:  
 Gass, D. (1997). Gatekeeping in primary health care. *Canadian Family Physician*, 43, 1334-5
- <sup>10</sup> Murley, R. Editor. (1995). *Patients or Customers: Are the NHS Reforms Working?* Institute of Economic Affairs, London.
- <sup>11</sup> According to the King's Fund's *Health Care UK, 1993/4*, 11% (6%) of patients reported being offered a choice of hospital (consultant) in 1992.
- <sup>12</sup> Department of Health (1996). *The Patient Partnership Strategy*. This initiative led to the development of new approaches to support greater patient, carer and public involvement.
- <sup>13</sup> Some individual practices explored patient involvement, but these forums may be disenfranchised by PCGs. Lay members of Trust, PCG and Health Authority Boards are nominated rather than elected representatives.
- <sup>14</sup> Klein, R. (1995). *The New Politics of the NHS*. Longman, 3<sup>rd</sup> edition.
- <sup>15</sup> Ovretveit, J. (1996). Informed choice? Health service quality and outcome information for patients. *Health Policy*, 36, 75-93.
- <sup>16</sup> Gage, H, et al. (1999). Evidence on the non-specific aspects of care: Implications for health care delivery. In preparation.
- <sup>17</sup> Fox, S. Is this the end of the family GP? *The Times*, 18<sup>th</sup> May 1999.
- <sup>18</sup> The New Zealand system is described in Grant, C, et al. (1997) Primary care and health reform in New Zealand. *New Zealand Medical Journal*, 110, 35-9.  
 Canadian opposition to rostering is voiced by:  
 Lofsky, S, et al. (1995). New approach to primary medical care. Nine-point plan based on flawed analysis. *Canadian Family Physician*, 41, 1831-1836  
 Rutter, P. (1994). Competition benefits both doctors and patients. *Canadian Family Physician*, 41, 1831-1836
- <sup>19</sup> Cited in: Richards, T. (1999). Patients' priorities. *British Medical Journal*, 318, 257.
- <sup>20</sup> MORI. (1997). *The Extent and Determinants of Patient Choice of GP Practice*. Report for NHS Executive.
- <sup>21</sup> The good GP guide. *Which Magazine*, September 1996, 8-13.
- <sup>22</sup> Curtis, R, et al. editors. (1998). *Creating Consumer Choice in Health Care. Measuring and Communicating Health Plan Information*. Health Administration Press.
- <sup>23</sup> Posnett, J, et al. (1996). *Primary Care Consortia and Patient Choice*. Final report for NHS Executive. York Health Economics Consortium, University of York.
- <sup>24</sup> Dixon, P, et al. (1997). *Patient Movements and Patient Choice*. Report for NHS Executive. York Health Economics Consortium, University of York.

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- Thomas, K, et al. (1995). Assessing the outcome of making it easier for patients to change general practitioner. *British Journal of General Practice*, 45, 581-586.
- <sup>25</sup> Davis, K, et al. (1995). Choice matters: Enrolees' view of their health plan. *Health Affairs*, Summer, 99-112.
- <sup>26</sup> Schmittiel, J, et al. (1997). Choice of personal physician and patient satisfaction in a health maintenance organisation. *Journal of American Medical Association*, 278, 1596-1599.
- <sup>27</sup> A MORI survey reported in King's Fund *Health Care 1993/4*, finds 14% of respondents not satisfied with their choice of GP.
- <sup>28</sup> Amooore, T. Fit to be an NHS patient for now. *The Daily Express*, 1 May 1999. Also an author's (HG) own experience.
- <sup>29</sup> ACHCEW. (1996). *An Analysis of the Complaints Work of CHCs*. This survey showed 50% of complaints against GPs concerned treatment, care, diagnosis and referrals, and 12% concerned staff attitudes.
- <sup>30</sup> ACHCEW. (1998). Litigation in the NHS – an epidemic round the corner. *Health Perspectives*, August.
- <sup>31</sup> Department of Health. (1996). *Acting on Complaints*. For a patient orientated interpretation of this see: ACHCEW (1996). The new NHS complaints procedure. *Health Perspectives*, April.
- <sup>32</sup> Ernst, E. Editor. (1996). *Complementary Medicine: An Objective Appraisal*. Butterworth, Heinemann.
- <sup>33</sup> Frank Dobson, Secretary of State for Health, 30 September 1997. It has been argued, however, that the internal market was not built on competition, but on contestibility and purchasers' threats to switch (Klein, op cit.)
- <sup>34</sup> Rogers, A, et al. (1999). *Demanding Patients? Analysing the Use of Primary Care*. Open University Press, Buckingham.
- <sup>35</sup> Rehnberg in Ham, op cit.
- <sup>36</sup> Azeem and Lawrence, op cit.
- <sup>37</sup> Smith, P. (1999). Setting budgets for general practice in the new NHS. *British Medical Journal*, 318, 776-9
- <sup>38</sup> Clinical governance, for example, is a framework for quality improvement and accountability within the NHS. For a discussion of how clinical governance might apply to PCGs see: Baker, R, et al (1999). A model for clinical governance in PCGs. *British Medical Journal*, 318, 779-783.