Review of
Primary Healthcare Market
Guernsey

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CICRA wishes to thank all participants in this review, in particular the General Practices and respondents to our survey. The information provided has been invaluable in informing our consideration of this key aspect of island life and in which everyone has a keen interest.

Executive Summary

Scope of the Review

Guernsey's Commerce and Employment Department (C & E) asked the Channel Islands Competition and Regulatory Authorities (CICRA) to review certain aspects of the primary healthcare market, particularly "out of hours" (OOH) services and the provision of Accident and Emergency (A & E) services.

The provision of General Practice (GP) services

At present there is a limit of 42 on the number of GPs allowed to operate in Guernsey. This limit has been in place since 1990. CICRA has indicated to the Health and Social Services Department (HSSD) that the requirements set out in Billet d'Etat II 1990 and the existing system of management of the lists of medical practitioners may be a contravention of Guernsey's competition law and should therefore be removed or significantly reformed. HSSD has consulted with medical professionals and the wider public on a proposal for the future management of and entry to the lists of authorised medical practitioners. CICRA understands that proposals for a new system were to be brought before the States of Deliberation by the end of 2014 but this has yet to take place.

The likely effect of limiting the supply of any service is to limit the availability of that service and therefore raise the price and/or cause a shortage of that service. There is no strong evidence of a shortage of medical services in Guernsey so the effect of limiting supply is likely to raise prices, which itself would reduce demand. In the absence of considerations specific to Guernsey that could justify placing a cap on GP numbers, there seems no reason to limit the number of GPs any more than there is reason to limit the number of lawyers, plumbers or vets.

GP services are provided by three practices. The practices also employ other health service professionals which provide a range of ancillary services. The existing three practices account for the vast majority of GPs under the cap. GPs wishing to enter the market are therefore largely dependent on the existing practices. This is the case because starting a new practice and attracting new GPs is feasible only if there are less than 42 GPs in the market. A new practice may also need to participate in existing arrangements for OOH services and A&E services in place between the three practices and would need to negotiate with competitors to access these services, which present additional challenges.

Unlike in the UK, but as in Jersey, people in Guernsey pay for primary care services, typically around £55 for a standard 10 or 12 minute consultation. Guernsey's Social Security Department (SSD) contributes a £12 grant towards the cost of each GP appointment for qualifying patients (the vast majority of residents) and covers the full cost of primary healthcare for those in receipt of specific social security benefits.

The charges levied by the practices were prior to the commencement of the competition law set by British Medical Association (BMA) members locally (originally based on a UK schedule of fees published by the BMA), and until the introduction of competition law in Guernsey[1], which came into force in August 2012, the practices operated a common approach to pricing. At present, prices are set independently by each practice, but there is little differentiation.

Each of the GP practices generates income of £5-7 million each year, with a surplus after expenses or profit of £2-3m. The typical distribution for a full time GP partner is in the range £170-£240k a year. This is higher than that of GPs in the UK where salaried GPs earn in the range £50k-£90k plus NHS pension benefits.

Accident and Emergency services

The three practices jointly own and manage the Primary Care Company Ltd (PCCL) which under contract to HSSD provides the doctors who staff the A & E service at the Princess Elizabeth Hospital (PEH) together with a combined out of hours service for all three practices. The practices charge a fee to their patients for A & E services and there is also a States grant per consultation to the practices (as with GP appointments) plus a direct payment of around £0.9m per annum for the provision of A & E doctors by PCCL.

The payment made by PCCL to the three practices significantly exceeds the direct costs of providing the service. The annual income of PCCL and the 3 practices for A & E services is about £2.2 million, comprising £1.3 million paid by patients and £0.9 million States grant. The direct cost of providing the doctors employed by PCCL to staff the A&E service is about £0.5 million. There are other costs. It is not possible to be precise about the financial flows in the absence of sufficient financial information. It may be the case that surpluses from the provision of A & E services subsidise other services.

There seems little justification for the contractual arrangements governing the provision of A & E services to be confidential, bearing in mind the substantial amount of public money involved. There is no service level agreement and no monitoring of performance required by the contract, and from the information available it is not possible to accurately assess the value for money of the current arrangements. If there is cross subsidisation it is desirable that this should be transparent and a result a conscious policy decision subject to political scrutiny in the usual way.

"Out of hours" service

PCCL also provides a combined OOH service at PEH, with the hospital providing space and supporting services free of charge. Charges for out of hours appointments are 2-3 times the

[1] The Competition (Guernsey) Ordinance 2012,

cost of standard appointments with the same States grant and SSD payment made as for standard consultations. The aggregate annual income from out of hours services to practices in 2013 was £0.536m and reported direct costs for OOH GPs was around £0.650m.

The practices estimate up to one third of the time for which the OOH doctors are employed is spent providing on call support and back up for the A&E service. This naturally raises the question why more resources are not directly allocated to serve A&E, which would be able to provide additional capacity and support for the OOH service when required. There is insufficient data provided in support of these estimates to enable a meaningful analysis of the financing of the service.

Views on GP services

A survey commissioned by CICRA showed that 88% of those questioned viewed GP services as good or very good, a higher proportion than in the UK. However, a high proportion (69%) considered that the costs of GP appointments were expensive or very expensive and 50% said that they had put off or delayed visits to GPs because of the cost.

Recommendations

This limited review suggests that there are four aspects of the primary healthcare market that merit consideration by the States or action to improve the functioning of the market.

1. The limit on GP numbers should be removed as proposed in HSSD's April 2014 consultation.
2. Consideration should be given to the risks posed to competition by the current market structure. The three practices together control what are essential access services for GP patients, including OOH and A&E services. Given the scale of the market it seems likely that patients of any new practice will need access to such arrangements.
3. The arrangements for the provision of A & E services and the OOH GP service should at a minimum be clear and transparent with adequate transparency of reporting for monitoring performance. This supports both ongoing management of the contract by the States and potentially new negotiations or tendering for services.
4. The effect of charging for GP consultations and A & E services is that a proportion of the population report that they are deterred from seeking medical support when they need it. This compares to a 'free at point of use' policy such as that applied in the NHS in the UK. The States may want to consider the impact of the current policy and whether it would wish to consider changes.

Purpose of Study

CICRA is responsible for promoting, administering and enforcing the competition laws in the Channel Islands: the Competition (Jersey) Law 2005 and The Competition (Guernsey) Ordinance, 2012. These laws prohibit anti-competitive or exploitative behaviour, such as price-fixing or abuse of a dominant position. CICRA also provides information and guidance to the islands' governments on competition policy and markets, in particular by completing market studies.

C&E requested that CICRA carry out a review of primary healthcare in respect of General Practice and associated services. This included out of hours arrangements and the services provided by the PCCL under contract to provide accident and emergency services at the Princess Elizabeth Hospital. The review does not consider ambulance, paramedic services and maternity care or ancillary services provided by GP practices, such as physiotherapy, travel clinics and alternative medicine.

The study has focussed on a limited number of areas and issues where CICRA can be most effective in contributing to the understanding of the market. These were identified as issues around the quality of services and overall value for money, which could be reviewed through the overall delivery and funding of the services and the overall financial flows in providing the services. These would be looked at together with issues of health inequality and access to services addressed through customer research.

Approach

Customers expect to benefit from a well functioning market that is effective in providing primary healthcare and efficient in how services are provided. Accountability gives reassurance to those who pay for the service that their money is well spent, and reassures patients that they are being treated fairly and consistently. Users who are well informed, policy objectives that are specific and measured, and the absence of unnecessary obstacles to GPs or new practices offering their services, all contribute to ensuring that the quality of services are appropriate and that charges are justified.

CICRA has collected information from the GP practices and sought to understand the financial flows associated with service provision for both GP and A&E services, how the arrangements compare with those elsewhere, and the extent to which information on performance is available for scrutiny. Island Analysis was commissioned to conduct a comprehensive survey of patient views on the affordability and accessibility of primary care, OOH and A & E services.

Primary healthcare services

Primary healthcare is the first point of contact for individuals into the healthcare system. It also acts as both an introduction to and gatekeeper for secondary care services. In Guernsey, while there is some States support, primary healthcare is provided privately on a "user pays" basis, in other words it is paid for by patients at the point of use rather than funded by general taxation or a national insurance scheme, for example. The cost of secondary care is generally covered by States of Guernsey funding or through private health insurance.

Primary care comprises a range of services but key elements are family doctor services (GP care including OOH services) and A&E services. There are a range of other services which may be considered as part of primary care, for example ambulance and paramedic services, but these are outside the scope of this market study and therefore not included below.

GP services

GP care – the main point of contact with the healthcare system for most people – is provided by three private GP practice groups that operate as independent businesses, namely Healthcare, Island Health and Queen's Road Medical Practice.

In Guernsey there is no central contract which defines the role and obligations of GPs. There is no equivalent, for example, of the NHS contract in the UK to set out the remit of the GP service, or to set specific targets or policy based incentives for GPs. Each practice is responsible for its own operating and capital costs and the appropriate certification and accreditation of GPs. Practices provide a wide range of services in addition to standard GP appointments, including practice nurses, phlebotomy, vaccinations, health screening and well man and well woman clinics. Each has 15-20 GPs, full and part time, plus a number of practice nurses and operates several surgeries at different locations in the island.

Patients must pay for the services they receive, with each practice having its own set of charges, and fees are typically £53-£56[2] for a standard 10-12 minute GP consultation. Each practice publishes its own schedule of fees, including for services such as practice nurse appointments, blood tests and vaccinations. In the past, charges were based on figures set out by the British Medical Association (BMA), a practice subsequently taken on by the BMA locally in Guernsey, which (before the introduction of competition law) agreed common prices for the services provided by the GP practices in the island. Since the advent of competition law[3] in 2012, practices have set their own prices independently. While charges in Guernsey have evolved for individual practices they have not so far diverged substantially

[2] £56-£58 following 3.5% to 6% price increases in January 2015
[3] The Competition (Guernsey) Ordinance 2012

from this starting point. However practices are beginning to differentiate themselves to compete more effectively and patients are beginning to see the benefits of competition, for example through the introduction of reduced charges for children's appointments by one practice and the waiver of the fee for in-hospital baby checks by another.

The States of Guernsey, through SSD provides support towards the cost of medical appointments for qualifying patients. Most patients, whether covered by insurance or not, are entitled to claim a £12 grant towards the cost of each standard GP appointment (£6 for practice nurse appointments). SSD provides a safety net which covers the full costs of primary healthcare for those on low incomes in receipt of specific social security benefits[4]. It has negotiated its own rates with the practices and pays lower fees (after deducting the grant) than a typical patient. The practices reclaim grants from HSSD and patients with the balance charged to the patient directly or their insurer as appropriate.

GP practices each generate income in the range of £5m-£7m per annum. This is derived primarily (up to 75%) from fees for GP and practice nurse appointments. Additional revenue is received from carrying out minor procedures and other activities, such as renting space to other medical services (pharmacies, hearing aid services, physiotherapy and chiropractic services). In addition practices receive income from charges to patients for A&E and OOH GP services, which are billed (and retained) by an individual's "home" GP practice.

A&E Services

The A&E service is a separate element of primary health care from GP services and is provided by HSSD at the PEH. As with other primary care services, patients "pay at the point of use" for A&E services and fees are levied by patients' home GP practice for services received. These fees are retained by the GP practice and are not passed back to either PEH or HSSD.

While HSSD provides and operates the A&E department, it contracts out the supply of doctors to staff the service to the three island GP practices through the Primary Care Company Limited (PCCL), a company jointly owned and managed by the practices. HSSD contracts with PCCL to provide appropriately qualified doctors to staff the A&E department and to provide on call back up across the hospital.

In return for providing qualified doctors and cover for the A&E service, PCCL receives a contract payment of approximately £0.9m a year. PCCL provides three suitably qualified full time A&E doctors. It also draws on support from both the OOH GP service, when not otherwise occupied, GPs drawn from the individual practices with specialist skills and

[4] There is also SSD supported cover for specific circumstances such as industrial accidents etc, but the number of patients covered this way is small.

knowledge, as well as locum support as required. All other facilities and services, including nurses and support staff and equipment, are provided by PEH.

Fees for a standard visit range from £100 to £200 depending on the time of day or night. There are additional charges for tests or other procedures carried out by the A&E doctors and this can add up to a substantial charge of several hundred pounds or more for a visit.

Out of hours (OOH) GP services

Out of hours GP care ("the OOH GP service") is a combined service provided by the three Guernsey GP practices through the Primary Care Company Limited (PCCL) which also holds the contract with Guernsey's HSSD to provide doctors for the A&E service at PEH. We understand there are no legal or contractual obligations for GPs in Guernsey to provide an "out of hours" service to their patients.

The OOH service operates out of the primary care centre at the PEH and offers consultations and carries out GP visits, providing overnight cover from 7pm to 7am every day, plus Saturday afternoons and all day Sunday.

As with ordinary GP consultations and services, patients are charged for services by their "home" GP practice. It is not possible to separately identify these from other GP practice charges – practices do not routinely report on "out of hours" appointments separately from other GP appointments. Fees for evening/weekend out of hours consultations at the primary care centre at PEH are £110 and £160 respectively, the cost of home visits ranges from £130 to £220 depending on the time. Fees for out of hours consultations are therefore 2 to 3 times the cost of standard consultations and qualify for the same SSD £12 grant.

The OOH service is staffed by four salaried GPs employed by PCCL. Total income for the OOH service in 2013 was £0.536m from 2,889 out of hours appointments and 1,127 home visits. PCCL reports direct costs of around £0.650m. This excludes costs incurred within the practices themselves and the costs incurred by PEH/HSSD in providing premises and support. Space and supporting services for the OOH primary care centre are provided at PEH without charge to PCCL or the GP practices, while PCCL provides reception cover for both the out of hours service and for A&E outside normal hours. On this basis the income generated in providing the service does not cover the direct identifiable cost to the practices of providing the OOH service.

CICRA was not able to assess whether the OOH service was achieving public policy objectives in the absence of available policy outcome sought. Greater detail and transparency in the provision of data and accounting for the cost of running each of GPs practices, the OOH service and A&E would assist in better understanding how resources are deployed in these areas, and their contribution to the achievement of objectives.

Accessing primary care services

The diagram below illustrates the routes of access for patients to primary care in the areas under investigation by CICRA in this review together with the arrangement of the different service providers (the GP practices, PCCL and A & E).

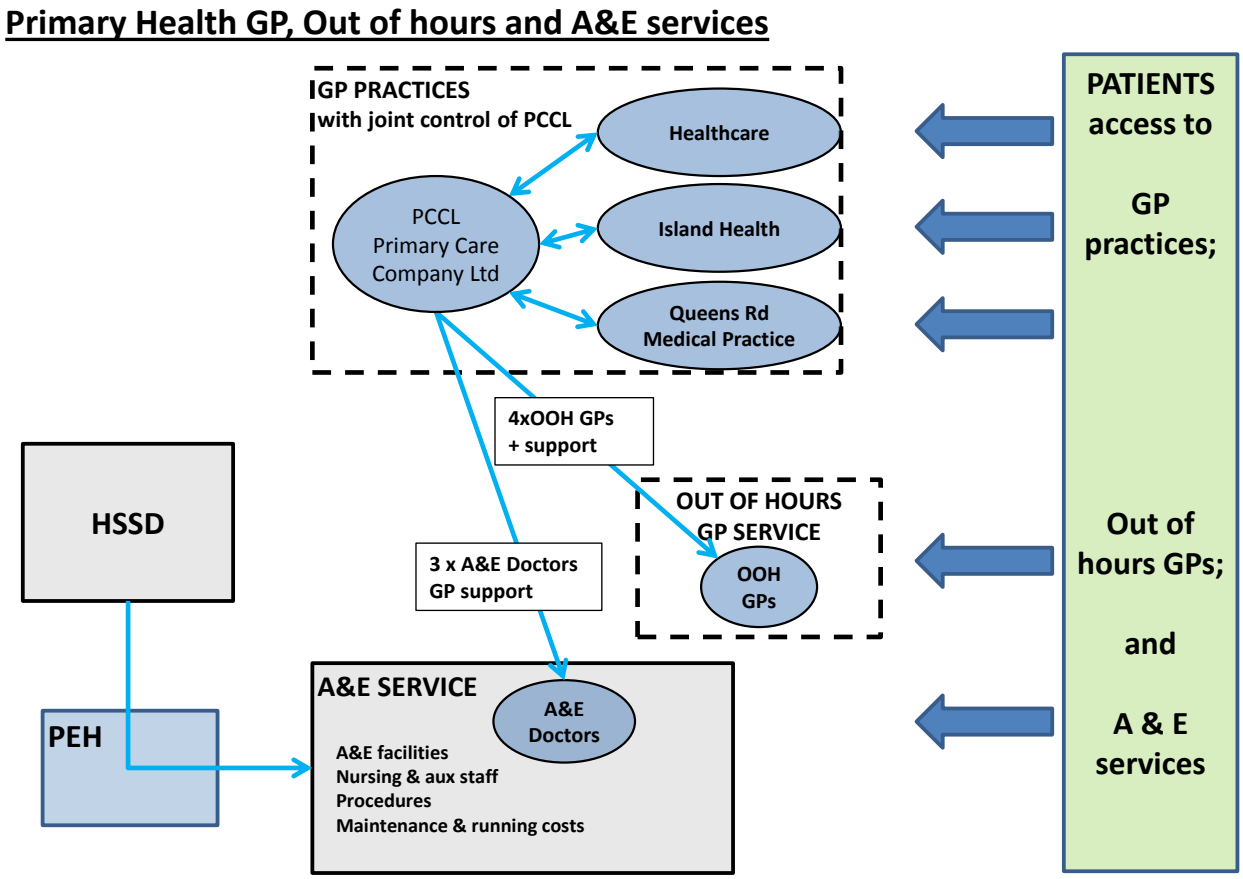


Figure 1 – Patient access routes to GP/A&E primary healthcare services

Cap on GP numbers

A number of HSSD decisions and States Resolutions, in particular the Billet d'Etat II 1990, have been used to regulate which doctors in primary care can refer patients for investigation by the pathology and radiology services provided free-of-charge by HSSD. These have also controlled which doctors could provide services that attract 'Health Benefits' paid by SSD, with HSSD required to manage such lists. This framework has been supported by a series of HSSD decisions regulating, with the agreement of the Medical Advisory Committee, the number of primary care doctors allowed to practice in Guernsey and eligible to be included in the lists, which is currently based on a ratio of doctor to resident population of 1:1600.

This cap acts as a barrier to entry into the market and therefore is likely to result in higher prices than might otherwise be the case. CICRA has indicated to HSSD that the current

operation of the formula in primary care risks contravening the competition law and HSSD recognises the need for competition to keep the costs to the consumer as low as practicable and sustainable. In the absence of considerations specific to Guernsey that justify some form of restriction there seems no reason to limit the number of GPs. Any cap on GP numbers should be fully justified by an impact assessment.

A related impact of a cap is where the existing three practices account for the large majority of GPs under the cap. GPs wishing to enter the market in practice must seek to join one of the existing practices. Certainly starting a new practice with sufficient GPs poses particular challenges in the current context. New practices may also need to participate in existing arrangements for out-of-hours care as well as accident and emergency services and this presents additional challenges for an entrant. CICRA notes the recent announcement by the Channels Islands Co-operative group[5] to enter the Jersey market by acquiring two established practices in Jersey, offering significant reductions in consultation fees in some cases. Given the size of the practices in Guernsey and a cap system, entry with a similar proposition appears to face greater challenges.

HSSD has stated it needs to ensure adequate competition between the practices and create no unnecessary barriers to entry for new players to the market. It proposes[6] to maintain a number of features of the current system, including a list of practitioners as currently required by States Resolution, privileges of access by GPs on the list to diagnostic facilities and health benefit grant and pharmaceutical benefit scheme. HSSD has also proposed new entrant criteria that is not based on a cap and that the 'manpower cap' is rescinded.

CICRA understands that proposals for a new system were originally planned to be brought before the States of Deliberation by the end of 2014 but this has been delayed and is now expected to go before the States in April 2015.

Financial flows

A&E Services

The provision of A&E services appears to be the area where there is greatest cause for concern over the cost of the service provided. In this area, we have focussed attention on the contract with PCCL in providing doctors to deliver the A&E service.

The contractual arrangements themselves are governed by strict confidentiality arrangements. It is difficult to see what specific or proprietary elements, or commercial

[5] https://www.channelislands.coop/news/launch-of-co-operative-medical-care-brings-more-affordable-healthcare-to-jersey/

[6] http://www.gov.gg/article/112273/HSSD-consulting-on-control-of-the-number-of-General-Practitioners

competitive concerns are involved to justify the degree of confidentiality. Greater transparency, not least to allow the parties to demonstrate that they are providing a service in the public interest at fair value, would in CICRA's view be more appropriate.

The service is provided by a combination of suitably qualified A&E doctors employed directly by PCCL (three) and appropriately qualified GPs with specialist A&E training drawn from the practices to provide 24 hour cover seven days a week. Further support is provided by PCCL's out of hours GPs based at the primary care centre at the PEH and an overnight reception service also provided by PCCL jointly with its own provision for the out of hours GP service. In addition, PCCL must cover the cost of any locum support required and the practices provide additional backup and cover through a number of GP partners who are qualified and trained in emergency medicine in addition to general practice. The receptionists employed for the OOH GP service also provided by PCCL cover A&E. The GPs employed to cover out of hours services are required to provide a second "on call" service to A&E.

Detailed information about the costs and income specific to the services provided under this contract is not recorded in a way that can reliably attribute costs and income to the specific services provided (and nor has PCCL been required to do so under its contract). We have found no quality of service standards or agreed value for money performance criteria set out in the contract. This makes it difficult for the States as the ultimate funder of the service, PCCL as its sub-contractor or the GP practices themselves to assess whether the inputs are achieving outcomes sought.

The overall flow of financing to support the service is summarised below in Figure 2.

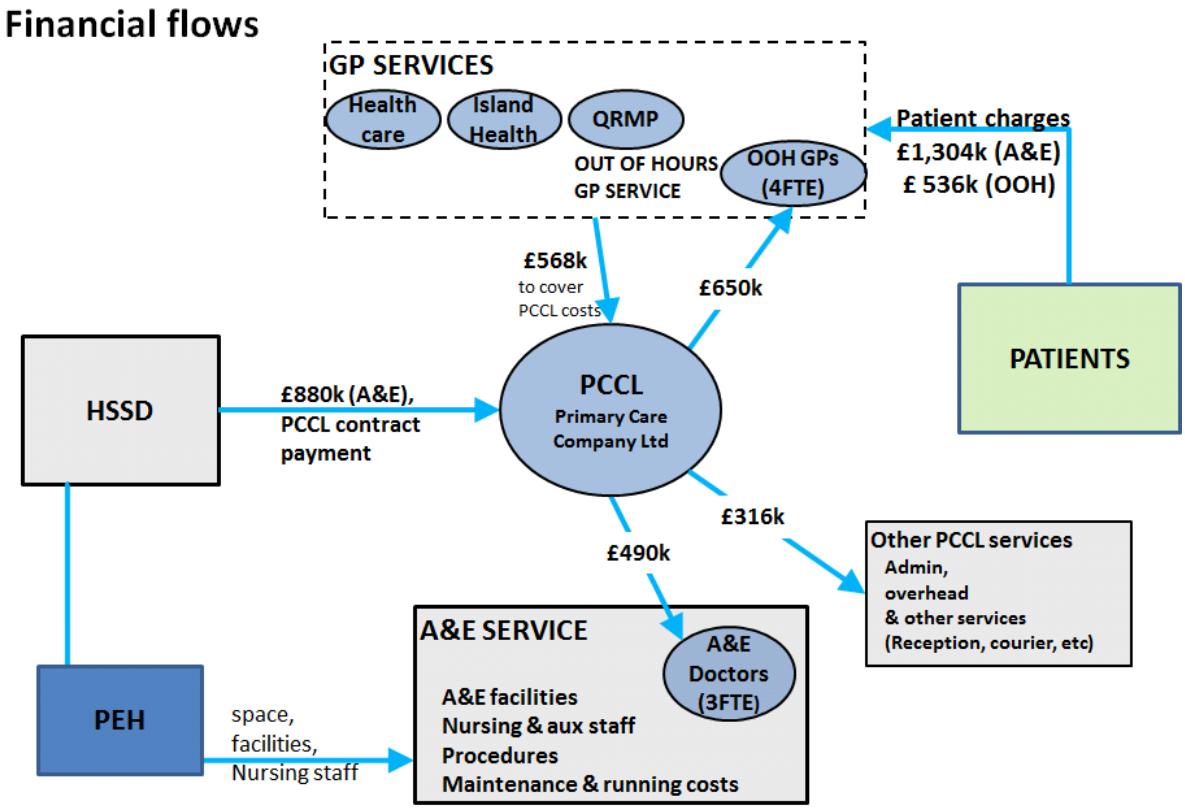


Figure 2 - Financial flows – A&E services

In return for providing qualified doctors and cover for the A&E service PCCL received a contract payment of approximately £0.880m in 2013. In addition, patients are charged for the A&E services and treatment received, which generated additional revenue of around £1.3m during 2013. The main costs incurred by PCCL under the A&E contract are the direct costs of providing three full time A&E doctors amounting to around £0.5m per annum, together with the overheads, administration and management costs incurred within PCCL.

We have sought to explain the significant difference between income to PCCL for A&E (£1.3m from patients and £0.880m in direct contract payments from HSSD) and its direct costs of around £0.49m, which we would anticipate comprise the large majority of its total costs given the arrangement with HSSD.

PCCL's explanation is that it estimates around one third of the out of hours doctors' time is used by A&E and therefore one third of their overall salary costs (approximately £0.210m per annum) should be reapportioned accordingly. Their estimate for the cost of admin time in support of the out of hours service is £0.226m, the cost of shifts undertaken by GP partners as £0.7m and the cost of study leave an additional £0.148m.

The estimated cost of time committed to A&E by GP partners therefore exceeds the total direct costs of full-time A&E doctors while the cost allocated to administration time appears high compared with the direct costs incurred. It has not been possible to confirm these estimates in the absence of appropriately detailed tracking and financial control which is not available within the systems employed by PCCL, nor is it required under the terms of the existing contract for services between PCCL and HSSD.

Overall, it would appear that the income from A&E services provides a significant surplus to the GP practices. It is possible that these surpluses cover other cost centres and that in effect there is significant cross-subsidy between A&E and such services but this is not explicable from the information we have available.

In the medium term, the States of Guernsey may wish to seek arrangements for the A&E service which are more transparent in its costs and in the levels of performance to be delivered. In addition, if HSSD continues to structure the service in the same way, it may wish to consider introducing arrangements to increase the degree of competition for contracts and encourage the practices (and other service providers as appropriate) to compete separately for the provision of the service on price and quality.

GP Practices

CICRA has also examined the revenue and costs of the individual practices. It is not for CICRA to determine what an individual GP is worth. However it is of interest to compare costs with the limited information available on costs from UK comparisons.

Each of the GP practices generates income of £5-7 million each year, with a surplus after expenses or profit of £2-3m. The typical distribution for a full time GP partner

In Guernsey, the typical remuneration for a full time practice partner is around £200k, but this varies from year to year and practice to practice, typically in the range £170-£240k per annum. This comprises partnership drawings, incentives and honoraria and the overall remuneration includes a share of any return the practice makes from other commercial activities – such as offering space to rent to pharmacies or other practitioners and the surplus generated from the provision of A&E services. While the total remuneration cited above include income other than for GP services, it is the case that such additional income is directly attributable to being a GP at a practice and therefore relevant to this review.

GP partners receive higher remuneration than salaried GPs reflecting the fact that partners are required to buy into partnership arrangements and may have considerable capital invested in the business as “goodwill”. Salaried GPs, who make up a minority of practitioners in Guernsey, and are often part time, are remunerated at lower rates than the “profit share” generated by practice partners. We understand that GPs coming to Guernsey often begin as employed GPs and are generally offered the opportunity to become practice

partners after a suitable period, as opportunities arise, but would be required to invest the appropriate "goodwill" into the partnership.

A salaried GP in the UK working in a clinical care group earns between £50k and £90k per annum[7] depending on, among other factors, length of service and experience. Equivalent figures for partners in UK GP practices are not easily available, but would be expected to be significantly higher since (as in Guernsey), they are taking on the costs and risks of the practice themselves but rely on a very different funding model. Information from the UK Health and Social Care Information Service[8] indicates that average earnings for a UK GP partner are around £121k pa. However this includes part time GPs and when converted to a full time equivalent figure translates to a figure more like £150k pa.

While GP remuneration in Guernsey is higher than a typical GP salary in the UK, these are highly qualified and trained individuals, the costs of living and particularly housing in the Channel Islands are generally higher than the UK and GPs locally do not benefit from the generous pension arrangements offered by the NHS in the UK – in Guernsey pension provision is not included.

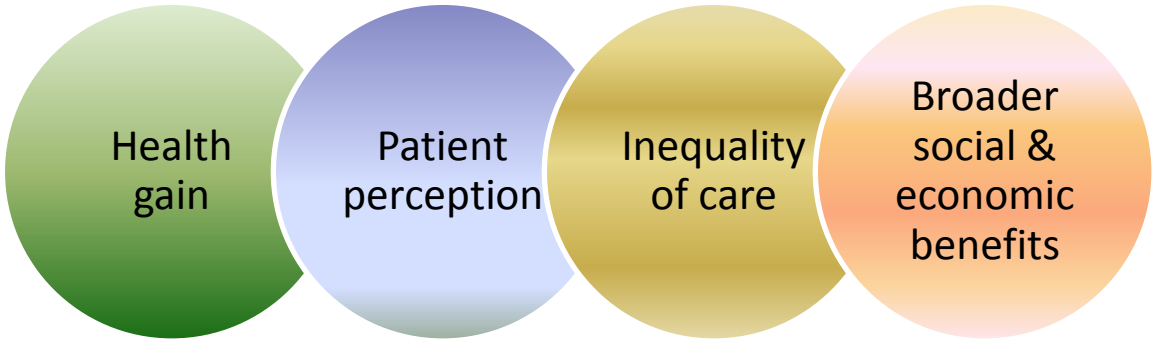
[7] http://www.nhscareers.nhs.uk/explore-by-career/doctors/pay-for-doctors/

[8] www.hsic.gov.uk; "GP earnings and expenses 2012/13" Published19/9/14.

What users say

Figure 2 below illustrates the main categories cited by health studies as potential objectives in healthcare. Valued outcomes involve a reconciliation of these potentially competing priorities.

Figure 2: Objectives in primary healthcare



It is apparent from studies elsewhere that assessment of this area has significant challenges. In primary healthcare, improvement to health is the essential objective. However, as in most markets, resources are scarce, and a balance is therefore needed in terms of how one competing priority is reconciled with others. Priorities such as improved life expectancy, vaccination rates, reducing infant mortality rates, targets for early identification of conditions etc., are not mutually exclusive. In the absence of policy objectives that allow for an assessment of whether or not the market for primary healthcare provision is effective in delivering the mix of valued outcomes appropriate for a community, medical practices, or individual doctors, will make choices between competing outcomes, within the context of professional standards and practice. CICRA is not placed to inform or critique such choices.

It has not been possible for this study to establish whether outcomes in primary healthcare are effective in term of meeting specified policy objectives, and therefore whether the market is delivering to expectations. This is the case for general practice provision, A&E and out of hours care. While the survey evidence provided by users of primary healthcare services in Guernsey demonstrates high performance in the area of customer satisfaction, and we have evidence that the 'user pay' principle may be affecting choices to access primary healthcare, there is no objective means available to us of assessing whether

competing claims on Guernsey's scarce primary healthcare resources have been reconciled appropriately.

Patients' ability to make informed choice, not just on the basis of price or location, but also on the quality of service, would therefore be assisted by information on the quality and performance of GPs. While all GP practices in Guernsey publish price lists and provide information on their websites about the range of services on offer, location and accessibility, there is no information on the quality and performance of the services delivered in a way that can be compared and contrasted.

Below we discuss the results from the survey carried out by Island Analysis that provide some indication of performance by the primary healthcare service as perceived by its customers. A full copy of the Island Analysis report is available on request, together with the questions and the written responses. A summary of the results is provided in Annex 2.

Customer perception of service quality

Our primary role is as an economic regulator and competition authority and our aim is not to judge the quality of clinical care provided by doctors or whether controls for safeguarding of patients are adequate. Such judgements can be better made by appropriately qualified medical review.

Overall there is a high level of customer satisfaction with GP services in Guernsey. 88% of respondents felt the quality of their GP service was good or very good and fewer than 5% considered it poor. 70% felt that availability of appointments and the choice of GP was good or very good. Compared to the UK, respondents had a more favourable view of the service delivered by their GP practice, for example the British Social Attitudes survey for 2013 put satisfaction with GPs at 70-75% with 10-15% considering the service poor.

It should be emphasised that this level of customer satisfaction is evident despite the concerns about price and access covered below, and significantly higher than for England and Wales where access to GP services is free of charge at the point of use.

Customer perception relating to accessibility

For 4 in 10 islanders, insurance (or friendly society subscription) to cover primary health care costs is not considered an option. While just under half of respondents were covered by some form of insurance cover for all or part of their primary care costs, of those remaining, more than 60% indicated that they could not afford insurance cover or that it would not offer them good value for money. Another 10-15% either could not obtain or could not afford insurance cover because of a pre-existing medical condition. So, for almost three-quarters of those respondents not currently covered, medical insurance was not considered an option.

Access to healthcare can be driven by a number of factors, such as the availability of GPs, the need (or desire) to see a specific doctor, physical accessibility of premises for patients – in terms of both location and building access – and affordability.

The results of our survey indicated that many patients were of the view that healthcare costs are too high. This view was shared by and was reflected across all demographic groups, including those on higher incomes. Respondents indicated that high costs had a direct impact on their choice to use services. A pay at point of use approach has by implication an impact in terms of self-rationing and to a large extent is driven by the price of access to primary care. A significant proportion of respondents reported that they had either put off or delayed visits to the GP for themselves (50%) or someone else in their household (32%) because of the cost.

It must be acknowledged that a pay at point of use approach can however also act as a restraint against unproductive cost escalation in the provision of primary healthcare. We have considered studies in this area to inform our conclusions and it is apparent, in particular from research carried out by the World Health Organisation[9], that the impact of a pay at point of use policy on accessibility to healthcare services is not conclusive. While the findings broadly support the view that user fees present a barrier to access to health services, it observes that the extent and strength of feeling in this area do not appear to be matched by evidence on the topic.

[9] http://www.who.int/bulletin/volumes/86/11/07-049197/en/

Conclusion

The Commerce and Employment Department of Guernsey requested that CICRA carry out a review of aspects of the primary healthcare market in respect of General Practice and associated services. We have drawn on analytical frameworks and studies in this area, as well as survey evidence and information provided by the GP practices to inform this review, which constitutes an initial review only. Our conclusions therefore need to be considered subject to that caveat.

GPs in Guernsey have emphasised their commitment to providing high quality care for their patients and to offer the services which they believe are best for them. However, the absence of a clear accountability framework that sets targets or objectives for the mix of valued outcomes sought by the primary healthcare market presents challenges in considering effectiveness and efficiency in their provision. This is an area policy can address.

The impact of the cap on GP numbers imposed by HSSD is difficult to quantify, but it is likely that it has led to costs (and prices) for primary care which are higher than they would otherwise be were a greater number of GPs (and practices) competing to provide services.

HSSD already plans to remove this cap and has consulted with the existing GP practices accordingly. There is a need to ensure that there are no other barriers to market entry and that other GPs entering the market, wishing to set up practices, have the same access to prescribing rights and hospital facilities as existing GPs. This would include the ability to access services such as OOH GP services where they are provided on a combined basis and/or make use of central facilities provided by the PEH/HSSD.

The survey of users of the Guernsey primary healthcare service does provide some measures of perceived satisfaction with the service, as well as the extent to which the 'user pays' principle influences choices to access GP services.

We have not been able satisfactorily to explain the size of the contribution by PCCL to the three medical practices. From our enquiries, the similarity of practice charges appears to be a function of an historic price setting approach that predates the introduction of competition law in Guernsey. CICRA would anticipate that as competition has replaced cooperation in primary healthcare, independent price setting by practices may see greater variation and diversity in approaches to price setting.