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Potential impact of removing general practice boundaries in England: A policy analysis☆

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A B S T R A C T

In 2015, the UK government plans to widen patient choice of general practitioner (GP) to improve access through the voluntary removal of practice boundaries in the English NHS. This follows a 12-month pilot in four areas where volunteer GP practices accepted patients from outside their boundaries. Using evidence from the pilot evaluation, we discuss the likely impact of this policy change on patient experience, responsiveness and equity of access. Patients reported positive experiences but in a brief pilot in four areas, it was not possible to assess potential demand, the impact on quality of care or health outcomes. In the rollout, policymakers and commissioners will need to balance the access needs of local residents against the demands of those coming into the area. The rollout should include full information for prospective patients; monitoring and understanding patterns of patient movement between practices and impact on practice capacity; and ensuring the timely transfer of clinical information between providers. This policy has the potential to improve choice and convenience for a sub-group of the population at lower marginal costs than new provision. However, there are simpler, less costly, ways of improving convenience, such as extending opening hours or offering alternatives to face-to-face consultation.

1. Introduction

From early 2015, all general practices in England will have the option to register patients from outside their practice boundaries [1,2]. Participating practices will not be required to provide home visits to these patients, who will use the local out-of-hours service where they live. NHS England (the national commissioning body responsible for contracting NHS general practice services) will be responsible for arranging this and any in-hours urgent medical care where such patients live. The policy change will allow a patient to register with a practice near his/her workplace or to stay with the same practice despite moving house beyond a practice boundary. Greater patient choice of practice is expected to produce higher quality care, improved patient experience and, ultimately, better outcomes, with practices competing to attract and retain patients. Critics point to potential adverse consequences such as fragmentation of care and inequity if more mobile patients are given priority. Unfortunately, there is very little evidence either from the NHS or other systems on the costs and benefits of widening patient choice of general practice, and specifically on the effects of removing geographic boundaries (see [3] for a summary of the Scandinavian, and [4–6] for the European, experience).

Box 1: The choice of GP practice pilot and its evaluation.

From April 2012–March 2013, 43 volunteer general practices in four English NHS primary care trusts (PCTs) (Westminster, Nottingham, Manchester and Salford) took part in a pilot to test the removal of general practice boundaries. In the pilot, patients living outside a practice catchment area could register as an out of area registered patient or visit a doctor as a day patient. The pilot was developed to address a growing concern that NHS GP services, based on patient registration with a single general practice, might not be sufficiently convenient for patients. The pilot was intended to improve access to general practice for workers who had trouble attending during normal working hours, commuters, or people moving house who wished to stay with their previous practice. Approximately half of the pilot practices (46.5%) were in Westminster. Eleven practices (25.6%) did not have any participating patients. A total of 1108 patients registered as OoA registered patients and 250 patients attended as day patients. Over 70% of pilot patients were registered in, or attended a practice in Westminster.

The evaluation of the pilot was a mixed method, mainly cross sectional study that included: semi-structured interviews with pilot patients ($n = 24$), GPs and practice managers ($n = 15$) in participating practices and staff in the 4 PCTs ($n = 13$); a survey of practice staff and GPs in all pilot practices (23/45, 51% response rate); and a postal survey of day (64/188, 34%) and out of area registered (315/886, 36%) patients over 18 years. Pilot patient survey results were compared with the GP Patient Survey data for year 7 wave 1 (January to September 2012) for the same PCTs and practices. The evaluation further included the collation of basic administrative data (from National Health Authority Information System, NHAIS) on out of area registered patients and anonymised clinical records for day patients and a Discrete Choice Experiment (DCE) to explore the determinants of choice of registered practice in a general population using a YouGov web panel ($n = 2431$).

A full report of the findings of the evaluation is available at www.piru.ac.uk/assets/files/General%20 Practice%20Choice%20Pilot%20Evaluation.pdf.

This policy follows the 12-month choice of GP practice pilot (the pilot, see Box 1 for details) where volunteer GP practices accepted patients from outside their practice boundaries in four former primary care trust (PCT) areas (PCTs were succeeded by Clinical Commissioning Groups (CCGs) in April 2013) [7]. This brief pilot is one of the very few sources of evidence about the potential effects of removing practice boundaries [7].

Practice boundaries were not an original feature of the NHS, but were gradually instigated by practices from the 1980s as a way of managing list sizes to maintain quality of care and avoid long waits, of preserving a full GP service (including home visits) and of encouraging a focus on a defined local population.

Removing practice boundaries is part of a series of recent efforts to improve access to urgent and first contact care by making the English NHS more responsive and flexible. Between 1997 and 2010, ten initiatives were introduced to improve access to, and choice of, primary and urgent care provider in the English NHS; several of these were additional sources of primary or urgent care services, such as walk-in centres or urgent care centres, to improve patient convenience, as opposed to competition with existing general practices [8].

We use the evaluation of the choice of GP practice pilot (see Box 1 for a summary of the study) [9] as the basis of an analysis of the likely impacts of the roll out of the pilot (Table 1 sets out the potential advantages and disadvantages in more detail).

2. The likely impacts of removing practice boundaries based on the pilot experience

2.1. Is there likely to be demand for out-of-area registration

Due the pilot's short duration, small scale and concentration in one area, namely Westminster (Westminster PCT accounted for over two-thirds of participating patients, though this was unsurprising as it is a dense urban area with tightly drawn practice boundaries that also receives a large number of daily commuters relative to its resident population, in addition to temporary residents from other parts of the UK and abroad), it is not possible to predict the scale of participation and patterns of service use once the policy is rolled out nationally directly from the pilot. However, the evaluation included a discrete choice experiment (DCE) that aimed to understand the preferences of the general population in relation to different ways of accessing GP services. The DCE proposed a choice of 'local' versus 'out of area' registration and found some appetite for out-of-area registration among sub-groups of the population, as a way of obtaining more convenient access to a GP (e.g. near a workplace) in preference to the greater convenience of extended weekday or weekend hours, or the benefit of having a GP familiar with the health care services in the patient's local area [10].

2.2. Is out-of-area registration likely to improve patient experience and service responsiveness?

Pilot patients considered it a convenient scheme, were very satisfied with their experiences of pilot practices and eager for it to continue. They were as likely to describe their last GP visit as 'very good' as other patients in the same practice, same PCT and the rest of England. This was despite the fact that they were younger, more likely to be in paid work and had better self-reported health than other patients – all characteristics known to be associated with lower than average levels of satisfaction [11].

It did not appear that patients in the pilot chose better performing practices or were predominantly motivated by dissatisfaction with their previous practices, so on this evidence, it seems unlikely that the removal of practice boundaries will necessarily encourage patients to seek better practices, thereby encouraging practices to become more responsive to their patients and/or to improve the

Table 1
Potential advantages and disadvantages of out of area registration with a GP practice.

Health system objective	Advantages	Disadvantages
Improved access to and choice of primary medical care	• Likely to make general practice more convenient to those willing and able to register out of area (OoA) (e.g. by allowing patients to register with a practice near a workplace) • Likely to widen choice by allowing patients to stay with the same practice when they move house (though this may make access more difficult) • Likely to suit patients who have intermittent, acute needs for first contact or immediate primary medical care, but who are time-poor • Consistent with making the NHS more like other 21st century services, accessible flexibly to suit the patient	• Does nothing to improve access for those who are already registered at a practice near where they live and who have long-term conditions requiring regular, frequent access to a GP and related professionals, and could lengthen waits if OoA patients compete for scarce GP/nurse time • Does nothing to increase capacity (e.g. in many places practices are full and/or stretched) and thus could reduce access (e.g. longer waits) in some cases if more patients are registered. It is not currently possible for practices to manage demand for registration by opening and closing lists flexibly • Could lead to some practices losing large numbers of patients (e.g. in a commuter area), becoming non-viable and threatening GP services for locally registered patients • Other options to improve access to first contact or immediate care may be more cost-effective (e.g. extending practice hours, telephone and other virtual consultations, more flexible 'outer boundaries', practice federations, walk-in centres) though comparative studies are lacking • May be difficult to access primary care near home if a patient's circumstances change quickly (e.g. due to a severe injury, or sudden onset medical condition)
Quality of care, including responsiveness and patient experience	• May increase the responsiveness of primary medical services • May increase the odds of some OoA patients consulting sooner for health problems that could escalate (but this could be at the expense of previously registered patients) • Improves continuity of care for patients who move house, who want to stay with the same practice/GP and who would otherwise have to register with a new practice near their new home • Patients can still seek a local practice if their needs change such that the OoA option is not able to provide them with good quality care • Option of OoA registration could increase competition for patients between practices which could, in turn, raise standards in poorer practices (assuming no systematic biases in funding available to different practices serving different types of people)	• Overall, generates potential problems integrating care (see specific instances, below) and thus runs counter to the Government's priority to encourage more integrated care • Previous experience with OoA registered patients (given that this happens to some degree informally already) indicates that it can be difficult to provide good, safe primary care to people with long term conditions and serious health problems when OoA. Time spent travelling to visit such patients, if feasible, has high opportunity costs in terms of fewer appointments being available at the practice providing the OoA care as a result • No requirement for continuity of care in that registered practice is not responsible for home visits or urgent care when the patient is taken ill at home • Registered practice may not know anything about local services (e.g. community nursing), may not have a contract with these services, and may struggle to make referrals • Information on visits and treatment needs to be shared between providers where patients live and OoA practice • Could lead to some practices attracting a disproportionate number of younger, more healthy patients without having any responsibility when these patients fall ill since the 'home' CCG will have to arrange this care • Prospective OoA patients will need full information on the potential pros and cons • May reduce the effectiveness of population-based health initiatives, e.g. immunisation
Equity	• Provides access to primary medical care for people whom enrolment with a local practice does not meet their needs	• Risks privileging the needs and demands of younger, healthier people over those with higher needs for care and/or local residents • Only available where practices volunteer to offer OoA registration • Risks individual CCGs having to pay for services used by OoA registered patients who are not currently included in the population data used for budget calculations
Value for money	• Relatively cheap to implement and improves responsiveness and access for specific sub-groups in the population	• Improving responsiveness and access for a predominantly low need sub-group in the population is unlikely to be good value for money
Policy consistency	• Consistent with move towards a more demand-led, responsive, patient-focused NHS providing episodic care	• In tension with other current developments towards named GP for all patients 75+, GPs as care coordinators, increased emphasis on extended primary care, etc., all focused on improving chronic care
Cost containment	• OoA registration is not costly to implement at practice or system level since it uses the existing system of registration	• Likely to increase overall costs modestly since OoA patients need access to in-hours urgent care services if taken ill at home, organised by NHS England as well as services at their registered practice. • Unlikely to lead to savings elsewhere in the NHS

quality of their services. For example, only 14% of pilot patients changed because they were dissatisfied with their previous practice or chose their new practice because it offered services unavailable to them previously.

While the evaluation was able to identify the advantages, in principle, of improving choice and access for out-of-area patients, it could not directly assess the impact on quality of care and health outcomes. In the short period of the pilot, pilot practices and commissioners did not report any adverse events that they could attribute to out-of-area status, although the GPs in two PCTs declined to participate in the pilot because of a range of concerns, including the ability of practices to provide a sufficiently high quality of care to patients living outside their catchments. For example, patients with high needs no longer within walking distance of their practice but still in the same CCG area, might forego care due to transport difficulties or go to a more convenient but inappropriate service (e.g. the accident and emergency department or even call 999). Equally, this might reduce the likelihood of a GP home visit because of the additional travel time. Although such problems did not occur during the pilot, this could change with the rollout of the policy.

2.3. What are the potential implications of out-of-area registration for equity of access?

There is a concern that the removal of boundaries could lead to an exodus of patients to better performing practices, leaving other, for instance, older or less mobile patients reliant on poorer quality services. However, there was no evidence in the pilot that patients chose better practices.

There is an issue related to equity of access, namely, how to balance the access needs of local residents against the demands of those, for example, working in the same area, who may also benefit from timely access and convenience. It is possible that the policy may improve patient-practice matching based on factors such as languages spoken, ability to meet the needs of specific ethnic minority groups, clinical specialisation, or access to female doctors. However, this could be to the detriment of local populations if the participating practice's list size grows so large due to out-of-area patients that they are forced to close their lists and unable to register local residents.

Opponents of the scheme also argue that equity of access will be undermined if practices receive significant inward flows of well-to-do commuters, such as from the Home Counties into East London, since there is then potential for 'cream skimming' by GPs, who may prefer younger, healthier patients, especially in areas of high deprivation, despite the needs weighting of the capitation payment generated for the practice by each registered patient [12–14]. A report by the Corporation of the City of London suggested a more nuanced picture in which the policy would particularly benefit lower paid city workers, who otherwise struggle to access NHS services for both routine and more urgent care, as well as higher income commuters, who expressed a particular need for services close to work that address stress, anxiety and depression [15].

Another potential equity-related impact relates to the risk pooling that occurs in practices. If young (typically healthy) rural or suburban commuters register at a central city practice, local rural/suburban practices could end up with a disproportionate number of higher-use older patients, patients with chronic conditions and children. At its worst, this could compromise a practice's financial viability, especially as the minimum practice income guarantee (MPIG) has been phased out [16].

A final potential equity issue relates to the additional complexity which the policy is likely to generate for the population funding of CCGs (the successor organisations to PCTs) and individual practices. In the pilot, the costs of drugs, diagnostics and referred services incurred by out-of-area patients registered with practices in a pilot area were met by the local commissioner for the area. If this approach continues in the roll-out, inequities in funding between CCGs may arise if CCG populations, and their profiles of health care need and use no longer match the actual populations using services in their areas. Even if resources follow the out-of-area patient, it is still important that up-to-date information is available on patients as they move between practices and across CCG boundaries, and as they use services both through their registered practice and near home. The new policy also places greater pressure on the formula used to allocate per patient funding to practices. When practices largely maintain geographic catchments, practice populations are more likely to have a mix of more and less healthy and needy people meaning that there is a degree of cross-subsidisation between patients, thereby reducing the requirement for a high degree of accuracy in calculating how much funding each patient should attract. Under the new system, there is a greater risk of 'cream skimming' with some practices disproportionately attracting healthier, low demand patients. In addition, there are highly likely to be additional costs to the system as a whole, since a commissioner (it has yet to be advised whether NHS England or the 'home' CCG) will have to fund access to in-hours urgent primary medical care for out-of-area registered patients who fall ill at home which would not normally be required.

3. What issues does implementation of this policy raise?

Information on the pros and cons of the scheme for prospective patients in different situations, including those contemplating staying with a practice despite moving out-of-area, needs to be made widely available. Patients must be aware that they will not receive home visits and know how to seek urgent care appropriately if they fall ill while at home either in-hours or out-of-hours. In both cases, they will also need to be aware that the local providers will have to establish new lines of communication with their out-of-area practice so that the latter has full details of any treatment received to add to their records. This is needed to ensure that patient safety is not unduly compromised and patients are not incentivised to seek urgent care inappropriately, for example, at a local A&E department. Practices accepting out-of-area patients could be required to offer alternatives to face-to-face consultations as a condition of participation. To aid their referrals, practices will also need ready access to information about community health services outside their immediate area, which, in turn, must

be willing to accept referrals from practices around the country.

There also needs to be a mechanism by which practice list sizes can be controlled to maintain quality of service, and a balance struck between access and responsiveness to the local community and the needs of others.

Further, it will be important to develop systems to ensure reliable, prompt and secure transfers of clinical information between, for instance, an out of hours service or community nursing and an out-of-area patient's registered practice.

Finally, it is important that the national GP payments system is able to identify the movement of patients between practices so that the relationships between net 'gaining' and 'losing' practices can be tracked over time. Currently, the database is over-written when a patient transfers registration and so the data are not usable for monitoring (e.g. of practice viability, 'cream skimming', etc.).

4. Discussion and policy implications

Critics of the policy argue not only that the removal of practice boundaries potentially risks harming patient care, but also that it is not worth the extra cost and system complexity [14,17]. From this perspective, there are higher primary medical care priorities such as improving the ability of general practices to maintain the health of people with complex, long-term conditions. Indeed, there is a tension in Government policy between a consumerist emphasis on choice and convenience for people wanting an episodic response to acute health problems, and a focus on continuity in chronic care, particularly for older patients. The 2013/2014 changes to the NHS General Medical Services embody this with the planned removal of practice boundaries from 2015, yet accompanied by the introduction of a named GP for all registered patients over 75 years of age to strengthen chronic care and strengthen patients' relationships with local practices. The Conservative Party, the larger of the two parties in the current Coalition Government, has reiterated its commitment to improving convenience for those with acute health problems with its recent pledge to roll out seven-day access to GPs across the country by 2020 if it is elected at the May 2015 general election [18].

Our view is that there are likely to be other simpler, less costly, ways of improving convenience and access than removal of practice boundaries (albeit not involving greater choice of practice in the same way), such as extending opening hours and offering alternatives to face-to-face consultation such as telephone consultations (although it has to be recognised that these have not been shown to decrease demand for face-to-face GP services) [19]. On the other hand, if properly implemented and regulated, removal of practice boundaries has the potential to improve choice and convenience for a sub-group of the population and at lower marginal costs than new provision (e.g. GP walk-in centres). However, it may lengthen waiting times in popular practices to the detriment of those previously registered. It will also increase overall costs modestly since there will have to be a degree of double

funding to provide in-hours urgent primary care in out-of-area patients' home areas.

If increasing choice of practice is the central goal rather than more convenient access per se, there remain policy options other than boundary removal such as wider practice boundaries, or practices working increasingly in federations or networks (with shared patient records), without the risks to quality of care caused by splitting responsibilities for care that removing geographic boundaries may generate.

We expect that proponents and opponents of the policy will continue to have differing views on its impact in the absence of further evaluation. The wider roll out deserves evaluation, not just the 12-month pilot. This should enable policy makers to modify the scheme, for example, in light of evidence of practice capacity problems in particular parts of the country or patient sub-groups being disadvantaged.

Conflict of interest

We have no competing interests.

Acknowledgements

References

[1] NHS Employers. Summary of 2014/15 GMS contract negotiations. London: NHS Employers; 2013. Available from: http://www.nhsemployers.org/PayAndContracts/GeneralMedicalServices Contract/GMSContractChanges/Pages/Contractchanges201415. aspx#8 [accessed 14.11.13].

[2] Bostock N. Practice boundary reforms delayed until January, NHS England reveals. GP online; 2014.

[3] Miani C, Pitchforth E, Nolte E. Choice of primary care provider: a review of experiences in three countries; 2013.

[4] Saltman RB, Figueras J. Analyzing the evidence on European health care reforms. Health Affairs 1998;17(2):85–108.

[5] Thomson S, Dixon A. Choices in health care: the European experience. Journal of Health Services Research & Policy 2006;11(3):167–71.

[6] Coulter A, Jenkinson C. European patients' views on the responsiveness of health systems and healthcare providers. The European Journal of Public Health 2005;15(4):355–60.

[7] Department of Health. Choice of GP practice: the patient choice scheme; 2012. Available from: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/152294/dh_133411. pdf.pdf

[8] Tan S, Mays N. Impact of initiatives to improve access to, and choice of, primary and urgent care in the England: a systematic review. Health Policy 2014;118(3):304–15.

[9] Mays N, Eastmure E, Erens B, Lagarde M, Roland M, Tan S, et al. Evaluation of the choice of GP practice pilot, 2012–13: final report: London School of Hygiene and Tropical Medicine; 2014. Available from: www.piru.ac.uk/assets/files/General%20Practice%20Choice%20Pilot %20Evaluation.pdf

[10] Lagarde M, Erens B, Mays N. Determinants of the choice of GP practice registration in England: evidence from a discrete choice experiment. Health Policy 2014, http://dx.doi.org/10.1016/ j.healthpol.2014.10.008 [in press].

[11] Kontopantelis E, Roland M, Reeves D. Patient experience of access to primary care: identification of predictors in a national patient survey. BMC Family Practice 2010;11(1):61.

[12] Pulse. LMCs stage boycott of practice boundary pilots; 2012. Available from: http://www.pulsetoday.co.uk/lmcs-stage-boycott-of-practice-boundary-pilots/13805188.article#.U5hcO1OIB8G [accessed 20.04.12].

[13] Farrelly G. Your choice of GP: the problem in a nutshell; 2014. Available from: http://onegpprotest.org/registering-with-the-gp-of-your-choice/

[14] Kaffash J. Gerada: removal of practice boundaries will break link between GPs and their communities; 2013. Available from: http://www.pulsetoday.co.uk/home/gp-contract-2014/15/gerada-removal-of-practice-boundaries-will-break-link-between-gps-and-their-communities/20005257.article#.U5hgfVOICSo [accessed 04.12.13].

[15] The public health and primary healthcare needs of city workers [press release]. London: City of London; 2012 [May 2012].

[16] British Medical Association. Funding changes will close practices, warn doctors leaders. British Medical Association; 2014. Available from: http://bma.org.uk/news-views-analysis/news/2014/may/funding-changes-will-close-practices-warn-doctors-leaders [accessed 22.05.14].

[17] Dreaper J. Choice of GP practice 'popular with commuters': BBC; 2014. Available from: http://www.bbc.co.uk/news/health-26654617

[18] Wintour P. GP access seven days a week by 2020 'guaranteed' under Tories–Cameron. Guardian 2014. Available from http://www.theguardian.com/society/2014/sep/30/gp-access-seven-days-week-2020-tory-cameron

[19] Arain M, Campbell M, Nicholl J. Impact of a GP-led walk-in centre on NHS emergency departments. Emergency Medicine Journal 2014, http://dx.doi.org/10.1136/emermed-2013-202410.