The new GMS contract explained

GPC
General Practitioners Committee

Focus on Sale of goodwill

This guidance note has been produced by the General Practitioners Committee to help GPs and Local Medical Committees with decisions about whether to take advantage of new Regulations in relation to trading in goodwill, and is one of a series of guidance notes on the new contract.

Definition of goodwill

Goodwill in relation to earnings from the provision of additional services, enhanced services and OOH services may be considered as the value of the super profits that the practice can earn where the fees from such work substantially exceed the cost of the provision. For example, if a GP practice were making £80,000 profit per partner from this work and the practice were offered for sale, the purchaser would aim to replace the partners with salaried doctors and would deduct from the level of profit per partner the market value of the cost of the salaried GPs who would have to do the work. Because the total cost of employing a salaried GP is getting close to £80,000 there would be very little return on the investment and very little value in the goodwill. Super profits would however arise if the profits per partner had been £120,00 per annum, but their work could be replaced at the cost (as above) of £80,000 per salaried GP. There would be super profits of £40,000 and a related value for the goodwill.

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The first thing therefore is to remember is that if, because of competition in the market place, super profits cannot be made there is no advantage in re-organising a practice so as to take advantage of the new Regulations.

Accountants have different methodologies for making the calculation. Professional accountancy advice must be sought for any individual set of circumstances.

Background

The New GMS Contract 2003: Investing in General Practice stated in paragraph 7.21 that the existing arrangements prohibiting the sale of goodwill of a medical practice would continue. However, the Department of Health subsequently believed this stated intention needed to be revised so as to ensure:
(a) that there were no barriers (e.g. a ban on the sale of goodwill) that would stop alternative providers from seeking to provide certain services (out-of-hours services, enhanced services and additional services); and
(b) that existing subcontractors' rights would not be infringed.

When the NHS was established in 1948, the Government compensated GPs for giving up their right to sell goodwill in order to become part of the NHS. This ban on the sale of goodwill for a medical practice has remained until the present day. The Department of Health, however, believed that that ban did not apply to certain

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alternative providers of primary care because they were subcontractors. Indeed, such providers, for example private providers of out-of-hours services, listed goodwill as part of their assets.

Some elements of the new GMS contract have led the Department of Health to decide to change the arrangements:

- the categorisation of services, with distinctions between essential, additional and enhanced services
- the transfer of responsibility for out-of-hours services from practices to Primary Care Organisations
- the desire for contestability, choice and competition when PCOs develop their commissioning strategy for enhanced services
- the clear distinction between the types of providers in primary care: GMS practices, PMS practices, alternative providers and the PCO directly providing services

To this end, the Department laid Regulations *The Primary Medical Services (Sale of Goodwill and Restrictions on Sub-contracting) Regulations 2004* [SI.2004/906], which have now been in force since 1 April 2004, that deliver the following:

(a) a relaxation of the current ban in relation to enhanced, out-of-hours and additional services, but not in relation to essential services; and

(b) a relaxation that applies to all providers, including GMS and PMS practices, while retaining the ban in relation to the provision of essential services by GMS contractors or, in the case of PMS, where the provider has a registered patient list or such a list is being held on its behalf.

The Department intends to review the outcome of this decision in two years.

Equivalent policies to these in England have been implemented in Wales and Scotland. The Primary Medical Services (Sale of Goodwill and Restrictions on Sub-contracting)(Wales) Regulations SI. 2004/1017 in Wales and The Primary Medical Service (Sale of Goodwill and Restrictions on Sub-contracting)(Scotland) SI. 2004/162 in Scotland. The comparable Regulations in Northern Ireland are still being drafted.

The GPC's policy

The GPC has consistently opposed this policy. We believe it increases the threat to holistic, coordinated, practice-based care and, in essence, the highly regarded UK model of general practice. We accept that the categorisation of services, the out-of-hours opt-out and contestability for enhanced services are initiatives that will lead to patients not always receiving all their primary medical services from the practice with which they are registered. The main reasons for agreeing to these developments were to control GP workload and to ensure the explicit delivery of more resources into primary care and specifically general practice.

We believe that the scale of fragmentation that will result from the Department's policy on the sale of goodwill, however, goes far beyond the impact of the arrangements contained within the new GMS contract. Furthermore, such a partial lifting of the ban will inevitably damage recruitment into general practice, owing to the resultant increase in the costs of buying into a practice that would act as a severe disincentive to a career as a GP principal. We believe that it is not necessary to partially lift the ban to encourage contestability in the provision of certain primary medical services.

Due to this opposition to the proposal, the GPC took comprehensive legal advice from Leading and Junior Counsel on all the possible legal avenues for challenging the Government's partial lifting of the ban on the sale of goodwill.

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The legal avenues explored included:

- whether private providers subcontracted to provide out-of-hours services under the old GMS contract could sell goodwill under Section 54 of the 1977 Act
- whether such providers could have their property rights under Article 1 of the First Protocol of the European Convention of Human Rights (ECHR) ignored in the public or general interest
- whether the Regulations, as drafted, discriminated against practices under Article 14 of the ECHR
- whether the Regulations might be challenged under competition legislation
- whether the Regulations could be deemed ultra vires if it could be demonstrated they contravened the intention of the primary legislation.

All of these have been explored thoroughly and we have been advised that there is only a very slim chance of a successful legal challenge to the Government's policy at this time. This is, therefore, not an appropriate basis on which to incur very significant costs pursuing such a challenge.

A careful watch will need to be kept on what transpires in the primary care market in order to inform the Government's review in two years time and to provide any relevant evidence for a possible challenge under competition legislation in the future.

Given this position to date, the GPC believes that it is now important that guidance is produced to provide an analysis of the Regulations and how they affect practices.

The Regulations – *The Primary Medical Services (Sale of Goodwill and Restrictions on Sub-contracting) Regulations 2004* [SI. 2004/906][1]
The critical part is paragraph 3(1):

"The following performers or providers of primary medical services –

(a) a GMS contractor;
(b) a PMS contractor that has a registered patient list;
(c) an APMS contractor that has a registered patient list; and
(d) a medical practitioner who is a performer, with a registered list, of essential services during core hours, other than –
    (i) solely under arrangements to provider enhanced services
    (ii) solely as a locum, or
    (iii) only under arrangements to provide enhanced services and as a locum,

may not sell the goodwill of their medical practices in any circumstances (and no other person may sell that goodwill in their stead)."

As a GMS contractor has to provide essential services to a registered patient list there is no reference to having a registered patient list in 3(1)(a). A PMS contractor does not have to have a registered patient list but if he/she/it does this will relate to the provision of essential services; hence the structure of 3(1)(b).

The effect of the Regulations is that for providers to trade in goodwill in relation to additional, enhanced and out-of-hours services, they will need to set up a separate entity, distinct from the provider that contracts with the PCO to provide essential services to a registered patient list. Once established the separate entity may bid in

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open competition to provide additional, enhanced or out-of-hours services. However, practices will need to have opted out of providing those services as part of their original contract with the PCO under which they provide essential services to a registered list if they wish to bid to provide these services under a new provider entity.

The structure of the Regulations does not make for easy reading but, nevertheless, it is clear that the arrangements under which an entity might bid to provide additional, enhanced or out-of-hours services and be able to trade in goodwill must be totally separate from a practice's contract to provide essential services to a registered patient list.

It would appear that this might be treating practices unfairly compared to commercial providers in terms of what they would need to do to get themselves into a position to compete with these alternative providers. This is not necessarily the case, however.

GMS practices have preferred-provider status for the additional services they were already providing, out-of-hours services, and for three enhanced services, or for any contracts extant before 1 April 2004 for the duration of that contract. This means that many practices currently have the advantage over any alternative provider that may wish to provide these services. Thus, the series of hoops the practice may have to jump through in order to reconfigure the entities that provide the different services, might be deemed necessary in order to level the playing field between practices and alternative providers.

Options for practices

Before embarking on plans to reconfigure provider arrangements to be able to trade in goodwill for additional, enhanced or out-of-hours services, practices must take professional legal and accountancy advice. It is not possible for the GPC to advise or recommend action in relation to these Regulations and furthermore the position will be different for each practice. Practices must make their own decisions based on professional specialist advice.

As a result of the Regulations, the GPC has identified a number of options that are available to practices, including:

A. GMS practices that provide essential, additional, enhanced and out-of-hours services or PMS practices providing essential services and equivalent services, may wish to continue as they are. Thus, no trade in goodwill will be possible for any of these services.

B. GMS or PMS practices may wish to specialise in expanding a number of enhanced services provided and to achieve this they may wish to set up a separate provider entity from their practice to contract with the PCO to provide these services – goodwill may be traded in relation to these services provided by the separate entity.

C. GMS practices may have opted out of providing out-of-hours through their GMS contract, but may wish to set up or join a separate entity to provide these services – goodwill may be traded in relation to these services provided by the separate entity.

These three scenarios are likely to be the most common. More unlikely, but clearly possible, are the following:

D. GMS practices wishing to separate additional services from essential services –

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this would require the practice to opt out and thus lose its preferred-provider status for additional services it had continued to provide on transition to the new GMS contract, and then to set up a separate provider entity and bid in open competition to provide these services again. In the meantime, the PCO may have asked another practice to provide the services, it may have provided it itself, or it may have brought in an alternative provider. In any of these cases, the new interim provider may be in a better position to continue providing these services than the practice through a separate provider entity that formerly provided these services.

E. When a practice opts out of providing additional services and the PCO is seeking another provider or seeking to set up parallel additional services, this would appear to be the best opportunity for practices to set up separate provider entities in order to provide either a full range to more patients, or to focus on a specific service to more patients.

While the Regulations therefore do threaten practice-based, holistic general practice, they also provide an opportunity for collaborative working amongst GPs at local level to become, in addition to the essential and other services offered to a registered patient list, major providers of additional, enhanced and out-of-hours services across a PCO area. The Government would argue that the lifting of the ban in the way delivered by the Regulations should incentivise and reward such investment by general practitioners.