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Quality, morale and the new contract with GPs

To boldly go . . .

THESE FAMOUS WORDS from Star Trek have current resonance in general practice here in the United Kingdom, although the optimism of the star ship *Enterprise*'s voyages is balanced with doses of anxiety. While many in the UK believe that the new contract with general practitioners may be the last chance for the profession, it will, as with the Star Trek voyages, take general practice in this country into uncharted worlds. Repeatedly, surveys find a GP workforce that is despondent, demoralised and overburdened by bureaucracy. Although the reasons for low morale are complex, it's not all about money: there aren't the same income disparities between GPs and consultants in the UK National Health Service (NHS) as there are in Australia.

There appears to be a more fundamental shift in UK general practice — the goodwill that has sustained the GP workforce is waning. There is a sense that something important has been lost, and that core commitment to the national public good can no longer be taken for granted. The fabric of Aneurin Bevan's uncompromising vision for a new, socialised health service in 1948 (to quote: "We know what happens to people who stay in the middle of the road; they get run down.") may be lost forever in New Labour's reforms.

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An average GP here might earn in the vicinity of £70 000, depending on where in the UK he or she practises, and, under the new contract, earnings could rise by as much as £15 000–£20 000. It's often recalled that Bevan remarked that in order to sell the idea of the NHS to doctors he "stuffed their mouths with gold". Some of that ethos is alive in the new general practice contract negotiations, but the GP workforce is weary, demoralised and distrustful — and a bit more streetwise than in 1948. They want improved pay and conditions, and to be able to treat their patients unencumbered by bureaucracy. But, instead, they seem to be getting a very complex package in their new contract, and very few people can confidently predict how it will work.

There is no doubt that general practice has become more complex over time. There are more meetings, recurring bed-capacity crises, long waiting lists, and the constant struggle with an increasingly dysfunctional secondary care sector. General practice here is facing a workforce crisis, as it is in Australia. Medical students in Edinburgh don't seem to want to go and work as GPs in the outer Hebrides or rural Fife; they want to be consultants in England! General practice registrars won't commit to permanency in practices, preferring more mobile, portfolio-style careers.

Will the new general practice contract arrest this decline? It may turn out to be the GPs' saviour, but it has had some unglamorous moments. They reached a peak in April 2003 with the release of the "Carr-Hill" formula (Box),[1] which allowed practices to calculate their incomes under the new arrangements. Despite widespread anticipation of 30% pay rises, many practices found to their amazement that their incomes would in fact decrease! Then the GP tabloids had a field day when, at the height of the crisis, the architect of the funding formula, Professor Roy A Carr-Hill, a highly respected economist from York, was sighted in the mountains of Nepal.

The contract targets several sacred institutions in UK general practice. Instead of capitation payments being tied to individual principals' lists, the contract will be between the "primary care organisation" (usually, but not always, a primary care trust) and the entire practice. GPs will be able to "opt out" of certain non-core services, depending on their skills and interests — hence there will be incentives for practices to join up and jointly provide such services. There will be no compulsion to provide after-hours services — it will be the responsibility of the local primary care organisation to make sure there is after-hours cover. Most importantly, incentive payments will be linked to quality targets.

In terms of its quality components, the contract has been described as "the boldest such proposal on this scale ever attempted anywhere in the world".[2] There will be 76 quality indicators in 10 clinical domains of care (eg, hypertension, diabetes management), 56 in organisational areas (eg, record-keeping, training, practice management), four in assessing patients' experiences (eg, satisfaction, consultation length), and others for additional services. For the first time, there is to be a serious attempt to link remuneration in general practice with quality — not a small undertaking.

About 80% of GPs voted in favour of the contract, yet many harbour deep suspicions. This stems in part from the perception that GPs will lose their "independent contractor" status — something they've always valued highly in a nationalised health service. Critics suggest that the contract is biased towards those areas of primary care for which there is "evidence" — which naturally tends to favour management of hypertension or cholesterol lowering, possibly at the expense of more complex areas of primary care such as mental health and cancer. Many believe that GPs will become administrators of disease management and prevention programs, and the focus on outcomes may undermine the holistic values of general practice. There are inevitably narrow definitions of good performance in the contract, largely centred around achieving certain markers of clinical outcomes. Undoubtedly, there will be a huge administrative burden on practices, and the need for better information technology systems. Further, there has been no attempt so far to measure the health gain that this initiative will offer to the population served.

All complex contracts are unavoidably incomplete, and they contain inevitable "gaps, errors and omissions".[3] Many

Key components of the Carr-Hill formula for the new UK general practice contract[1]

The various payments that make up the new contract are weighted for factors that influence relative needs and costs. The formula includes adjustment for:

- the age and sex structure of the population, including patients in nursing and residential homes;
- the additional needs of the population, relating to morbidity and mortality;
- level of turnover of patients on the practice list; and
- the unavoidable costs of delivering services to the population, including variations in costs of hiring staff, and rurality.

argue that the need for contracts such as these has arisen out of the erosion of the relationship of trust between doctors and their patients. The government has trusted the profession to deliver high-quality care to the NHS — but events such as the Bristol paediatric cardiac surgery inquiry and the long-undetected Shipman serial murders have effectively undermined this trust. However, it is argued that, instead of replacing this old-fashioned trust with complex contracts, there should be greater emphasis on transparency, with “acknowledgement of deficiencies in patient care and clear, incentivised policies for remedying them”.[4]

So what will happen when the new general practice contract takes effect in April 2004? At one level, the government must surely be anxious, with all the disaffection and criticism that has been expressed. But perhaps politicians don’t care — if the whole thing unravels there are always organisations distant from the centre of government to blame. There are also established, simpler alternatives to escape to such as Personal Medical Services — a scheme by which providers and local primary care organisations can negotiate local service contracts (often quite financially attractive) which encourage better integrated care and multidisciplinary teams.

It’s hard to interpret the values behind current healthcare reforms in the UK, and this has been part of the problem in selling the contract. The old Labour principles of equal access for equal need and of universality do not figure highly in the current government’s agenda; for example, foundation trusts seem designed to increase the distance of government from the provision of healthcare. The trend towards selection of patients, treatments and services on the basis of financial risk rather than healthcare needs seems unstoppable.[5]

At least, though, there is a plan for general practice. This is in stark contrast to the lack of a coherent approach to the problems facing general practice in Australia. There is no doubt that the Divisions of General Practice in Australia have become a significant lever for change, and the investment through the Primary Health Care Research, Evaluation and Development Program is welcome. However, broader developments, such as the ill-fated flirtation with corporatisation, as well as changes to Medicare, give an impression of drift.

At the very least, the new UK general practice contract is taking it somewhere — probably “where no man has gone before”, but let’s hope it’s a journey that leads to renewed hope and vision.

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