General practice in the United Kingdom: meeting the challenges of the early 21st century

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In May 2013, the Royal College of General Practitioners (RCGP) published its vision for general practice in the NHS, *The 2022 GP*.1 The document outlined how the RCGP saw general practice developing in the next decade, including expanding the capacity of general practice and giving general practitioners a greater role in managing the healthcare needs of the population. This includes areas such as the ageing population, multi-morbidity, dealing with frail patients with complex health needs and greater integration of primary, secondary, community and social care. The report also proposes enhanced training for general practitioners and an increase in community-based academic activity.

For many general practitioners in the United Kingdom, however, the aims of the document, although worthy, are overshadowed by the many more immediate problems they face.2 In the last few years, many general practitioners have seen a dramatic transformation in their circumstances. Practice budgets have been cut, consultation rates have increased, patients are presenting with more complex problems, tougher performance targets have been introduced, there is considerable pressure to limit use of secondary care and there are greater demands on general practices to take part in new initiatives such as integrated health and social care programmes.3 General practitioners are also under pressure to improve access to services, for example, by offering rapid access to patients when they request appointments, as well as routine appointments during the evenings and weekends. The reduced funding and higher clinical workload have also been accompanied with higher administrative workload in areas such as the commissioning of services and dealing with non-clinical requests from patients, such as letters to support appeals by benefit claimants.4 To add to these woes, general practitioners also repeatedly find themselves blamed for many of the problems experienced by the NHS, such as the difficulties faced by emergency departments in coping with patient demand, the poorer survival of patients with cancer in the UK than in many other developed countries and poor child health indicators.

What underlies many of the problems faced by general practitioners is the method by which general practices are funded and the independent contractor model of UK general practice. The typical general practice obtains its funding largely via weighted capitation, by which it receives a fixed sum for each patient on its patient register with weightings for factors such as age, deprivation and population mobility. This means that the funding received by a general practice from the NHS is largely a fixed sum based on list size and, unlike the tariff-based payments made to hospitals, it does not increase if a practice’s workload increases. Moreover, this funding mechanism was devised some time ago and does not take into account recent changes in areas such as primary care consultation rates, patient complexity or the new demands placed on general practitioners for non-clinical and managerial activities.5 In effect, under the current funding and employment models, general practitioners face unrestricted demands for their services and on their time while having to operate on a fixed budget. Inevitably, when general practitioners are not able to cope with their workload, this will increase pressure on other parts of the NHS – such as emergency departments – as well as impacting on access to primary care services and on how well general practitioners can manage patients with complex health needs.

Although capitation-based budgets have been the cornerstone of UK general practice for many decades, it may be time to consider modifying this method of funding primary care in favour of methods that link workload more closely to funding. This could be done by incorporating tariff-based methods of funding in place of or in addition to capitation payments so that additional workload is accompanied by...
additional funding. To prevent any additional funding being used just to increase general practitioners’ income, more standardized levels of support staff – such as managers, nurses and healthcare assistants – may be required across practices to ensure that general practices have a primary care team that can meet the needs of their patients. An even more radical step would be for general practitioners to give up their independent contractor status and become NHS employees under similar employment terms to those offered to doctors working in acute, community and mental health trusts. This could potentially allow general practitioners and their staff to be employed on national NHS terms of service and overcome the divide that is being created between self-employed general practice principals and salaried general practitioners. Other, less radical alternatives to the loss of independent contractor status include the establishment of ‘super-partnerships’ involving the merger of general practices to allow the formation of larger primary care organizations; or greater collaboration between general practices via the formation of general practice networks or federations to allow sharing of clinical and managerial resources across the general practices in a locality.6

Changes to primary care funding or employment mechanisms could take considerable time to put into place and may not be possible politically because of a failure of general practitioners and the government to reach a mutually acceptable agreement; or because of the government’s unwillingness to increase spending on primary care. We do though need to look radically at the nature of the contract between the general practitioners and the NHS to allow general practitioners to offer the NHS the high-quality, accessible primary care services required to meet the needs of the UK in the 21st century. General practice in the UK cannot continue on its current workload or funding trajectories and, without radical reform, the only remaining alternative to enable general practices to receive an appropriate level of funding and limit general practitioners’ workload is the even less politically acceptable option of introducing patient co-payments for primary care services.7

Declarations
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References
5. Royal College of General Practitioners. Fair Funding for General Practice. London: Royal College of General Practitioners, 2013. See http://goo.gl/6JDkC (last checked 1 September 2013).