BMA

The value of general practice: the facts
March 2008

The new UK-wide GP contract was introduced in full in April 2004 following lengthy negotiations and full agreement by all parties - the Government, NHS Employers and the BMA's General Practitioners Committee. Since April 2004 GPs have been mainly working under two contracts; the nationally negotiated General Medical Services (GMS) contract or the locally negotiated Personal Medical Services (PMS) contract. The two contracts are broadly analogous in terms of how services are provided to patients. The National Audit Office (NAO) recently issued the report *NHS Pay Modernisation: New Contracts for General Practice Services in England*, a report on the GP contracts in England. This fact sheet has been produced by the General Practitioners Committee (GPC) of the British Medical Association (BMA) to clarify the facts about why and how the contract was introduced and the benefits to patient care it has delivered.

Key messages:

"Since 2004 more services are being provided in GP surgeries and practices are offering structured management of chronic diseases which has resulted in consistency of care throughout the UK." Dr Laurence Buckman, Chairman, General Practitioners Committee

- Benefits of the contract include better consistency and quality of care for patients and fewer problems with recruitment, retention and morale of GPs
- Although GP earnings have increased under the contract, this was an intended consequence and the BMA predicted the level of increase
- Since 2006/07 GPs have received no inflationary uplift to the contract and have taken on additional areas of work through changes to the QOF. Global sum payments have not increased since 2004.
- Since the introduction of the contract the number of consultations has gone up, the time spent with the patient has increased and the work GPs do is more complex.

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Why was the contract introduced?
The contract was brought in to address the severe shortage of GPs, to reduce the excessive hours they were working and to redress the pay imbalance – before 2004 the UK's GPs were among the worst paid in the developed world.

What are the key benefits of the contract?
The NAO report (England) recognises that the new national GP contract is delivering benefits:

- Structured management of chronic diseases has resulted in consistency of care throughout the UK
- More services are being provided in GP surgeries
- Patient satisfaction with access has improved (84% of patients said they were satisfied with GP practice opening times in the 2007 national GP patient survey)
- There are fewer problems in recruiting and retaining GPs

How has the GP contract and QOF improved patient care?
The contract delivered benefits to patients through the improved monitoring and treatment of acute and chronic health problems and the development of nationally determined and locally appropriate enhanced services beyond those that GPs traditionally supplied. For the first time the contract linked increases in practice resources to delivering proven higher quality care for patients through the Quality and Outcomes Framework (QOF). The QOF provides a framework for processes that, if followed, will ensure a high quality service for patients. The NAO report asserted that the QOF has not focused enough on health outcomes although it is important to note that QOF was designed to incentivise GPs to do the work that would lead to improved health outcomes. A recent article in the BMJ supported the use of process measures to monitor the quality of clinical practice[1]

The clinical indicators, which include disease areas such as coronary heart disease, stroke, diabetes and asthma, draw on best research evidence and only those areas for which there is evidence to underpin their inclusion can be found in the QOF. The QOF is reviewed and updated as necessary in the light of changes to the evidence base and advances in healthcare. These decisions are based on a review of the quality framework by an appointed expert panel with input from the BMA and NHS Employers. In 2006 new areas of clinical work were introduced as a result of this process.

The BMA, during negotiations on revisions to the 2008/09 contract, was keen to build on the success of the QOF and had agreed, with advice from the expert panel, to give over 38.5 points in the QOF to introduce new clinical indicators, including peripheral arterial disease and osteoporosis, into the QOF. Unfortunately the Government rejected this proposal and imposed the use of all these freed up points to just two access targets, which are already within the contract.

GPs have exceeded the quality targets they have been set (although the BMA always predicted that this would be so) and this has resulted in higher pay. The QOF is an important aspect of the GP contract. Research from the National Primary Care Research and Development Centre has shown that "quality of care for asthma and diabetes showed more rapid improvement after the QOF" and that "patients with controlled blood pressure increased from 48% in 1998 to 82% in 2005, and the percentage of patients with controlled cholesterol increased from 17%

[1] 2007;335;648-650 *BMJ* Richard J Lilford, Celia A Brown and Jon Nicholl. *Use of process measures to monitor the quality of clinical practice*

to 73% in the same period."[2] The QOF is well-respected world-wide and many other countries are monitoring its development closely.

How much does the average GP earn?
The most reliable indicator of GP income is the Information Centre's Earnings and Expenses Enquiry (EEQ). This recently estimated that, from all professional earnings sources (including NHS, private and out-of-hours work), self-employed, non-dispensing GPs working under the GMS contract earned an average net income of **£102,648** 2005/06. This is much less than the £250,000 widely quoted and misinterpreted by the media (this figure is often based on income before expenses have been deducted and applies to only a tiny minority of GPs working in exceptional circumstances). The figure is often inflated by other contractual arrangements, such as PMS and dispensing practices. It is therefore not reasonable to suggest that the nationally negotiated GMS contract changes are solely responsible for the increase in overall GP pay. This is a UK figure. It should be noted that the earnings of GPs differ significantly across the four countries[3]. In addition, the earnings of salaried GPs are not included in this figure. On average, salaried GPs earn less than GP principals, partly as a result of reduced responsibilities, particularly those to do with running the practice as a business. When taking into account salaried GPs the average NHS GP earnings figure is currently approximately **£88,000.** It is anticipated that the EEQ figure will fall in 2007-08 and 2008-09 to reflect increases in practice expenses and lack of uplift to the contract.

How have GP earnings changed since the introduction of the new contract?
The NAO report stated that the average pay of GP partners increased by 58 per cent in the first three years of the contract (this figure includes both GMS and PMS partners). This is broken down as 18 per cent in 2003-04, 23 per cent 2004-05, and 10 per cent in 2005-06. It is important to recognise when referring to this pay increase figure that the rise in GP earnings was an intended consequence of the new contract with the explicit purpose of demonstrating high quality general practice, through the delivery of new work including the Quality and Outcomes Framework and enhanced services, and counteracting well-recognised recruitment, retention and morale problems. GP pay was falling behind pay rates for equivalent professionals and the contract was specifically designed to address this. The BMA was not surprised at the extent of the increases in GP income as the BMA repeatedly told the Government's negotiators what the rise would be.

Since 2006 there has been no inflationary increase in the value of the contract and GPs have taken on more work through the QOF. In addition, practice expenses have continued to rise, so most GPs will actually have seen their real earnings, for an increased amount of work, fall over the past two years. This is not widely reflected in press reports as official figures reflecting what GPs earn now will not be published until Autumn 2009.

What will happen to GP pay in 2008?
The Doctors' and Dentists' Pay Review Body (DDRB) recommended a zero increase for contractor/partner GP pay in 2007-08. In an opinion survey by the BMA two thirds of GPs reported that their personal income had stayed the same or decreased in 2006-07. Two thirds expected a decrease in income in 2007-08 but official figures will not be available until Autumn 2009.

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[2] November 2007, National Primary Care Research and Development Centre; *What should happen to the Quality and Outcomes Framework?*

[3] Average net profit for contracted GPs in 2005/06 was **£113,614** in England, **£98,656** in Northern Ireland, **£90,619** in Scotland and **£102,194** in Wales

In 2008-09 the Department continued to put pressure on GPs to work harder and longer within the current contract funding streams by introducing proposals for extended hours. The BMA could not agree to the Department's proposals which were inflexible to local patients' needs and so polled all GPs on the options available. The package that will be implemented for 2008-09 includes the provision of an additional 3 hours per week for the average 6000 patient practice for the same level of funding, and harder-to-achieve access targets being introduced into the QOF. Any inflationary rise to the contract terms for 2008-09 will be determined by the DDRB which has yet to issue its report.

What difference has the QOF made to GP income?

The negotiations on the contract were predicated on the overwhelming bulk of new money being delivered through performance-based income streams and 75 percent of new money was intended to be delivered via the QOF. Since the introduction of the new contract, most of the increase in practice income has indeed been channelled through the QOF as performance-related pay. As the GPC had anticipated, practices have attracted additional resources by demonstrating that they deliver high quality care and work across the range of specific areas identified by the Government. In 2006/09 practices in England demonstrated top quality services with an average of 955 out of the 1,000 points available. These achievements were significantly higher than the Government had anticipated and are a great tribute to the work of GPs and their staff.

Weren't GPs already doing much of the work in the QOF?

The Government wanted rises in GP incomes to be linked to demonstrating the delivery of high-quality care (see above). Of course, as all parties were aware, GP practices were already undertaking some of the work that now falls under the remit of the QOF. Much of this work had been transferred from secondary care with increasing specialisation in secondary care. Unfortunately the resources for the work remained in secondary care and GP practices were becoming increasingly stretched by providing the care without resources. While the Government seemed to doubt that GPs would do well in the QOF, the GPC stated that it not only expected most practices to earn 750 points, because they had been delivering quality work for years, but that it fully expected many to top 900 points. The introduction of the QOF has indeed incentivised GPs to employ extra staff and invest in even better services for patients. It has also provided practices with the resources to identify patients with certain conditions before these would otherwise have come to light. Both work that had been initiated prior to the new contract and work undertaken since the introduction of the QOF have contributed to GPs' excellent performance in this area and improvements in patient care.

What hours are GPs working now?

The average length of surgery consultations with GP partners has increased from 8.4 minutes in 1992/3 to 11.7 minutes in 2006/7. The length of appointments is one of the best determinants of quality of care. GPs are therefore working with greater intensity during the day, and offering a higher quality service than they have ever done. The Information Centre's 2006/2007 UK General Practice Workload Survey showed that GP partners, who regard themselves as full time, work on average 44 hours a week. This figure does not include any out-of-hours work, which was included in the 1992/3 survey. Further studies have confirmed that at least 25% of GPs still do out-of-hours work, on top of this average figure. The out-of-hours work carried out by GPs now is also more intense as they are no longer "on call" but tend to work shifts seeing patients almost continuously. The report states: "Direct comparison of results with the 1992/93 GP workload survey is difficult. However, average weekly hours for GMS(PMS/ PCTMS) activities, excluding out-of-hours work, are very similar."

Prior to April 2004 GPs were responsible for the provision of out-of-hours care. Under the new contract, practices were given the opportunity to transfer responsibility for out-of-hours provision to the PCO. This was for two reasons; to give doctors a reasonable balance between

their profession and personal life and to allow PCTs to re-commission out-of-hours services using a mixture of new and existing providers.

Has productivity fallen since the new contract was implemented?
The NAO reports that National Statistics show productivity has fallen since the new contract was implemented. This conclusion is supported by comparing costs to activity, which shows that whilst consultations with patients have increased these are not in proportion with the increase in costs.

GP activity cannot be measured in this way. General practice has changed and primary care is now provided by a whole team working in the surgery. The number of consultations has gone up, the time spent with the patient has increased and the work GPs do is more complex. An increasing number of conditions that were once managed solely in hospital are now managed solely by GPs and their teams. The entire way GPs work has changed so it is meaningless to talk about productivity in the way the NAO has done. GP productivity should be measured in improvements in health, not the frequency of consultations – and the early evidence is that the contract is leading to improvements in clinical care. Care for patients with asthma and diabetes has improved, more cases of raised blood pressure are being picked up and while it is too early to give exact numbers, this will prevent many more serious problems like strokes or heart disease.

What improvements have been made to the contract since its introduction?
For the year 2006/07, in addition to receiving no inflationary uplift to the contract, the GPC agreed 'efficiency' changes in the QOF, amounting to some 15 percent, and the introduction of additional areas of work, on the explicit and publicly agreed understanding that the Government's perceived value-for-money issues would not be revisited in future negotiations. This included the recycling of 138 points from the QOF into new areas of work that required practices to work harder – this included new targets for dementia, depression, chronic kidney disease, atrial fibrillation, obesity and learning disabilities. This work was undertaken by practices for no additional funding.

Is it true that GPs are now taking a greater proportion of gross income home as profit?
No. GPs are often cited as taking a greater proportion of practice income as personal profit and the Government has said it regrets the fact that GPs have not invested more of the increase in gross income in patient services. EEQ figures show a fall from 59.5 percent in 2003/04 to 54.2 percent in 2005/06. Although a small change in the earnings/expenses ratio had been anticipated during the new contract negotiations, these figures are generally misleading because raw figures conceal several changes in the way GPs are paid under the new contract including the fact that GPs are no longer responsible for certain elements of their business expenditure, including IT, and that fact that many partnerships were opened up to non-clinical members, many of whom were previously employed by the practice.

The suggested present level of expenses does, in any case, no more than take the percentage back to its level in 1990/91 when the previous contract came into being. It had reached its higher level as GPs were prepared to invest heavily in their practices even when gross incomes were rising more slowly.

Are GPs investing in practice staff?
Contrary to accusations, GPs have increased investment in their staff and practices since the introduction of the new contract. According to the EEQ average expenses rose from £120,064 to £129,926 between 2003/04 and 2004/05. The increase in staff costs in 2004/05 was 17 percent, a fairly significant increase. The areas where expenses grew slowly or fell were business expenses and car and travel costs together with depreciation on capital assets. GPs value their

hardworking staff and have honoured the pay increases put forward by the national body that decides nurse pay. The BMA has always supported paying practice staff well.

Did the contract over-deliver funding to practices?
The main causes of the overspending in the first two years was a significant underestimate by the Government of achievement levels on the Quality and Outcomes Framework (QOF) and the additional cost to Primary Care Trusts of providing out-of-hours care. The BMA made the potential QOF scores quite clear on a number of occasions and the costs of providing out-of-hours services were also known at the time and were never planned to be covered completely by the removal of £6000 from GPs. Government negotiatiors were fully aware that out-of-hours replacement costs would be about £13,000. The global sum payment, provided to practices to deliver basic general practice defined as essential services, was defunded to increase investment in the QOF. As a result the Minimum Practice Income Guarantee (MPIG) had to be created by funds taken from premises, QOF and PCO funds to ensure that practices would not be worse off under the new contract arrangements. Had more funding been put into essential services in the first place, as the BMA wanted, the MPIG would not have been necessary.

Does the Minimum Practice Income Guarantee (MPIG) add to health inequalities?
The introduction of the MPIG was deemed essential to the contract proceeding and the alternative would have seriously damaged the viability of 90% of GMS practices. MPIG is a recognition that many practices, with the support of their Health Authority, had invested to a greater extent in practice staff in order to provide a greater range of services. The MPIG has led to funding for the contract being based more on historic funding that would have been ideal. The BMA is keen to work with the government to address these health inequalities but it is too simplistic to suggest that removing MPIG from GMS practices would achieve this aim. If the MPIG were to be abandoned this would significantly destabilise many practices that are most dependent on it and who would be forced to make large numbers of their staff redundant thereby affecting patient services currently provided.

Are GPs still good value-for-money?
The UK Governments expressed some value-for-money concerns following the introduction of the new contract, even though it had been negotiated and agreed by all parties, including Treasury. Although GP income did rise as intended, following the introduction of the new contract, GPs remain excellent value-for-money. General practice delivers high quality services with fewer doctors per head of population than most of our European neighbours. The Personal Social Services Research Unit at the University of Kent has calculated that, in 2005/06, the unit cost of each face-to-face GP consultation was just £21[4]. This figure compares very favourably with other NHS costs. Increasingly, GPs are providing services which used to be done in hospitals, e.g. minor surgery, diabetic care, preventive treatment of heart disease and strokes at a much lower cost to the commissioner. In the House of Commons on 28 November 2006, the Secretary of State for Health, Patricia Hewitt said that the new GP contract 'has led to primary care services being rated as better in our country than in almost any other advanced country'.

General practitioners are represented by a UK-wide committee, the BMA's General Practitioners Committee (GPC), plus three national committees, which work alongside it. The committees represent all general practitioners whether or not they are members of the BMA.

[4] *Unit Costs of Health and Social Care 2006,* compiled by Lesley Curtis and Ann Netten. Personal Social Services Research Unit, University of Kent, Canterbury, 2006