



A decade of change for general practitioners in the UK

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Another reorganisation is planned for UK general practice.¹ Many are familiar with the radical general practitioner contract introduced in 2003 that included quality indicators as performance targets.² While it has evolved since then, performance related pay still comprises one third of general practice remuneration where practices earn payments if they achieve targets in the clinical care of chronic diseases such as hypertension, diabetes and ischaemic heart disease. This Quality and Outcomes Framework,³ was designed to recognise measures of quality in practice but the thresholds for payment have gradually been raised and more targets added. It is important to recognise that this is not additional pay or a bonus but an integral part of practice income. To achieve these targets, practices require systems to record and retrieve data, call and recall patients, considerable organisation within a large team and, the integration of computerisation into every consultation. Chronic disease management has undoubtedly improved although some argue that standards of care were already rising, that non incentivised conditions may have been neglected and that there is a loss of continuity of care.^{4,5}

All is set to change again. A recently negotiated new contract, with precise details to follow, will reduce by one third the quality and outcome targets, increase the proportion of payment related to the number of patients, and increase individual GP responsibility for patients over 75 years of age. On first reading, these changes seem designed to promote more personal, primary and continuing care. No one yet knows how it will affect individual practices and the response has been muted in a profession worn down by continuous change.

There have been other more gradual changes in the

last ten years. Chronic disease management has been shifting from secondary to primary care and the GP is now seen as the key coordinator of care.⁶ And, demographic changes within the workforce means increasing numbers of women general practitioners.⁷ In response to this and other factors, general practice is moving towards larger multi doctor centres with a range of semi specialist skills, variable commitment contracts, with support from a range of paramedical, nursing and secretarial staff. The independent contractor status is gradually being eroded and, with increased monitoring and accountability, the benefits of such a contractual arrangement are greatly reduced. Some practices have had difficulties recruiting partners who are willing to take on the responsibility of running a business such as employing staff, providing premises and all the organisational complications. There is an increasing move towards amalgamations or federations creating larger groups where management is taken out of the hands of the doctors who focus primarily on clinical care.

While changes in the gender composition of the general practice workforce may initially have stimulated a greater awareness of work life balance, there is now widespread recognition that the 24 hour, 7 day a week model had to change. Many GPs now work part time with a portfolio career that may include hospital sessions, occupational health and part time work in out of hours care.

The landscape of general practice has changed greatly in the last ten years and the future will be very different. There have been major changes in the structure and delivery of care with considerable emphasis on target driven management of chronic disease. There is increasing central control and much less opportunity for variation in practice and the salaried option is becoming increasingly attractive. As health services in other countries look towards reorganisation, they might usefully wait for the outcome of this latest experiment in reorganisation.

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CONFLICT OF INTEREST

Nil

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