TALKING POINT

Remuneration of GPs in community and cottage hospitals

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Expensive, high-technology medical care, together with need to make the best use of scarce specialist medical skills, has led to the increased centralisation of facilities. This has meant that much hospital-based care has moved away from local communities. Only patients who really require this type of care should receive it so local communities must have their own "community hospitals" where extended primary care can be carried out in a hospital setting. In 1974 the Government accepted the case for community hospitals, though carefully pointing out that it would be some time before they became a reality on any scale.¹

From discussions with general practitioners in Clwyd on the establishment of these hospitals I am convinced that before any progress is possible there will have to be an appropriate system of payment for the work that is likely to be done in them. Such a system must be financially attractive so that it becomes unnecessary to refer to the "increased professional satisfaction" to be gained—true though that is—when attempting to persuade uncommitted GPs to enter this field.

Present basis of remuneration

The present arrangements for remunerating work done by GPs in cottage hospitals have existed since the NHS started. They are based on the staff fund and the clinical assistant session and the details are set out in the regulations governing the employment of medical and dental staff in NHS hospitals in England and Wales.² Briefly, health authorities have to pay into a staff fund each year a fixed sum in respect of each GP-controlled bed occupied on average throughout the year in the hospital(s) concerned. The fund is then shared out among the general practitioner staff as the GPs determine. Clinical assistant sessional rates are paid when no other rate is appropriate for work which is not covered by the staff fund and which does not form part of the practitioners' duties under family practitioner committee arrangements.

Apart from the payment levels there are two

major drawbacks to the existing system. Firstly, who and what is covered by the staff fund is ambiguous. For example, does the fund only reflect payments to be made in respect of inpatients who are not on the practice lists of the participating doctors? Secondly, the staff fund and clinical assistant sessions are by their nature too inflexible to cater for the wide range of demands which are likely to be made on the time and expertise of GPs who decide to work in community hospitals.

New system

Any new system of payment must reflect five factors: work load—more work should attract more remuneration; unpredictability—the disruptive effects of unpredictability of demand, particularly in relation to GP-manned casualty departments, are well known to the profession; inducement—there should be a real financial incentive to encourage GPs to take on the work; continuity—health authorities must have long-term contracts for community hospital work so that practitioners can plan with confidence to take on additional partners to meet increased work load; and familiarity—it would be advantageous to use familiar methods of payment.

The proposed system is based on the application of the above factors to some of the functions which a community hospital might be expected to undertake. It combines existing family practitioner committee and hospital methods of payment.

For inpatients the present staff fund would become a bed fund only and payments would be made into it in respect of the number of beds occupied on average during the year. Furthermore, the bed fund would be two tier, so making it possible to allow for larger payments for short-stay as opposed to long-stay beds. This proposal assumes that short-stay patients would mean more visits by GPs and hence a greater work load.

The present system of fees for maternity would be retained.

Because day hospitals—especially for the elderly—are expected to be a prominent feature of community hospitals, a fee per average daily patient attendance would be paid to participating doctors for day patients. Where such day hospitals are under consultant control, clinical assistant or hospital practitioner sessional rates would be payable.

GPs helping at consultative outpatient clinics could be paid clinical assistant or hospital practitioner grade rates.

Casualty work is viewed with considerable apprehension, especially by GPs who have no experience of working in cottage or community hospitals. The unpredictability of demand and the lack of financial reward make them reluctant to enter into any commitment in this respect. I believe, however, that the following method of paying for casualty work could

dramatically change matters: a standard increment on the capitation fee for each patient, to be paid to every GP who accepts a contract with the hospital to provide casualty "cover"; a standard night visit fee, for attendance at the casualty department during agreed hours; emergency treatment fees in respect of attendances on casualties who are not on the practice lists of participating doctors; and temporary resident fees in respect of all visitors seen.

Other work, such as hospital administrative duties, would be recognised by payment of a fee.

Discussion

The system of payment described above is based on discussions I have had with several GPs whose views seem broadly in line with the current thinking of the General Medical Services Committee's working group set up to produce recommendations for use as a basis for discussion with the DHSS.³ If the Government and the medical profession really intend the community hospital concept to flourish then "the means must will the end." Possibly those general practitioners who serve the 300 or so existing cottage hospitals and who are dedicated to them might be prepared to "soldier on" into the community hospital era under the existing financial arrangements. But it is most unlikely that other general practitioners would be willing to follow suit. There is, therefore, an evident need to develop a work-sensitive payment system. I believe that these proposals would achieve that objective.

References

- ¹ Department of Health and Social Security, *Community Hospitals. Their Role and Development in the National Health Service*. London, HMSO, 1974.
- ² National Health Service, *Terms and Conditions of Service of Hospital Medical and Dental Staff (England and Wales) and Administrative Medical Staff of Regional Hospital Boards (England and Wales)*. HMSO, 1971.
- ³ *Report of the General Medical Services Committee to the Annual Conference of Representatives of Local Medical Committees, 1977*, para 101.

From the GMSC continued

Ancillary staff pensions

The GMSC decided that court action might be called for if "reasonable" pension schemes for ancillary staff entered into before 6 March are rejected by the DHSS for reimbursement purposes under the ancillary staff scheme (1 July, p 70). In many instances it may be necessary for GPs to lodge appeals with the Secretary of State and the committee would like to hear of any that are unsuccessful.

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Correction

New charter for OMPs

We regret that in the article on a new charter for OMPs (30 September, p 976) we referred to Mr M J Gilkes as the chairman of the Ophthalmic Group Committee. He is the deputy chairman, and Mr Lorimer Fison is the chairman.