Enriching Careers in General Practice

Could the right contract improve morale?

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This is the fifth in a series of articles examining ways to increase fulfilment from a career in general practice.

Many general practitioners still blame the 1990 contract for the problems in general practice, claiming it has reduced morale to levels of the 1950s and 1960s. The contract was introduced to improve the quality of care and to provide some measures of standards, but the government failed to convince general practitioners that the contract was what the profession needed. Further change seems inevitable. Ideally a contract should improve efficiency, enable rationale planning, and ensure public accountability. This article gives the history of the 1990 contract and discusses changes which could be made towards reaching this ideal.

If the recent changes in general practice seem drastic, it is worth considering Ronald Gibson's recollection of the days leading up to the inception of the NHS. Gibson, a general practitioner, foundation fellow of the Royal College of General Practitioners, and later chairman of the BMA's council, described the feelings of "being just a pawn in a rather bewildering game, in which the rules were partly being dictated and partly made up from week to week. I doubt if any of us in general practice then fully realised how our discipline was to be isolated and denigrated."¹ After 1948 there were 27 wilderness years before the charter for general practice was drafted. Even after general practitioners entered the promised land of group practices, better premises, practice teams, higher income, and retirement pensions in 1966, murmuring and complaining continued.²

Standards rose in some practices but not in all. General practitioners continued to complain about trivial consultations,² hospitals began to extend their empires into the community in "outreach" schemes and through open access clinics, and it was said that general practitioners had become less accessible.³ The BMA and Royal College of General Practitioners suggested ways in which general practice could be made more rewarding, through minor surgery, improved care of chronic diseases, and disease prevention but these floundered.³ If the scope of general practice was so limited, it was asked, did a practitioner need a medical degree to do the job?⁴

At the same time, general practice was lauded: the General Medical Services Committee noted in 1983 that accountability was "a familiar responsibility to each general practitioner."⁵ Successive governments declared their intention to transfer resources from secondary to primary care. A feasibility study concluded that "there are good grounds for believing general practitioner services to be efficient, both from the point of view of the patient and with regard to the use of total NHS resources."⁶

The 1990 contract has successfully raised the low rates of childhood immunisation

Performance related pay

The government's discussion paper on primary health care in 1986 suggested that a good practice allowance might improve general practitioners' quality of care.⁷ Pereira Gray *et al* agreed that there was a problem: patients had difficulties registering with doctors or could not change doctors, access to some doctors was inadequate, too few children received immunisation, paediatric surveillance was inadequate, record keeping was not good enough, and there were unaccountable variations in rates of referral.⁸ The authors developed a framework for the government's idea of a good practice allowance based on clinical performance, anticipatory care, and practice organisation.⁹ They suggested that money used for fixed allowances such as seniority payments, the group practice allowance, and the vocational training allowance—around a fifth of a general practitioner's income—might become dependent on fulfilling performance criteria.⁹

Robin Fraser, professor of general practice at Leicester University, supported the notion of performance related pay but disagreed that there was a substantial problem in the 1980s. He said, "60-70% of practices were doing a good job. The real problem was

the reluctance of the GMSC and family practitioner committees to accept that a minority was not, and to do something about it."

Marinker *et al* predicted that "Those that failed to meet the criteria might in the process become demoralised and disheartened" and foresaw the development of "two nations of general practice." They did not foresee, however, that even those who did achieve the targets might resent the paperwork and intrusion on their professional integrity. The government's white paper on primary care, *Promoting Better Health*, which linked general practitioners' pay more closely to performance in certain activities,¹⁰ created a surge of protest. An acrimonious period followed. Negotiators from the General Medical Services Committee failed to change the Department of Health's plans substantially,¹¹ general practitioners were divided over whether to fight or put up with the proposals,¹² the Royal College of General Practitioners was marginalised, and the new contract was imposed.¹³

The 1990 contract

The 1990 contract made more of a general practitioner's income dependent on providing evidence of particular activities: immunisation and cervical cytology targets, child health surveillance, medical checks on new patients. There were incentives to provide health promotion and perform minor surgery. Doctors had to provide evidence of training to maintain some of their income. Not only did a practice have to meet targets and do additional work but the cut in basic practice allowance meant that it had to have a large list to maintain its income. There was talk of mass resignation, but the target of disquiet was unclear: the government had reformed the whole NHS. A few resigned and some retired early, others gritted their teeth, and some agreed to play the government's game, hoping that fundholding would help them to regain some autonomy.

What contracts do and do not mean

A contract is an agreement between two parties to establish a working relationship. Each party says what it will do and states conditions for the other party to meet. It should safeguard the interests of both parties and allow them to get on with the job without worrying about being exploited. It should be possible to put the contract away and forget about it: it acts as a reference for arbitration when negotiations are difficult. A tightly worded contract can reduce waste, improve efficiency, enable rational planning, and ensure public accountability. The same contract may devalue creativity, benefit the herd at the expense of the individual, and enfeeble professionalism.¹⁴

Contracts establish standards: criteria of adequate performance. Financial incentives have helped to improve premises and increased the provision of family planning, cervical smear tests, and immunisation.¹⁵ The standards may motivate those whose performance is below the standard but could induce complacency in those whose performance exceeds it. A contract that is too prescriptive does away with professional judgment.¹⁶ It offers no incentive to improve further and may promote a mercenary approach to work. The counterargument is that the veneer of professionalism may cover sound or rotten wood, and that "as a profession we have failed to address seriously the problem of bad practice."¹⁷

Which way forward?

The new contract spawned suggestions of how it could have been done better. David Morrell, professor

Doctors oppose National Health Insurance, 1911

of general practice at the United Medical Schools of Guy's and St Thomas's Hospitals, said that there was no place for complacency and agreed with the government's stated aim of bringing "all parts of the NHS up to the very high standard of the best."¹⁸ He took issue with the greater emphasis given to capitation, noting that the encouragement this gave to larger lists meant that the good doctors to whom patients were supposed to gravitate would have less time to see them. He proposed that an audit committee should be established to assess the quality of services provided by practices and link payment with the outcome of the evaluation, repeated every two years. The audit committee was to be independent both of the government and of the profession but to include representatives of all interested parties.

Ian Bogle, chairman of the General Medical Services Committee, saw excessive and inappropriate work and mismatching of the expectations of independent contractors and NHS managers as key issues in the current expressions of low morale and low job satisfaction.¹⁷ He presented a paper to the General Medical Services Committee which explored the feasibility of replacing the individual contracts with a contract for the whole practice. The contract would define the content and volume of services to be provided, with different elements of service being negotiated separately. The elements he envisaged were general medical services, divided into normal hours and outside normal hours, and non-general medical services. General medical services would include the services currently covered by item of service payments as well as what is now known as general medical services. Non-general medical services would include minor surgery, dispensing, more advanced surgical or investigative procedures, or community care assessments—the services provided by some but not all practices. By contracting separately for services outside normal hours it might be possible to arrange services according to local needs and the preferences of doctors.

Bogle suggested that payment should be negotiated nationally, and once a practice had agreed a contract with the family health services authority it

would be allocated a budget. The budget would include funds for agreed development and practices would have to submit a practice plan, naming their aims and objectives, targets, and intentions for audit. The practice would have to report on its progress and revise its plans at intervals. In addition a reaccréditation scheme was envisaged that would serve as a quality guarantee. However, he thought that the traditional form of contract should continue to be available for those who wished to remain in it. He also suggested that the option of a salaried service should be made available.

Through introducing a system of quality assurance and defining the work of general practice more clearly, Bogle hoped to stop the ad hoc dumping of tasks on general practitioners and make the system of payment both more simple and sensitive to levels of activity. Thus, general practitioners' morale should be restored. The risks included more explicit terms of service, a loss of the expectation of a job for life, and the inevitable resistance of the government to a scheme which might cost more money than the current one. Indeed when I spoke to him last autumn, he said that such a contract was not on the government's current agenda. In October the General Medical Services Committee discussed this paper and took the view that such a contractual arrangement presented far too many disadvantages for doctors and patients and that the idea should not be pursued.

A view from the NHS management executive

I spoke to Roger Bolas, a senior medical officer in the primary care group of the NHS Management Executive and former general practitioner, and asked him what further changes the government planned. He said, "It is fair to say that the changes haven't stopped. We are probably in for some years of development. The department is concerned about morale among general practitioners and is working with the BMA and the Royal College of General Practitioners to address the issue and relieve pressures where it can. Rapid change in any organisation can be uncomfortable, whatever its eventual benefits."

Roger Bolas suggested an agenda similar to that suggested by Honigsbaum.⁴ "General practitioners are asking what are our central responsibilities, who has the skills to do the job at a reasonable cost, and how do we identify what is ineffective and stop doing it? The health service reforms flow from the principle that the NHS exists to serve patients' needs rather than those of large institutions. We are moving away from a situation in which health professionals practise by divine right to one governed by patients' needs and reflecting their expectations. General practitioners are overskilled for many of their tasks, and often feel frustrated by not having time to use their skills. Practices and family health service authorities need to debate how to use the skills of the wider primary health care team. Making better use of the team can free time for doctors and their families."

I detected a glimmer of threat here. If general practitioners are overskilled, are they overpaid? Could they be replaced with nursing staff? There seems to be a discrepancy between this and the power and influence general practitioners have gained through fundholding. Roger Bolas cited work to support the view that fundholders lead the way in evaluating their work and proving their worth¹⁹: "Fundholders have reduced the rate of increase of prescribing cost more than non-fundholders, but there is still a lot of waste in prescribing. We need to challenge received wisdom constantly and make sure that all we do makes the best use of NHS resources."

I asked for reassurance about what has been called

patient imperialism. "Patients need to be a part of the process of improving health. They need to feel free to complain as complaints can lead to improvements in service. We need to be able to use complaints constructively, rather than becoming defensive and losing the opportunity of examining areas of difficulty. If this can be achieved, services to patients and job satisfaction will improve."

Academic views

The basis for *Which way forward?*²⁷ can be traced back to a paper by Marshall Marinker in a 1984 pamphlet called *A New NHS Act for 1996?*²⁰ The seeds of fundholding are also there—the shift of the workload of outpatient departments into the community, and the idea of nurses and managers becoming profit sharing partners. Marinker stated that the dilemma facing a new contract was that "Unless a quality-sensitive reward system is introduced, motivation for change, and improved performance, will continue to rely on professional good conscience alone." He still feels happier with the idea of rolling contracts with practices rather than reaccréditation for individual general practitioners. He rejects consumerism as the basis of an adversarial relationship rather than one based on cooperation, and sees a paradox between a doctor-patient relationship based on trust and one based on a contract. But there has to be a balance.

Eric Caines, professor at the Centre of Health Services Management at Nottingham University and formerly the personnel director of the NHS Management Executive, believes that market forces have not been given the chance to work. "The NHS allows people to operate at 60%. The health market was set up with a simple aim: to put pressure on to do more, better. The gap between the money available and the demand for services is growing, but purchasers are still making contracts on the basis of traditional constraints rather than putting them out to tender. There are huge increases in productivity to be made, and staff can be used more creatively." He bemoans the lack of rewards for success in the new NHS: although some of the perverse incentives have been removed market forces are not yet being applied effectively.

Caines believes that the idea of applying market forces to health services was a good and brave one. "The challenge is to make better use of what you've got. What I call Caines' paradox states that more equals less. If you pump money into the health service, staff relax. Performance is better in a crisis. Evenhandedness is the curse of the NHS: the notion that if you can't do it for everyone, don't do it for anyone. Democracy generally equals inefficiency, shared misery. We have to encourage elitism; teams work better with leaders. The NHS is much better clinically than managerially, but doctors lack interest in management." Eric Caines told me how he turned up at a London hospital to give a talk on management to medical students and junior doctors, expecting 400 to attend: there were seven there. He believes that doctors regard managers as fly by nights, but, as long term staff, doctors have to learn how to manage work and budgets and get value for money.

The argument is plausible but raises questions. Performance may be better in a crisis, but can it be sustained? Medicine is about dealing with the crises of others all the time: perhaps it is unreasonable to expect its practitioners to have a wartime spirit for management as well as clinical practice. But a competitive system might reduce the gap between the best and worst performing units. Caines has argued that the NHS could work at current capacity with 200 000 fewer staff and improve the motivation of those who

remain by rewarding better performance. The pot is not big enough to sustain further growth in the health service run as it is. Efficiency can be improved if expensive workers spend more of their time doing what they alone can do and less expensive workers do the work they are capable of but which currently ends up being done by more expensive workers.⁴

Quality assurance

Efficient ways of working are part of quality service. In introducing annual reports, targets, and audit into general practice, the 1990 contract took a step towards quality assurance. The message was lost amid the acrimony of the contract's imposition and the failure of the government to persuade the profession that this was what it had been looking for itself. The details may have been trite; to many they appeared irrelevant and unnecessary, but they offer an opportunity of measuring and defining our activity and assessing whether we do as well as we would like to believe.

Donald Irvine, general practitioner at the Lintonville Medical Group in Ashington and a regional adviser, welcomes the opportunity of defining what general practice is. Fundholding to him was a new stimulus to build a corporate identity for the practice. He sees individuality as both a strength and a weakness for general practitioners. The current change of culture is from "unfettered individualism to a managed health care system, with general practice as its foundation." He sees fundholding practices of today as small NHS trusts of tomorrow, provider units of "a specified range and quality of service for a defined population, at an agreed cost."²¹ Hospital care would be added on as required. Like Bogle, he envisages personal contracts remaining for some, and salaried posts being developed for others.

Salaried posts

The idea of salaried posts becomes attractive when the balance of independent contractor status tips from autonomy towards bureaucracy. The General Medical Services Committee's poll of general practitioners, *Your Choices for the Future*, indicated some support for a salaried service.²² One reason is based on the political economy of general practice, which is that of a public sector franchise.²³ Franchising enables local proprietors (general practitioners) to trade under the name of a central organisation (the NHS) that offers its logistic support. As the franchise network becomes more complex, the franchiser (NHS) may increase control to maintain a standardised product, eroding the independence of the franchisee. This sounds familiar when decoded. The other attraction of the salaried service is to avoid the expense and commitment of buying into a practice.²³

Steve Iliffe envisages small numbers of partners who share a financial interest in the practice premises, who employ salaried doctors to work alongside them. A fixed term contract might, through time and experience of working style, help doctors to make better decisions about partnership later on without the need for either party to feel it had failed a period of mutual assessment. A salaried job might be long term or for a fixed term and could be used to attract general practitioners to posts that might otherwise be difficult to fill.²⁴

Conclusion

There are limits to what we can expect of contracts. Good or bad, some general practitioners will make the best of them and others will find them a burden. Denis Pereira Gray, professor of general practice at Exeter University, warned me, "There is a terrible danger of muddling professional and contractual issues. Super family doctoring can occur in all sorts of places, with very different contractual arrangements, all over the world." But whereas the 1966 charter left our autonomy intact, increased our support, and reduced risk, the 1990 contract tightened controls, reduced support, and increased risks.²⁵ There is scope for change in the current contract to reduce general practitioners' unhappiness.²⁶ The Department of Health has shown itself ready to change on health promotion, three yearly checks, and removal of violent patients from doctors' lists.

The 1990 contract does not explain fully the problem of general practitioners' morale. No contract will suit everyone—by their nature contracts are either blunt instruments or ineffective. We should probably expect our contract to become more rather than less prescriptive. If the profession's attitude to standards is positive then it will be less difficult to meet imposed standards.¹⁸ A profession that is seen to be setting and achieving high standards may be given more freedom to work them out in its own way.

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