CHOICE AND OPPORTUNITY: Responses to the Government's White Paper

17 December, 1996

Executive Summary

- **The profession is divided in its reaction to the introduction of a salaried option:**
  - Generally those new to the profession or currently in part-time or non-principal posts are in favour
  - Those who have been in the profession for a longer period of time are less enthusiastic about it
- **The additional authority to be granted to the Health Secretary via the Primary Care Bill is seen to take power away from the GPs and the patients**
- **The details of the new system are being surmised:**
  - Some are concerned about the lack of detail
  - Others are forging ahead with plans for new projects already
  - The question of hypocrisy was raised in the government's plans to create or develop new cottage hospitals while simultaneously closing others
- **The GMSC has produced a document defining core and non-core work in general practice. This has received a mixed reception:**
  - Some are pleased that the Committee has at last done something on this matter
  - Others are concerned that following the Committee's instructions about what not to perform as non-core services will put them in breach of contract

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1. Sources of information accessed:

- *Choice and Opportunity: primary care the future*: the government's White Paper and its press release
- Journals taken by the King's Fund (handsearched) which have contained useful sources:
  - *British Medical Journal* 16 November 1996, 30 November 1996
  - *Community Care* 14-20 November 1996
  - *General Practitioner* 15 November 1996, 22 November 1996, 29 November 1996,
  - *Health Service Journal* 28 November 1996
  - *Nursing Standard* 20 November 1996
  - *Pulse* 16 November 1996, 23 November 1996, 30 November 1996,
- Databases:
  - King's Fund's Unicorn database
  - Medline
  - DHSS-Data
  - HealthStar
  - World Wide Web

2. Information gleaned:

- The implications of the Primary Care Bill in relation to the Health Secretary's future powers is causing concern
- The issue of core/non-core work has been emphasised following the publication of the GMSC's document on this
- The potential reality of salaries and employment by other bodies is still being discussed
- Some other issues surrounding cottage hospitals have arisen
- The practicalities of the new system and its possible complications have been debated
- There are still worries surrounding staffing, resourcing and workload issues within all of these other topics

3. The reactions in detail:

3.1 A salaried service with employment from other organisations

3.1.1 Employment by other organisations

More examples of potential employers have been put forward in the professional press in the last weeks, among them social service departments[1], GPs themselves[2], LMCs[3], primary care employment agencies[4] and private health insurers[5].

Pulse recently ran a readers' poll of 652 GPs[6] on the issue of salaries. They state that although 60% of the surveyed population claimed that they would consider employing salaried GPs and more than half would consider taking a salaried post themselves, opinion on the option of working for a health insurer was divided equally between those in favour and those against, with 20% being undecided.

One way in which GPs themselves could become employers would be for them to form themselves into co-operative "trusts". This is something which has been proposed by the chairman of the National Association of GP co-operatives, Dr Krishnan Korlipara[7]. He suggests that GPs could provide such services as acute admissions, management of some acute conditions and some surgical treatments. He is also adamant that this idea differs from that of the "Superfundholder" which has already been mentioned in the primary care debate. Ultimately Dr Korlipara sees these GP trusts buying hospitals. He describes this idea as something which is smaller than a fully fledged hospital but certainly more than a cottage hospital. The idea of GPs forming their own primary care trusts is also endorsed by Dr Tony Stern. He sees this happening with LMCs being a co-ordination point and thinks that this would be preferable to being employed by a community or a hospital[8].

This reality of a service in which surgeries can provide hospital type treatments is already in place in Southend according to one practice. The Queensway Surgery already has a contract with South East Essex Health Authority to carry out hernia operations on behalf of non-fundholders as well as fundholders[9].

3.1.2 The GPs' opinions of salaries

The generalised characteristics of those in favour of salaries and those against are starting to emerge. It seems that it is the younger GPs[10] and those currently in part-time or non-principal jobs[11] who would be happy to be salaried for at least part of their careers. Already some GP registrars are choosing to stay away from full-time partnerships when they have finished their vocational training scheme placements[12]. This trend is recognised by both the young GPs themselves and their older counterparts. Dr Katherine MacLurg, a GP from Sandhurst, is quoted as saying that a salary would help ensure that she does not become trapped in a partnership which, although stable, does not present many opportunities for further advancement:

> "I want to be continually challenged in my career and not feel I have reached the top at 32 years of age as a partner in a practice."[13]

Another advantage to the salaried option was voiced by Dr Gill Jenkins, a part-time restricted services principal in Bristol:

> "[Y]ou know exactly where you are and how much you are going to earn each month."[14]

Despite claiming that they might consider taking up a salaried post in theory, the practicalities of the remuneration which would be required for such a post have yet to be settled. Some of the professional commentators have asked some members of the profession for their ideal package and several figures and perks have been bandied about. Examples of these desires are[15]:

> "Paid leave and superannuable pay which I am not entitled to as a locum...I would say £40,000 for in-hours work with half-time work paid pro rata; tax relief for childcare and a salaried option for term time only.."

"£120 an hour and given the environment that I work in...a Jeep Grand Cherokee - worth about £30,000."

"[A]bout £50,000, a BMW and six weeks paid holiday and an allowance so that you could have a week's proper course without having to pay for it yourself."

"I should be paid in the region of £30,000 to £35,000...and I would not want to be on call after midnight. I do not mind how hard I work during the day as long as I do not have to be on call at night."

One interviewee in this small group pointed out the discrepancies in earnings which salaried employment would bring up and which is demonstrated in the varying requests of the others questioned. This medical student stated that she thought that it was unfair that "[a] GP in the East End of London can be working extremely hard for £29,000 while someone in another area can earn £60,000."

Those who are against salaries are less easy to pigeon-hole. The worries they voice include the problems in a return to a two-tier system of GPs which might bring back the "bad old days of assistants with a view who never get full partnership"[16]. This assumes however that every GP wants to have a partnership, a view which is gradually being debunked. Other opponents of salaries fear that:

- The service will become fragmented[17]
- Resentment between salaried and non-salaried GPs will erupt[18]
- A "second-class grade of doctor" will appear (Medical Practitioners' Union)[19]
- Continuity of care will be destroyed[20]
- The medical profession will be exploited[21,22,23]
- The lack of a national contract will lead to inequity[24]
- GPs will lose their independence, autonomy and freedom of criticism of the health service[25]
- Trusts will be allowed to wrest control of GMS from salaried GPs[26] as it would no longer be ring-fenced[27]
- The GP's advocacy role will be stretched "to the limit"[28]
- GPs will not be allowed to be a part of the NHS superannuation scheme (this is currently undecided[29])
- Consultations will be longer and more expensive because a GP will not know his or her patients and will have to establish their medical history in each session[30]
- The salaried option brings all the disadvantages of being employed to the disadvantages of being self-employed: not much would change except that "[y]ou would be expected to cover for sick leave and holidays."[31]

Concern is also voiced over the ability of GPs to act as employers. Dr Stephen Henry, co-founder of the National Association of Fundholding Practices, thinks that before they all begin purchasing services and employing other GPs, practices should have to prove that they are competent to buy secondary care[32]. He suggests that peer group review and comparisons between practices will help GPs to understand that management is a tool for use and not of command control.

If the surveys undertaken by *Pulse* and *General Practitioner* are to be credited with some credence then the profession seems to be split in this issue. *Pulse*'s survey claimed that 60% of its survey population would consider taking up a salaried position[33]; *General Practitioner*'s survey on the other hand returned an entirely different result. 71% of their

responses claimed to be against salaries with only 36% stating that they might consider working for someone else like this[34]. Unfortunately, neither publication includes the questionnaire they used for these surveys and their survey populations were of quite different numbers (*Pulse*: 652; *General Practitioner*: 250) and so their results may not be relevant. Nonetheless some of the comments returned by the GPs questioned are useful in establishing some of the issues currently worrying the profession.

3.1.3 The existence of salaried GPs to ease the recruitment crisis

Despite these perceived advantages and disadvantages of a salaried profession, the reality of salaried GPs already exists. This has been necessitated by the current GP recruitment crisis. West Kent Health Authority have already taken on salaried GPs to help avert a recruitment crisis in the Medway district in West Kent[35]. The Authority predicts that 47% of its GPs will retire in the next five to ten years and so they have created 4 GP associate posts for a year each with a guaranteed salary of £34,000 to help ease manpower problems. The chairman of the Overseas Doctors Association, Dr Surenda Kumar, predicts that 75% of GPs will be salaried within 10 years due to this need to attract younger people into the profession[36].

The Labour Party also accept that a salaried option might go some way to ease the GP recruitment crisis but are concerned about the introduction of private companies into the equation[37].

3.1.4 Privatisation worries

Other members of the primary care world are still voicing worries that the White Paper opens the door to the privatisation of the NHS. This fear has been heightened through the proposals in the Primary Care Bill[38] to move general medical services from part II to part I of the NHS Act, thus enabling the Secretary of State to seek the provision of general medical services from alternative sources, including the private sector[39] (for more information on the reactions to this particular piece of news, please see section 3.3).

Even putting this concern aside, some GPs are still convinced that the White Paper proposals are part of "a long-term covert intention to break up and ultimately privatise the NHS."[40] The possibility of private companies being GP employers has caused some to consider the impact that this will have on the service. As Dr Andrew Dearden points out, these businesses exist to make money and as such could possibly exploit GPs or ignore the poorer areas of the country:

> "Poorer areas don't tend to be so health conscious, so they wouldn't be so good for business. If I was a businessman, I'd target the wealthier areas."[41]

Even without the threat of a completely privatised health service, some members of the profession are concerned about the introduction of the private sector into the internal market.

3.2 The core/non-core work issue

3.2.1 the GMSC document

The GMSC has recently released a core services document[42] and advised GPs to stop doing non-core work unless they are paid extra by purchasers. This document has caused some debate in the professional press over the implications it will have for GPs' terms and conditions of service and for the White Paper proposals.

The document itself advocates the following changes:

- Allowing a charge for all travel immunisations
- Removing the following:
  - The requirement to provide certificates for social security purposes
  - The requirement to offer annual health checks to the over 75s
  - The training of general practitioner registrars
  - Intrapartum care
  - Minor surgery
  - Child health surveillance
  - Dispensing[43]

The GMSC insists that the document is not up for negotiation with anyone, including the government, as it is a "declaration of intent" following years of consultation with GPs[44]. Despite this firm stance, however, some commentators believe that the GMSC has been "outmanoeuvred" by the government over the changes to primary care[45]. The GMSC's reasons for producing the document have been reported through Dr Ian Bogle. He said that it was designed to stop any fragmentation of the service[46], to protect GPs' core duties, to help control workload and to help to ensure that GPs fulfil their true role as clinical generalists[47]. He also said that the document was an invitation for Health Authorities to make new arrangements for services that they should not automatically expect from GPs.

Stephen Dorrell has responded to the GMSC's proposals by branding the definition of nursing-home work as non-core as "ridiculous"[48]. Simon Hughes on the other hand is in favour of defining core services and ringfencing funding for GPs[49]. Stephen Dorrell is also said to be "dismayed" that GPs have been advised against taking on nursing home patients unless they have contracts with Health Authorities.

The GPs however are well aware of the extra workload which the nursing-home work would mean for them. Dr Ivan Wisely, an Aberdeen GP, has been reported as saying that "to expect GPs to take on patients who are essentially in geriatric hospital without even recognising the extra workload is the con of the century."[50]. Some Health Authorities recognise this too. Bromley Health has appointed a GP to provide specialised care for nursing and residential home patients to ease pressure on other GPs who cannot cope with this extra work[51] .

Many commentators are concerned about the position in which the GMSC's document will put GPs in light of their terms of service. The GMSC has said that GPs need to give "reasonable notice" to Health Authorities of their intention not to provide certain services[52]; however, it seems that there are some services among the list of non-core ones which GPs are still obliged to provide under their current terms of service[53]. These are health checks for the over 75s, travel immunisations and social security certificates[54].

Despite this, the GMSC have also advised GPs to draw up new contracts with Health Authorities as soon as possible in order to allow the authorities time to get something in place[55]. They have also reassured GPs over the legality of refusing non-core services next April[56]. GMSC negotiator, Dr Simon Fradd has said that the committee had taken detailed legal advice on the matter and, in the non-core document, have produced a "responsible body of opinion which supports the view that it is reasonable to define these as non-core services"[57].

3.2.2 GP opinion of the non-core document

Pulse interviewed a range of GPs in order to gauge their opinions of the GMSC document. These are some of the views which they found[58]:

> "Doctors should be paid for the extra work they do in nursing homes...people feel emotionally blackmailed into doing this work."
>
> "I do not think it is very realistic and to some extent it's not a very professional attitude"
>
> It is time for GPs "politely but firmly" to say no to these new patients
>
> "There has been a big increase in GPs' work demands because of nursing and residential homes...This sort of thing could reduce the scale of the problem...I would prefer that the work we are already doing is recognised in our basic pay."

Another commentator, Dr PL Hays from Hailsham, believes that the document could be divisive. In a letter to Pulse he or she states that the core/non-core debate is a "red herring" and that it provides "considerable potential for the Government [to make] this another factor that divides the profession against itself."[59].

The LMCs are concerned about the document. They have been reported as being apprehensive about how GPs could set about refusing to carry out non-core work without extra payment and fear that the implementation of the document could lead to GPs alienating their patients, being pitted against each other and breaching their terms of service[60]. They also worry that clinical services and especially service development will suffer through the extra work needed in negotiating for non-core services[61].

3.2.3 Local negotiation

The role of the LMCs has been brought under review through this issue as they may have had a role in helping family doctors with negotiating and preparing contracts to provide non-core services[62]. They have been told by GPs' negotiators that they should not set prices which are then adopted by doctors but that they can respond on behalf of doctors by simply negotiating contracts with Health Authorities. If LMCs were to take the initiative in setting prices that were followed by all local doctors this might give rise to a complaint to the Office of Fair Trading. The LMCs themselves do not seem to be entirely happy with this arrangement, however; some of them believe that such local negotiations will only produce more work for little gain[63].

Another point on the topic of local negotiations over core services has been made by Northern Ireland GMSC member, Dr Ian Banks. he has been quoted as saying that "[i]f other organisations are allowed to employ doctors they will decide what are the core services by a contractual arrangement"[64]. This suggests that the introduction of primary care into the internal market like this could render the GMSC's document irrelevant. If they who wield the contracts and the salaries choose not to pay for what the GMSC sees as non-core work then there will be little that the GPs can do about it, despite the GMSC's attempts at national equity of some sort.

Inequity is seen by some to extend to the individual GPs as well. Gloucestershire LMC believe that fundholders will have the advantage over non-fundholders when it comes to taking on non-core work as they will not have to bid against other potential providers and already have experienced management teams primed for negotiations[65]. According to Dr

Martin Bailey, the LMC's secretary, the fundholders will be geared up to provide many non-core services that they will be able to pay themselves to do, thus avoiding competitive bids.

3.3 The Primary Care Bill and a second White Paper

The Primary Care Bill following on from *Choice and Opportunity* and setting out proposals for GPs to pilot alternative contractual arrangements is making its way through parliament. Many of the professional commentators also refer to a second primary care White Paper due out in early December[66,67]. This is supposed to be a substantial document containing detailed information on how the new primary care system can be implemented and should contain detailed plans to improve information technology in general practice[68]. Nothing has been seen of this second White Paper yet.

One worry which has recently evolved surrounds the new powers to be granted to The Health Secretary once the Primary Care Bill has gone through parliament. The GMSC has been reported as worrying about the proposal to move GMS from part II to part I of the NHS Act[69,70]. Dr John Chisholm is quoted in *Pulse* as saying that there was always a danger with enabling legislation as it could give increased power to a Health Secretary[71]. The same article cites the BMA as being concerned that the changes to the 1977 NHS Act will go far beyond what is strictly needed for the first wave of GP pilot schemes. Stephen Dorrell has been quoted as justifying these legislative changes through the need to give Health Authorities the discretion to try out new things[72].

Pulse's "Comment" section puts the profession's worries in a wry way, relating them to Dorrell's previous promises of flexibility and democracy:

> "[H]e [Stephen Dorrell] - and his successors...will have a lasting legal mandate to meddle in primary care provision. The vehemence of Mr Dorrell's denials of a looming Big Bang in primary care should have alerted GPs to the dangers. Quite simply, the Health Secretary doth protest too much."[73]

Dr Hamish Meldrum sees the extension of the Health Secretary's powers as being a way of removing control from patients and GPs and giving it to the Secretary of State[74]. This turn of events has had a large impact on those members of the profession commenting on it. None of them have welcomed the change, rather it seems to have confirmed in some minds the fact that *Choice and Opportunity* really is the description of a "Big Bang" and foretells the deregulation of primary care. Jenny Popay, professor of community health at the University of Salford implies that the government has another political agenda which includes creating a few more openings to the private sector[75].

Another area of power change effected by the Bill concerns the Medical Practices Committee (MPC) and this too has caused some anxiety[76]. As the MPC would have no say over pilots, those GPs involved would be removed from the "manpower pool". GMSC negotiators felt that this could lead to an unequal distribution of GPs with some areas overpopulated with doctors and others struggling to recruit. Mary Leigh, MPC chairman, agrees:

> "I have grave reservations that it will be difficult to ensure an equitable distribution of GPs if power is devolved from the MPC to the health authorities over manpower control for pilots."

The MPC is also concerned that more fake doctors could slip through the system if the Committee itself was not checking the certificates.

The Bill itself is being attacked in parliament by the Labour Party on other issues. Chris Smith has told Pulse that although he broadly welcomes the incremental approach of the Bill he intends to attack it on two main areas: the ending of ring-fencing of GMS cash and the possible introduction of private sector companies as GP employers[77].

3.4 The practicalities of the new system

3.4.1 Cottage hospitals

Some GPs are enthusiastically embracing the idea of cottage hospitals. In Minehead, the Harley House Surgery is planning on piloting a primary care trust with a local hospital[78]. Meanwhile, Derek Day, deputy director of the NAHAT, believes that cottage hospitals will make no difference to the realities of patient care:

> "Most people now recognise that the right thing to do is to have people in NHS accommodation only if they need active medical care. Cottage hospitals won't change that, but they may act as an intermediate resource so that someone who still needs nursing care can get it."[79]

Other GPs see the cottage hospital idea as embodying governmental hypocrisy. As Rickford points out "as there is no extra money for the changes, more community beds would presumably mean fewer acute hospital beds". Some GPs in Norfolk, Lincolnshire and Hampshire are experiencing this already and feel angry that their local hospitals are threatened with closure at a time when the government is promoting cottage hospitals. Some of these hospitals are in fact cottage hospitals themselves (Odiham cottage hospital in Hampshire and Bourne cottage hospital in Lincolnshire) thus making their closures even more striking.

3.4.2 Gatekeepers/health maintenance organisations

The dismantling of the GP gatekeeper role in favour of a health maintenance organisation model has been dismissed by Gerald Malone as something that will not happen[80]. He sees the gatekeeper role as "essential". He is also reported as saying that there is no reason why doctors should not continue to act as advocates for their patients.

This role of gatekeeper is being eroded in other ways though as the roles of nurse practitioners extend. It is these members of the primary health care team who have become the first line of the health service and who can refer patients on elsewhere, i.e. to the GP, if necessary. Dr Tony Stern does this in his practice and claims to have good reason:

> "In my experience, about 20 per cent of ordinary consultations between a patient and a nurse practitioner need GP input."[81]

Although those GPs who run their surgeries in this way claim that it saves time and money, this does still impinge on their roles as traditional gatekeepers to the health service.

Other, more obvious attempts are being made to introduce US style managed care into the UK. Latham House Medical Practice in Melton Mowbray is currently discussing just such a service[82]. The scheme they are considering would allow the practice to hold its entire budget which it would actually share with a local trust. The GPs are aware that such a scheme could lead to drug companies delivering packages of care for specific diseases and are in favour of deregulation and possession of a total budget in order to implement these changes.

The Liberal Democrats have seen difficulties in the proposed management of finances within primary care. Bringing GPs into the internal market and then making them responsible both for purchasing and providing health care seems to Simon Hughes to be problematic:

> "We need to look more carefully at whether we have a single budget for GMS, health and community services and prescribing. If you keep the purchaser-provider split, the GPs are sometimes neither one thing nor the other and we need to resolve that."[83]

This looks likely to be a question which will run and run and which will divide the profession into two.

3.4.3 The Pilots

The lack of detail surrounding the pilots' remits is still causing concern. Judy Hardagon, chief executive of the Primary Care Support Force emphasises the need for clarity and simplicity in enacting the White Paper's proposals:

> "There is quite a lot of detail to be worked up in the implementation of the White Paper but we need to be careful that in solving small problems we don't end up creating complicated structures."[84]

While many of the suggestions for change from the profession are similar in, for example, the area of salaries, others are very complex. Dr Tony Stern describes his ideas for a new version of primary care in *General Practitioner*. His ideas include the following:

- GPs to form their own primary care trusts
- GPs to be fundholders for private medical insurance companies (an extension of the gatekeeper role)
- Patients should be allowed to consult their NHS GP privately in the same way that they can with consultants
- The abolition of practice areas so that GPs can see patients from other areas
- The introduction of smart cards and other information technology to help cut down on bureaucracy
- The devolution of Health Authority management to small localities where health commissioning could be more focused on local GP requirements
- Health Authorities, large GP fundholders or trusts to set up centres to monitor the quality and quantity of consultant and GP care, including the appropriateness of referrals
- The introduction of "face-to-face" contracts along with regulations to control the quantity and quality of care[85]

Many suggestions of new ways of working have been put forward but worries still revolve around the nature of the positions of those GPs who do not participate. *General Practitioner*'s survey of its readers revealed that two thirds fear that GPs who do not grasp the opportunities in the White Paper will get left behind, implying that not to join in would result in indirect penalisation[86]. Gerald Malone refuted this criticism when he addressed a special GMSC and LMC meeting:

> "We want to give doctors a return ticket which will be the same class as the one they left with and the train will leave immediately if they choose to take the train back." [87]

In fact even this ability of GPs to return to their old ways of working if they want to is causing some concern. Jeannett Martin is worried that this will cause costly problems for

those GPs working in deprived areas. They may not have the resources to start up the pilots in the first place and even if they do enter the scheme they may not have the resources to continue it and so will have to pay out more money to return to the old method:

> "[P]ractices could go back to how they worked before, with no penalty. Costs may be considerable. In areas where even basic services are not available, this "try it and see" approach, will be difficult to justify."[88]

Some information on the financial aspects of the pilots has been released, such as the announcement that £6 million will be set aside for 1997/98 for preparing, monitoring and evaluating new schemes under the Primary Care Bill. John Chisholm of the GMSC has been quoted as criticising this amount:

> "It is piddling. That works out about £200 per GP which Mr Malone said was not enough."[89]

On top of this, the chairman of the GMSC information management and technology subcommittee, Dr Grant Kelly, has estimated that each practice will need at least £2,000 to buy the appropriate computer systems to run and monitor the pilots[90].

Not only are the resources for the introduction of the pilots under fire but some are also concerned that the evaluation procedures will not be performed effectively. Professor Patrick Pietroni of the Department of General Practice in the University of Warwick has warned that pilot projects need at least a decade to flourish before their benefits or otherwise can be perceived[91]. Ten years ago Professor Pietroni pioneered the inclusion of complementary medicine and social care services within his general practice remit. This has been a success; however, despite the experiment's popularity, meaningful outcomes were only available in the last couple of years. He suggests that incomplete results may be obtained about the effect of the primary care changes if the pilots are evaluated too soon.

4. Conclusion

- The profession is divided over its reaction to the introduction of a salaried option: generally those new to the profession or currently in part-time or non-principal posts are in favour, while those who have been in the profession for a longer period of time are less enthusiastic about it.

- The additional authority to be granted to the Health Secretary via the Primary Care Bill is seen to take power away from the GPs and the patients. This issue is causing much debate.

- The question of the details of the new system is worrying some, while others are forging ahead with plans for new projects already. The question of hypocrisy was raised in the government's plans to create or develop new cottage hospitals while simultaneously closing some others.

- The GMSC has produced a document defining core and non-core work in general practice. This has received a mixed reception, with some pleased that the Committee has at last done something on this matter and others concerned that following the Committee's instructions about what not to perform as a matter of course will put them in breach of their terms of service.

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