Family doctors and payment systems: the local option

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This is the sixth in a series of articles commissioned in response to the General Medical Services Committee's strategy paper "Building Your Own Future"

How can family doctors begin to shape their own future? Long term the greatest adverse effect of the contract could be the loss of autonomy rather than the immediate symptom of excessive paperwork. The strength of family doctors lies in their power to innovate and to relate to patients and their needs. They can meet targets, but they cannot be cogs in a large health machine without losing most of the achievements and the potential for development of British primary care. Family doctors have to find a payment system that will enhance their power of initiative in the new world of the internal market.

There is a danger of excessive pessimism about the current state of general practice. Achievement under the Family Doctor Charter was massive, even though the results varied among areas. This achievement was not just the recruitment of a new generation of family doctors and improvement of premises and staffing but the development of a new philosophy that went beyond the demand led consultation. In fact it was the family doctors' work in developing health promotion and investing in information technology that made the contract possible. Britain is now well ahead of the rest of the world in the strength of its primary care.

For all their doubts about the contract, family doctors have responded remarkably well. It may have been predictable that 89% of family doctors in Suffolk would have reached the higher target for uptake of cervical cytology in the first six months of the contract but so have 93% of family doctors in Barnsley, 90% in Wakefield, and 70% in Bury.¹ Even in the transition many practices have continued to invest in staffing and to develop new premises, often adding to their own financial risk. The early response to fundholding has also been strong. There are uncertainties and some less positive developments such as an increased rate of break up of practices, but general practice is not in the 1964 situation of imminent collapse.

Payment systems should be related to aims in activity, which should in turn relate to health needs. Health needs can be described in terms of particular client groups or, more generally, in terms of family based primary care aimed at health promotion and effective treatment for people with long term illness. What payment system would contribute most to progress towards these needs and associated activities?

Pressure for larger practices

Payment systems also have to relate to a changing economic environment. The most obvious effect of the contract over the next few years will be to encourage larger practices. There will be demands for new services in between primary and secondary care. These will arise partly from change in the number of inpatient beds, with a likely reduction of 20% between 1988 and 1995, and partly from an increase in day care.² Increased screening, especially of elderly patients, will also raise the demand for services with the development of new kinds of rehabilitation. Family doctors have already given a strong lead in computerisation, and further investment in new technology is likely both for diagnosis and for treatment, which is going to make

it much more possible to increase services in primary and ambulatory care.³

The contract has already brought about a substantial rise in management costs both in staffing time and in partners' time. At the moment much time is taken up in complying with the new contract but in the longer term extra management costs will arise because partnerships need to negotiate on staffing, premises, and health promotion with family health services authorities. These costs fall much more heavily on small practices.

There will be pressure to invest in larger premises. The space standards set by cost rent schemes will soon seem inadequate for practices providing wider primary care. Again it will be easier to spread risks across a larger number of partners. Practice staffing should be considered not just in terms of numbers but in terms of pay and qualification. Practices will have to compete more in labour markets and will face rising costs. Most obviously practices will be under greater pressure to pay personal pensions as they recruit more highly qualified staff.

Larger practices may find it easier to face up to changes in professional relationships. Partnerships could be widened to include nursing staff in ways that could be highly attractive to patients. Practices will also have to meet new standards for professional quality.⁴

Effect of fundholding

The spread of fundholding is likely to accelerate these changes, which would otherwise have occurred more slowly. The fundholding practice will have the advantage of control over a much larger budget. It will be able to employ a wider range of staff and to use any surplus to finance expansion in services and premises; it will also be better able to compete for patients by offering attractive new services.

Fundholding is also likely to result in larger practices, perhaps serving 15 000-20 000 patients and offering services that might even include minor emergency treatment and day treatment in a community hospital. Until now such large practices have emerged only under peculiar conditions of local monopoly in market towns in Dorset and East Anglia, but they are likely to become more common. There will also be consortium arrangements between smaller practices to develop new services.

Changes in national policy will lead to an increase in local innovation. The development of primary care used to be a slow linear progression, but practices will now have to react quickly to new opportunities and to negotiate as providers within internal markets. Family doctors will start with a strong competitive position because of their primary care base with its unique access to patients, but they will also want to be able to offer attractive new services.

Problems of larger practices

This likely change towards large practices will have obvious implications for access and standards in primary care. The rate of take up of incentives under

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With local payment money could be related to local needs

the Family Doctor Charter was much higher in affluent areas, where more practices invested in premises and staffing.⁵ Practices in affluent areas were more able to use incentives because of expanding list size and income. Behind the reassuring averages of the review body reports lie considerable differences in net incomes among areas. Thus, in a survey of seven areas in 1986-7, 36% of practices in "Midlands Urban" had an income per partner under £20 000 compared with 3% of practices in "East Rural."⁶

The baseline position from which the new model primary care must be introduced varies greatly among areas. Areas that had a low take up of improvements under the cost rent scheme and of reimbursement for practice staff start with a much lower level of spending. In these areas it will be more difficult to reach performance targets and there will be fewer applicants for fundholding status. There will be less local innovation by larger practices. Disparities will increase in practice incomes and list size, and areas will come to differ even more in their attractiveness to new general practitioners.

An increased pace of innovation may lead to greater differences in services. The test for managers and policy makers will be to find ways of ensuring that all areas can benefit. There are already differences in pay, standards of service, and prospects, and managers will have to try to stop them growing wider.

There are many reasons for trying to ensure that smaller practices can continue to have a major role. Not all patients will want to go to large practices, and in many urban areas, especially in London, large practices will have difficulty with premises and patient access. Many doctors prefer to work in smaller practices. It would be wrong for any payment system to reward only very large practices, not least because large practices are likely to lead to local monopoly. Investment in smaller practices can encourage competition and diversity.

Local pay system

At one time the independence of family doctors was best protected by a national payment system. The position is now very different. The future of doctors depends on their ability to compete as providers within internal markets meeting needs for new services with different kinds of staff and technology. The General Medical Services Committee should take a lead in seeking to negotiate change rather than waiting for change to be imposed on it.

The review body could provide a framework agreement, allowing the current structure to continue for

the present while permitting the development of locally negotiated elements in pay. This would recognise the declining role of the review body, which for the past few years has been concerned with the mainly arithmetic task of pricing decisions made by the Department of Health. Its traditional role of ensuring that doctor's salaries kept up with inflation has become much less important. The ceremonial trappings of the review body have concealed a fall in bargaining power and an increase in the relative weight of the Department of Health. Family doctors are much more likely to be able to shape their own destinies through a series of local negotiations.

Such negotiations could eventually cover up to 60% of total practice income. Local negotiations would allow larger practices to develop their full potential in terms of the new model of primary care; they would enable practices to bid for the larger budgets available from purchasing authorities to bring about greater integration of services. Smaller practices would be able to form consortiums and to bid for appropriate local funding, and it would be possible for local purchasers to recognise the important element of additional access that they offer.

Local bargaining would make it easier to deal with the problem of disparities in standards of care among areas. Funding could be related to local needs to offset the inheritance of poor conditions in the older industrial areas. Pay could be linked to local agreements on list size and manpower. General managers of family health services authorities and local family doctors would be able to develop common strategies for meeting health needs. Such a system would give much greater flexibility in developing primary care and allow practices to compete more actively with other providers.

How would a local pay system work in practice? The simplest approach would be to localise the capitation payment and to maintain target payments for the present. Practice allowances would be paid for overheads and would be able to be claimed by all sizes of practice. The review body would set a guideline figure for the average capitation payment per head but local negotiators would decide whether this could be supplemented by contracts for more services. Some of the additional payment could be negotiated on an area basis by the profession as a whole; other elements might be negotiated between individual practices and the family health services authority.

Under this system the role of the review body would change to that of regulating, monitoring, and setting the terms organised at the national level. Some initial guidelines on the length of contracts might be needed to give some reasonable continuity, but tax funding would give stability. Family doctors would be able to bid for shares of the total budget rather than being confined to the small amounts of special payments in the scheme recommended by the General Medical Services Committee.

- 1 Bottomley V. Parliamentary written answer. *House of Commons Official Report (Hansard)* 1991 Feb 11;185:cds 352-6. (No 53.)
- 2 Bosanquet N. *Investing in health care for the 1990s: a case study in planning for an NHS trust*. Chichester: Carden, 1990.
- 3 Leese B, Hutton J. Desk top analysers in general medical practice: how useful are they? *Medical Laboratory Sciences*. 1990;47:256-62.
- 4 Irvine D. *Managing for quality in general practice*. London: King's Fund, 1990.
- 5 Bosanquet N, Leese B. *Family doctors and economic incentives*. Aldershot: Dartmouth/Gower, 1989.
- 6 Leese B, Bosanquet N. High and low incomes in general practice. *BMJ* 1989;298:932-4.

Correction

Response by women aged 65-79 to invitation for screening for breast cancer by mammography: a pilot study

The name of one of the authors of this paper by P Hobbs *et al* (8 December 1990, p 1314) was inadvertently omitted. A W M C Owen should have been included as the penultimate author.