Berkshire

davidoliver372@googlemail.com Follow David on Twitter @mancunianmedic

Cite this as: *BMJ* 2022;376:o259
http://dx.doi.org/10.1136/bmj.o259
Published: 02 February 2022

ACUTE PERSPECTIVE

# David Oliver: Making GPs hospital employees won't solve pressure on hospitals or general practice

David Oliver *consultant in geriatrics and acute general medicine*

There's a communications tactic in politics of "flying a kite,"[1] where nascent policy proposals are strategically placed in sympathetic media outlets to start a discussion, gauge reaction, or soften us up in advance—although they're often dropped or watered down if they don't land well. We also see diversionary "squirrel"[2] policy announcements, designed to distract the press and public from current government difficulties.

This January we saw both, in the form of stories based on an ongoing internal review of the NHS commissioned by England's health secretary, Sajid Javid. First, a widely repeated story in the *Times* described hospital models akin to academy chains in schools, operating as semi-autonomous entities.[3] The *Times* then wrote last week of "GPs nationalised in Javid plan to reduce hospital admissions."[4] The leaked proto-plan was that GPs would be encouraged or offered the chance to move to salaried employment by hospital trusts (although not forced to).

Why? Because politicians believe that the independent contractor model of GP partnerships makes it harder for ministers to pull levers to deliver their performance objectives and that more direct line management would somehow help reduce pressure on hospitals. We'll see if this particular kite is quietly shelved and whether this squirrel has legs. I think that it's misguided and doomed to fail.

Changing GPs' contractual arrangements won't create more GPs. Since 2015 we've seen a slight fall in the number of full time equivalent qualified GPs,[5] while hospital consultant numbers have increased.[6] During that time the GP workload has grown significantly. Our GPs see far more daily patient contacts than their counterparts in comparable high income nations.[7]

The modest increase in the number of junior doctors entering GP vocational training schemes won't compensate for the number of older GPs retiring or stepping down their hours because of burnout, worsening morale, or a desire to restore some work-life balance. Workforce gaps are another major policy risk for Javid, but I've still to see a credible workforce plan.

I can't see how new employers for some salaried GPs, or hospital takeovers of partnerships, would meaningfully affect pressures on hospital beds. Acute admissions to beds are in patients who, having been seen by specialists in emergency and acute medical specialties, are deemed sick enough to require hospital admission, or where no alternative community health and social care services are rapidly available.[8 9]

The social and community healthcare crisis is another major problem for Javid but also one with no solutions in sight.[10 11] Reviews of the reasons for hospital admissions have shown numerous factors at play, well beyond general practice,[12 13] and studies on whole system interventions to reduce admission have modest benefits at best.[14 -16] Yet some evidence suggests that continuity of primary care in helping people to live with long term conditions can modestly reduce acute illness episodes and demand.[17] Making GPs work for hospital trusts won't deliver that. Adequately resourced and staffed general practice just might.

Many doctors chose a career in general practice partly because it did not involve being on the payroll of a large organisation. Hospitals' expertise isn't in primary care. That expertise lies with GPs. And a GP's role is far, far more than "keeping people away from hospital."

Competing interests: See bmj.com/about-bmj/freelance-contributors. David Oliver is an unpaid trustee of the Nuffield Trust, an unpaid visiting professor at City University, London, and an unpaid visiting fellow at the King's Fund. He writes both as a professional freelancer and unpaid for several publications but has never been told what he should or should not write about. He has never taken fees from pharmaceutical companies or consultancies and has never practised private medicine.

Provenance and peer review: Commissioned; not externally peer reviewed.

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