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Reforming the GP partnership model?

Considering alternatives makes sense, but form must follow function

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General practice in England is in crisis. The situation—recognised by the Health and Social Care Select Committee in autumn 2022[1]—has worsened through winter. A combination of high levels of seasonal illness[2] and record hospital waiting lists[3] are buffeting an already-stretched service. Identifying causes of these problems is not difficult. Activity in GP services has increased rapidly.[4] But attempts to recruit GPs have not kept pace with numbers of GPs leaving or reducing their hours.[5] Neither staff nor patients are happy: GP job satisfaction has fallen[6] and patient satisfaction with general practice has plummeted.[7]

Against this backdrop, Labour's Shadow health secretary, Wes Streeting, announced a desire to "re-think what primary care looks like," including "phasing out the whole system of GP partners."[8] Streeting should be careful what he wishes for. 35% of GP partners say they are "considerably" or "highly" likely to leave direct patient care in the next 5 years.[6] Retaining them is essential. The NHS in England could face GP gaps of as much as 1 in 2 of projected GP posts by 2030/31.[9] Describing general practice as a "murky business" will not win the trust or support Streeting will need from GPs if he is serious about reform.[8]

Streeting's language was blunt, but debate about what general practice should look like in future is needed. In some areas the partnership model works. But nationally, the number of GP partners is declining fast—by almost 10% in 5 years.[10] Partners make up just 53% of GP headcount.[10] Partnership is no longer an aspiration for many early career GPs.[11] The number of practices handing back contracts or consolidating is rising.[12] Faced with "GP deserts," there is a risk that in some areas—particularly the most deprived[13]—general practice may not be able to perform its core functions. People will suffer as a result.

Different ways of organising general practice are already emerging. In some places, multiple practices have merged to create "super-partnerships" (some containing as many as 100 partners). In others, a small number of GP partners have created large provider organisations serving hundreds of thousands of patients across multiple sites. Some of these groups have retained their original GP ownership. Others have been bought by US corporations.[14] Some NHS trusts have also taken a greater role in managing GP services,[15] including in Northumberland, Somerset, and Wolverhampton. Future models of organising general practice are being left to innovative GPs, hospital leaders, or the market. This comes with risks.

Start with a vision for general practice

Whichever party is in power, government needs to play a more proactive role in putting general practice on a sustainable path. First, policymakers should articulate a positive vision for the future of general practice. Instead of starting with business models and contracts, they should define the desired goals and functions of the service. Understand the problems. Consider what better models could look like. Ask what it would take to improve job satisfaction for GPs and their teams. Engage patients and the profession. Genuinely listen and learn. (Government has undertaken listening exercises on primary care in the past.[16])

Second, policymakers must consider what general practice needs to meet these objectives. The NHS has experienced a decade of low spending growth[17] and woeful workforce planning.[18] A large part of the answer will be enough staff and money—including capital investment in buildings, equipment, and IT. But policymakers should also consider options for how general practice is organised to deliver high-quality care in different contexts. The partnership model is thought to be efficient,[19] benefitting from much discretionary labour from GP partners. Proponents argue the model engenders deep understanding of population needs together with flexibility and autonomy to respond.[20] Detractors say a salaried model would lead to better working conditions, more management support, and tackle inequity between GPs.[21]

Are the benefits of partnership over or under-stated? Could they be replicated—bettered—in alternative ways of organising general practice? What would it cost to deliver a salaried GP service (including for the >50% of GP premises owned by GPs[22])? What would be the benefits for patients? And would GPs stick around to work in it? Serious engagement with these questions is needed before progressing alternatives.

Third, policymakers should consider how any changes would be implemented. The most pressing issue right now is retaining GPs and recruiting more in future. So the profession must be convinced that any change would benefit patients and staff—and policymakers will need to recognise the importance of creating options that can be adapted to fit local context and GP preferences. Big-bang changes would be a massive distraction. Top-down reorganizations of the NHS are common, costly, and can bring unintended consequences.[23] But well designed pilots

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could be used to rigorously test and evaluate proposed changes.

The attention generated by Streeting's comments illustrates the strength of feeling surrounding the partnership model—a core feature of the NHS's structure since its birth in 1948. But the number of GP partners is falling fast, and government must play a central role in ensuring the long term sustainability of general practice in England. Wholesale change would be foolish—and a far greater priority should be boosting investment in general practice and increasing staff numbers. But giving GPs a mix of options for how they organise in future makes sense. We should welcome evidence informed debate on what general practice should be delivering and the range of organizational forms needed to support that vision.

Competing interests: Becks Fisher is on sabbatical from roles as an NHS GP, and Senior Policy Fellow at the Health Foundation.

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