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PRIMARY COLOUR

Helen Salisbury: Sajid Javid's plan for a salaried GP service

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In general practice we're becoming wearily accustomed to learning about the next proposed upheaval in our working lives by reading about it in the newspapers. This week we read in an article in the *Times* about the health secretary's suggestion that hospital trusts should run GP surgeries, turning primary care into a fully salaried service.¹

Since the NHS's creation in 1948 general practice has been an anomaly, with doctors operating as private contractors to the service rather than being its direct employees. Over the years the contract has become more complex and arcane, and arguably less fair.² There are many reasons why GPs might welcome a salaried service. If we didn't run as private businesses, perhaps we wouldn't need to worry about fixing leaky roofs or recruiting new nurses or receptionists. Someone else could organise the vaccination clinics and worry about who will staff the unpopular extended hours shifts. We'd be freed up to focus entirely on looking after the patients under our care, rather than being distracted by the business of running a practice.

But the main problems facing primary care would not be solved by new management. Even if we had confidence that hospital trusts would manage us better than we manage ourselves, this change would not fix the GP shortage. We don't have enough GPs: there are more in the pipeline, but the existing ones are burning out, retiring early, or emigrating to places with better working conditions more quickly than we can replace them. Some GPs have opted for salaried contracts where they're more likely to be able to control their hours, but many doctors, both salaried and partners, are working 12 hour days to cover for our missing colleagues. I'm not sure the health secretary realises that if we were all paid for the actual hours worked, the bill would be significantly higher than it is now.

For many partners, one compensation for the long hours and responsibility is autonomy: we can arrange our appointment system to suit our patients, and we can decide how many and what sort of staff we work with, within our financial constraints. If that freedom was lost, so too would be many more experienced GPs who wouldn't stay on in a salaried service.

Paradoxically, it's possible to see this suggested nationalisation of general practices as a route to their eventual re-privatisation. Despite some attempts to buy up surgeries by large corporations, the majority of practices are still small and very individual businesses, which are not an easy source of corporate profit.³ One fear is that, once practices are under the control of hospital trusts, US-style health maintenance organisations covering both hospital

and community care would be a natural conclusion, which may be far more attractive to private investors. We'd need reassurance that any new model would provide a universal, tax funded, cradle-to-grave personal service, embedded in the community and offering continuity of care.

On first reading, this proposal looks like a distraction from the main problems of workforce and premises—and a way to antagonise a group of professionals the health secretary needs to work with, not against.

Competing interests: See www.bmj.com/about-bmj/freelance-contributors.

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- 1 Smyth C. GPs nationalised in Javid plan to reduce hospital admissions. *Times* 2022 Jan 29. <https://www.thetimes.co.uk/article/gps-nationalised-in-javid-plan-to-reduce-hospital-admissions-h0d90cxjs>
- 2 Fisher R, Allen L, Malhotra AM. Tackling the inverse care law: analysis of policies to improve general practice in deprived areas since 1990. Health Foundation. Jan 2022. <https://www.health.org.uk/publications/reports/tackling-the-inverse-care-law>
- 3 Kollwe J. NHS GP practice operator with 500 000 patients passes into hands of US health insurer. *Guardian* 2021 Feb 26. <https://www.theguardian.com/society/2021/feb/26/nhs-gp-practice-operator-with-500000-patients-passes-into-hands-of-us-health-insurer>