

How general practice is funded in the United Kingdom

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The National Health Service (NHS) has undergone fundamental reform since 1948, but the fabric of UK general practice remains more or less intact. Fundholding was probably the most significant change in financial arrangements (Box). Essentially, this was an experiment for the NHS to contain costs, stimulate competition and bring resource allocation decisions closer to the patient — fundholding general practitioners assumed significant roles in local healthcare economies. Nevertheless, there was much debate over whether it was equitable. Many saw it as a basis for partnerships with the private sector and fragmentation of the healthcare service.¹ Others showed that it reduced non-emergency medical admissions.²

Fundholding grew from the Thatcher government's strongly held belief that markets are the best way to achieve efficiency in healthcare. At the same time, fundholding established general practice as the cornerstone of the NHS.³ Further, it brought a questioning of the "status quo" in the NHS, and the prospect of higher standards of care. These expectations remain in the eyes of the public, government and the profession.

Reforms aside, under "standard" contracts, UK general practitioners have been rewarded for increasing patient list size, and for providing specific services to achieve target payments. Unlike in Australia, there is no incentive to overservice, but an incentive to limit the availability of appointments, and pressure to keep appointment times to a minimum. Interestingly, salaried GPs in the personal medical services pilots (Box) have similar productivity without affecting other GP behaviours or quality of care.⁴

The new contract

The new GP contract, operative from April 2004, brings more funding, fundamental structural change, greater regulation and

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How it works

- Most UK general practitioners are independent contractors with the National Health Service. They own their own premises, hire their own staff, and supply general medical services.
- Remuneration is based mainly on capitation (ie, a payment dependent upon list size), supplemented by fees for certain specific services (eg, maternity care) and for achieving certain "target" levels of service (a complex system, although it only involves childhood vaccination and cervical cytology). Payments are also made for seniority and postgraduate education activities.
- Alternatives: the NHS (Primary Care) Act of 1997 allowed GPs to provide "personal medical services" (PMS) on a salaried basis through local service contracts that are designed to meet the particular needs of the locality. More than 35% of GPs are now salaried.
- Fundholding was a system of general practice purchasing services from secondary care. It operated between 1991 and 1999. Fundholding practices were given greater autonomy over aspects of practice expenditure such as drugs, diagnostic testing and staffing (within defined budgets), and could "shop around" for the best deal on procedures such as hip replacement. A further initiative, "total purchasing", allowed practices to purchase a wider range of services from both primary and secondary care — for example, community nursing.
- Primary care trusts were established in 1997 (they began as primary care groups; in England, these became trusts in 2002, but have taken different forms in Scotland, Wales and Northern Ireland). Individual practices were replaced as purchasers by regional organisations, which could assess and plan for local needs.
- A new GP contract took effect in April 2004, with GP payments more closely linked to "quality targets" for both clinical and organisational activity. This has been coupled with increased funding and structural change — for example, GPs are no longer obliged to provide out-of-hours services, and the contract is with whole practices rather than individual GPs.

performance monitoring. There are concerns that many of the quality targets (eg, the incentive to diagnose, investigate and treat hypertension) have not been adequately costed.⁵ Further, this new environment has a strong emphasis on performance management and holding doctors to account. Some people see this as an erosion of public trust in the medical profession, which could undermine doctor–patient relationships; others see it as an essential mechanism of delivering proven, cost-effective care.

For patients, NHS general practice is well integrated with the wider health service, and gives access to a multidisciplinary primary care team, including health visitors and practice nurses. On the downside, a non-competitive system means there are not the same incentives to attract patients as exist in Australia's fee-for-service environment, and there is a culture of demand management, which often takes precedence over making services attractive and convenient to patients.

In many ways, the NHS places GPs at the centre of the healthcare service and gives one a sense of being part of a team, with less of the fragmentation and isolation that often exists in

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Australian general practice. Whether the new GP contract will improve experiences and outcomes for patients, at a cost the NHS can afford, remains to be seen. On the downside, many GPs believe the wider healthcare service has not been able to accommodate the needs of patients in recent years; this may, despite the best efforts of individual primary care teams, lead to a demoralised workforce.

Towards the end of New Labour's second term, the NHS is being pulled in several directions — involving performance management, quality payments, new contracts, and greater engagement with the private sector, including American managed care organisations. The competition and “constructive dissonance” of these changes is very reminiscent of the Thatcher reforms. How general practice will fare in this turbulent environment is unpredictable, but no doubt being a GP or a patient in the NHS will be a very different experience in 2010.

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