

The New General Practice Contract and Reform of Primary Care in the United Kingdom

Le nouveau contrat de services médicaux généraux et la réforme des soins primaires au R.-U.

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Abstract

In April 2004, the United Kingdom introduced a new General Medical Services (GMS) contract that provided new governance and incentive arrangements for general practice. In particular, the new Quality and Outcomes Framework is a points-based system that sets targets for clinical, organizational and practice-related standards with financial payments for achieving set levels of performance. This paper describes the new contract arrangements and their impact on general practice – focusing on the experience in England, where wider policy changes are also having an important impact on practices – and drawing out potential lessons that will be of interest to Canadian practitioners and policy makers.

Résumé

En avril 2004, le Royaume-Uni a introduit un nouveau contrat de services médicaux généraux (*General Medical Services*, ou GMS) qui prévoyait de nouvelles dispositions en ce qui a trait à la gouvernance et aux mesures incitatives pour les généralistes. En particulier, le nouveau cadre de contrôle de la qualité et des effets (*Quality and Outcomes Framework*) est un système de points qui établit des cibles pour des normes cliniques, organisationnelles et de pratique et prévoit des encouragements financiers pour l'atteinte des niveaux de rendement établis. Ce document décrit les dispositions du nouveau contrat et leur incidence sur la pratique générale – en particulier en Angleterre, où des changements de politique plus vastes ont également une incidence importante sur les pratiques – et en dégage des leçons potentielles susceptibles d'intéresser les praticiens et les décideurs canadiens.

RECENT POLITICAL AND ORGANIZATIONAL CHANGES IN THE NATIONAL Health Service (NHS) of the United Kingdom have created shifting contexts for the delivery of primary healthcare. In England, most attention has been paid to market reforms, which incorporate patient choice, Choose and Book (a patient-driven electronic booking system), payment by results, Foundation Trust status, creation of a provider market and practice-based commissioning and purchasing (PbC) – although the supply-side reforms in Northern Ireland, Scotland and Wales provide useful comparative context within the UK. However, it is the introduction of the new General Medical Services (GMS) contract that has had the greatest impact on general practice and continues to have the greatest potential for change, especially when combined with other changes in the English NHS, such as the Information Management and Technology (IM&T) Strategy. The new contract offers a unique experiment in the use of incentives to reward quality through the Quality and Outcomes Framework (QOF), which provides financial rewards to general practices based on a points system of over 150 quality indicators covering clinical, organizational and patient-focused aspects of practice (Smith and York 2004).

This paper focuses on the impact of the new GMS contract within the changing organizational and policy context of the English NHS. It begins by outlining the current policy context for the English NHS before moving on to describe the new contract and current contractual arrangements for general practice. The next section discusses the potential impacts on general practice in the UK. The paper ends by considering whether there are lessons for the Canadian healthcare system and the development of primary care.

The Policy Context

The aims of the current range of NHS reforms in England are threefold. The first is to stimulate a self-sustaining set of incentives that foster continuous organizational reform, including practice-based commissioning, patient choice and payment by results (a national tariff activity-based payment system). The second aim is to allow greater autonomy at a local level, but on a selective basis. The default approach appears to be the *status quo ante* (i.e., hierarchical control) rather than a blanket policy of decentralization; hence, some organizations will be “granted” decentralized powers (“freedoms”). The selective decentralization is also conditional in the sense that decentralization will be afforded only to those organizations whose performance (as measured by government measures) is rated highly, such as granting Foundation Trust status to NHS hospitals that are rated as performing well.¹ The third aim is to create a pluralistic model of local provision within the public, private and not-for-profit sectors. The purchaser–provider distinction (first created in the 1990s quasi-market) is being extended to allow new market entrants, and patient choice policy requires patients to be given a choice of four to five providers at the point of referral by the general practitioner (GP), one of whom has to be a private or independent organization – a process built into the new Choose and Book software used to arrange referrals (DoH 2004, 2005a, 2006). These organizational developments in commissioning and service use provide a rapidly evolving context for general practice within which changes to the GP contract need to be analyzed, especially as the contract is UK-wide and there are different policy and organizational contexts in England, Northern Ireland, Scotland and Wales (Exworthy 1998; Greer 2004, 2005).

Changes in primary care also need to be set within the wider health and social care context in the UK. There is growing recognition of the need to support self-care and informal care (DoH 2006; Kerr 2005), with a concomitant recognition that long-term and chronic health problems are not satisfactorily addressed within the NHS (Coulter 2006). In England, recent White Papers have stressed the importance of self-care and the role of the NHS in supporting it, the need to build people’s skills for preventing ill health and the need to support people with long-term conditions to manage independently (DoH 2004, 2005b, 2006). People with chronic disease are more likely to be users of the health system, accounting for some 80% of all GP consultations, while as much as 40% of general practice consultations are for minor ailments that could be taken care of by patients themselves (DoH 2005c; Wilson et al. 2005). While there is widespread public support for self-care, recent surveys suggest that despite a well-established structure for managing individual care through general practice, the primary healthcare team and Primary Care Trust (PCT)² coordination, the NHS is poor at providing support for self-care (Coulter 2006; DoH 2004, 2005d; Ellins and Coulter 2005; Wilson et al. 2005).

General practices are also being encouraged to do more public health activity through a system of changes in the contract and the introduction of financial incentives. The need to develop a stronger public health approach in primary care has long been recognized, but despite changes to GP contracts in 1990 and making public health a key objective of primary care organizations from the mid-1990s, developments have been limited (Peckham and Exworthy 2003; Peckham 2003). The most recent annual report on the NHS by the Healthcare Commission (2006) has highlighted the lack of investment in, and priority given to, public health.

General practice in the UK also faces a number of other challenges resulting from changes in the workforce, and greater pressure to apply evidence-based medicine and treatment protocols and meet centrally set targets – a complex context into which the new contract has been introduced. In addition, access to primary care in the UK has fundamentally changed in recent years with the introduction of NHS Direct (a 24-hour telephone/Internet advice service), walk-in centres, increased private provision of general practice, complementary and alternative medicine, and physiotherapy and counselling services (Peckham 2004, 2006). These challenges are not unrecognized by the profession, and the need for general practice to respond to social change was the topic of a Royal College of General Practitioners working group on the future of general practice (Wilson et al. 2006).

The New GMS Contract

In 2004, the new General Medical Services contract was introduced in the UK. The contract marked a major change in the way GPs are contracted with the NHS. Under the old system, GP principals held an individual contract that, despite changes in substance, remained based on the original contract established in 1948. GP incomes were made up from a mixture of funding for registered patients (capitation), undertaking specific activities and support for practice development, such as nursing and administration staff (Moon and North 2000). The new GMS contract has been developed from pilots of new contractual forms introduced in the late 1990s under Primary Medical Services designed to stimulate innovation in practice (Riley et al. 2003; Meads et al. 2003).

The main principles of the new contract are:

- a shift from individual-GP to practice-based contracts
- contracts based on workload management, with core and enhanced service levels
- a reward structure based on the new Quality and Outcomes Framework and annual assessments
- an expansion of primary care services
- modernization of practice infrastructure (especially IT systems).

Aspects of the new contractual arrangements for general practice that are less discussed are the Personal Medical Services (PMS), Alternative Provider Medical Services (APMS) and Specialist Provider Medical Services (SPMS) contracts. PMS originated in 1996 to encourage innovation in structure and services in general practice, and about one-third of practices held a PMS contract in 2005. While there

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has been some innovation – with greater emphasis placed on multi-professional models with less GP involvement – PMS contracts have not as yet significantly challenged the dominant general practice model of a small team of GPs supported by other staff. The introductions of salaried GPs and of nurse practitioners were identified as key new approaches. Yet, there has been little encroachment on the organization of practices, and nurse-led practices and nurse practitioners remain scarce – only nine nurse-led practices have been developed, and growth in the numbers of salaried GPs in non-PMS and PMS practices is similar (Sibbald et al. 2000). Structural barriers to non-GP provided practice remain engrained in professional guidelines and statutory responsibilities for prescribing and patient care (Houghton 2002). Importantly, the experience of PMS paved the way for the introduction of the new GMS contract (Smith et al. 2005).

Contracts under APMS and SPMS are much rarer, and while the opportunity to develop new forms of primary care practice exists, few contracts have been let. These variations on the GMS contract were introduced by the government to encourage NHS commissioners to explore alternative organizational models of primary care, particularly from the independent and private sectors, but local hostility has limited success. In Derbyshire, an APMS contract was let to United Healthcare, but local residents have forced a judicial review of the PCT's decision. The process has now resumed, but with three local residents sitting as patient/public representatives on the commissioning panels. Medical professional groups remain generally hostile to the encroachment of large private companies in general practice. SPMS contracts have also been used to develop local primary care services, but again, on a limited scale. To date, such contracts have been used to develop specialist private services (nurses and therapists working in the community in Surrey are proposing to use SPMS to establish a limited company) or to establish new formal relationships in virtual organizations to deliver care in well-defined circumstances (e.g., integrated care services in Epsom and North Bradford, and drug abuse and long-term care services) (CSIP 2006).

Quality and Outcomes Framework

While there are a number of controversial aspects to the new contract, the Quality and Outcomes Framework (QOF) has generated most debate and discussion. The QOF provides financial incentives for general practices to meet a range of clinical, organizational and patient experience criteria. It is a voluntary system that practices opt into and is worth approximately £125,000 per annum for a practice if maximum points are achieved. Practices accumulate points for reaching set targets and then receive income for each point achieved (Smith and York 2004). In 2004/05, the first year of operation, 222 practices (2.6%) achieved the maximum number of points (1,050), with the average score being 958.7 points, although nearly half of all practices in England (4,243) achieved a score between 1,000 and 1,050. The QOF underwent changes in the second year to expand the range of clinical areas and place more emphasis on health promotion activities. The outcome for 2005/06 showed that practices had improved their performance across the areas identified in the QOF (see the Framework website at <http://www.ic.nhs.uk/services/qof>), but little research has examined the impact of the use of such incentives on the overall process of patient care in general practice – particularly the extent to which the use of financial targets alter local practice. Similar improvements in achieving standards occurred in Wales and Scotland, suggesting that despite differing institutional frameworks and policy environments, general practice has responded to QOF incentives in a similar way across the UK. Discussions are currently underway between the British Medical Association (negotiating on behalf of GPs) and the Department of Health on focusing the QOF more on self-care support and interventions to reduce demand in primary care.

Two aspects of the QOF are of interest. The first is the use of financial targets to change behaviour and the second, the impact of target systems on practice. While the Framework is still fairly new, there is some indication that both these factors are likely to be of increasing importance in the development of primary care services. Marshall and Harrison (2005) have suggested that use of targets and financial incentives may have unintended consequences on practitioner behaviour such as goal displacement and rule following, leading to the “crowding out” of and reduction in focus on non-incentivized tasks. Thus, areas of clinical activity not included within the QOF may become seen as less important. Studies have also found that financial reward is not necessarily the main incentive for practitioners to engage in quality improvement (Spooner et al. 2001), and while targets clearly deliver changes in behaviour, they may distort practice goals in ways that are detrimental to overall quality of care and patient outcomes (Harrison and Smith 2004). In terms of impact on practice, the fact that practices have universally opted in to the QOF demonstrates that financial payments are a key incentive to adopt new processes. However, embedding the QOF in practices has implications for both organizational and clinical processes, as discussed later in

this paper. At a minimum, participation in the QOF is dependent on adequate IT systems and the ability of practices to run the relevant software to collect data.

IM&T in General Practice

The development and introduction of IT systems to “manage” QOF data has been central to new approaches to patient management in general practice. Practitioners must ensure they record data on visits so that these can be collected to produce QOF returns at the end of the year. Practitioner prompt/reminder programs are widely used to ensure that patients have had a variety of tests and screening at each visit. The impetus of national programs has sharply increased IT usage in practices. The

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combination of the national IM&T Strategy, the recording framework for the QOF and the Choose and Book system in England (part of the patient choice program giving patients the potential to book appointments directly) has pushed computer usage and IT more centrally into local general practices. There has been

a mix of one-off financial incentives for practices to develop their IT infrastructures through additional contract payments, primary care organization (PCO)³ investment in network IT systems and payment for adoption of IT systems in connection with the QOF. The aim has been to provide a common operating system so that practices can still opt for different suppliers and IT platforms but with a requirement to be able to run a minimum level of data systems, such as the QOF or the Choose and Book referral system in England.

Computers are now a key component of UK general practice. Over 90% of practices used computers for clinical care in 2004, and this percentage has now increased to virtually 100% through the QOF. However, the range of use varies among practices (DoH 2002), and there are important questions about the clinical safety of extensive reliance on IT systems (Fernando et al. 2004). The national Information Management and Technology Strategy is also driving forward changes in IT use in primary care, although there have been recent concerns about both technical and ethical aspects of this program in relation to the ability to achieve full linkage among practice, PCT, hospital and (eventually) social care IT systems and establishing a national electronic patient record (Cross 2006a,b). What appears to be clear, however, is that a mix of

national policy drivers, together with incentive frameworks such as the QOF, directed financial support and local implementation of IT strategy through PCOs, has successfully supported IT developments in UK general practice, providing the basis for a number of developments and enhancements to information handling. Whether the government's ultimate aims of seamless transfer of information among professionals and agencies across the health and social care sectors will be successful is still unclear. Patient information systems that would support the Choose and Book referral system were delivered late, and the system for recording childhood immunizations failed to provide proper records for practices (Cross 2006a,b). In England, developed IT systems will be essential as robust, practice-based commissioning (PbC) is extended. Accuracy, and systems that work alongside each other, will be needed to deliver information support for practices and PCTs alike.

Implications for Practice

What impact will these changes in the GMS contract, and the introduction of PbC, have when combined with the wider reforms within the English NHS? Wilson et al. (2006) have suggested that there are four broad areas upon which the performance of primary care, and general practice specifically, should be measured. These are equity, quality of clinical care, responsiveness to patients and efficiency. UK general practice scores high on these criteria, but concerns about lack of support for self-care (DoH 2005c,d), poor support for people with long-term conditions (Coulter 2006) and the fact that inequalities in health at a primary care level persist (Wilson et al. 2006) raise questions about whether general practice will retain this strong position.

Equity

To date, general practice in the UK has scored very highly in comparisons of equity of access (Blendon et al. 2002), although the inequity in the distribution of GPs continues to worsen, with fewer GPs per registered population in more deprived areas (Hann and Gravelle 2004). Research on financial incentives for public health found that financial reward for practices bore no relation to local need; recent research in Scotland found that there are small inequalities between practices in service provision for simple monitoring interventions, but larger inequalities for diagnostic, outcome and treatment measures (Langham et al. 1995; McClean et al. 2006). In addition, the QOF may skew practices to completing labour-intensive interventions (such as screening and treatment for hypertension) rather than interventions with greater potential for health gain (such as prescribing angiotensin converting enzyme (ACE) inhibitors in heart failure) because the former receive higher financial reward (Fleetcroft and Cookson 2006). Early analysis of the QOF also suggests a correlation between excep-

tion reporting (the exclusion of patients from reported figures for such reasons as patients' refusal to attend interviews, patient frailty, lack of service) and social deprivation indices (Sigfrid et al. 2006; Galvin 2006).

Quality of care

While progress on improving clinical care in general practice has been substantial, there are still gaps, with wide variation in the quality of care for different patients (Seddon et al. 2001). Major successes have occurred in areas where targets have been set or additional resources have been provided (Campbell et al. 2003, 2005). Therefore, the QOF process should lead to improvements in clinical care as it provides targets associated with additional funding. There is emerging evidence, though, that the QOF is changing relationships in practices, with responses directed primarily towards the technical problem of designing information systems to rationalize practice and collect relevant data rather than addressing clinical issues for guiding practice (Checkland 2006). What impact this response will have on the quality of care is not clear at present, but it challenges the concept of individualized care. In addition, the numbers of practitioners dealing with the care of individual patients because of the need to meet 24/48-hour targets,⁴ and the increasing range of people involved, raise questions about continuity of care and clinical quality.

Responsiveness to patients

UK general practice enjoys a high level of patient satisfaction, although patients express dissatisfaction about their levels of involvement in decisions about their care (Healthcare Commission 2005; Wilson et al. 2006). High satisfaction may be influenced by more general factors such as location, relatively easy access, longer consultation times and improved use of the wider primary healthcare team (Wilson et al. 2006). Responsiveness also includes the appropriate application of resources in accordance with need.

Efficiency

International comparison demonstrates that the NHS system has reduced health costs in the UK and that the wide access to general practice services reduces demand for specialist hospital care (Starfield 1998; Roberts and May 1998). Data from the QOF have identified that practices are undertaking more activity; whether this is actual or better measured is perhaps open to debate, and there are concerns about the impact of the QOF on equity. The introduction of PbC may help to drive further cost

efficiencies in patient care, although the evidence to support significant cost savings in previous primary care-led purchasing has been equivocal (Smith et al. 2005). How far PCTs can maintain a coordinated approach across practices to reduce inequities and allocative inefficiencies remains to be seen – particularly as patient choice will increase uncertainty in local healthcare systems.

Other implications

The increasing emphasis on self-care and public health should mean that general practice, as the most local and universally accessed part of the NHS, plays a key role in these areas. The development of QOF criteria focusing on public health measures and clinical care for people with long-term conditions such as coronary heart disease and diabetes represents a shift towards trying to provide incentives for specific activities. However, the steep increase in GP earnings and questions about actual increases in activity have been highlighted in the media, and there has also been criticism from within the nursing profession that while pay rises were meant to reward additional work in the practice, the main group of staff undertaking these wider health promotion and patient support roles are in fact nurses, not GPs (Amicus/CPHVA 2006). The contract raises important questions about the internal relationships within practices and the appropriate staff mix to provide the required services, and also whether processes (e.g., for meeting QOF targets) have become more important drivers in general practice than clinical expertise. Early evidence suggests that while there is potential in these contract mechanisms to change practice behaviour and work process, the current direction would seem to be one that creates more techno-bureaucratic approaches to patient care. PCTs and other healthcare purchasers have not yet made sufficient use of the flexibilities that the contract provides to explore new models of primary care, and the focus on private provision may be unhelpful, as it has led to conflict. In fact, most private primary care provision has been developed by GPs and employs traditional models of general practice that, on the face of emerging evidence, have not been particularly successful at addressing either the long-term care needs of patients or key public health problems in local communities (Coulter 2006; Kai and Drinkwater 2003).

Finally, tensions are evolving in the system among competing demands and targets. Patient choice and the Choose and Book system focus attention on responsiveness to choices about location of secondary care. However, recent concerns about funding and the need for PCTs as strategic purchasers to manage demand have led to the increased use of central referral centres as intermediaries between the GP and the provider. In addition, there have been concerns about the NHS's IM&T systems, and uptake of Choose and Book has been slow, with many GPs still not using the system (Cross 2006b; Pothier et al. 2006).

Conclusion

So, what can Canadian primary care and family practice learn from recent UK and, more specifically, English experience? There are clear organizational similarities. Regionalization and local integration of funding in many Canadian provinces (such as the development of LHINs in Ontario) certainly mirror the development of PCTs (England), Local Health Boards (Wales) and Local Health and Social Care Groups (Scotland). However, a key difference is that funding for family practice in Canada remains separate from other healthcare funding, whereas in the UK, general practice funding has been more closely aligned with other funding streams – for example, the general practice contracts now held by PCTs. There are a number of tensions in current policy that may be particularly relevant to Canada. A central tension is that between measures seeking to integrate and control general practice through centrally defined performance targets, adherence to policy goals, increased managerial involvement such as managing referrals (Davies and Elwyn 2006) and regulation of professional practice on the one hand, and pressures for diversity and fragmentation through the development of different contract models, new providers, patient choice and the redesign of general practice on the other.

Despite differences between the two health systems, the mechanisms being developed to measure quality and reward practices are clearly transferable, and the new GMS contract has generated a lot of international interest. As suggested here, the use of the financial incentives in the QOF to change practice does work and is leading to improvements in clinical care across the UK. The more difficult assessment is whether these incentives produce the right improvements or, in fact, the best-value improvements. The QOF may actually discriminate against deprived area practices. Smaller practices in deprived areas do less well in the QOF than larger practices in affluent areas, reducing their ability to develop the kinds of organizational systems needed to tackle the problems associated with deprivation and to achieve greater success in meeting QOF targets (Wang et al. 2006). Two points that are highly relevant in the Canadian context are the need for good organizational structures and processes in family practice for a QOF system to operate (and for practices to improve the most), and concerns about the skewing of payments towards more affluent areas away from more deprived areas, creating further disincentives for practitioners to provide services to socially disadvantaged populations.

The development of PbC and extension of private providers is uniquely English (rather than UK), building on previous approaches to primary care-led commissioning and purchasing. How replicable this approach would be in Canada remains uncertain, as with fundholding in the 1990s (Peckham 1997). The UK experience suggests that the most successful PbCs will be small and focused, but many of the models being developed are locality based. It is still too early to tell how PbC will develop – especially in the absence of real incentives to support its development compared

to development of the early fundholders. As for private provision, here there may be more similarities with Canada, given the independent nature of general and family practice in both countries. Yet, the dominant private model in the UK is similar to the traditional GP model and actually builds on the position of the GP as an independent practitioner. The new contract structures and emphasis on self-care and public health are key elements of policy, but the GP model remains central in these developments. While local funders (such as PCTs) have the potential to develop new, innovative models of care using new contractual structures, to date little has been done to achieve these. How far private and not-for-profit providers are willing to enter such a market remains to be seen. The present model consists mainly of companies run by GPs, offering services similar to traditional general practice, which may explain why these private providers have not been challenged by local professional committees.

Fortunately, the health system in Canada is not under the same pressure of rapid reform, nor has it experienced the continuous raft of policy change to which the NHS has been subjected. For Canadian observers, the devolved UK NHS provides a unique policy laboratory, with four system models emerging but sharing the common features of the GMS contract and the QOF. In this sense, perhaps, Canadian policy makers should watch and learn.

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NOTES

1. The star rating system is operated by the Healthcare Commission and rates all NHS organizations as 0–3 star performers based on a basket of performance indicators.
2. Primary Care Trusts are the main commissioners of healthcare services in England and hold over 75% of the NHS budget for primary and secondary care. General practice contracts are held between practices and PCTs. Following reorganization in October 2006, there are now 150 PCTs (reduced from 302) in England, varying in size from populations of 136,000 to 1.2 million.
3. Primary Care Organization (PCO) is a generic term applied to Primary Care Trust (England), Local Health Board (Wales) and Care Trusts Community Partnerships (Scotland).
4. Patients are guaranteed access to a primary care practitioner within 24 hours or a general practitioner within 48 hours. This does not have to be the patient's own GP.

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