INFORMATION ON GP CONTRACTS

1. **WHAT IS THE BACKGROUND TO THE GP CONTRACTS:** The intention to modernise the Contracts was set out in a Green Paper on primary care which we published in 1986 and was made a definite policy aim in a White Paper in 1987. For the last 12 months the Government has been engaged in more than 100 hours of negotiations with the BMA in which the BMA have shown little willingness to come to any conclusion. The BMA do agree on the aim to have the new Contracts in place by April 1990 and the Government is anxious to settle the terms soon so that GP's can have the maximum time to prepare for the new arrangements. Talks with the BMA are still in progress. The recent White Paper on NHS Reform merely restated the aim of having a new contract and clarified the Governments objectives in the long running negotiations. Uncertainty over the new contract needs to be resolved soon to clear the way for sensible talks on the major NHS reforms. The BMA seem very anxious to confuse the two as they prefer to present themselves as concerned about the Service and patient care rather than about money. The contract issue is about remuneration and incentives to better practice.

2. **WHY DO GPs NEED A NEW CONTRACT:** The GP remuneration system has not been significantly altered for over 20 years. Yet during that time major changes have occurred in practise. The numbers of doctors in general practice has grown and practise teams have developed across the country. The structure and growth of the population has changed and much more positive attitudes to health promotion and disease prevention have developed. At the same time there have been changes to the way health care is delivered. For example, all new entrants to general practice are now vocationally trained. Other health professions such as nurses have extended their role in patient care. In other words it was important to bring the contracts up to date to meet modern developments.

3. **WILL THE NEW CONTRACTS AFFECT THE PATIENT:** Yes, very much for the better. But the Contract itself is a legal arrangement setting out terms of service between the GP and his NHS employer, the Government.

4. WILL GPs STILL BE PART OF THE NHS AND PROVIDE THE USUAL SERVICE: GPs will provide the usual service, free to all, regardless of income.

5. WILL DRUGS STILL BE FREE AND READILY AVAILABLE UNDER THE NEW PROPOSALS: Drugs will be free to exempt groups and as readily available as ever before. We are asking doctors to keep a record of the drugs they prescribe and encouraging them to avoid expensive brand names. Many doctors have been practising in this way for some time but we want to encourage all doctors to monitor their drug prescribing. Overprescribing is not good for patients, but there is no question of doctors not being able to prescribe your drugs in the usual way or of funds for drugs being suddenly exhausted.

6. WHY IS THE GOVERNMENT MAKING THESE CHANGES: The Contract is being changed to reward those doctors who attract patients, and who provide a really comprehensive service to the patient. A service which will cover PREVENTION AS WELL AS TREATMENT of illness.

7. WILL GPs HAVE TO BECOME MORE COMPETITIVE: Many GPs already provide a high quality service. However under the present system such services are not fully recognised. The Government believes that the remuneration system should now be changed to reflect developments in good practise and encourage GPs to provide a comprehensive service covering the treatment, management and prevention of illness. The intention is that GPs who provide high quality services should be better remunerated.

8. WHAT ACTUAL IMPROVEMENTS WILL PATIENTS SEE AS A RESULT OF NEW GP CONTRACTS:

A. The proportion of income paid through capitation fees will increase so that GPs income is more responsive to their ability to attract and retain patients.

B. There will be a sliding scale of supplements for each patient living in a deprived usually inner city area, for those patients in scattered rural areas and especially for elderly patients to make sure their needs are particularly well catered for. Our opponents try to exploit and frighten the elderly about the new initiatives but they can be completely reassured.

C. Health promotion and disease prevention will represent a greater part of general service. This includes the provision of advice and care through screening and regular check-ups.

D. GPs will have to make themselves available to patients for direct consultation for a specified amount of hours per week spread over at least 5 days, and at a time convenient to patients.

E. GPs, under guidance from their FPCs will be required to live within reasonable distance of the surgery.

F. Changing doctors will be made easier. The patient will simply ask the doctor of his choice to accept his or her on to that doctor's list. It will not be necessary to approach either the FPC or the GP to whom the person was previously registered.

G. Medical lists will contain additional information about GPs, namely the sex of the doctor, date of qualification or year of birth, clinic sessions available and the professional staff in the practise team to facilitate choice of a new doctor.

H. GPs will be required to issue practise leaflets.

I. Consumer surveys will be carried out by FPCs and the results used to highlight where services need improving.

J. In consultation with Local Medical Committee (LMC)s FPCs will take steps to inform consumers about the family doctor services that are available and how to make best use of them.

K. A postgraduate education allowance will be paid to GPs to encourage them to continue their medical education. There will also be an allowance for GPs who teach under-graduate students and sessional fees for those who perform health promotion work over and above their contract obligations.

L. The night Visit Fee will be retained, but a higher rate will be payable to the doctors from your own practise who make the call than will be paid for use of a deputising service.

M. A new Child Health Surveillance Supplement will be paid to those GPs who carry out services for children under the age of 5.

N. Payments for child immunisation and cervical cytology will be made if the GP immunises 90 per cent of screens 80 per cent of his target population. Setting targets is a far more effective way of raising performance than the alternative of simply paying on items of service fee for however many vaccinations or screenings are carried out.

O. Minor surgery performed by a GP will be rewarded by a sessional fee. GPs will only be able to perform such surgery if they have attended the appropriate training course. This will both save money and reduce pressure on hospitals.

9. **IS IT TRUE THAT THE ELDERLY WILL SUFFER UNDER THE NEW SYSTEM:** No: It will be MORE advantageous for a GP to take on elderly patients than before as capitation fees will be specially enhanced to provide for the elderly in recognition of extra duties required.

10. **WILL GPs BE ABLE TO TURN PATIENTS AWAY:** GPs have always been able to turn away patients and should a patient find it especially difficult to find a GP the matter is sorted out by the FPCs. This system works reasonably well now and certainly ensures that no-one goes without a GP.

11. **AT WHAT LEVEL WILL CAPITATION FEES BE SET:** The Government intends to raise the average remuneration accounted for by capitation fees from 46 per cent to at least 60 per cent as soon as possible.

12. **HOW WILL INCREASED CAPITATION FEES BE FINANCED:** Payments previously made in respect of seniority and group practise allowance will in future be distributed through increased capitation fees. Group practise allowances were a useful mechanism in the past in encouraging group practise. Now that group practice is an established feature of the family doctor service, the Government considers that there is no case for a special payment to encourage it. Seniority payments reflect years spent in service and have no place in a contract based on workload and performance. We consider

that a GP's income should, in future, be more directly related to the number of patients the GP attracts to his or her list and to the services provided.

13. **THERE WILL BE ENHANCED CAPITATION FEES FOR THE ELDERLY BUT ALSO FOR CHILDREN UNDER 5, HOW WILL THIS WORK:** A new capitation fee will be introduced for patients under 5 to whom Child Health Surveillance Services are made available. Parents will have the choice of having their child's development monitored by their GP or by the local community health services. The new payment will encourage the growth of child surveillance services. GPs who provide these services will need to be appropriately trained. This provision has long been sought by GPs' representatives and should be welcomed by them.

14. **HOW WILL THE NEW TARGET PAYMENTS OPERATE:** To encourage GPs to achieve higher levels of cover for childhood immunisation and for screening for cancer of the cervix, item of service payments for these services will be replaced by target payments. Such payments will be made for achieving or helping to achieve within the practice population 90 per cent cover for childhood immunisation (the WHO target) and 80 per cent for cervical cytology. All GPs are of course paid generally through their capitation fees for the provision of these services which are now an established feature of general practise. The extra payments will go to those who attain demanding performance targets and these targets are intended to encourage an extra health promotion effort from many practises.

15. **IS THERE ROOM FOR A SLIDING SCALE ON THE IMMUNISATION AND SCREENING TARGETS:** We are quite prepared to continue to discuss the system of target levels. However they are supposed to be incentives to better preventative medicine and we are not prepared to contemplate targets which everyone will achieve simply on the basis of patients coming through the door.

16. **HOW WILL A GP BE ABLE TO REACH HIS TARGETS WHEN HIS WORK IS BEING DONE BY THE COMMUNITY HEALTH SERVICES:** He will be paid according to the work that he does allowing for the work done by the Community Health Service but obviously the fee would be scaled down.

17. **WHAT IS THE AVERAGE GP LIST SIZE:** The average GP list size in 1969 but some GPs have as few as 500 patients on their list.

18. **HOW WILL A GP BE ABLE TO COPE WITH A LARGER LIST:** In the last ten years the Government has brought the average list down by about one quarter. Meanwhile GP remuneration and allowances has risen steadily. There is no reason that a good GP should not be able to cope with an average patient list or a slightly higher one, given modern facilities. He also has the option of taking on additional staff. However it is a misrepresentation to claim that the Government's proposals are aimed at encouraging bigger lists. A doctor will lose patients if he tries to take on more than he can give a good service to. A doctor with an average list who wants to raise his income is far more likely to aim for performance targets or develop new services than to try to take on more patients.

19. **WILL HE HAVE SUFFICIENT TIME TO GIVE TO AN INCREASED NUMBER OF PATIENTS:** Under the new system the doctor will have an incentive to PLEASE his patients. He will want to spend time with them. Should the doctor take on so many patients that he does not have sufficient time, patients will have the choice and the opportunity to move to another doctor.

20. **WILL THERE BE SPECIAL ARRANGEMENTS FOR DEPRIVED AREAS:** GPs providing services to deprived areas will receive a BPA supplement in respect of all patients on their lists who live in such areas.

21. **WILL THERE BE SPECIAL ARRANGEMENTS FOR RURAL PRACTICES:** The Government recognises the problems of rural practise and is considering representations made on this matter. Under the Government proposals, the present rural practice payments scheme will be replaced by a new BPA capitation supplement. This would be fairer and more sensible as it would be based on density of population and not, on now, on long out-of-date definitions of "rural" areas.

22. **HOW WILL THIS NEW SUPPLEMENT OPERATE:** For the purposes of this supplement a new definition of rurality related to population density will be introduced. Payment at the appropriate level of supplement will be made for each patient living in a qualifying sparsely populated ward.