

#### INTRODUCTION

Workload in general practice has been increasing, with direct clinical workload for GPs rising by 18% in 7 years.<sup>1</sup> But funding for general practice<sup>2</sup> and investment in workforce have not risen to keep pace.

Research by the Royal College of General Practitioners shows that GPs are routinely working 11-hour days in clinic, with up to 60 patient contacts per day. GPs are now working harder than ever. It is not surprising then to find that one in three GPs think that their current workload is unmanageable.<sup>3</sup> Workload is consistently identified as a key reason underpinning the current exodus of many GPs from direct clinical care.<sup>4</sup>

Promises of more GPs made by NHS England, along with £2.4 billion in extra funding for general practice, are welcome.<sup>5</sup> But progress addressing workforce issues has been slower than anticipated, and major issues in the recruitment and retention of GPs persist. Indeed, against government ambitions to increase the overall number of GPs by 5000 by 2020, the 1-year period between 30 September 2016 and 2017 witnessed an overall decline in the full-time equivalent number of GPs of 1193, representing a 3.5% reduction in GP capacity.

Adequate and fair remuneration are necessary to attract and retain GPs, as part of wider efforts to build a sustainable and thriving general practice workforce. Using data from more than 300 000 primary care patients, Mukhtar and colleagues provide a timely contribution to wider debates about funding allocations for general practice in their linked paper.<sup>6</sup> Multilevel analyses using linked data on patient and practice characteristics show that consultation rates increased with age and female sex, and varied by ethnicity and deprivation. Consultation rates were also associated with an increase in the number of GPs at a practice.

These data could potentially be used to support workforce planning, and to inform resource allocation formulae.

#### GETTING FUNDING ALLOCATIONS RIGHT

NHS England is committed to fair funding allocations, and to reducing inequalities in funding at both local area and practice level. This is important because it has been argued that the funding formula used to allocate core funding to most practices is out of date, and may not adequately

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reflect practice workload.<sup>7</sup> A more up-to-date funding formula based on local needs was introduced in 2016–2017 and further changes are planned for 2020–2021.<sup>8</sup>

In their paper, Mukhtar and colleagues call for more sophisticated staffing models and resource allocation formulae, identifying a number of pertinent variables that may help with this. Although this approach could help to inform workforce planning, how and to what extent these variables should be used in developing allocation formulae is not yet clear.

It may seem reasonable that funding for general practices should reflect the work they do. However, complexity is introduced when considering the subtle — but important — distinctions between need, demand, and activity. Funding formulae used historically in general practice, for example, the Carr-Hill formula, have included factors such as age and premature mortality as proxies for patient need. This is based on the conjecture that the average activity attributed to certain patient types across the NHS is a reasonable proxy for average need. However, activity at any individual practice may deviate from this average, due either to variations in actual need not captured by funding formulae, or to different responses to the same level of need. Although the work of Mukhtar and colleagues may refine estimates of need, it is a matter for debate as to whether practices should be remunerated according to how they respond to that need.

#### SHOULD ORGANISATIONAL FACTORS BE INCLUDED IN FUNDING FORMULAE?

It remains unclear how practice structure

and organisation might reasonably be reflected in funding formulae. The Carr-Hill formula explicitly does not adjust capitation payments to account for practice size due to concerns about perverse incentives. Mukhtar and colleagues identify the number of FTE GPs and number of FTE nurses as significant predictors of activity. They concluded that such data can be used to inform service provision and planning both locally and nationally. However, whether that information should be used in funding formulae, in the same way as variables such as patient age and deprivation, remains unclear. And because primary care sits within a wider health system, the quality of services provided by local government, hospitals, and the voluntary sector can also impact on GP workload. Whether and how such differences might be factored into funding formulae is unclear.

Using the model presented by Mukhtar and colleagues to inform resource allocation implies that if you had two GP practices of different sizes, both serving patient lists with similar population profiles, a smaller GP practice would receive disproportionately less funding than a larger practice on the basis that patients registered at this larger practice would, on average, consult more often. It is not clear if this represents the same time spent with patients spread over a larger number of shorter consultations, an appropriate response to patient demand, or inefficiencies in service delivery. Larger practice size is associated with loss of personal continuity.<sup>9</sup> Loss of personal continuity could, conceivably, lead to high rates of reconsultation if patients present to different doctors with the same

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clinical problem. Whether a trend towards developing larger practices (practice 'at scale') might contribute to rising consultation rates — potentially through loss of continuity — remains uncertain.

## IMPLICATIONS FOR POLICY AND PRACTICE

Tailoring funding to individual practice workload is challenging. Data to assess activity in individual practices are not readily available. It is also debatable whether funding should be based on activity or need. Current funding formulae are based on estimates of average workload, which will differ from workload in any one practice, but may be a reasonable proxy for need.

Within these constraints, there is still scope for updating and improving the current formula, for example, through better addressing the challenges faced by practices caring for atypical populations, and practices providing care in deprived areas.<sup>10</sup> Funding formulae should address how best to allocate resources in the context of new models of care, and resolve unanswered questions about what to do with consultations for administrative purposes. Simply excluding non-standard consultations, for example, video or online consultations or, of increasing importance, consultations undertaken on the telephone,<sup>1</sup> is likely to represent a problem.

Mukhtar and colleagues provide a timely and useful contribution to discussions about funding formulae for general practice. The implications for primary care of addressing challenges associated with fair resource allocation should, however,

not be underestimated. Introducing such potentially important changes in the present service environment needs to be very carefully planned and considered, and based on clear and widely accepted evidence. Not doing so risks destabilising the service and disenfranchising both patients and health professionals.

Changes to funding formulae are unlikely to provide a panacea to the challenges facing general practice at present. Conversations about resource distribution should not distract from the very real issue of an adequate funding envelope for general practice,<sup>11</sup> and for the NHS as a whole.

Alongside funding, a robust workforce strategy is critical for addressing issues of workload and securing a sustainable long-term future for general practice.

### Charlotte Paddison,

Deputy Director of Policy, Nuffield Trust, London.

### Gary Abel,

Senior lecturer, University of Exeter Medical School, University of Exeter, Exeter.

### John Campbell,

Professor of General Practice and Primary Care, University of Exeter Medical School, University of Exeter, Exeter.

### Provenance

Commissioned; not externally peer reviewed.

### Competing interests

The authors have declared no competing interests.

DOI: <https://doi.org/10.3399/bjgp18X695873>

## ADDRESS FOR CORRESPONDENCE

### John Campbell

University of Exeter Medical School, General Practice and Primary Care, Smeall Building, St Luke's Campus, University of Exeter, Exeter EX1 2LU, UK.

Email: [john.campbell@exeter.ac.uk](mailto:john.campbell@exeter.ac.uk)

@profjcampbell

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