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Experience of contractual change in UK general practice:

a qualitative study of salaried GPs

Abstract

Background
General practice in the UK underwent major change in 2004, with the introduction of new contracts and a significant element of pay for performance. Although salaried GPs form an increasing proportion of the general practice workforce, little is known of their experiences.

Aim
To explore the views and experiences of salaried GPs working in English general practice.

Design and setting
Qualitative study using semi-structured interviews in 17 practices across England, between July 2007 and September 2009.

Method
Interviews were conducted with 23 salaried GPs. A topic guide included questions on motivations for a career in general practice, descriptions of their daily working environment and duties, practice relationships, and future aspirations.

Results
The new ability to opt out of out-of-hours responsibilities was deemed positive for the profession but not a major driver for choosing medical speciality. Views regarding the impact of the Quality and Outcomes Framework were ambivalent. Differences in pay were regarded as largely reflective of differences in responsibility between salaried GPs and principals. Most participants reported conducting varied work in collaborative practices. Participants held varying career aspirations.

Conclusion
Salaried GPs' working experiences were dependent upon personal aspirations and local context. Most salaried GPs were reportedly content with their current position but many also had aspirations of eventually attaining GP principal status. The current lack of available partnerships threatens to undo recent positive workforce progress and may lead to deep dissatisfaction within the profession and a future workforce crisis. Further large-scale quantitative work is required to assess the satisfaction and future expectations of those in salaried posts.

Keywords
general practice; primary care; workforce.

INTRODUCTION

The introduction of a new general medical services (GMS) contract in 2004 was intended to reward and improve quality of care,[1] as well as addressing existing workforce issues by improving doctors' working lives.[2] As part of this process, for example, GPs were allowed to opt out of providing some services including their out-of-hours responsibilities.[1,3] With regard to rewarding quality, various factors have contributed to the ability of practice to achieve high Quality and Outcome Framework (QOF) scores. These include the increased use of practice nurses for routine chronic disease management and use of standardised electronic templates for the collection of QOF data, as well as changes to practice organisation, such as the introduction of internal peer review and surveillance.[4–7]

Prior to the new contracts, surveys indicated declining GP job satisfaction,[8,9] and a looming workforce crisis arising from retention and recruitment issues, as new doctors opted to avoid the long hours and inflexibility associated with general practice.[10] However, a survey of 1349 GPs indicated that a year after the introduction of the new contracts, GP principals' overall job satisfaction had increased.[11] The rise in satisfaction was attributed in part to increased income (pre-tax take-home pay for GP principals in England increased by 58% 2005–2006 compared to salaried GPs who received a 3% increase),[2] and in particular to reduced hours.[11] Furthermore, a report in 2008 indicated a 15.3% increase in whole-time equivalent GP numbers since 2002–2003.[2] Increasing numbers of salaried GPs have contributed to this rise and they now comprise 21% of the workforce in 2009 (up from 3% in 2001).[12] However, relatively little is known about this group of GPs as much of the post-2004 research has focused on GP principals and practice nurses.[13–15]

Before 2004, salaried GPs were reported as experiencing lower stress levels than their principal counterparts,[16] and were located in democratic, collaborative practices conducting highly satisfying and varied 'nice work'.[17] By contrast they perceived their GP principals as conducting the 'unrewarding' or 'burdensome' work.[17] The only post-2004 study to date that has sought to elicit the views of salaried GPs in relation to the recent changes reported a very different situation.[18] Salaried GPs were found to be conducting the unrewarding work by adopting 'the left-over or discarded jobs, mopping up the less complex and perhaps less professionally satisfying or challenging patients'.[18] In addition, salaried GPs were 'acutely aware' of differences in status and autonomy in decision making, leaving this group of GPs feeling disenfranchised, disillusioned, and concerned for their future prospects.[18]

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How this fits in

Salaried GPs form an increasing proportion of the GP workforce yet little is known of their experiences since the 2004 contractual changes. This study focuses exclusively on this group of GPs and highlights their attitudes to the QOF as well as their working experiences. The findings illustrates that while some make agential choices to be salaried and are content to continue in their salaried posts, others having recently qualified had little choice but to accept salaried positions having entered a market where partnership availability is limited. With many participants expressing desires to eventually hold GP principal status, the current lack of available partnerships may lead to a dissatisfied workforce and a possible future workforce crisis.

However, it should be noted that this later study included only seven salaried GPs.

This study aims to explore the post-2004 views and experiences of salaried GPs specifically as salaried GPs comprise a large and under-researched part of the GP workforce. Their views on the new GMS contract and QOF cannot be assumed to be the same as those of the GP principal counterparts or practice nurses whose views are represented in the literature. Furthermore, the existing literature indicates that salaried GPs have moved from a position of relatively high satisfaction to one of disillusionment and that this has in part been due to the contractual reforms. This study therefore aims to provide further evidence in relation to this GP population.

METHOD

Participants and setting

Semi-structured interviews with 23 salaried GPs were conducted over a 2-year period (July 2007 to September 2009) by two of the authors as part of a wider study.[19] Participants were recruited by a combination of techniques. Snowball sampling was employed initially, and recruitment was completed by utilising support from the Primary Care Research Network (PCRN).[20] Participants were drawn from 17 practices across 11 primary care trusts (PCTs) nationwide. Salaried GPs in the sample had, on average, been in general practice for 5.7 years and were predominantly (78.3%) female. All except three (who had previously been GP principals) had only held salaried GP posts. Participant and practice characteristics are shown in Table 1.

Data collection and analyses

Interviews lasted between 46 and 93 minutes. All interviews for the research were digitally recorded and transcribed verbatim. The analysis of transcripts involved two members of the research team reading and re-reading the transcripts and meeting regularly to discuss emerging issues and interpretations, enabling the identification of key concepts and themes. Codes were created on the basis of these themes and linked to the data collected using a software package, Atlas.ti. These themes were fed back to the wider members of the team, who acted as a critical sounding board to provide feedback on the emerging themes and interpretations of the data. Any disagreements were discussed until consensus was achieved. Salaried GPs were assured of the anonymity and confidentiality of their responses.

RESULTS

Professional values

Although participants emphasised the importance of traditional general practice values, such as holism and continuity, the majority felt that the 2004 changes had impacted on these values. Participants related that patients now experienced less continuity with their GPs. Participants highlighted two major contributing factors to this: the role of practice nurses in conducting the day-to-day QOF template work, and the impact of opting out of providing out-of-hours care. While the changes meant individual GPs had increased flexibility in terms of work–life balance, they often perceived that patient care had declined as a result:

'... obviously it had a positive [effect] *because you are not on duty 24 hours ... But from the care point of view, I think it brought negatives, I would say, the standard has dropped.'* (GP19)

Some ($n = 4$), however, were wholly positive, regarding the changes as timely and necessary, producing positive outcomes both for the profession and for patients:

'I don't know how they were coping before. Because it's difficult. General practice is a very stressful job. You can only cope with so much pressure. And the fact that after 6:00 or 6:30 you're free, I think that really makes the work a little bit more enjoyable. And it's safer for the patients. I'm sure you wouldn't like to be seen by a doctor who is working

Table 1. Sample characteristics

Participant ID	Sex	Self-reported experience (years fully qualified)	Practice ID	Practice list size	Practice Index of Deprivation quintiles (1 = most affluent and 5 = most deprived)	PCT ID
1	M	18	1	16 030	4	1
2	F	4	1	16 030	4	1
3	M	4.5	1	16 030	4	1
4	F	4	2	2514	5	1
5	F	1	3	4538	4	2
6	F	11	4	6267	5	3
7	F	2.5	5	10 238	5	3
8	F	17	6	3609	1	4
9	F	2	7	9421	3	5
10	F	2	8	14 158	1	6
11	F	2.5	9	2939	3	5
12	M	12	10	5554	1	7
13	F	2.5	11	16 237	3	7
14	F	4	12	5567	5	8
15[a]	F	3	13	24 730	2	9
16[a]	F	2	13	24 730	2	9
17[a]	F	5	13	24 730	2	9
18[a]	F	3	13	24 730	2	9
19[a]	F	6	13	24 730	2	9
20	M	2	14	9883	2	6
21	M	0.5	15	5705	1	7
22	F	15	16	7840	5	10
23[a]	F	10	17	9934	2	11

[a]*Those who were interviewed by telephone; the remainder of interviews were face to face.*

18 hours. It's difficult.' (GP20)

While most (*n* = 21) of the participants were exercising their right to opt out, recent, that is post-2004 entrants (*n* = 11) stated that the 2004 changes had not particularly influenced their career choice, as they desired attributes unique to general practice, such as the variety of work. Only one participant, GP20, stated that he would not have chosen general practice had these changes not occurred.

In terms of autonomy and holism, some participants reported misgivings with regard to particular aspects of the QOF, particularly in areas where they questioned the evidence base for some of the targets. Concerns were raised about the prioritisation of incentivised care and the loss of holism:

'... well I think it has put a lot of strain on the partners and practice to get all the QOF points ... I mean when it came to get all these points just to get more money, I think it's put more strain on doctors and it has lost the ... just normal care for patients, taking them as a patient rather than as another ... object to get points.' (GP23)

However, the vast majority (*n* = 20) of participants reported that they complied with all areas of the QOF, regardless of their personal opinions. Various reasons were cited for this, including pressure from internal surveillance, direct responsibility as part of the practice QOF team, contractual obligation, trainee loyalty to the practice, and finally their desire to eventually become a partner in the practice:

'I am also looking for a partnership maybe in the years to come. So, I have to like, I think I have to prove my mettle really, isn't it, in the years to come otherwise you are not going to make it.' (GP10)

Finally, despite any concerns, most (*n* = 20) believed that the QOF had led to improved and standardised clinical care across the profession via the emphasis and reward of evidence-based practice.

Professional status in the workplace

All participants acknowledged the sizeable pay differentials between themselves and their principals that had arisen due to the contractual changes. A small number (*n* = 3) had received QOF-related financial bonuses in the early stages of the contract at least, but these had since ceased. Whereas some (*n* = 6) were resentful of the differences, others (*n* = 17) felt that the inequality fairly reflected the contrasting levels of responsibility:

'I think the balance of, of that is [partners] *have a lot more responsibility ... you have to take a lot more responsibility for the practice and more leadership. And I quite enjoy ... coming in doing the job and, and not having to worry about that so much. And you get paid more money but I think the balance of the hours you'd be spending and the stress of the job would probably be higher as a partner, so it works quite well for me, doing the sessions I'm doing here.'* (GP2)

Despite their status as employees, most (*n* = 20) felt that they were fairly treated and highlighted examples such as their regular inclusion in practice meetings and the variety in the types of work that they were able to undertake. However, they also highlighted that this was somewhat context dependent:

'Where I trained it was salarieds, trainees and registrars, who basically took the brunt of all the rubbish! ... But here, actually everyone does an equal amount of stuff, I think ... So I think it is really quite fair here compared to other places. And on the visit

screen it's obvious who's got which visits that day. And everyone does a pretty similar amount, actually. So, yeah, that doesn't bother me.' (GP13)

Finally, it was also apparent from their accounts that participants' attitudes to their salaried status were dependent upon their personal aspirations. For example, a small number ($n = 3$) had actively rejected their prior principal status, trading off higher income for less responsibility and more time to pursue other careers. Others held no current desire for a partnership and wanted lower levels of responsibility due to family commitments, or they simply wished to concentrate and build up their clinical knowledge:

'What are the good points? I don't think there are any bad points. Gosh ... The salaried GP, for me it's good because I can work part-time and I can say to a point some of the days I'm not here, because I'm putting the family first those days ... So to me, I want to be here part time, and I know that that goes with a certain salary, and I think the salary for me is fair, or good.' (GP14)

Most ($n = 17$) participants, however, did eventually wish to become a partner, in order to have more control over practice affairs:

'But, sometimes you do feel that you're not really involved in decision making. That's fine for some people, but for me, I do like a bit of control. [laughs] *So, I think at the moment it's fine, but I think eventually I would want part of the decision-making process.'* (GP9)

Future prospects

All participants were aware of the lack of availability of partnerships. For those who had actively chosen a salaried post, this was of little personal concern. Those who desired partnership status were mostly content to serve a period of 'apprenticeship', but held concerns over its duration. While many were hopeful that the situation was temporary, they were concerned as to long-term effects on their career prospects, as well as professional morale:

'If ... you've got fewer people controlling more sort of minions beneath them, I don't think that's a particularly good idea. You're going to get more revolts, as it were, going on. I've certainly had friends who have worked in practices where there are sort of two older male GPs, and they have 10 salaried part-time females working under them, and they just treat them like shit ... And I think that they will not allow anybody else to become a partner because they want to keep control of it all and control of the finances and make lots of money for themselves, but control everybody below them.' (GP17)

DISCUSSION

Summary

The views and experiences of salaried GPs in relation to contractual change were varied and somewhat echo prior research. The QOF was regarded as being successful in improving and standardising clinical care for patients across general practice but was felt to have led to unintended consequences.[13,21] The findings do highlight, however, that GP principals were perceived by some as too QOF focused and that this could lead to negative implications for patient care. Although differences in pay were recognised, most felt fairly rewarded and that the disparity fairly reflected differences in responsibility. In addition, most felt fairly treated in terms of the distribution of work and their inclusion in practice meetings. However, many eventually desired to become a partner and, rather than just participate in practice meetings, have more of an influence over the decision making. The current lack of partnerships was seen as tolerable in the short term, but concerns were expressed over the long-term impact on salaried GPs' future career prospects.

Strengths and limitations

Strengths of the study include an in-depth focus on a significant and under-researched subsection of the GP workforce, the extended period of data collection, and the rigour with which the data were analysed by an experienced research team. Furthermore, although the sample was not nationally representative, participants were recruited from a variety of settings and the sample characteristics reflected the fact that salaried GPs tend to be younger (<35 years) and female (71% versus 33%) in comparison to GP principals.[22] Limitations include a lack of inclusion of GPs employed in other settings (for example, social/commercial enterprises); however, these are a small subgroup and the researchers were interested in the experiences of those working in mainstream, traditional partnership practice arrangements.

Comparison with existing literature

Much research evaluating the impact of the

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Ethical approval

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Competing interests

The authors have stated that there are none.

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2004 contractual changes has been quantitative in nature and does not allow for an in-depth exploration of the perceived impact on those conducting the work. While the views and experiences of GP principals and practice nurses have been reported elsewhere,[13,14,23] only two studies have focused on salaried GPs and reported almost diametrically opposing findings.[17] Furthermore, both studies also had limitations. The Jones and Green study sample[17] consisted primarily of locums and therefore is not representative of a typical salaried GP — one employed over a long(er)-term duration in a single practice. The study by Lester *et al* was based on a small sample of seven salaried GPs.[18]

While this study supports the view of Lester *et al* that salaried GPs may be concerned over future prospects (reflecting the current market situation for available partnerships),[18] it also suggests that the salaried GP experience is not as dire. As in Jones' and Green's study,[17] most salaried GPs continue to report working in collaborative practices, conducting varied work, and enjoy their lower levels of responsibility. In fact, this study suggests that their experiences are largely dependent upon personal aspirations and local context. The fact that a recent survey reported that many GPs remain in salaried posts some 5 years after the completion of training[24] is therefore not necessarily due to a lack of opportunities but may reflect the changing gender profile as well as a continuation of the changing priorities and needs of those entering the profession, as identified over a decade ago.[10] Finally, although the issues identified here may have arisen within a UK context, they may be of relevance to other European countries such as The Netherlands, where similar trends within the GP workforce, that is, an increasingly salaried service, have also been identified.[25]

Implications for research and practice

Research to date regarding the impact of the 2004 contractual changes has focused largely on the effects of rewarding quality of care. However, the changes were also intended to address workforce issues. Research in this area has been somewhat lean in comparison. What this study suggests is that the views of salaried GPs are variable and complex. Furthermore, there is seemingly potential for cleavage to occur within the profession should the lack of partnerships continue in the long-term. This may result in a profession that is stratified between the 'haves' and the 'have-nots', which may create disincentives for recruitment. However, it is also important to note that there is seemingly a subset of salaried GPs who are content to remain salaried and for whom the traditional career expectation of attaining a partnership no longer applies. There is a clear need for a national, longitudinal survey regarding the career intentions and job satisfaction of new entrants to the profession, to help inform policy in relation to salaried GPs.

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