

Debate & Analysis

Should general practice give up the independent contractor status?

INTRODUCTION

The independent contractor status of GPs has been an article of faith since the NHS was established in 1948. A salaried service was devised for hospital consultants but essentially, GPs have been self-employed ever since. This has led to the small business model of general practice and was at the heart of the partnership system. Now many GPs opt for sessional, salaried, often portfolio employment, and the number of GP partners is in steady decline. Some regard the disappearing partnership system as the loss of a golden age of general practice, a flowering of the independent contractor arrangements. Partnerships were invested in the local community, quick on their feet, and able to respond swiftly to change and challenge. A recent survey by the General Practitioners Committee of the British Medical Association (BMA) revealed strong support for the independent contractor status, even among salaried GPs. Others see the small business approach as inefficient, outdated, and unattractive, with a trend towards federations, super practices, and increased salaried working, to achieve economies of scale in management, infrastructure, and clinical resources, and to provide wider ranges of patient services. We asked five well-qualified commentators for their views on whether the time has come for general practice to give up the independent contractor status.

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THE ACADEMIC PERSPECTIVE



Azeem Majeed

An increasing proportion of GPs are salaried (around 28% in England in 2014),

and currently employed on contracts that can vary considerably in salary and employment rights. Medical students and junior doctors who want to pursue a career in specialist medicine know under what terms they are likely to be employed when they become consultants. The same is not true for people who would like to pursue a career in primary care. This uncertainty is one of the factors deterring junior doctors from applying for GP training schemes and for these schemes not meeting their recruitment targets.

In the 2015 UK election campaign, we saw both the main political parties making major commitments about access to primary care; in particular, how rapidly people could be seen when they need an appointment with a GP. Neither party though was clear on how these commitments would be funded, nor on how NHS primary care services would be reorganised to deliver them. Because primary care services are largely delivered through 'independent contractor' general practices and not NHS trusts, governments in the UK have been able to impose substantial additional commitments on primary care teams without providing adequate funding or determining the implications for workforce planning. Inevitably therefore, in the past few years we have seen a rising workload for GPs combined with increasing problems for patients in accessing primary care services. This has led to frustration and dissatisfaction among GPs and their patients.

Under a standard salaried NHS contract, GPs could be employed on similar terms to NHS consultants, with a salary based on experience and with additional payments for taking on duties in areas such as management, clinical leadership, teaching, and training. As NHS employees, GPs would have the same employment rights as other NHS staff. The NHS would become responsible for ensuring there were sufficient GPs employed to meet demand, including providing rapid access for patients with acute problems; and the management of complex or older patients with long-term conditions. Providing adequate premises for GPs to work in and meeting the requirements of the Care Quality Commission would also become the responsibility of the NHS, as would the management of primary care services.

In the absence of a national NHS contract for salaried GPs, the alternative will increasingly be employment by commercial companies on significantly worse terms than those offered to its medical employees by the NHS, further exacerbating our current problems with the recruitment and retention of GPs.

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THE FRONT-LINE PERSPECTIVE



Naureen Bhatti

I took over as finance lead for my practice last year, a General Medical Services (GMS) practice in the deprived inner-city area of Tower Hamlets in London, dependent for 25% of its income on minimum practice income guarantee (MPIG). I had never worried about funding before, but here we were, a large teaching practice providing high quality care, meeting all our national and local targets despite an often very challenging population, yet the partnership had already, even before MPIG started to be cut, taken a significant hit on profit, which disproportionately affected my younger partners already struggling to afford to live in London. How had this arisen?

A vote in 1948 resulted in the independent contractor status, a model rarely questioned, that has been repeatedly modified to maintain it, for example with the introduction of Personal Medical Services (PMS) and Alternative Provider Medical Services (APMS) contracts, adding complexity and inequity along the way. GMS practices continue to be reimbursed on historic patterns based largely on age,

with no recognition of workload related to deprivation or rurality. Those of us topped up with MPIG are now having it removed before any attempt to devise a new funding formula. Further inequity is introduced in the three-tier employment of partners, salaried doctors, and sessional GPs, all with different levels of 'autonomy' and reimbursement, not necessarily related to workload or responsibility. Concerns are often expressed that a salaried service will have the potential for loss of innovation and drive, as if our hospital colleagues are immune to these consequences. Furthermore, mixing money intended for patient services with money intended for GP remuneration can lead to government reluctance to invest more in general practice for fear that money intended for service improvement will end up boosting GP income.

And for patients? In an inner-city practice, as our resources dwindle, we try to manage increasing demand in complex patients long before they are recognised for additional funding by the Carr-Hill formula, and struggle with the dichotomy between access and continuity, play with systems, telephone triaging, and case-mix. But the reality is that we just cannot continue to provide the service we have been. We will struggle to recruit new partners or afford salaried GPs, so return to poor inner-city services as referenced in Colling's seminal 1950 work, inner-city practice is 'at best ... very unsatisfactory and at worst a positive source of public danger'. And ultimately it is unviable.

After nearly 20 years as a GP I still find the day job a privilege. Primary care remains the bedrock of the NHS and value for money as highlighted by the Commonwealth Report last year. None of this is upheld by the independent contractor status. We need to future proof our profession, not only attracting young doctors but ensuring we have meritocratic and fair ways to develop leaders for tomorrow. We cannot leave it to the current system where there is a random mass of small businesses and no transparency or clear structure for training and leadership. Young doctors are not attracted by the burdens of running a practice, poor premises, or the uncertain reimbursement this brings. They want clear job plans, career progression, time for management and clinical leadership, plus guaranteed employment rights such as maternity, paternity, and sick pay. We need to build on federations developing NHS primary care provider organisations that are not-for-profit, and employ GPs

and practice staff with mandatory standard NHS contracts. Our representative bodies need to lead this change or the alternative will be GPs employed by commercial companies. This is too important to leave to market forces.

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THE UPHOLDER PERSPECTIVE



Peter Murchie

From the severally-assailed perspective of a salaried GP within an under-resourced and over-managed NHS out-of-hours organisation, I reflect on a more fulfilling, albeit brief, period spent as an independent contractor GP.

For 3 years, before taking the plunge into full-time academic primary care, I was a partner sharing equally in the endeavour of shaping a practice aiming to meet the needs and expectations of a population of 7000 patients.

There were challenges and frustrations, but also rewards. I had acquired my basic skillset as a GP trainee, which I then burnished and added to as I saw fit, in response to my own interests, but also in response to my perceptions of the needs of my patients and the wider practice population. I undertook BASICS education and studied for a management certificate, and I had an equal vote in key decisions affecting the practice, the appointment of new staff, and the rejection or adoption of new work as the majority saw fit. Decisions were made with full cognizance of our workload and shared goals. I had partners with whom I cooperated, and sometimes clashed, being forced to reconcile self-interest with the needs of colleagues and the practice. The views and behaviours

of our patients were patently obvious, without recourse to questionnaires. We had the power to innovate or to respond quickly as shortcomings or opportunities presented themselves. There was progress and reverses, success and failure, but ultimately we achieved a balance between the interests of self, the practice, and the practice population, and the momentum was towards a resilient and successful organisation.

And then I surrendered my independent contractor status to become a salaried employee with an NHS out-of-hours service. To me this now equates to a surrender of power and the right to self-determination. I can no longer organise my work to best meet competing demands. I can no longer negotiate with equal partners, but must accept the impositions of a cost-cutting management which seems to work toward the lowest common denominator. I can no longer decide what to accept and reject. A good recent example has been the removal of the out-of-hours community psychiatric nurse service, with completely predictable effects upon my workload. Not that our views were sought before the axe fell. I no longer have total freedom to develop my skills according to personal interest or to best meet the demands I perceive. I must instead undertake ordained 'mandatory' training on such delights as information governance, and diversity in the workplace. This is boring, irrelevant, and time-consuming, the main purpose appearing to be to protect the monolith for which I work, not to improve the care I give. When I identify a real opportunity for workplace improvement I have no real power to address it. I pass it up a non-responsive bureaucratic chain to a distant and removed manager, focused on budgets and generalities. My concern is either ignored or cursorily acknowledged and placed at the bottom of a list of priorities with cost cutting, and not service improvement, at the top.

In the preceding paragraphs I give a view of the world through a narrow and personal prism. A few imaginative jumps, however, should enable the reader to scale things up and envision a future army of defeated and demoralised GPs working in a degraded and declining NHS. GPs' independent contractor status equals power. Guard it jealously.

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THE BMA PERSPECTIVE



Richard Vautrey

UK general practice has been successful because the people who run the business are on the shop floor day in, day out. They are in direct contact with, and accountable to, those who use their service. GP contractors generally commit to their practice and local community for the long-term, providing continuity of care from one generation to the next. They not only know their patients and families, they are part of the community. As a result it's in the direct interest of the GPs running the practice to ensure they deliver what their patients need. Overwhelmingly, they achieve this, as demonstrated by consistently higher levels of satisfaction than other parts of the healthcare system.

It's in GP contractors' financial interest to manage their practice as efficiently as possible and also to accept a degree of risk that an employee would not do. This is seen in GPs' gatekeeper role which, while an unfashionable term, is essential for a cost-effective and sustainable NHS. It also protects patients from potential harm from over investigation and unnecessary treatment.

GP partners work together, going the extra mile to get the work done. Although commissioners exploit this by failing to resource rising workload, GP contractors are empowered clinicians, with a degree of autonomy no longer enjoyed by many employed NHS colleagues, and can use this to decide for themselves what they do and don't do. It also gives GPs far more freedom to publicly stand up and advocate for their patients.

Being independent enables practices to be flexible and to quickly adapt to the latest policy change or yearly contract changes. It's why many practices are at the leading edge of healthcare innovation, as seen with GP IT systems being years ahead of those in hospital settings.

Many GPs want to work in a salaried capacity but also have the option to become

a partner at some point in their career. Equally even those who want to continue as salaried GPs prefer to be employed by an independent contractor practice.

The current crisis in general practice is largely related to unreasonable funding cuts not the contractual status. The reality is that general practice, built around independent contractors looking after a registered list, is why the NHS has remained sustainable since its creation and will be why it survives into the future. Undermine this foundation and the whole house risks collapsing.

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THE POLICY ANALYST PERSPECTIVE



Rebecca Rosen

Should general practice give up the independent contractor status? Only if GPs choose to do so as the most sensible local option for them.

There is only one game in town at the moment and that is the transformation and modernisation of general practice and the wider NHS. The transition from a form of cottage industry into a modern cornerstone of the NHS will be painful and difficult for many GPs and will depend on visionary, professional leadership and lots of developmental support. Not on contract types and payment arrangements.

Enforcing removal of independent contractor status would create a huge distraction. It's hard for GPs to find time for any discretionary activities at present, but I'm convinced that protest meetings about changes to terms and conditions would trump time devoted to system transformation.

Certainly, the financial incentives inherent in contracts can be effective levers for change. But the transformation we are seeking needs fundamental reform of interprofessional working relationships, rethinking of the roles and responsibilities

of all practice staff and a step change in the use of enabling technologies. All this while preserving the essence of good general practice; holism, continuity of relationship, localness, and other characteristics that are much valued by patients.

Contract reform is about altering the external context but much of the transformation we are seeking is within organisations, at grass roots level and beyond the reach of contracts. The aligned financial incentives of an integrated capitated system employing GPs could underpin some of the changes needed. A cadre of competent managers could no doubt implement organisational systems and processes needed for innovative approaches to access and good patient experience.

But we also need relational transformation for interprofessional working, integrated care, and coordination for people with complex needs. Hierarchical management can not bring this about. People need to participate willingly, confident that their core professional role is secure, and able, therefore, to focus on how to practice differently. For some, this may be by choosing to be employed. For others, a battle to preserve the status quo could consume all their energy.

And what about the entrepreneurialism inherent in the current system of GP ownership? The past few years have seen increased GP productivity: more appointments delivered at lower cost. Would that be sustained if they were employees of a bigger system? Would the motivation for innovation exist? And if motivation remained, would being part of a bigger system speed up innovation or stifle it under a mountain of whole-system bureaucracy?

There would no doubt be some 'wins' from a whole-system perspective, of removing independent contractor status. But overall, there are bigger and more important fish to fry. An enforced departure from independent contractor status is a battle not worth fighting.

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