The new GMS Contract — a Trojan horse?

THE proposal for a new United Kingdom-wide General Medical Services Contract heralds the biggest shake up of National Health Service primary care since 1948. The general practitioner (GP) monopoly over the provision of primary care services in the NHS is to be further broken up. The new GMS Contract transfers the control and accountability for primary care services from GPs to Primary Care Organisations (PCOs), and signals increasing dominance of market forces over the patterns of service delivery.The 43 000 GPs in the UK have yet to vote on the recently costed Contract.[1] But what are the consequences of the new Contract?

First, the provision of 24-hour, 365-days-a-year medical cover by GPs, a hallmark of British primary care, will end. The contracting out of out-of-hours cover has been under GP control. Now routine primary care services are to be commoditised and broken up into discrete elements. GPs will be remunerated for providing a basic level of 'essential' services for patients who are acutely ill but all other routine GP services, such as cervical screening, vaccination and immunisation, and child health surveillance, will be optional and priced separately, using a UK-wide tariff.[2] These services are deemed 'additional' and practices will be able to opt out of providing them, as they already can of out-of-hours care. Enhanced services will be priced and commissioned separately by PCOs.

Second, the new GMS Contract will pave the way for local pay bargaining, to be conducted between PCOs and practices, breaking with the previous national terms and conditions of service negotiated between the individual GP through the BMA and the Secretary of State for Health. The BMA's GPC will become redundant. While this may result in greater flexibility, enabling increases in local pay and improving GP recruitment, especially in under-doctored areas, it will also widen existing inequities in pay.

Third, GPs will no longer be reimbursed for the costs and expenditure of providing services, according to the nationally negotiated Statement of Fees and Allowances (the Red Book), nor will they receive funding for direct staff and premises costs. Instead reimbursement will come in the form of a new cash limit, a global budget linked to practice populations. Crucially, this means that the link between funding for services, staff, and premises will be broken, returning us to the era before the negotiation of the 1966 GP Contract when the funding system did not reimburse GPs for the costs of services and premises. The 1966 GP Contract led to the expansion of primary care, improved pay and conditions — including reimbursement of premises — and addressed the differential status between GPs and hospital specialists. A further feature of the new reimbursement scheme is the introduction of performance or quality-related pay, presented to GPs as extra income. In reality this will equate to roughly a third of a GP's income, rather than the current 4% of total GMS expenditure. Thus payments will increasingly be linked to quality measures.

The new Carr–Hill weighted capitation formula is intended to allocate resources to practices more fairly, accounting for patient need. Yet using a formula to allocate a budget for small practice populations will amplify any technical inadequacies and fail to account for differences between patients with different comorbidities and needs. A better method of allocating resources according to population need would be to allocate a ring-fenced budget for primary care on the basis of a weighted capitation to PCOs which, with their larger populations of around 150 000, are better able to manage the financial risks than practices.

Currently, the NHS picks up the costs of primary care through the non-discretionary element (not cash-limited) Red Book's reimbursements. GPs do not have to consider the financial risks of providing care to costly patients, as this is reimbursed. But under the new funding system, each of the 11 000 practices will be responsible for providing all care and services from a cash limit or global budget. In this way, the risks and costs of providing primary care are being passed from the government to practices, which will not have a sufficiently large risk pool to manage them. PCTs are unlikely to pick up the bill if practices fail to manage within the global budget and run into financial difficulties.

Proponents argue that global budgets linked to practice populations rather than individual doctors will protect practices and patients, as the cash stays when doctors move on. However, there is no guarantee that global budgets will keep pace with pay and health care costs. Already, the 70% of GPs whose current Contract estimates are too low can already see the potential effect on income.[3] Any annual shortfalls will result in financial deficit and will have to be met by cutting staff or GP budgets, through cuts in services or other measures, such as income generation. These in turn could reduce quality payments received by practices.

Experience from the United States shows that devolving financial risk downwards will result in practices seeking to minimise risk. This may be by 'cherry picking' younger and healthier patients at the expense of the sick and the old. For example, allocation of money under the new Contract is based on registered patients, and so groups such as the homeless or asylum seekers will tend to find it harder to get primary care.

The focus on quality or performance payments also means that GPs will have further incentives to cherry-pick not only patients, but the services they provide. Moreover, the responsibility for achieving the set quality thresholds lies with practices, not with PCOs, yet practices work in varying circumstances with different levels of resources and population needs, so that service quality variations are often outside their control.

PCOs will have the authority to decide which primary care services practices may or may not provide. While this is not in the proposed Contract, it is important to note that where practices opt out of providing services, PCOs will be free to choose to provide services themselves or place elements of them with other practices or non-GP providers, including the private sector. For example, PCOs may find the idea of establishing a primary care cardiology service an attractive idea, to maximise the income generated from the quality payments. Some practices may find that it is not financially viable for them to provide services, but once practices have opted out of providing services they may no longer be able to opt back in, especially where PCOs have subcontracted out such services to private providers.[4]

For GPs the new GMS Contract signals a turning point. Unlike Marshall and Roland, we are less optimistic about GPs' ability under the new Contract to maintain the core values of general practice.[7] We anticipate that the price of GPs lightening the onerous responsibilities of providing comprehensive primary care will be the loss of professional freedoms and advocacy for patients and a greater role for private health care corporations in delivering primary care. Patients will be faced with a new model of general practice, which requires them to be more knowledgeable 'consumers' of care delivered by panoply of healthcare providers. At stake are both universal health care and the tradition of family-centred medicine that has been the hallmark of UK general practice for 50 years.

SHAMINI GNANI
Specialist Registrar in Public Health Medicine

ALLYSON M POLLOCK
Professor of General Practice
Public Health Policy Unit, School of Public Policy, University College London

References

1. NHS Confederation. *Investing in general practice – the new General Medical Services Contract*. NHS Confederation, February 2003.
2. Department of Health. *Reforming NHS financial flows — introducing payment by results*. London: Department of Health, 2002. URL: www.doh.gov.uk/nhsfinancialreforms/financialflowsoct02.htm
3. Keating M. New GP contract tagged a 'monumental cock up'. *The Guardian*. 26 March 2003.
4. Pollock AM, Player S, Godden S. How private finance is moving primary care into corporate ownership. *BMJ* 2001; **322:** 960-963.
5. UNISON. *Foundation Hospitals and the NHS Plan*. London: UNISON, February 2003.
6. *Health and Social Care (Community Health and Standards) Bill*. London: The Stationery Office, March 2003.
7. Marshall M, Roland M. The new contract: renaissance or requiem for general practice? *Br J Gen Pract* 2002; **52:** 531-532.

Address for correspondence

Dr Shamini Gnani, Public Health Policy Unit, School of Public Policy, University College London, 29-30 Tavistock Square, London WC1H 9QU. E-mail: s.gnani@ucl.ac.uk

Disclaimer

Are we better than we can say? Altruism in general practice

TWO studies in this issue of the *BJGP* express, in different ways, concerns about altruism — or its absence.[1,2]

There are at least three problems one encounters in trying to think clearly about the role of altruism in medical research and public health programmes. First, we are often unclear what we mean by altruism. Two versions seem particularly relevant: what one might call the 'saintly and pure' strain, and a somewhat more 'rough and tumble' variant. Second, how important altruism is for the particular setting, and what form of altruism is needed, may not be obvious. Third, and most important, concerns about altruism may represent much deeper worries about the nature of one's culture, especially the moral norms that govern us and the connections we have with one another. A close examination of the two studies suggests that, while continued moral vigilance is needed, rumours of the death of altruism are premature.

Altruism muddled

There is a tendency to carve up the universe of moral motivation into two portions. By far the larger share is presumed to belong to self-interest — actions taken to promote our own goals and good. The entire science of economics is predicated on rational beings behaving according to their judgments about what best furthers their own interests. The other piece of the pie is altruism. Depending upon your view of human psychology, biology, or ethics, you might imagine this to be anywhere from a sizeable piece to a vanishingly small sliver.

This model is too simple; it leaves out another ubiquitous and important category of motives, and it fails to distinguish between the possible meanings of altruism. It oversimplifies its approach to human actions, which commonly spring from a complex mixture of motives. Many, indeed, will be expressions of self-interest — short-term and ill-considered, perhaps, but self-interested nonetheless. However, additional motives may also be at play, including those directed by regard for others, such as compassion, love, or a more impersonal sense of social duty. It is quite common to have a mixture of self-interest and regard for others behind a particular decision.

The simple model also ignores mutuality. Parents rapidly learn about mutuality as they care for their children. Only by aiming for one's child to flourish and to achieve wellbeing does a parent derive the deep and lasting benefits that come from a loving relationship between parent and child. It is not strictly altruism, because the parent gets a great deal from the relationship. But neither is it simple self-interest, because it is only by intending to further the child's interests that both child and parent flourish.[3] So, a third category of moral motivation — common to the most central human relationships — must be acknowledged.

Confirmed sightings of 'saintly and pure' altruism are rare.

This bird is identified both by what one sees and does not see. It appears as an action, often requiring self-sacrifice or abnegation, that benefits another. Closer examination must not reveal any tint of self-gain, enjoyment, or even self-satisfaction. Sceptical altruism-watchers can usually supply a plausible account, raising the suspicion that one or more such imperfections are present, even if they are not readily visible. In contrast, rough-and-tumble altruism's existence is affirmed when the intent to benefit another, not solely because of the benefit that will accrue to oneself, can reasonably be demonstrated. Life is complex, and the mere possibility of some benefit to a person does not neutralise whatever other motives, inspired by concern for others, also animate their action.

Altruism in action

In the first of the two studies, Lawton and colleagues claim that altruism 'did not appear to be a key influential factor' in the willingness of subjects to enroll and remain in a 20-year study of diabetes treatment, the United Kingdom Prospective Diabetes Study (UKPDS).[1] The Lawton *et al* study is interesting and useful for what it suggests about how participants may understand what it means to be a research subject, as well as how to encourage participants to remain in such long-term clinical studies. Asking ten people to remember why, perhaps more than two decades ago, they agreed to participate in a project that required them to appear several times each year at a special clinic, may be subject to overwhelming recall bias. What they do remember, and repeatedly mention, is the attentive care they received while in the study and the excellent relationships they had with the research team. By the end, these ten individuals felt that any sacrifice they might have made was more than compensated for by the fine personal care they had received.

Why did the subjects respond to the interviewer's questions as they did? It is, of course, possible that there never was any regard for others motivating their participation as research subjects. However, in addition to recall bias, these interviewees might have been reluctant to sound self-congratulatory or morally superior. It is almost always safer to offer the self-interested justifications that pass as the hallmark of rational, prudent choice. And although we must be cautious about comparisons between the UK and the United States, an important study by Bellah and colleagues showed that the depth of Americans' lived moral commitments often far outstripped the moral vocabulary available to them to explain and justify those commitments.[4] Bellah *et al* found that we are often, literally, better than we can say. The same may have been true for the people interviewed by Lawton *et al*. In any event, the study was not designed to prove something negative. The most that can be said is that their ten subjects did not spontaneously emphasise altruistic accounts of their participation in the UKPDS.

In the second study, Vernon acknowledges that motives can be complex in vaccine programmes.[2] The phenomenon of herd immunity entails that immunising one's own child at the same time enhances the protection against infection of all other children in the community. Whether parents understand this, or whether the desire to benefit other children is any part of their motivation for agreeing to immunise their own child, is an empirical matter. The paper's discussion of altruism in vaccine policy unfortunately fails to distinguish between (a) the undeniable fact that individual parental decisions to accept or refuse vaccines for their children have consequences with regard to others, and (b) the moral motivations determining those parental decisions. One wonders if most parents would be surprised to learn that their individual decisions concerning vaccinations actually had implications for other children. Vaccine programmes can suffer from the 'free rider' problem — parents and children who reap the benefits that come with large numbers of other parents accepting the risks for *their* children.

This confusion is a minor defect in an otherwise excellent paper that identifies the dangers attending falling immunisation rates and the need for more public involvement and more transparency in vaccination policy, lest suspicion of public health officials, allopathic medicine, and what is known in the US as the 'medical–industrial complex', leave large numbers of children exposed to preventable epidemics of infectious diseases.

A tale of two cultures? Altruism, shared needs, and solidarity

By the time Richard Titmuss published his influential book, *The Gift Relationship*, the US was already transforming its whole-blood supply programme from one predicated on the assumption that people would provide blood only in return for some benefit, such as money or so-called 'blood credit' plans, to a system that relied on voluntary donors, thoughtful organisation, and a clear articulation of the need for blood.[5,6] How is it that famously self-sufficient Americans offered their veins by the millions? It cannot be through remnants of the Fabian socialist tradition — the explanation offered by the famed economist Kenneth Arrow for the UK's voluntary blood system.[7] In *The Gift Relationship*, US theorist Lewis Hyde framed the problem for American culture: 'It remains an unsolved dilemma of the modern world … as to how we are to preserve true community in a mass society, one whose dominant value is exchange value and whose morality has been codified into law.'[5]

Altruism is as much an expression of fellow-feeling and solidarity, an affirmation of community, as it is a solitary moral emotion. It is, I suspect, a concern about the possible loss of solidarity and community that leads us to bemoan any sign that altruism may be flagging. These two studies add little to whatever cause for concern we may have. Indeed, a closer look at the responses of the UKPDS participants reveals that their relationships with the researchers were deep and lasting. The authors describe the sense of 'bereavement' some felt upon the study's conclusion. One interviewee lamented, 'I felt as though I was losing friends.'

Both studies alert us to problems and possibilities. Avoid contributing to the confusion between therapy and research so common among research participants. Treat your subjects respectfully, considerately, and competently, and you may be rewarded with great loyalty (and astonishingly low attrition rates). Do not feed into the suspicions and fears that spring so readily among patients and parents when trust is impaired; do all you can to become trustworthy by giving parents a stake and a voice in vaccination policy decisions.

Know also that our shared embodiment, and our frailties, remind us ceaselessly of the moral — and human — importance of community and solidarity.

THOMAS H MURRAY

President, The Hastings Center, Garrison, New York.

References

1. Lawton J, Fox A, Fox C, Kinmonth AL. Participating in the United Kingdom Prospective Diabetes Study (UKPDS): a qualitative study of patients' experiences. *Br J Gen Pract* 2003; **53:** 394-398 (this issue).
2. Vernon JG. Immunisation policy: from compliance to concordance? *Br J Gen Pract* 2003; **53:** 399-404 (this issue).
3. Murray TH. *The worth of a child*. Berkeley, CA: University of California Press, 1996.
4. Bellah RN, Madsen R, Sullivan WM, *et al*. *Habits of the heart: individualism and commitment in American life.* Berkeley: University of California Press, 1985.
5. Titmuss RM. *The gift relationship.* New York: Pantheon, 1971.
6. Drake AW, Finkelstein SN, *et al*. *The American blood supply*. Cambridge, MA: MIT Press, 1982.
7. Arrow KJ. Gifts and exchanges. *Philos Public Aff* 1972; **1(4):** 355-360.
8. Lidz, CW, Appelbaum PS. The therapeutic misconception: problems and solutions. *Med Care* 2002; **40(9 Suppl):** V 55-63.

Address for correspondence

Dr Thomas H Murray, The Hastings Center, 21 Malcom Gordon Road, Garrison, NY 10524, USA.