# Debate & Analysis

# The Family Doctor Charter:

## 50 years on

### INTRODUCTION

Among innumerable white papers and contractual revisions, three legislative milestones bestride the organisational development of British general practice in the second half of the 20th century. Two of these events form 'book-ends' to the third. First, the NHS Act of 1947 cemented the place of general practice in the new health system. Second, the Family Doctor Charter, enacted in 1966, revitalised the discipline after a period of stagnation and ushered in a 'golden age' of general practice. The expansionism of this era extended its range of responsibilities in various ways. To these were added a purchasing function following the *Working for Patients* white paper of 1989. The consequences of this third milestone are still being worked through. Why was the Charter required, what did it portend, and how should we look back on it half a century on?

### EARLY YEARS

Rose-tinted historiography in support of Beveridge's vision has obscured shortcomings in the NHS.[1] In reality, general medical care was reorganised but not transformed. For GPs, the NHS represented an elaboration of the system of National Health Insurance (NHI) established in 1911, under which a capitation system also operated. Many of the regulations of the NHI scheme were simply transferred into the NHS. These were compiled in that industrial artefact of hallowed memory, the 'Red Book'. The major change was to extend health care free at the point of delivery from insured working class males to the whole population. However, there were limited economic incentives to provide good patient care; rather, they kept lists long and costs low. The standards and social ethos of care were largely a continuation of the old panel system.[2]

Workloads rose with the incorporation of more women and children onto patient lists and the take-up of free health services. Until the Danckwerts pay award of 1952, remuneration stagnated and morale (ever a commodity that GPs could talk down) declined. Therapeutic advances extended the range of conditions that family doctors could manage effectively. The notorious Collings Report had long since drawn attention to the poverty of many premises and the variable quality of care.[3] By the early 1960s, general practice was in crisis as economic realities failed to match professional aspirations.

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### A DIFFICULT BIRTH

In 1961 the Central Health Services Committee set up a special sub-committee to advise on the future field work of the GP. The Gillie Report of 1963 described general practice as a 'cottage industry'[4] and made recommendations that were agreed with the British Medical Association (BMA) leadership. A working party chaired by Sir Bruce Fraser, Permanent Secretary at the Ministry of Health, set about the details of implementation.

Following a now familiar pattern, negotiations were disrupted by a bout of professional militancy over unpalatable recommendations from the pay review body. A perspicacious minister, Kenneth Robinson, intervened to avert the threat of mass resignation and broker agreement with the profession's representatives. They were adroitly led by James Cameron, new chairman of the BMA's General Medical Services Committee. The resulting Family Doctor Charter was translated into a new contract in 1966.[5] It introduced major changes to remuneration that were to have lasting effects on practice organisation and structure.

### THE NEW DISPENSATION

Overall pay was increased while the proportion of capitation-based income fell relative to basic practice allowances and fees for services such as immunisation. Each doctor was reimbursed for 70% of the wage costs of up to two nursing and/or ancillary staff. Several new schemes were devised to subsidise the costs of premises development. Extra allowances encouraged group practice and vocational training.

Beyond these changes, the Charter facilitated a subtler ideological shift. The newly instituted College of General Practitioners hastened the development of academic departments and the promotion of higher clinical and training standards. The Charter provided an indispensable material base from which to attain these standards.[6]

The proportion of doctors in single-handed practice declined by three-quarters to 12% over the next 25 years as the primary care workforce diversified. The proportion of female practitioners doubled over the same period to 25%. The advent of practice nurses further changed the face of primary care. The large-scale expansion of purpose-built health centres and owner-occupied premises supported the growing primary healthcare team in its evolving roles. Only 28 health centres were built in the first years of the NHS; in the decade following the Charter over 700 new health centres appeared.[7] Reception staff allowed for structured appointment systems and more efficient allocation of practitioner time according

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to clinical need. The average number of patients per principal declined from 2282 in 1966 to 1812 in 1991.[8]

These developments gradually altered the doctor's working day. The proportion of patients visited at home halved over the same period just as the annual number of consultations per patient rose from three to five per patient. The increasing size and complexity of practices was one reason why more practitioner time was spent on activities other than patient care: administration, meetings, and training. In the light of various College reports and the work of pioneers such as Julian Tudor Hart, their remit expanded beyond the treatment of minor illness to complex chronic disease management and anticipatory preventive care.

The advent of timed appointments helped to make the consultation a central focus of training and research. The cultural changes associated with the analytical work of Michael Balint and his disciples on the psychodynamics of the doctor–patient relationship are hard to compute.[9]

Not all the products of the Fraser Working Party were advanced. For example, progress on a comprehensive scheme for universal vocational training of new entrants was delayed by the shortage of doctors. Nevertheless, a quarter of a century on, general practice was a self-confident discipline with a burgeoning research base and enviable training standards able to attract those from the highest rungs of Moran's infamous career ladder.[10] Its focus was quality of care as much as organisational standards. For many doctors in practice at the time, these years are a high watermark.

This is not the place to rehearse the consequences of the *Working for Patients* white paper, the 'internal market' to which it gave birth, or its impact on primary care. General practice has been, in a sense, the victim of its own success. The same self-confidence with which early fundholders assumed responsibility for addressing the wider service's inefficiencies looks oddly hubristic in retrospect but it is hard to deny the parlous state of general practice today. The roots of the current workforce crisis and relative underfunding are complex but reflect poverty of central planning, political ignorance, crude managerialism, and neglect. The personal, implicit contract with the patient has steadily loosened as the public, explicit contract between doctor and state continues to tighten.[11]

## CONCLUSION

The Charter has to be viewed in the social, political, and technical context of its time but can any relevant lessons be drawn after 50 years? This was a suite of top-down, clearly targeted, and well-financed innovations — no place for pilot projects or energy-sapping policy research. The money went on basic building blocks — staff, training, premises — rather than mystical quick fixes. It was the fruit of careful planning over years and painstaking negotiation in which the profession's leaders played a decisive role. The timely stewardship of wise politicians was vital. Policymakers at that time faced exactly the challenge that they face today: how to incentivise collaborative integration between practices, between primary and secondary care, and between health and social care.

The idea of the NHS as *the* fundamental turning point remains prevalent because the new service symbolised, then as now, an equitable welfare state in times of austerity. However, for general practice more significant discontinuities arguably attended the Charter. Of course, its importance can be exaggerated and many of the developments described above were being led from within the profession. Nevertheless, at a time when the discipline is once more under threat, the Family Doctor Charter remains an iconic event in the late history of general practice. A settlement of comparable significance is long overdue. The *General Practice Forward View* signalled welcome extra investment but its impact remains to be seen.[12]

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