Changes in general practice organization: survey of general practitioners' views on the 1990 contract and fundholding

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SUMMARY

Background. *General practitioners' views on two major changes in the organization of general practice — the 1990 contract for general practitioners and fundholding, introduced in 1991 — have not been researched in any great detail.*

Aim. *A study in 1993 sought to investigate the views of general practitioners from group practices and of single-handed general practitioners, in family health services authority areas with different socioeconomic characteristics, on the 1990 contract for general practitioners, fundholding and the effects of these two changes in general practice organization.*

Method. *One general practitioner partner from each of 323 group practices in six family health services authority areas of England was invited for interview and 142 single-handed general practitioners in the study areas were sent a postal questionnaire. The interview and questionnaire sought general practitioners' views on the 1990 contract and fundholding, reasons for their opinions, and views on the effects of these reforms on workload and the quality of service. Other information was recorded on fundholding status, workload pressures, outreach clinics, budget surpluses, retirement plans, and opinions on a salaried service.*

Results. *A total of 260 group practice general practitioners (80%) participated in the study and 80 single-handed general practitioners (56%) returned questionnaires, 78 of which could be analysed. Over half of all respondents were opposed or strongly opposed to both the 1990 contract and fundholding. However, despite this opposition, a sizeable minority of group practice practitioners (38%) agreed that the quality of services provided had improved or considerably improved since the 1990 contract. Workload appeared to have increased, with the proportion of respondents who reported being always under pressure increasing from 12% in 1987 to 41% in 1993. All but one respondent considered administration to have increased. Some respondents were considering early retirement. One of the solutions proposed to alleviate problems in inner city general practice, a salaried service, received little support, even from those general practitioners working in areas which might be expected to benefit.*

Conclusion. *Dissatisfaction of general practitioners with the National Health Service reforms was expressed in continued opposition, in concerns about workload and levels of administration, and in a desire to retire early. Suitable ways of improving general practitioner morale must be sought.*

Keywords: health service reforms; general practice budget holder; conditions of service; general practice; doctors' attitudes.

Introduction

TWO major changes to the organization of National Health Service general practice, the 1990 contract for general practitioners[1] and the introduction of voluntary fundholding in 1991,[2] have caused stress,[3-5] a decrease in morale,[5] an increase in workload[6-10] and dissatisfaction[9] among general practitioners. There has been ambivalence towards the reforms,[11] with reports that general practitioners are joining the voluntary fundholding scheme not because they want to, but because they feel that they should.[12]

General practitioners' opinions about the 1990 contract were explored, in a pilot study in late 1992 in one family health services authority.[9] This was part of a larger comparative study of the effect on practice structure and process (activity) of the 1990 contract reforms, in areas of England with different socioeconomic characteristics.[13-15]

Practices that became fundholders in April 1991, when the scheme was introduced, are known as first-wave fundholders. Practices could choose to become fundholders in subsequent years and are known as second-wave and third-wave fundholders, and so on. By 1993, three waves of practices had taken up fundholding. Issues relating specifically to fundholding have been investigated. These include: the use of budget surpluses,[16-18] as there has been some comment about their use for improving premises;[18-21] whether and how general practitioners informed their patients that they were taking up fundholding; and which specialist outreach clinics were being held on their practice premises.[22-27] A salaried service, as an alternative to the current fee for service system, has been promoted as a possible solution to workload problems, particularly in inner cities,[28] since the introduction of the 1990 contract.

After the pilot study,[9] the study was expanded in 1993 to investigate the views of general practitioners from group practices and of single-handed general practitioners, in family health services authority areas with different socioeconomic characteristics, on the 1990 contract for general practitioners, fundholding and the effects of these two changes in general practice organization. Views were also sought on plans for retirement and on a salaried service.

Method

Six family health services authorities, or parts of family health services authorities, took part in the study. They were designated: east rural, London inner city, Midlands urban, north east industrial, north west suburban and Thames valley. They were the same areas in which a study was undertaken in 1987,[13,14] that investigated practice structure and process issues.

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The practices can be divided into two distinct groups. The east rural, north west suburban and Thames valley areas represent affluent rural and suburban areas and have a higher proportion of group practices than single-handed general practitioners. The London inner city, Midlands urban and north east industrial areas are urban and inner city in character and have a higher proportion of single-handed practitioners than group practices.

One practice partner, randomly selected from lists provided by the family health services authorities, from all 323 group practices in the six areas was contacted by telephone to arrange an interview with a locally based interviewer. If the first general practitioner contacted did not agree to be interviewed, another partner was approached, and so on, until one (or none) agreed to take part. The 142 single-handed general practitioners in the study areas were sent a postal questionnaire; up to three reminders were sent.

During the interview, which lasted a minimum of 30 minutes, a semi-structured questionnaire was completed. The postal questionnaire contained similar questions to those in the interview questionnaire. General practitioners' age and sex were recorded, as was the fundholding status of their practices. General practitioners were asked for their views (strongly in favour, in favour, no strong view, opposed, strongly opposed, do not know) on the 1990 contract for general practitioners and on fundholding. The questionnaires also sought general practitioners' reasons for their opinions, and their views on the effects of these reforms on workload and quality of service for patients in general practices.

General practitioners from fundholding practices were asked whether and how patients had been informed of the practices becoming fundholding and, if the practices had a budget surplus, what use was planned for the surplus.

Responses to statements on workload pressures (able to cope, sometimes under pressure, always under pressure) were compared with responses to the statements in a survey in 1987.[13,14]

Other information recorded was on the number and type of outreach clinics provided in the practices, the age at which the general practitioners planned to retire and whether the general practitioners would consider becoming salaried.

In some instances responses of group practice general practitioners were compared with those of single-handed general practitioners and with those of fundholding general practitioners, and responses of general practitioners from the six family health services authority areas were compared.

Interviewers had attended an induction day at the University of York to train them in conducting interviews and in the use of semi-structured questionnaires.

Statistical analysis was by means of chi square tests.

Results

Response rates and general practitioner characteristics

Response rates for the general practitioners from group practices are shown in Table 1. Overall, 260 of the 323 general practitioners approached for interview (80%) agreed to take part in the study. Response rates ranged from 71% in the east rural area to 94% in the north west suburban area.

Eighty of the 142 single-handed general practitioners (56%) returned questionnaires (Table 1). Response rates ranged from 49% in the Midlands urban area to 75% in the east rural area. One single-handed practitioner in the London inner city area and one in the Thames valley area had too few patients (100 and 16 patients, respectively) to be included in the study; responses from 78 single-handed practitioners were therefore analysed.

Of the 260 general practitioners from group practices, 215 (83%) were men, compared with 772 of all 1047 general practitioners in the group practices (74%). A total of 171 of the group practice respondents (66%) were aged between 40 and 59 years compared with 559 of all general practitioners (53%) in the group practices. The group practice respondents were therefore in their middle years in general practice and had considerable experience of working in the NHS before the reforms were introduced.

Table 1. Response rates of group practice general practitioners and single-handed general practitioners in six study areas.

Area	% response of GPs	
	Group practice	Single-handed
East rural (*n* = 56/4)	*71*	*75*
London inner city (*n* = 46/40)	*72*	*50*
Midlands urban (*n* = 61/49)	*75*	*49*
North east industrial (*n* = 62/26)	*90*	*69*
North west suburban (*n* = 53/6)	*94*	*67*
Thames valley (*n* = 45/17)	*78*	*65*
Total (*n* = 323/142)	*80*	*56*

n = number of group practice/single-handed GPs in area invited for interview/sent questionnaire.

The fundholding status of group practices at the time of the study is shown in Table 2. In total, 64 group practices were already fundholders as part of waves one to three, representing 25% of the 260 group practices in the study. The proportion of practices that were fundholding varied between areas, ranging from two of the 33 London inner city practices (6%) to 20 of the 50 north west suburban practices (40%).

As not all respondents answered all questions, denominators for the responses in the following sections vary.

1990 contract for general practitioners

Opposition to the 1990 contract for general practitioners was less apparent among 259 general practitioners from group practices than among the 78 single-handed general practitioners; 18% of group practice general practitioners reported being strongly opposed and 37% reported being opposed compared with 28% and 38%, respectively, of single-handed general practitioners. For group practice general practitioners, 20% reported being in favour of the 1990 contract and 3% reported being strongly in favour compared with 9% and 4%, respectively, of single-handed general practitioners.

Views of the group practice general practitioners in the six areas on the 1990 contract are shown in Table 3. The lowest proportions of respondents reporting that they were in favour of the changes were in the east rural and London inner city areas, 10% and 15%, respectively; the highest proportion was in the Thames

Table 2. Fundholding status of group practices, by area.

Area	% of practices	
	Fundholding (1st to 3rd wave)	Non-fundholding
East rural (*n* = 40)	*35*	*65*
London inner city (*n* = 33)	*6*	*94*
Midlands urban (*n* = 46)	*15*	*85*
North east industrial (*n* = 56)	*18*	*82*
North west suburban (*n* = 50)	*40*	*60*
Thames valley (*n* = 35)	*31*	*69*
Total (*n* = 260)	*25*	*75*

n = number of GP respondents from group practices in area.

Table 3. Group practice general practitioners' views on the 1990 contract for GPs, by area.

Area	% of GPs responding			
	(Strongly) in favour	No strong view	(Strongly) opposed	Do not know
East rural (n = 40)	10	18	73	0
London inner city (n = 33)	15	27	55	3
Midlands urban (n = 45)	22	40	36	2
North east industrial (n = 56)	29	13	57	2
North west suburban (n = 50)	30	12	56	2
Thames valley (n = 35)	31	11	54	3
Total (n = 259)	24	20	55	2

n = number of GP respondents from group practices in area.

valley area, 31%. Opposition was most prevalent in the east rural area (73%) and least prevalent in the Midlands urban area (36%). More of the group practice general practitioners in the Midlands urban area and in the London inner city area than group practice practitioners overall had no strong view on the 1990 contract, 40% and 27% respectively, versus 20%.

Reasons for opposition to the 1990 contract for general practitioners were numerous. Respondents could list more than one reason. Fifty three of the 465 responses (11%) of group practice general practitioners were by those who reported disliking the 1990 contract 'on principle'; 17% of responses were by those who thought that too much screening was performed in general practice; and 8% by those who were concerned about increased administration, this being particularly high in the Thames valley area (17% of 52 responses).

A total of 97 of 255 group practice respondents (38%) agreed that the quality of services provided in their practices had improved or considerably improved since the introduction of the 1990 contract. This level of agreement was similar in all areas except in the London inner city area where only eight of 33 group practice general practitioners (24%) agreed that there had been an improvement or considerable improvement. Most commonly respondents thought that there had been no change in service quality (43% of all respondents), with 55% of the 33 respondents from the London inner city area holding this view. The view that services had deteriorated was held by 12% of 255 group practice general practitioners; only 6% of the 33 London inner city group practice general practitioners held this view although more of the respondents in this area than group practice respondents overall agreed that the change had been only cosmetic, 15% of 33 versus 7% of 255.

Single-handed general practitioners held similar views to those in group practices on the quality of general practice services since the introduction of the 1990 contract except that 28% of the 78 single-handed practitioners thought that the quality of services had improved or considerably improved.

There was almost unanimous agreement among both single-handed practitioners and respondents from group practices that the administrative workload of the practice had increased or considerably increased since the 1990 contract was introduced with only one general practitioner from a group practice not holding this view.

Fundholding

Eight per cent of 258 group practice general practitioners reported being strongly in favour of fundholding and 16% reported being in favour, compared with none and 17%, respectively, of the 78 single-handed general practitioners. Opposition to fundholding was voiced by 83 (32%) of general practitioners from group practices and strong opposition voiced by 72 (28%), compared with such opposition voiced by 16 (21%) and 30 (39%), respectively, of the single-handed general practitioners.

Opposition to fundholding was mainly concerned about inequalities of service provision between fundholders and non-fundholders; 25% of 352 reasons for opposition expressed by group practice respondents raised this concern. Opposition to fundholding 'on principle' accounted for 18% of the responses.

Views expressed by 258 general practitioners from group practices on fundholding are shown in Table 4. The percentage of group practice respondents who reported being in favour or strongly in favour of fundholding ranged from 12% in the London inner city area to 29% in the Thames valley area. Overall, opposition to fundholding was widespread, with 155 of 258 group practice general practitioners (60%) being either opposed or strongly opposed; opposition or strong opposition ranged from 50% of Midlands urban group practice practitioners to 76% of those in the London inner city area.

Results for the 64 general practitioners from fundholding group practices revealed that 29 general practitioners (45%) reported being in favour or strongly in favour of fundholding compared with 24% of 258 group practice general practitioners and 17% of the 78 single-handed general practitioners overall who reported this. Opposition or strong opposition to fundholding was voiced by 22% of the 64 general practitioners from fundholding group practices.

Of the 64 fundholders, 43 (67%) reported that they thought that the quality of service provision had improved or considerably improved as a result of the practice controlling its own budget; there was almost unanimous agreement (with one dissenter) that the administrative workload of the practice had increased or considerably increased as a result of fundholding.

Most of the 64 fundholders considered that fundholding had, to a large extent or to some extent, led to shorter waiting times for hospital outpatient appointments (69%), improved access to hos-

Table 4. Group practice general practitioners' views on fundholding, by area.

Area	% of GPs responding			
	(Strongly) in favour	No strong view	(Strongly) opposed	Do not know
East rural (n = 40)	18	10	70	3
London inner city (n = 33)	12	9	76	3
Midlands urban (n = 44)	27	20	50	2
North east industrial (n = 56)	25	18	55	2
North west suburban (n = 50)	28	14	58	0
Thames valley (n = 35)	29	14	57	0
Total (n = 258)	24	15	60	2

n = number of GP respondents from group practices in area.

pital inpatient services (59%) and an improvement in patient services (69%). Only 14% of the fundholders felt that fundholding had, to a large extent or to some extent, improved relationships with patients.

From the reports of the general practitioners from fundholding group practices it was determined that 27 (42%) of the 64 fundholding practices definitely had a budget surplus and six (9%) did not; 31 (48%) of the general practitioners were unable to give information on budget surplus because their practices had not been fundholders for long enough. The 27 fundholding practices with a budget surplus planned to use their surplus for a number of purposes, most prominent of which were to build and improve premises (15 respondents) and to buy equipment (14). Other uses were to: increase/train staff (six); improve services for patients (five); introduce services for cataracts (four), physiotherapy (three), orthopaedics (three) and chiropody (two); reduce waiting times (three); and upgrade telephones (two).

Responses from the 64 fundholders indicated that 14 practices (22%) had not informed their patients that the practice had become a fundholding practice. The most widely used methods for those who had informed their patients were by practice leaflet, in 20 practices, and by a notice in the surgery, in 12 practices.

Outreach clinics

Responses from 260 group practice general practitioners indicated that 50 (19%) of the practices had held outreach clinics, and that 23 of these (46%) were fundholding practices. The outreach clinics most commonly held were for psychiatry (17 practices), dermatology (11), ear, nose and throat problems (11), orthopaedics (nine) and gynaecology (nine). Some outreach clinics were held in health centres and patients could be referred to the clinic by all general practitioners practising there, whether from a fundholding practice or not.

There were variations among group practices in different areas in provision of outreach clinics, with the north west suburban and north east industrial areas having more sessions than practices in the other four areas, in 29 practices (58%) and 32 practices (57%), respectively. Eight of the 11 of the dermatology sessions (73%) had been held in the north west suburban area, and four of the seven general surgery sessions (57%) had been held in the north east industrial area. These two areas had the greatest number of practices that had held psychiatry sessions (five each) whereas no practices in the London inner city area had held a psychiatry clinic.

Workload pressures

All general practitioners were questioned about their workload. Four of the 260 group practice practitioners reported being under no pressure and two did not respond. Responses of group practice general practitioners are shown in Table 5, compared with responses to the 1987 survey of general practitioners in group practices in the same areas.[13,14] The proportion who reported being able to cope within normal working hours in most weeks fell from 43% in 1987 to 16% in 1993, while the proportion who reported being under great pressure and continually short of time increased from 12% in 1987 to 41% in 1993. The proportion who reported being sometimes under pressure remained relatively constant between the two surveys. There was a significant difference over all three responses from group practice general practitioners between 1987 and 1993 in all areas except Thames valley.

In the present survey, 14% of the 78 single-handed general practitioners said that they could cope, with 36% reporting being sometimes under pressure and a further 46% reporting being always under pressure. One single-handed practitioner reported being under no pressure and two did not respond.

Table 5. Workload pressure of 235 and 254 group practice general practitioners in 1987 and in 1993, respectively, by area.

	% (no.) of GPs reporting					
	Able to cope[a]		Sometimes pressured[b]		Always pressured[c]	
Area	1987	1993	1987	1993	1987	1993
East rural**	*48* (19)	*13* (5)	*45* (18)	*48* (19)	*8* (3)	*40* (16)
London inner city**	*44* (12)	*15* (5)	*41* (11)	*42* (14)	*15* (4)	*42* (14)
Midlands urban**	*38* (18)	*13* (6)	*52* (25)	*28* (13)	*10* (5)	*57* (26)
North east industrial**	*51* (24)	*13* (7)	*38* (18)	*45* (25)	*11* (5)	*38* (21)
North west suburban*	*54* (22)	*28* (14)	*32* (13)	*44* (22)	*15* (6)	*26* (13)
Thames valley	*19* (6)	*11* (4)	*63* (20)	*46* (16)	*19* (6)	*40* (14)
Total**	*43* (101)	*16* (41)	*45* (105)	*42* (109)	*12* (29)	*41* (104)

Full statement: [a]I can cope within my normal hours in most weeks; [b]I am sometimes under pressure to complete all that needs doing in a week; [c]I am under great pressure and continually short of time. Difference between 1987 and 1993 responses, chi square: *$P<0.05$, **$P<0.01$.

Retirement

All general practitioners were asked about their retirement plans. Of 257 group practice practitioners, 69% planned to retire when aged either 60 years or 65 years and 18% planned to retire when aged 55 years. If pension rights were protected then 45% of 253 group practice practitioners would plan to retire when aged either 60 years or 65 years and 34% when aged 55 years. Responses from 78 single-handed general practitioners indicated that they intended to retire later than those in group practices: 15% intended to retire when aged 70 years (compared with 4% of 257 group practice respondents), 58% when aged 60 or 65 years and 14% when aged 55 years. If pension rights were protected, 8% of the single-handed practitioners would plan to retire at the age of 70 years, 45% when aged 60 or 65 years and 35% when aged 55 years.

Salaried service

Views on a salaried service were sought. Of 253 general practitioners from group practices, 5% said that they would like to become a salaried general practitioner and 30% said that they would consider the option. However, 65% said that they definitely did not want to become salaried; this differed little between areas, ranging from 59% in the north east industrial area to 80% in the Thames valley area.

Of 77 single-handed practitioners, 6% reported that they would like to become salaried, 45% said that they would consider the option and 48% said that they were definitely against the option. In the London inner city area, six of 18 respondents (33%) indicated that they would consider becoming a salaried general practitioner, although only two (11%) said that they would like this option.

Discussion

The general practitioners who were most willing to complete the lengthy interview questionnaire were those in their middle years in general practice, with considerable experience of the NHS before the reforms.

Over half of all the general practitioner respondents were opposed or strongly opposed to both the 1990 contract for general practitioners and to fundholding, two to three years after the introduction of these two changes in general practice organization. This continued opposition is a cause for concern, for policy makers and for general practitioners themselves, as is the perceived workload increase when compared with general practitioners' views in 1987 on workload.

In the pilot study in late 1992, conducted in one family health services authority, 51% of 37 interviewed general practitioners thought that the quality of service provided had improved or considerably improved as a result of the 1990 contract,[9] compared with 38% of group practice practitioners and 28% of single-handed practitioners in the present study. This decrease in the proportion perceiving positive effects of the 1990 contract on service quality could be related to ongoing workload and administrative increases.

Opposition or strong opposition to fundholding was expressed by 60% of interviewed general practitioners and by 22% of fundholders. These data compare with those reported by Appleby: among lead fundholders, 80% were in favour of fundholding but this fell to 45% of non-lead fundholders and to 10% of non-fundholders.[11] The lack of much perceived improvement in relationships with patients as a result of fundholding, revealed in the present study, could be linked with the reluctance of general practitioners to inform patients of the changed status of the practice. This further links with concern among general practitioners about inequalities as a consequence of fundholding.

One solution that has been suggested for alleviating workload problems in inner city general practice is to introduce salaries for general practitioners in such areas.[28] However, this was not a popular option, even among general practitioners in the areas, such as the London inner city area, likely to be targeted.

A feature of fundholding is that practices are allowed to keep any budget surplus, to use in the improvement of services for patients. Concern has been expressed about the use of fundholding surpluses to build and improve premises from which general practitioners may ultimately gain personally on retirement.[18] In spite of these misgivings, 56% of respondents with fundholding surpluses in this study were planning to make premises improvements; this is in line with other research findings.[20] As this practice is widespread, policy should be made more explicit.

Outreach clinics are increasing in number but have yet to be evaluated.[26] The findings in the present study are similar to those of other researchers,[26] with psychiatry, dermatology and orthopaedics being among the most commonly held sessions. The holding of outreach clinics in practice premises is not confined to fundholders since such sessions were sometimes held in health centres for the benefit of the patients of all general practitioners practising there.

Results from this study indicate that there is dissatisfaction among general practitioners with the NHS reforms, which was expressed in continued opposition, in concerns about levels of workload and administration, and in a desire to retire early. Nevertheless, this dissatisfaction is coupled with increased incomes for general practitioners,[15] and a sizeable minority of group practice respondents (38%) agreed that the quality of services provided in general practices had improved or considerably improved since the introduction of the 1990 contract. The proposal for a salaried service received little support from general practitioners. Other ways of improving general practitioner morale must be sought.

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