Recruitment and retention of general practitioners in the UK: what are the problems and solutions?

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SUMMARY

Recruitment and retention of general practitioners (GPs) has become an issue of major concern in recent years. However, much of the evidence is anecdotal and some commentators continue to question the scale of workforce problems. Hence, there is a need to establish a clear picture of those instabilities (i.e. imbalances between demand and supply) that do exist in the GP labour market in the UK. Based on a review of the published literature, we identify problems that stem from: (i) the changing social composition of the workforce and the fact that a large proportion of qualified GPs are significantly underutilized within traditional career structures; and (ii) the considerable differences in the ability of local areas to match labour demand and supply. We argue that one way to address these problems would be to encourage greater flexibility in a number of areas highlighted in the literature: (i) time commitment across the working day and week; (ii) long-term career paths; (iii) training and education; and (iv) remuneration and contract conditions. Overall, although the evidence suggests that the predicted 'crisis' has not yet occurred in the GP labour market as a whole, there is no room for lack of imagination in planning terms. Workforce planners continue to emphasize national changes to the medical school intake as the means to balance labour demand and supply between the specialties; however, better retention and deployment of existing GP labour would arguably produce more effective supply-side solutions. In this context, current policy and practice developments (e.g. Primary Care Groups and Primary Care Act Pilot Sites) offer a unique learning base upon which to move forward.

Keywords: general practitioners; workforce; recruitment; retention.

Introduction: the current GP workforce debate

MANY believe that general practice is facing a significant and deepening workforce crisis with a number of long-term changes in labour supply giving cause for concern. First, there is the apparently declining interest in a general practice career among medical graduates, partly explained by increasing competition from the hospital specialties.[1-3] Secondly, migration from overseas has declined following changes to UK immigration requirements in 1985. Importantly, migration from the European Union, possible under the free movement provisions of European legislation since 1975, has been insufficient to offset the loss of skilled labour from elsewhere.[3] Set against these initial recruitment difficulties (i.e. inflows), several trends in the retention of existing labour (i.e. outflows) also suggest potential workforce problems (Figure 1). For instance, although the majority of vocational trainees still go into general practice, this varies across geographical areas.[4] Moreover, doctors aged under 35 years appear increasingly hesitant about making the commitment to full-time partnership on completion of vocational training.[5] Equally as important is evidence that, encouraged by the 1995 changes to the NHS superannuation scheme that allow doctors to retire with an abated pension from age 50, many experienced GPs are leaving the profession earlier than previous generations.[3]

These trends have been attributed largely to dissatisfaction with government health reforms and to associated perceptions of professional uncertainty and high levels of workload-related stress.[6] However, much of the evidence for this is anecdotal. In fact, in the 10 years to 1996, the actual number of GP principals in England and Wales rose to its highest ever level of 28 937 — an increase of 9%.[3,7] The number of GP registrars also continued to match overall vacancies;[8] analysis of turnover in the GP Census for 1990–1994 revealed more entries to the workforce than exits.[9] Finally, the Review Body on Doctors' and Dentists' Remuneration (DDRB) and the Medical Practices Committee (MPC) have both questioned the scale of GP recruitment and retention difficulties.[10,11]

How, therefore, can what appear to be genuine concerns about the inadequate supply of GPs be reconciled with evidence of relatively few problems in absolute terms? Based on a review of the published UK literature, we have attempted to answer this question by establishing a picture of those labour market instabilities (i.e. imbalances between demand and supply) which do clearly exist. In particular, we argue that there is a need to go beyond national entry and exit statistics alone — that is, to examine how far the GP labour market is internally stable, and the extent to which it works to achieve the most effective utilization of the current active and inactive stock.

Method

Searches of the GP recruitment, retention and workforce literature were carried out using the MED-LINE, BIDS-EMBASE and ISS, and HELMIS databases; a survey of articles in recent issues of relevant professional journals was also undertaken.

Our analysis centred on two main analytical themes that shed light on the imbalances revealed in the literature. First, the fact that distribution of labour market opportunity has been shown to be socially constructed. In other words, employment outcomes have to be understood in the context of ascribed characteristics, such as age, gender, and ethnicity, as well as individual effort and experience.[12] This is particularly important given the changing social composition of the GP workforce. Secondly, the view that the structures and processes that constitute occupational labour markets vary over time and between different local areas.[13]

In the rest of the paper, we explore the impact of these factors and provide a framework within which their underlying causes might be addressed.

Changing attitudes to work among GPs: the impact on labour supply

The most notable long-term trend in the GP labour market is its rapidly changing gender mix. Overall, 32% of GPs were female

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in 1996, compared with 22% 10 years earlier,[7] following a 40% drop in the number of male GP registrars between 1985 and 1995.[14] Such trends are important because they have reduced the average GP's hours of work, with women more likely both to take 'career breaks' and to seek part-time employment before going full-time.[3,15] In consequence, 14% of all GPs and 9.1% of principals now work part-time.[7] The estimate is that 110–150 new entrants are required to provide care equivalent to 100 retiring principals.[8,16] Importantly, however, this expanded female labour force appears to be significantly underutilized by 'traditional' employment arrangements for GPs. Vocationally-trained women are, for example, more likely than men to be employed as assistants or retainees or to have left general practice altogether because of family commitments. Much of the explanation is that mothers who wish to return on a part-time basis often cannot find a suitable post or training opportunity.[17,18] For instance, 61% of Scottish retainer scheme members would not have joined if a part-time principalship had been available.[19] In another study, only 49% of mothers had achieved their career goals compared with 80% of women without, and 78% of men with, children. Only 65% of women had achieved principal status, compared with 87% of men.[5]

It seems, on evidence such as this, that a distinct core-periphery relationship[20] may have developed in the GP labour market, based principally upon the social characteristics of potential workers. In particular, vocationally-trained doctors unable to conform to the 'standard pattern' of a life-time commitment to full-time partnership are either excluded from general practice altogether or confined to relatively poorly remunerated jobs offering little personal development. The situation is reinforced by the lower status and bargaining power afforded to non-principals, 'flexible' workers, and those wishing to re-enter after a period out of the labour market. Non-principals, for example, have not been entitled to the same level of continuing education as principals and have been excluded from the NHS superannuation scheme. The lack of firm national guidelines for retainees' pay and conditions is also problematic with, for instance, 53% of Scottish retainer scheme members unable to obtain BMA-recommended rates.[19] Moreover, it will take a distinct change of attitude if part-timers generally are to be given an equal say in the development and management of many practices.[21] For those from the ethnic minorities (e.g. Asian doctors from UK medical schools and refugee doctors from overseas) there may be added problems of racial discrimination to contend with.[22,23]

Undoubtedly, there is a need to balance any wider choice of working arrangements for doctors with requirements for continuity in patient care. However, over half of medical graduates are now female and it is essential to address their particular employment needs if their skills are to be utilized effectively. Importantly, the vast majority of younger male GPs also want the option of less than full-time partnership and increasingly support flexible working to accommodate family and home responsibilities.[17,24,25] Therefore, it is vital to consider just how 'attractive' general practice is to all new recruits in light of the New Deal for junior hospital doctors and obligations in alternative non-medical careers. In addition, older established principals are reportedly considering part-time working as the means to avoid professional burnout.[26] Despite the long-standing awareness of these issues, however, general practice career structures remain much the same as in previous decades.

National versus local perspectives: the hidden imbalances in GP supply and demand

Several studies have revealed significant inter-regional variations in the shape of the GP labour market.[27-29] Significantly, however, these differences largely reflect inequalities on a much more local scale.[30] In particular, the supply of GPs in a given area has been shown to reflect perceived differences in local living (including housing and schools) and working environments.[27] Not surprisingly, therefore, it is deprived urban areas which appear to have greatest difficulties filling GP vacancies,[31] attracting vocational trainees, encouraging qualifiers to remain,[32] and retaining new entrant principals.[33] Importantly, although the MPC has achieved its goal of a more equitable distribution of GPs across the country as a whole, the particular recruitment and retention difficulties of inner-city practices have been very much taken for granted.[11] There is, for example, no guarantee that practices given permission to recruit in 'under-doctored' areas will be successful. Moreover, labour demand as delimited by the MPC does not necessarily correspond with a locality's underlying need for services. Accordingly, there have been no areas classified as designated since 1986,[34] but GP distribution still does not fully reflect neighbourhood differences in health status.[27,35]

What emerges from the literature, therefore, is the view that recruitment and retention in local areas would be better dealt with as a separate issue from concerns over the national distribution of GPs. Rather than relying on national planning bodies, there may be a complementary role for local-level workforce planning and development directly addressing differences in the ability of local labour markets to match supply and demand. Such an approach would facilitate a more sophisticated analysis of where and what workforce adjustments are necessary. After all, not every inner-city area suffers from high need and underprovision, while not all suburban and rural localities have sufficient applications either for principal or vocational training posts. Finally, without explicit recognition that the GP workforce operates in a series of distinct local labour markets, rather than a single national market, there will be little impetus for planners to develop systematic mechanisms to transfer lessons and experience across the country.

Tackling both problems simultaneously: flexibility as a potential solution

The two issues for the GP labour market highlighted above are closely connected. Geographical variations in labour availability and turnover are, as much as anything else, a function of the social characteristics of a given workforce.[30] Significantly, those at the periphery of the GP labour market (i.e. women, ethnic minorities [primarily Asian], older, and overseas GPs) are considerably over-represented in those urban areas where, traditionally, practices have found it difficult to recruit.[36] Such trends have implications both for numbers of available whole time equivalents and for workforce losses likely as a result of accelerated retirement patterns. It seems, therefore, that workforce programmes are most likely to succeed if they are tailored simultaneously to meet the needs of the changing workforce and the specific problems of different localities. Analysis of the literature suggests that one of the main ways to achieve this is to encourage greater flexibility in the following four areas.

1. Varying time commitment across the working day and week

Not only would more flexible working arrangements (e.g. part-time, job-share, temporary, and short-term working available, whatever a GP's employment status and career stage) make general practice more attractive to a workforce which increasingly needs to accommodate family responsibilities, it could also

improve recruitment and retention by reducing the chances of work-related stress and professional burn-out.[37] Flexible working, as well as the provision of alternatives to the traditional 24-hour commitment, have also been shown to reduce the disincentives to GPs practising in deprived urban areas.[38] In addition, some doctors might be encouraged to phase their retirement through part-time working, so reducing the impact of early retirement on workforce numbers. However, despite the provisions for flexible working in the 1990 Contract, there are a number of disincentives to its development in reality. Part-time options (i.e. half-time and three-quarter-time) are only available to GPs in a partnership with at least one full-time member. Although two doctors job-sharing can be counted for this purpose, the system for job-share itself is not flexible enough because two individuals in the same area must have exactly complementary and unchanging needs.[5,34] Similarly, the GP retainer scheme, which was intended to assist doctors unable to commit to full-time practice, appears not to have provided the flexibility needed by those for whom it was designed.[3,17]

2. Offering a wider choice of long-term career paths

In addition, both recruitment and retention might improve if general practice offered a wider choice of long-term career paths.[39] Significantly, anecdotal evidence suggests that practices are beginning to consider locum and associate positions equal to full-time principal posts in terms of status and long-term viability. The latter have been adopted as the means to combat labour shortages in remote rural areas[40] and inner-city practices where the quality of premises might not justify a commitment to long-term equity partnership.[41] There is also an argument that more varied long-term career structures would raise retention rates through improved morale. At present, most GPs have 'nothing more to achieve' after the age of 30,[42] but established principals who can undertake alternative activities (e.g. research, training in management skills, a part-time educational post, or hospital attachment) are much more professionally fulfilled.[43,44] In terms of recruitment, such changes would also bring general practice into closer line with the highly structured, goal-oriented career available in hospital medicine.

Finally, studies show that, because of the lack of avenues for career variety and progression, many GPs see moving practice as the most practical way to develop professionally. This is despite the financial losses and perceptions of many years' effort 'thrown away'.[25,45-47] If relocating is an increasingly acceptable risk for individuals, should there be a generally more positive view of job mobility in general practice as a whole? As others have already argued, recruitment mechanisms that rely on attracting newly qualified GPs and fail to accommodate partnership moves, could result in a substantial skills-pool being less than optimally deployed within the profession.[45,48]

3. Fine-tuning education and training

A third area where adjustments are needed is education and training. For example, earlier exposure to general practice and clearer careers advice might ensure that fewer potential recruits are discouraged by not knowing what the job involves.[17,42,49] Improved vocational training could equip doctors who enter general practice with skills better suited to working in deprived areas, thereby encouraging them to remain on qualification.[50] Providing innovative — and therefore more professionally stimulating — training (e.g. with homeless and addicted people[51] and in community obstetrics and gynaecology[52]) also appears to improve recruitment in general.

To improve utilization of the skills of vocationally-trained doctors not currently working in general practice, several commentators argue that more appropriate re-entry training is needed.[17,19,25,39] This could centre on the much-improved GP retainer scheme offering: (i) an opportunity to work more than the currently allowed two sessions per week and, hence, a better income; (ii) the flexibility to vary workload depending on individual circumstances; and (iii) a structured training programme to update skills and boost confidence to return to more 'standard' working arrangements.[53] Of course, the continued education requirements of established principals are also important if they too are to be provided with greater career variety.[54] Significantly, the RCGP has itself suggested that higher professional training could be the means by which established principals update skills and gain additional experience needed in a primary care-centred NHS.[55]

4. Widening the scope of remuneration and contract conditions

Finally, appropriate remuneration mechanisms have a key role in improving GP recruitment and retention. One argument is that measures may be needed to reduce the income differential between general practice and hospital work and that current arrangements are inadequate to compensate for added workload in inner cities.[56] The demands of flexibility must also be carefully and equitably costed to remove the disincentives for less than full-time employment.[5,37] Importantly, the DDRB has noted the "advantage in moving to a system" based on whole time equivalents, "because the growth in the proportion of practitioners with less than full-time commitment will make it increasingly difficult to interpret not only the value of IANR (Intended Average Net Remuneration) in comparison with other earnings, both within and outside the medical profession, but also data such as workload" (page 38).[10]

It is possible that significant change could be achieved simply through continued widening of the employment mechanisms open to GPs. There are, for example, a number of health authority-organized salaried schemes aimed at improving recruitment in

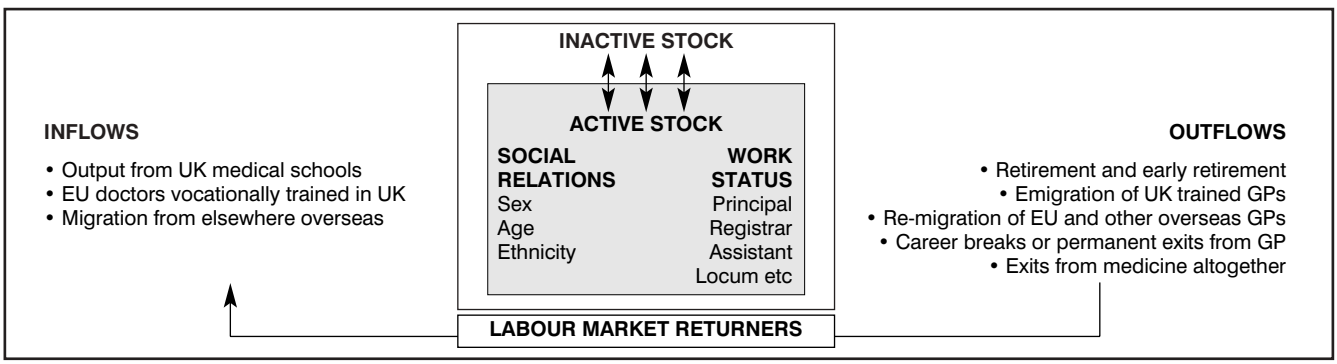

Figure 1. The structure of the general practitioner labour market.

deprived urban areas (e.g. Newcastle,[57] Liverpool,[58] and Sunderland[59]). Local Medical Committees could also form trusts to take on the employer role where existing arrangements have failed to overcome local labour shortages;[60] many larger practices, particularly those acting as total purchasing pilots, are keen to employ fellow GPs.[61] There is also an argument that salaried options are both inevitable (because they remove financial risk and facilitate the greater flexibility and more structured working life needed by a growing proportion of GPs) and desirable "as the balance of independent contractor status tips from autonomy towards bureaucracy" (page 458).[43] Clearly, it is important for the profession to evaluate such arguments, given that the Government has stated its view that salaried service is the best way forward "to solve the GP recruitment crisis".[62] However, it must be acknowledged that the idea of salaried service has yet to gain acceptance with the majority of established principals,[63,64] despite the introduction of a salaried option within the Primary Care Act Pilots.[65]

Conclusion

The evidence of this review stands in sharp contrast with medical workforce planners' continued emphasis on national changes in medical school intakes as the main mechanism to balance labour demand and supply.[66] The issue of better retention and deployment of existing labour, which has at least been acknowledged by the DDRB,[10] has been largely ignored as a possible solution to GP workforce problems. For example, although the Medical Workforce Standing Advisory Committee examined the question of 'wastage', no specific recommendations were made about how to achieve more effective use of the existing labour pool.[66] Arguably, however, such a strategy could enable relatively swift supply-side adjustments because of its concentration on mobilizing the labour of already-qualified GPs. By contrast, simply educating more students provides little guarantee that, in the long-run, adequate numbers will choose general practice instead of the alternatives.

The argument for a more sophisticated approach to maintaining an adequate GP workforce is not new to the research literature.[67] What is new is that such views are now being acknowledged by policy makers. *Primary Care: The Future* specifically recognized the need to tackle a possible GP workforce 'crisis' by two main methods.[68] First, replacement of the single national contract for primary care with a flexible framework in which workforce problems can be addressed by local-level contracts. Secondly, development of alternative approaches to the GP contract to reflect changes in workforce needs, including the desire for less than 24-hour commitment. These measures (including salaried service and skill-mix changes) will be taken forward through the Primary Care Act Pilot Sites[65] and Primary Care Groups[69] both of which are intended to develop provision structures corresponding to local needs.

Although the predicted 'exodus' or 'crisis' seems not yet to have occurred in the GP labour market as a whole, there are clear indications that changes are needed to offset possible future problems. In particular, planners risk the cumulative growth of existing disparities in local labour market conditions unless urgent action is taken. Also, as the GMSC has argued,[3] recruitment and retention measures will be effective only if judged against an objective understanding of the impact of wider forces in society on GPs' employment needs. Responses must then be considered with plans for the NHS workforce as a whole that establish accurate projections of future demand. Current policy and practice developments clearly offer a unique learning base upon which to move forward. It is essential that lessons are heeded if the best possible use of increasingly scarce and valuable resources is to be achieved.

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