So how was it for you? A year of the GMS Contract

INTO THE SUNLIT UPLANDS?

As a PMS practice we were already comfortable with structured care, particularly in diabetes and ischaemic heart disease. At the beginning of the process of capturing data for the Quality and Outcomes Framework (QOF) we were fortunate to employ a truly excellent manager who went about this task with military thoroughness. The practice team has worked hard and each individual has contributed, so it has also been a good team building experience. We have achieved high QOF points and our income is likely to improve. Even better (O frabjous day!), we are no longer obliged to cover Saturday mornings or out of hours. Personally, I am much better off.

So, if I knew what I know now, would I have voted for the new contract rather than against? Should I eat my words, admit I was wrong, and humbly apologise to Dr Reid's cadres and to the GPC that this ignorant worm is now enlightened and grateful for their wisdom and foresight in making my life so wonderful? One way of approaching this question is to reflect on whether I would be quite so happy if we had to do all this without the increase in income, or if the removal from out-of-hours cover had not been on such ridiculously favourable financial terms.

The profession has essentially been bribed to implement a population-based disease management programme that often conflicts with the individual patient-centred ethos of general practice. As a consequence, the ideal of general practice with the consultation (and all its ramifications) as its most important transaction is being undermined by a centralised drive for population targets and bureaucratic indicators. And to anyone trying to justify these targets and quality indicators by claiming that they are 'evidence-based', I would observe that they are evidence-based only in the sense that a karaoke night is the same as a performance of *The Magic Flute*, or a painting-by-numbers kit the same as a Monet. The new contract comes dangerously close to medicine by numbers and, in the long run, threatens the professional basis of general practice, indeed its very existence as a specialty.

TOBY LIPMAN

NEVER OFFER GPs MONEY, THEY WILL JUST TAKE IT

So how good are GPs at jumping through hoops for small amounts of money? Probably expert. And when will any government remember? Probably never.

Yet again GPs have been given silly things to do and have leapt in, feet first, just like the brain dead contestants in Jeux Sans Frontières. Have we no shame? No. Why do we behave like so many decerebrate sheep and get paid so little. Not that we don't get paid reasonably well, but not very much in modern terms and certainly not very much in comparison to hospital colleagues or our neighbours. GPs have slid down the comparative ladder over the last two generations. We have slid so far that we can no longer thumb our noses at despicable targets and our professionalism being ruined. We just cannot afford not to chase the points.

And we do it very well. Successive governments have forgotten how well we can do it. Many will remember the health promotion clinics fiasco of the last new contract before this new contract. We earned so much money that they had to take it away from us in the following year because we earned too much. Ahhh, the good old pooled income system.

Now it looks like many practices are going to pass the 900 point, 950 point and even the 1000 point mark. I know of several practices who are hoping to get 1050 points or damn close to it. The problem is that the government has not budgeted for this. Initially it only expected 90% of practices to get 900 points, but following the minimum practice income fiasco (so many fiascos, so little time) it had to reduce its forecast to 80% of practices getting 800 points. Very scientific.

So PCTs and health boards are going to be short — very short — of money. This will have to be found from somewhere. So GPs will be in the unenviable position of being the cause of cuts in other services because they are hoop-jumping experts. When will governments learn? Never incentivise GPs.

CHRIS JOHNSTONE

AN IMPORTANT STEP FORWARDS

The Quality and Outcomes Framework (QOF) has been a very positive part of the new contract. For the first time, instead of having a payment system that penalised them for investing in their practices, GPs are instead rewarded for developing services to a high standard. The QOF has clearly involved a huge administrative workload, but I think that this will be much easier in future years as the system beds in. I also think that some GPs whose workload has increased greatly this year will see that there are opportunities to delegate significant parts of chronic disease management to other members of the practice team.

It has been interesting that, of all the adverse comment about the QOF, there has been relatively little criticism of the actual indicators themselves. Past research suggests that incentives are most likely to be effective if they are in line with existing professional values, and I think that this has broadly proved to be the case. My main concerns are twofold. The first is that continuity of care may be threatened by an increasingly fragmented disease-

oriented approach to management. The second is what effect these large financial incentives will have on our professional values. It is never going to be possible (or desirable) to incentivise many of the most important aspects of practice, especially the inter-personal ones. In 2002, Martin Marshall and I wrote:

> '*If we can respond to the challenges of the new contract without losing our core values, then we will be providing primary care that will truly be the envy of the world*.'[1]

That remains our key challenge.

MARTIN ROLAND

REFERENCE

1. Marshall M, Roland M. The new contract: renaissance or requiem for general practice? *Br J Gen Pract* 2002; **52:** 531–532.

IS THE GMS CONTRACT JUST FOR DOCTORS? OR DO PATIENTS BENEFIT AS WELL?

Patients do not want to be treated by overworked, over-tired doctors and would be likely to sympathise and agree that GPs who work during the day should be able to choose not to be on call at night. However, as patients cannot choose when they will be ill and need medical help, there needs to be an efficient, well managed system for out-of-hours service that is well understood by the public. In year one there is anecdotal evidence that in some parts of the country there are fewer GPs covering a wider geographical area, with the result that patients have to wait for a very long time before being seen by a doctor. From the patient perspective such waiting causes considerable distress and even harm.

The difficulty for those needing out-of-hours help is to know what to do. Advice can be sought from NHS Direct if the person lives in an area covered by that service. But NHS Direct has been overstretched, with callers having to wait for long periods for their call to be taken. There is also evidence that there has been a rise in the use of A&E departments since the introduction of the GMS contract. Of greatest concern is the impact of the new arrangements on the continuity of care, particularly for the most vulnerable in our society — with the frail, the elderly and the terminally ill unable to find alternative arrangements for out-of-hours services.

Other changes in general practice, in particular the emphasis on the delivery of care by the multidisciplinary team rather than by an individual doctor, have added to the depersonalisation of general practice. While the GMS contract, with its emphasis on public health, may benefit groups of patients, the emphasis on bureaucratic indicators makes patient-centred care more difficult. Many patients are becoming increasingly despondent about what has been a much valued service. It is hoped that this is not the decline of general practice.

PATRICIA WILKIE

CAREFUL WITH THE UNINTENDED CONSEQUENCES

By some quirk of timing I was one of my practice's executive partners when the new contract came in, and found myself in charge of the Quality and Outcomes Framework (QOF) business. It's like putting your only teetotaller in charge of the Christmas party: it can be done, but the evident distaste with which the task is approached could influence how much pleasure the drinkers get out of it.

I find the QOF deeply depressing. It is likely to improve the 'health' of some people, but at what cost? Here are just a few of the potential harms:

- The clear shift (already in place from the last change in the contract) away from doctors always addressing patients' agendas, with more time devoted to the box-ticking to notch up the points.
- The game-playing to maximise points. We all know GPs are very good at this kind of thing, but it corrupts us all to know that some data have been doctored.
- The perverse incentive, where it becomes advantageous financially to focus our therapeutic efforts on those with milder illness while exception reporting (ignoring) those in most need.
- The distortion of resources into those areas earning QOF points. It's not clear where this will lead, but already the efforts of lobby groups to get their interests recognised in the QOF formula lends support to the fear of it becoming more complex and overloaded with an ever longer list of boxes to be ticked. Further on is the fear of primary care in the UK becoming a less human, more mechanistic enterprise.
- Worst of all are the long-term consequences of living in this kind of managed environment, where what happens in the whole NHS is dictated from the centre. When people first pointed out that the NHS is the largest employer in Europe, there was so much diversity and idiosyncrasy within it that it didn't live up to (or down to) the monolithic image. Now that the managers have their hands on the levers at the centre, I'm worried about what kind of doctors will be staffing the NHS in a generation's time, when I shall be needing them.

DAVID JEWELL