Twenty-one years ago we wrote a series of articles for this journal (they appeared in Connexions) about the need to target resources to the 'forgotten areas of deprivation' to give our patients an 'average chance of health'. Over 65 years, between us, of service within socio-economic deprivation, it was our clear experience that advocacy on behalf of the health resource needs of patients, needs to be a constantly repeated teaching theme. Resource providers start out not understanding, learn in dialogue, then move on and the educational process has to start all over again.

The mutual support that Deep End group participants have experienced is relevant for Deep End workers everywhere. The involvement of policy advisers from the Scottish Government Health Directorate is important. We look forward to hearing more about the trajectory of this initiative. As Watt says: 'addressing the Inverse Care Law is not rocket science', but it is vital to the health of deprived patients. Would that a similar group could establish itself south of the border.

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Patients’ views of pay for performance in primary care

In the results section of their research into patients’ views of pay for performance in primary care, Hannon and colleagues state that, ‘the majority of patients were surprised to hear their practice received bonuses for doing “simple things”’. This is a fundamental misconception. The money intended for potential QOF payments was taken out of the guaranteed/secure income to practices and is then paid only on achievement of certain agreed targets. And no one is going achieve 100% so not all the money was ever going to be paid back. Thus QOF payments are in no way ‘bonuses’: overall the scheme is of pay deductions for not achieving the desired targets. In fact in our practice, payments for QOF achievements equal, in very rough and ready terms, half of partners drawings, so in a very real sense if we don’t achieve we don’t get paid. Let patients understand the system as ‘pay for performance’, OK, but, please, not as bonuses.

But things are worse than that. In order to make sure that the targets are achieved GPs often have to create new systems, new clinics, or anyway do more work, and this costs the practice something, hopefully at least paid for by the QOF-related income. Yet now some QOF targets are being ‘retired’ on the grounds that change has been secured, achievement is the norm. We are expected to carry on with the work needed to carry on the achievement, yet suddenly it is not being specifically funded any longer. The only way for this not to be a net financial loss to a practice is to make efficiency savings somewhere else, or simply stop doing something else. Moreover new targets introduced will mean more new work, and cost.

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REFERENCE

DOi: 10.3399/bjgp12X644138.