

Primary care in England:

coping with financial austerity

General practices in England are currently facing possibly their most challenging financial circumstances since the NHS was founded in 1948.¹ GPs and their primary care teams have traditionally been patients' point of first contact with the NHS. Primary care teams are responsible for providing access to health services for all residents of England and dealing with most of the acute medical problems patients present with, as well as providing long-term care for people with chronic diseases. They also provide a wide range of systematic and opportunistic preventive and health promotion activities, such as smoking cessation services, NHS Health Checks, and screening for alcohol misuse. A strong primary care sector has allowed the NHS to make efficient use of resources, through the gatekeeping role that GPs have in controlling access to specialist services, and through the wide range of medical, social, and psychological problems that GPs and their teams manage through a mix of person-based and population-centred care.

In the past decade, GPs have benefited from increased health spending on the NHS, leading to improved access and shorter waiting times for specialist services; and access to a wider range of services within primary care that are closer to patients' homes. General practices also benefited from the implementation of a new contract and the introduction of the Quality and Outcomes Framework (QOF) in 2004 that led to an increase in the resources that the NHS allocated to primary care, and a greater focus on health targets. Additional flexibility in the provision of primary care services came from the introduction of personal medical services (PMS) contracts and local enhanced service (LES) schemes, which facilitated greater tailoring of services to local health needs. However, this era has now ended and general practices in many parts of England are faced with primary care trusts and clinical commissioning groups (CCGs) that are making substantial cuts to primary care funding, through the imposition of reduced budgets to practices with PMS contracts, the abolition of many LES schemes, list cleaning exercises that reduce the capitation payments made to general practices, and linking some practice payments to additional performance targets.² This has left many general practices in England facing reductions of

greater than 20% in their annual operating budgets.

RECONFIGURING GENERAL PRACTICE BUDGETS

The main vehicle for reducing primary care budgets is through reconfiguring PMS contracts for general practices. These contracts were introduced to support innovation in primary care through locally negotiated general practice contracts that aimed to deliver a high-quality service and reflect more accurately the health needs of the practice population. In many areas, elements of practice budgets have also been linked to meeting new 'key performance indicators'. Failure to meet the targets in these indicators will result in even greater loss of funding for general practices.

These cuts to general practice budgets have followed a period of several years during which many GPs have had little or no growth in the budgets they receive from the NHS. GPs are now suddenly faced with running their practices on substantially reduced budgets, while at the same time being expected to meet increasing demands for care from an ageing population, and undertake some of the work previously carried out in hospitals. Further pressure on GPs and additional workload is arising from 'demand management' schemes whereby CCGs aim to reduce emergency medical admissions; and attendances at accident and emergency departments and outpatient clinics, both of which have increased substantially in the past decade.³ With the NHS proposing to make up to £20 billion in efficiency savings by 2014, strong pressure is being exerted on general practices by CCGs to implement effective demand management strategies to reduce healthcare utilisation in these areas. As well as national initiatives, through the QOF, many CCGs have introduced their own local demand management schemes. However, it is unclear how practices faced

with operating on substantially reduced budgets can maintain access to primary care services, and at the same time reduce use of secondary care; and maintain a focus on improving public health through health promotion activities.

FINANCIAL PRESSURE ON GPs

These pressures will continue when CCGs complete their takeover of local NHS commissioning and the NHS Commissioning Board completes its takeover of the commissioning of primary care services, including general practice contracts. GPs in England will find themselves caught between the priorities of these two organisations, with CCGs requiring ever greater efficiencies in the use of secondary care services in an attempt to stay within budget; and the NHS Commissioning Board demanding even more 'value for money' from general practice contracts and further cutting funding for core general practice services. With the continuing poor performance of the UK economy leading to government borrowing reaching record highs, no early end is likely to the difficult financial environment that GPs will face.

Although the NHS is now operating in an era of financial austerity, is it appropriate to make such major cuts in the funding for primary care? Previous research from England's NHS has shown that better access to primary care is associated with improved population health outcomes in a range of areas. This includes reduced emergency hospital admissions for conditions such as chronic obstructive pulmonary disease,⁴ lower rates of late diagnosis of cancer,⁵ and lower hospital mortality.⁶ There will also be an impact on wider public health indicators. For example, international evidence shows the association between better access to primary care, more efficient use of healthcare resources, and improved health

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outcomes.^{7,8} Many of these benefits may be adversely affected as a consequence of lower spending on primary care.

IMPACT ON PATIENT CARE

As the picture across England is not uniform, with some primary care trusts and CCGs making substantial cuts, while others are protecting primary care budgets, this inadvertently creates a 'natural experiment' whereby it will be possible to investigate the association between changes in general practice budgets with population health outcomes such as health inequities, premature mortality, and measures of hospital activity, such as emergency admissions for patients with chronic diseases, and attendances at accident and emergency departments. Impacts on areas such as patient-centred care, patient choice, and hospital length of stay also need to be assessed if GPs find themselves dealing with higher workloads with reduced staffing levels as a result of these funding changes, and are therefore unable to devote sufficient time to patients with complex health needs and multimorbidity. In health systems in high-income countries, because of ageing populations and improved survival of people with chronic diseases, multimorbidity is now becoming the norm, with expectations that around 50% of those aged ≥ 65 years will have at least three chronic conditions within the next decade.⁹ It is primary care that will be the source of the comprehensive, integrated services that coordinates care for all the health problems experienced by such patients and that engages individuals, families, and the community in disease prevention and early detection programmes.¹⁰

In the current fiscal situation that the NHS is facing, it is appropriate for CCGs and the NHS Commissioning Board to review their funding for primary care. However, a well-planned rational process should be followed in designing and implementing changes; and the impact of any changes in funding should be closely monitored. This will include examining the impact of these new financing measures on areas such as relevance of healthcare delivery to local

needs, equity, quality, cost-effectiveness, sustainability, person- and population-centredness, and innovation. The impact on health inequities will be particularly important to monitor as increased resources for primary care preferentially improve health status and access to health care in more socially disadvantaged populations. The NHS has always prided itself on the access to care it has given to the most socioeconomically deprived groups of the population, and this is a focus it should continue to retain even in the current, very difficult, financial circumstances that it is experiencing.

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Provenance

Commissioned; not externally peer reviewed.

Competing interests

Azeem Majeed is a part-time GP at the NHS General Practice of Dr Curran & Partners in Clapham, London. Salman Rawaf and Jan De Maeseneer have declared no competing interests.

DOI: 10.3399/bjgp12X659150

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