# Editorials

# Just another GP crisis:

## the Collings report 70 years on

### INTRODUCTION

It often seems that general practice lurches from crisis to crisis. Yet crises sometimes turn out to be opportunities. In this editorial I describe a number of crises that turned out to be opportunities, and end with the hope that the present one will do so too.

### THE COLLINGS REPORT (1950)

General practice was certainly in crisis in 1950. A *Lancet* editorial the preceding year had discussed whether modern medicine could only realistically be practised in hospitals,[1] and Joseph Collings' description of general practice, published as a 30 page report in *The Lancet*, was damning, including judgements that *'the overall state of general practice is bad and still deteriorating'*, and, for inner city practice, *'at best ... very unsatisfactory and at worst a positive source of public danger'*. He noted that GPs were constantly being asked to do more work for less pay, and concluded that *'if the present trend continues, it must result in the elimination of general practice as an effective agency of medical care'*.[2] The report was met with fury by the profession, but as historian Charles Webster commented *'Most of his shots hit the mark with explosive impact'*, describing the report as the single most effective factor in mobilising opinion in favour of constructive change.[3] Among the positive things that happened over the next few years were a very large backdated pay increase in 1952 (the Danckwerts award[4]), the foundation of the College of General Practitioners the same year, and a government report in 1954 concluding that general practice was *'fundamental to the best practice of medicine and the best interests of patients'*.[5]

> "'The overall state of general practice is bad and still deteriorating ... at worst a positive source of public danger.' [The Collings Report, 1950[2]]"

### THE 1965 CHARTER AND 1966 GP CONTRACT

General practice stumbled on through the 1950s and early 1960s, but discontent came to a head again in 1965. The 1965 recommendation of the Review Body on Doctors' and Dentists' Remuneration had been rejected by the profession with a comment from a British Medical Association (BMA) meeting that *'the GP would for all time be the lowest form of animal life in the NHS'*.[6] Late in 1965, the BMA asked all 23 000 GP members whether they would be prepared to resign from the NHS and 17 200 sent in undated resignations.[7] The BMA had a number of demands in a 'Family Doctors' Charter' that provided the basis for the negotiations that then took place. These included the right to practise good medicine in up-to-date, well-staffed accommodation, the right to practice medicine with the least possible intrusion by the state, the right to enjoy proper payment for the services rendered, and the right to financial security.[8] In the event, the government acceded to almost all of the BMA's demands and the 1966 GP contract provided a large increase in income, 100% reimbursement for rates and rents, partial reimbursement for staff salaries, inducements for doctors to work in under-doctored areas, a group practice allowance, and seniority payments. Although some GPs did still resign, the 1966 GP contract was seen by many as the start of a renaissance in general practice, in particular through the support for staff and premises.

### THE 2004 GP CONTRACT

In 2001 Prime Minister Tony Blair promised an increase in NHS spending to bring the country up to mid-European levels in terms of GDP. This was a massive increase and specialists immediately started to propose how the money might be spent. For general practice, it was not so easy. Morale was again low, incomes had been falling behind those of specialists and recruitment to GP training posts was poor. The BMA decided that offering improved quality was the way to secure a proportion of the new funding for general practice. This was a change from their previous position: in 1986 they had opposed the idea of a 'good practice allowance', arguing that it must have been prepared by *'a policy unit whose main contact seemed to have been with philosophers, privateers and trendy professors'*.[9] The 2001 negotiations led in due course to the Quality and Outcomes Framework (QOF) in the 2004 GP contract and a large increase in GP income that was temporarily successful both in raising morale and recruitment to GP training posts.[10] The BMA were not surprised that most GPs rapidly got maximum or near-maximum rewards from the QOF. They had argued all along that the quality of general practice was high because of unfunded investment by GPs in their own practices over preceding years. The government, however, was irritated that the amount of money going into general practice in the first year of the contract was much more than they had estimated and hence began a long period in which government sought to claw back the money, leading to stagnant or falling practice incomes over the following decade.

> "'... general practice was 'fundamental to the best practice of medicine and the best interests of patients.' [The Cohen Report, 1954[5]] "

### THE 2016 GP FORWARD VIEW

Following a period with increasing work being transferred from hospitals to general practice usually without any accompanied flow of resources, government realised in 2016 that the NHS risked collapse without proper support for general practice. In his introduction to the 2016 *GP Forward View*, Simon Stevens, chief executive of NHS England, wrote:

*'... if anyone ten years ago had said: "Here's what the NHS should now do — cut the share of funding for primary care and grow the number of hospital specialists three times faster than GPs", they'd have been*

> "'I know we're in a crisis; I hope it's also an opportunity'. [RCGP Council member, 2020]"

*laughed out of court. But … that's exactly what's happened'*.[11]

Maybe his comment reflects the sad truth that governments over 70 years have consistently neglected general practice in favour of hospital medicine, with the result that general practice lurches from crisis to crisis. So the *GP Forward View* arrived with promises of more GPs, an expanded multidisciplinary workforce and 2.4 billion GBP extra a year into general practice.[11]

So why is general practice still in crisis? The promise to recruit 5000 GPs by 2021 has been a failure: more GPs are being trained than ever before, but more are retiring early than ever before.[12] We now have a promise by the new government of 6000 more GPs and 50 million more GP appointments a year, though without any clear idea how either will be delivered.[13] Also, the promised new staff and Primary Care Network structures to support them are coming, but inevitably slowly and experiencing the predictable birth traumas of any significant organisational and cultural change. A 1950 *Lancet* editorial following the *Collings report* read *'We have to decide what the general practitioner should be doing and then — whatever it is — enable him to do it properly'*.[14] One challenge for government is certainly to provide GPs with the means to deliver the top quality professional service that they want to provide, and this would address two of the Royal College of General Practitioner's (RCGP) current policy priorities, namely: to reduce unnecessary workload and provide a sustainable infrastructure for general practice. However, the RCGP's third but equally important priority, to re-invigorate relationship-based care, is a particular challenge given the changing nature of the workforce.[15] Young GPs emerge from hospital training with little concept of personal responsibility for patients. Furthermore, they have different expectations of work commitments from previous generations, with both men and women choosing to work part time and with young doctors often seeing locum work rather than partnership as a long-term career option.[16] As one RCGP Council member put it to me recently, *'I know we're in a crisis; I hope it's also an opportunity'*.

## THE CURRENT SITUATION

But now we are in a new crisis, this time caused by an unforeseen external factor, COVID-19. This is leading to rapid changes in the ways GPs consult, with dramatic increases in alternatives to face-to-face consultation. This crisis will result in changes that are sure to be permanent, with video-consultations and a range of digital offerings being certain to form part of GPs' future interactions with patients. These were coming slowly before COVID-19 but have developed dramatically in the past few weeks. We can only hope that there will be a silver lining to look back on in terms of more efficient ways of working that have the potential to benefit both patients and practices.

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**Provenance**
Commissioned; externally peer reviewed.

**Competing interests**
The author has declared no competing interests.

DOI: https://doi.org/10.3399/bjgp20X710813

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