Recent developments in family practice in the UK – can South Africa learn by example?

Magennis, S, MBChB; FRCGP,
Community Clinical Teacher, General Practitioner, University of Liverpool, United Kingdom
Gibbs, T, MBChB; M Med Sc; FRCGP,
Director of Health Sciences Education, Faculty of Health Sciences, University of Cape Town, South Africa
Hellenberg, D, MBChB; M Fam Med; MFGP,
Professor of Family Medicine, Faculty of Health Sciences, University of Cape Town, South Africa

Correspondence to: Prof. Trevor Gibbs, Barnard Fuller Building Angio Road, Observatory, 7925, South Africa
Tell: (021) 406 6630, Fax: (021) 406 6244, e-mail: tgibbs@curie.uct.ac.za

Introduction

South Africa is just one of the many countries trying to balance the conflict between the seemingly unlimited demand for health care and the limited resources available. As government and health service managers battle to persuade clinicians to adhere to financial controls, clinicians throughout the system try to produce quality service. Although, historically, doctors have proved remarkably resistant to changing their behaviour in response to management pressure, opportunities to bring about effective change do arise. In the United Kingdom, such opportunities have arisen as a result of public and governmental pressures due to medical negligence: 2003 has seen the introduction of radical new interventions that demonstrate a huge commitment of increased resources to primary care and the acceptance by the majority of the United Kingdom's general practitioners of a new contract with tight managerial controls. This paper describes the background that led up to this change and discusses the possible lessons to be learned for South Africa. *(SA Fam Pract 2003;45(10): 5-8)*

Background

Two relatively recent scandals have had a huge impact on the media's and the public's fears about the National Health Service. In January 2000, a general practitioner from the north-west of England, Dr Harold Shipman, was tried and convicted for the murder of 15 of his patients and was subsequently found to have killed a further 200 patients. The Bristol Royal Infirmary Inquiry followed soon after this scandal, in July 2001, demonstrating excessive mortality at a paediatric cardiac surgery unit, where 35 babies were found to have died unnecessarily.[1]

In both cases, charges of inadequate regulation and a lack of accountability were levelled at the medical profession. The UK Government was consequently galvanised into hastily adopting the principle and implementation of Clinical Governance

(a framework through which health care organisations are accountable for continuous quality improvement and safeguarding high standards of care).[2]

In order for the government to implement clinical governance in general practice, it was necessary to help GPs account for the quality of care through three processes:

- By defining good practice
- By establishing the ongoing assessment of doctors
- By creating an opportunity to link pay to performance.

Defining good practice

The General Medical Council (GMC) described good medical practice in general terms and the Royal College of General Practitioners (RCGP), working with the General Practice Committee (GPC) of the British Medical Association (BMA), specified in detail what is regarded as excellent and as unacceptable in the performance of a GP in Good Medical Practice for General Practitioners.[3] They divide these criteria into seven categories:

- Good clinical care
- Maintaining good medical practice
- Teaching and training
- Relationships with patients
- Working with colleagues
- Probity
- Health

Primary Care Trusts (PCTs – local NHS organisations responsible for managing primary care) have been able to use these criteria to help them draw up Personal Medical Service (PMS) contracts with GPs, specifying explicit performance outcomes that reflect good practice. The concept of linking GP contracts to quality and accountability measures embodies the Department of Health's commitment to clinical governance and has also driven the drafting of the new General Medical Services (GMS) contract.

The National Institute of Clinical Excellence is a further source of clarification of good practice and its remit, to publish regular clinical guidelines, might help doctors to improve the quality of their practice.[4]

Assessment of doctors

a) **Appraisal**

The appraisal process evaluates the doctor's performance in each of the above seven categories.[5] The government has decreed that all GPs should have their first annual appraisal by April 2003. Although the speed of introduction of the policy has precluded the achievement of this goal, the majority of UK GPs have now started the appraisal process. Appraisal was designed to be a formative process that would encourage reflective practice and motivate continuing professional development and quality improvement. The UK appraisal model is essentially a peer review. Funding arrangements are the responsibility of local primary care organisations, but most provide locums or locum funding in recognition of the doctors' time required for the appraisal. The process is designed to identify patient unmet needs and doctor's educational needs and to generate a personal development plan for the doctor for the following twelve months. The process begins by the GP completing a reflective proforma analysing his or her performance in each of the seven categories of good medical practice. The doctor is asked to collect documentary evidence to support these reflections and to highlight any aspects in which they feel some change is necessary. This preparatory stage is likely to take several hours. The doctor is then offered a choice of several appraisers, who are likely to be local GPs and who must have had training as appraisers. The actual appraisal interview lasts for two to three hours, in most cases, and culminates in the formulation of a personal development plan for the following 12 months that addresses what the GP and the appraiser agree are the priority learning needs for the doctor under appraisal. The whole process is confidential, except that the agreed personal development plan is submitted to the Medical Chairman of the Primary Care Trust (PCT). At the next appraisal, one year later, the process is repeated, although it then also explores whether the doctor has addressed the learning needs expressed in the previous appraisal's personal development plan. Should the appraiser feel that there are areas of the appraisee's performance which give rise to serious concerns relating to patient safety, there is an obligation for the appraiser to submit these concerns to the chairman of the PCT. This aspect is controversial, as it is felt that it flies in the face of the formative and supportive nature of the appraisal process and might reduce the willingness of doctors to embrace appraisal, deter doctors from becoming appraisers and prevent doctors from being honest in the appraisal process.[6]

b) Revalidation

By the end of 2004, all doctors wishing to continue to practice in the UK will require a license to practice, which will be offered automatically to all doctors registered in the UK at that time.[7] In order to keep their licence to practices, all doctors must take part in the revalidation process.

The revalidation process will begin in the spring of 2005 and will be based on full participation in successful appraisals over a five-year period. Unlike the formative nature of the appraisal process, the concept of revalidation was originally of a summative nature, capable of openly determining the fitness of any doctor

to continue practising. Pringle seriously challenges the ability of this revalidation process to achieve either of its two prime objectives of protecting the public from incompetent doctors and involving the public in the revalidation process.[8]

With regard to doctors whose performance gives cause for concern, the National Clinical Assessment Authority (NCAA) was established in April 2002 with the remit to support the local management of these doctors and to provide a uniform national process by which they can be professionally assessed by trained experts.[9] Although this is a step forward, concerns remain as to the difficulty of identifying these doctors in the first place, which is difficult in an area with as broad a remit as general practice.

Performance-related pay

GPs in the United Kingdom have been unhappy with the terms and conditions of their service for many years. Their concerns centre around perceptions that, despite the fact that huge amounts of work in primary care previously carried out in hospitals have been transferred to GPs, there has not been an accompanying increase in the funding for primary care to reflect this. While being unable to prevent this increase in their workload, GPs see themselves as poorly paid in relation to their consultant colleagues in hospitals. They consequently believe that this is making it difficult to attract doctors into general practice and to retain those who are already there. An additional concern is that those doctors who provide the highest quality of care for their patients often suffer financially for doing so, as they invest more personal time in clinical care and more resources in their staff and premises without any recompense for the extra investment.

The British Medical Association set out its aims for a new GP contract as:

- A radical new contract providing a better working life for GPs and improved patient services
- Giving GPs control over their workload
- Increasing funding of general practice
- Paying GPs fairly for their work
- Improving recruitment and retention of GPs

The new contract is between the Primary Care Organisation and the practice, rather than with individual GPs (as the current contract is), and the personal GP list system will cease, with patients entering into a contract with the practice. The 24-hour commitment requirement will also cease and funding will be based on patient needs. Three categories of clinical work are specified, i.e. essential, additional and enhanced.

GPs will be obliged to provide essential services (management of acute and chronic illness), but can choose to opt out of providing additional (e.g. maternity services) and enhanced (e.g. anticoagulant monitoring) services and Out of Hours Care (at a cost of £6 000 per average practice). Those who choose to provide additional or enhanced services will be paid extra for them. It is expected that about half of the GP's income will come from providing essential and additional services, with the other half coming from the new quality payments and enhanced services payments. The new quality payments will provide a maximum of £126 000 (R1,5 million) in the second year of the new contract to the average practice with 5 500 patients. It is not expected that many, if any, practices will achieve the maximum payment in the first few years of the contract, but well-organised practices, which are already delivering many of the quality targets, can expect to earn a

large proportion of it. Further benefits include improved seniority and pension benefits, additional salaried options and increased career flexibility.

Previous experience has shown that setting practitioners specific objectives linked to pay can be a successful way of meeting public health targets. Target payments have been made for clinical areas such as cervical smear screening and childhood vaccinations since 1990 and the uptake by the public of these medical services improved significantly as a result. In July 2003, nearly 80% of the UK GPs who voted on a new contract came out in favour of it. The new contract links substantial extra remuneration to the achievement of explicit quality targets. The contract negotiations involved the National Health Service Confederation on behalf of the Government and the BMA and RCGP on behalf of the doctors. The quality targets cover a broad area of GP activity, mainly clinical, but also address organisational and patient satisfaction issues. The government is committed to increasing its annual funding of primary care from the current £6,1 billion to £8 billion over a three-year period.

A further strand of DOH strategy is to expand the numbers of salaried GPs. Many young doctors who choose to become a GP feel reluctant about becoming involved in the business and practice management aspects of general practice. Medical schools provide little training and many doctors feel that their learning priorities are clinical and that the management of staff, buildings and finances is time-consuming, irrelevant to their personal development and interferes with their patient care. The DOH feels that some GPs exploit the freedom and flexibility of their current contract and are not accountable. Many areas in the UK do not easily attract doctors under the current self-employed GP contract, but have found that offering the alternative of salaried posts has attracted applicants where previously there were none. Salaried service would appear to offer a solution to meeting many of the aspirations of both the doctors and the DOH. The performance of the doctors can be regulated by the clauses of the individual contract.

Conclusion

Governments throughout the world are struggling to provide the resources required to deliver high quality health care to their populations, despite a high expenditure per capita and a wide variety of funding mechanisms. They find that an increase in expenditure is not always easy to link to a measurable improvement in desired health outcomes. The UK has adopted a series of measures to try to ensure that the planned increase in primary care spending from £6,1billion to £8 billion over the next three years will lead to a demonstrable increase in widely accepted quality targets. At the same time, the country is attempting to bolster public confidence in doctors and encouraging all doctors to adopt a lifelong learning strategy. As 90% of health care episodes occur in primary care, both in the UK and in South Africa, major improvements in its quality are likely to lead to better use of health service resources. It is both unfeasible and very unlikely that similar amounts of money will be transferred into South African primary care. However, since South Africa is faced with similar managerial and developmental challenges, the government might benefit from observing whether the above measures adopted by the UK succeed in their aims and whether they might be useful for meeting some of the Health Care 2010 objectives.

Conflict of interest – nil

References

1. The Bristol Royal Infirmary Inquiry: (Accessed 21 July 2003).
2. Clinical Governance: (Accessed 9 August 2003).
3. Royal College of General Practitioners and the General Practitioners Committee of the British Medical Association. *Good Medical Practice for General Practitioners*. London: RCGP; 2002.
4. National Institute of Clinical Excellence: (Accessed 9 August 2003).
5. Jelley D, Van Zwanenberg T. Peer appraisal in general practice: a descriptive study in the Northern Deanery. *Educ Gen Pract* 2000;11:281-7.
6. Lewis M, Elwyn G, Wood F. Appraisal of Family Doctors: an evaluation study. *Br J Gen Prac* 2003;53:454-450.
7. General Medical Council. A Licence to Practice & Revalidation. London: GMC; April 2003.
8. Pringle M. Re-evaluating revalidation and appraisal. *Br J Gen Pract* 2003;53:437-8.
9. Samuels N. Scotland A. The National Clinical Assessment Authority: a healthy sign of the times. *Clinical Medicine* 2003;3(1):42-4.