

## **THE FUTURE FOR NON-PRINCIPALS IN GENERAL PRACTICE**

### **Address to Non-Principals' Conference**

BMA House Saturday 27th February 1999

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I may have been invited here at this time of day partly to delay you catching your trains home, but being the chairman of the GPC's education and audit sub-committee may have had something to do with it. However I suspect that Rebecca might not have displayed deference to that office were it not for my reputation for thinking outrageous thoughts and then not being wise enough to keep my mouth shut about them.

In order to satisfy protocol, therefore, I will begin by giving the party line of GPC policy on the future of different types of GPs and how their education should be managed, and then go on to share a personal analysis with you about developments in general practice.

So, here comes the GPC policy bit. The GPC exists to support, advise and protect all NHS GPs, whatever the nature of their contractual arrangements, and including all kinds of non- principals. The committee supports proper education for all GPs and has a policy intent to re-absorb the postgraduate education allowance into general remuneration and secure proper funding for education for all GPs.

There, that didn't hurt did it? Everything that follows is a personal view for which you must hold me and not the GPC responsible - indeed I took a fairly comprehensive caning in the Committee for expressing the views you are about to hear, only last week. However, listening to previous presentations here today, it is clear that many of you have already arrived at the conclusions you are about to hear, so I hope you are not disappointed.

My thesis changes the title of my talk to "The future IS non- principals in general practice" or "The future of general practice IS non-principals". Much to the chagrin of many of my colleagues, I see the role of traditional independent contractors in NHS practice as diminishing over the next decade. Although it is highly likely that doctors of my age will, if they wish, be able to retire as independent contractors, I have very great doubt about whether doctors 20 years younger entering practice now can expect to retire from NHS practice on the same basis.

### **IS THERE ANYTHING TO BE SAID FOR INDEPENDENT CONTRACTOR STATUS?**

There certainly is. The ability to manage one's own affairs within the constraints imposed by fulfilling one's Terms of Service, and in the knowledge that one is unlikely to be made redundant are the principal practical benefits, to which must

be added the psychological advantages of being 'the boss' and not having to kow-tow to management in any form.

As the SCOPME report showed, though, these traditional benefits do not appear to be greatly valued by the rising generation. Therefore much as older doctors may value them personally it is important to be aware that we cannot expect to fill all practice vacancies with like minded individuals.

In addition as the much vaunted independence becomes increasingly constrained by prescribing budgets, referral criteria, compulsory primary care group membership, target payments, allocation of patients, hours of availability and possible compulsory incorporation into a level four primary care trust, it is increasingly doubtful whether the independence is real or imagined.

### **The Legacy of 1948 - how did we evolve as independent contractors?**

Historically the impetus was for GPs to join their consultant colleagues as salaried doctors, and it was only the enormous power of the GP medical lobby that prevented GPs from joining consultants in having their mouths stuffed with gold in order to join a salaried National Health Service. It is remarkable that resistance to the inexorable march of history has held up for as long as 50 years. That delay has probably been occasioned both by the natural inertia of Government and the profession, coupled with Government's dawning realisation that it was easier to get away with exploiting GPs by having them as independent contractors than as employees.

So what are the problems with the independent contractor status, apart from the fact that young doctors don't seem to be interested in it?

#### **1. Partnership risk management**

Other people have always been astonished that we accept the massive personal liability that attaches to sole trader or partnership status. Unlike the directors of limited companies or employees our liability is unlimited and includes every last penny of our personal assets.

## **2. NHS Risk management**

The concept of the unified budget puts the GMS cash limit in with the prescribing and HCHS budget. The unified budget is a creature of 'The New NHS' White Paper that has I believe only been temporarily neutralised by the 1998 Milburn concessions, Gilley's estimates (BMJ 16th January 1999) are from accurate sources and give the national figures as:-

HCHS	24 billion
Prescribing	4 billion
GMS Cash Limit	1 billion

Given that at practice level the GMS cash limit is a vital contributor to practice profits it is uncomfortable in the extreme to have that in their cash limited pool in which as little as a 4% overspend on the HCHS budget is sufficient to completely wipe out the GMSCL and therefore most of practice profits.

## **3. The primary health care team**

It has been an anomaly for many years that all members of the primary healthcare team, except the GP, are salaried. That, combined with an uncertain job definition for GPs themselves, means that when it comes to deciding on roles within the team there is always the undercurrent that when GPs off load work onto other members of the team they are being lazy and enhancing their profits, whereas when other members of the team seek to off load work onto the GP (or the staff towards whose salary a GP contributes 30%), any resistance by the GP must be the result of reprehensible greed. For a primary healthcare team to work effectively one can argue that all members need to be salaried. Such an arrangement would also do much to solve some of the perceived difficulties between non-principals and principals arising from the 'master-servant' relationship.

## **4. Secondary to primary shift**

Similar arguments apply when hospitals (containing salaried employees) seek to move work out into general practice. The GMSC Core Services document has helped to define the boundaries of teamwork and secondary to primary shift, but requires assertiveness and consistency for its local implementation which is apparently beyond many GPs.

## **5. Employment Law**

Every time there is an enhancement in employment law for employees, including GPs' staff, this is an added liability to the GPs as employers, and yet another right that they do not have as self employed persons. Sick leave, maternity leave, the facility to sue one's employer for needlestick injuries or seeing nasty

accidents are all examples of things that GPs not only fail to benefit from as employees, but are also liable for as employers.

## **7. Property ownership**

The slowing of increases in property values, and indeed the continuing fall in the commercial values upon which surgery valuations are based, combined with an increasing unwillingness to commit to a particular area for 30 years makes young doctors understandably nervous about investing in practice premises. In the Seventies and Eighties, even a new surgery development would commonly have reached a valuation equivalent to its cost by 10 years. Nowadays it can take nearer 20 or 30 years. An upcoming issue of BMA News Review will contain an article by Peter Holden questioning the wisdom of investing in premises.

### **So non-principals hold the key to the future:**

Against the background I have described, then, it does seem to me that the best situation for a doctor to be in at present is either working in a salaried post or being a roving locum, filling the many gaps created by recruitment difficulties and the increasing need for doctors to absent themselves from their practices to run the NHS.

Such doctors need to be prepared to be flexible about their sources of income, have made secure pension arrangements outside the NHS superannuation scheme as well as taking advantage of any superannuation they can pick up, so they are not subsequently tied in by superannuation as so many older doctors now are.

Our discipline, responding to patients who are or believe them themselves to be ill, which is the very essence of general practice, is and will remain popular with patients, as it has been in various forms throughout the history of mankind. The present dominant method of providing general practice under the NHS in Britain may seem to have the permanence of granite, but in historical and geographical perspective is a brief snapshot which is hardly reflected anywhere else in history or in the world. I believe that we are entering a period of turbulence in the mechanism of provision under the National Health Service, but should be encouraged by the enduring popularity of our art, and view the future with optimism and flexibility - particularly if we are fortunate enough not to be constrained by the increasing pressures which bear on traditional independent contractor practice.

I wish you a safe journey home, and a safe career which will inevitably be rather different from mine.