THE FUNDING OF GENERAL PRACTICE

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INTRODUCTION

At present, we live in a very money-orientated society. Money from people who work hard and pay up to 50% of their salary in tax, pays for healthcare and healthcare education. As healthcare providers we therefore have a duty to ensure that this money is spent wisely. A knowledge of how money is spent in healthcare and education is therefore important.

The UK health service (The NHS) is among the most efficient in the world in terms of health outcomes per pound spent (1). This is in no small part due to comprehensive and cohesive coverage of the entire population by a primary care service (1). We have seen how the clinical approach in general practice contributes towards this efficiency - taking a holistic approach to patient care and seeing patients in a time-efficient manner.

A second contributory factor to overall efficiency is that each general practice is responsible for deploying its own budget. This means that spending decisions are made ‘close to the ground’ with the priorities of particular practice populations upmost in practitioners’ minds. It also saves a whole layer of NHS management that would otherwise be employed in managing these funds. GPs are therefore independent clinical contractors, sitting halfway between being employees of the state and independent businesses. Different approaches to certain aspects of NHS funding may also exist across England, Scotland, Wales and Northern Ireland. This hybrid model (private/state, central/local) is highly unusual, conforming neither to conventional corporate or governmental management structures. However, as we have seen it returns outstanding outcomes.

• What are your views on private and public ownership of health services?
• What are your views on this hybrid (public-private / central/local) model?
• What are the main funding differences in the devolved nations (Scotland, Wales, Northern Ireland)?
Funding for UK General Practices

**COMMISSIONING IN ENGLAND**

CCGs hold budgets for both GPs and hospitals and commission care from them. This is supposed to allow inefficient or substandard care to be phased out and more efficient or more innovative models to be introduced in response to local demand. This arrangement provides a mechanism for private providers to play a part in healthcare introducing ‘competition’ into healthcare. However, criticisms of this policy include ‘top slicing’ of easy and profitable care by private providers, and the dissolution of a comprehensive service that increases inefficiency and decreases health outcomes. CCGs are increasingly dealing with federations of practices - each with approximately 30-50,000 patients. Practices are therefore working far more collaboratively with each other.

- Should the NHS continue to be a systematic healthcare system with a single management system, or should more competition be introduced with the risk of fragmentation?

**PRACTICE FINANCE**

Practices receive income from three main sources:

1. NHS
2. CCGs
3. Public Health bodies.

These bodies pay money to practices for the following services:

- General care of patients registered at the practice - the practice list. This money is called the global sum. This is paid per patient, according to a formula taking into account factors such as age of each patient and where they live. This formula is known as the Carr-Hill formula. Criticisms of this formula centre on the fact that it may not adequately recompense GPs for the effects of deprivation and therefore morbidity and demand on services. Follow this debate [here](#). The global sum accounts for about 75% of most practice’s income.
• Enhanced prevention services (immunisations and screening).
• Enhanced services; to address national priorities (e.g. improving quit rates for smoking).
• Enhanced services to address local priorities (e.g. incentives for GPs in a locality to work more closely together in Federations).
• Quality of care offered to certain groups of patients (QOF).
• Reimbursement of expenses such as rates, rent, etc.

Other sources of income for practices derive from ‘extras’ such as teaching, research and work for private organisations (providing insurance reports etc). Practices may also derive income from the property (see the section on property finance).

Over time, the payment mechanisms have changed. Initially practices received a single ‘global sum’ from one central source. This has changed to a more complicated system:

• Centralised/Government funding for maintaining a list.
• Payment according to locality (CCG) priorities (often known as ‘enhanced’ services).
• Payment reflecting individual practice innovation, including money from private providers.

This hybrid of centralised, locality and individual funding, makes general practice funding very responsive to changing healthcare needs at all levels. The drawback is that this system is complex to administer at practice level.

Against this income are balanced expenses:
• Staff costs (usually between 60-70% of overall costs)
• Premises expenses, repairs and upkeep
• Heating, lighting, stationary, postage.

What is left at the end is the wage that the GP partners take home. As the amounts vary each year for all the above variables, GP pay is not static but tends to alter year on year. GPs are fortunate in earning more than 90% of the population - the average wage for a full-time GP being about £130,000 per year.

• What are your views on inequality of wages?
• Is this kind of inequality justified (the average wage is £30,000; the wage of a city trader is frequently over £1,000,000)?
GP premises can be owned by a variety of organisations:

- The partners at the surgery
- The health authority (CCG)
- Private companies who buy the property from GPs and then charge rent to the remaining GPs.

For GP-owned premises, the landscape has changed considerably. These GPs take out mortgages from banks to pay for the premises, splitting the costs between themselves. Traditionally, the Government has paid for most of the interest on these loans and the banks historically have not asked for any of the original loan money back. Since the banking crisis of 2007, banks have asked for the loan money back to recoup their losses. GPs therefore pay more money to banks. At present, therefore, there is reduced incentive to take up partnerships and this in turn has led to many GP premises being sold off to the private sector or handed back to the NHS.

- Should government ‘back’ general practice or apply free-market thinking, allowing 'inefficient' practices to fail?
- Like some banks, is UK General Practice too big to fail?
- Managing finances can increase autonomy to make decisions based on patient need – however it is an extra responsibility. What do you think?

An ‘average’ practice in the UK has about 8500 patients and 2-3 full time GPs - each covering about 2,500 patients each - and receives an average of about £1,000,000. This means an ‘average’ patient costs about £100/year.

Source: AISMA

FINANCING MEDICAL SCHOOLS AND MEDICAL EDUCATION

As medical students you might be interested to know how medical education is supported. There are now around 7,500 medical students entering medicine each year, servicing a population of approximately 65 million. The numbers of doctors per person in the UK is therefore one of the lowest in Western and Eastern Europe.

Education of medical staff within the NHS is the responsibility of an organisation known as Health Education England (HEE), a branch of the NHS, with its own budget. Paying for medical student training costs approximately £1B (or 1% of the NHS budget). All medical schools in England (arrangements are different in devolved nations) are now paid a tariff of approximately £2000/student/year for preclinical teaching (“HEFCE” funding), and £35,000 a year per student for clinical teaching (“SIFT” or “Tariff” funding) and each medical student pays an additional £9,000.
This makes medical student teaching in the UK amongst the most expensive in the world. For comparison, a US medical student pays about $35,000 per year with little or no state funding. Medical schools receive extra money from HEFCE for the quality of the research they carry out. The quality of research is assessed every 5 years in a major exercise known as the REF (Research Excellence Framework). Similar performance related payments are now being introduced for teaching (TEF – Teaching Excellence Framework). Simple arithmetic therefore shows that most medical schools deal with an annual turnover of tens or hundreds of millions of pounds. The way in which this income is disposed has been the subject of considerable debate (2). An overview of the distribution process is summarised below:

Funding for preclinical and clinical teaching therefore comes from two different sources. This makes mixing the funding to provide gradual progression from preclinical to clinical training difficult. The money for clinical teaching is usually paid direct to the hospital associated with a medical school. The medical school then claims money from the hospital and then distributes this money to GPs and other non-hospital teachers. There is a large variation in mechanisms for how this process takes place, however it can make it difficult for medical schools that wish to alter funding allocations between primary and secondary care as paradoxically medical schools have little influence over this process. This process is summarised below:
ACTIVE LEARNING

✓ Debate with your placement partner or in your small groups, the issues raised in the text.

✓ How do you think medicine should be funded in the UK? What role do you think private enterprise and competition should play?

✓ What are your views on the funding for your medical education?

✓ What would you do if you wanted to change it?

✓ Ask your placement provider or practice manager about their views on how the practice is paid by the NHS.

✓ If possible, ask your practice manager to explain some of the finance regarding the practice you are at. Who is involved?

✓ To what extent should clinicians be involved in cost-related decisions about clinical care? What are the ethical implications of this?

✓ You are the clinical lead of a large CCG (some of you will be). You have been tasked with reviewing the payment mechanism for local GPs. Based on the information above, what would be your 3 overarching ‘principles of change’? Try discussing with your placement provider.

FURTHER LEARNING

RESOURCES

https://www.bma.org.uk/advice/employment/contracts/general-practice-funding

REFERENCES


The following resources have been developed in conjunction with SAPC Heads of GP Teaching. If you have any queries or questions regarding the resources on offer, please contact Prof. Joe Rosenthal or Prof. Alex Harding, Co-Chairs of SAPC’s Heads of GP Teaching Group.