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Introduction:

In this submission, we aim to answer two of the Terms of Reference of the Committee:

- Is the traditional partnership model in general practice sustainable given recruitment challenges, the prioritisation of integrated care and the shift towards salaried GP posts?
- Do the current contracting and payment systems in general practice encourage proactive, personalised, coordinated and integrated care?

There are probably only two academic teams who have analysed primary care funding in detail, using econometric modelling: our own team at King's College London (collaborating with Prof Hugh Gravelle at the University of York) and the team led by Prof Matt Sutton at Manchester University. In submitting evidence to the Committee, we are presenting a strong view emerging from our own analysis of available general practice healthcare funding data.

Our own research has shown the fundamental flaws in a funding model based on capitation fees and pay-for-performance incentives. This model worked when the NHS was formed but managerial complexity has meant that GPs now have too great a conflict of interest between three factors:

1. Providing clinical excellence within the consultation (consultations by GP, nurse of other healthcare worker)
2. Providing an efficiently run practice based on modern health service management skills
3. Ensuring an adequate 'profit' for each GP partner

Indeed, the conflict of interest between the first two factors and ensuring adequate 'profit' is stark. The less that is spent on healthcare (premises, healthcare equipment, staff wages and staff numbers, consultations provided by GPs and other healthcare professionals), the more that can be taken as 'profit', the earnings received by each GP partner.

Reflecting these priorities, our research has demonstrated a typology of general practices in which some practices choose to prioritise factor 1 (clinical excellence), some factor 2 (managerial excellence) and some factor 3 (high GP partner profit).

A key argument AGAINST further investment in primary care, is that additional income may simply be diverted into additional GP partner profit/earnings.

Taken together, we consider that the independent contractor status of primary care has led to substantial conflicts of interest which would not be tolerated in any other public sector service and which has deterred long term investment in primary care.

That said, it should be noted that by almost any measure, primary care as a whole has provided an extremely cost-efficient service to the NHS (90% of all NHS contacts, currently on 8% of NHS budget) and any proposed change should not reduce the efficiency of current primary care.

Data analysis and findings:

We are aware that you do not require copying of any already published evidence. Instead, in our presentation of findings, we will collate the data, presenting the relevant parts as evidence for the Committee.

We examined five measurable 'outcomes' from general practice:

1. Secondary care utilisation rates: https://doi.org/10.3399/bjgp17X693101 (1)
2. CQC inspection quality domains: http://dx.doi.org/10.1136/bmjopen-2019-030624 (2)
3. Patient satisfaction: https://doi.org/10.3399/bjgp21X714233 (3)
4. Primary care mortality (unpublished)
5. Provision of so-called 'additional services': https://doi.org/10.3399/bjgpopen20x101141 (4,5)

Methodology

Our methodology is described in each of the above references. We analysed longitudinal econometric data for all GP practices in England, available from NHS Digital. Total funding (capitation fees per registered patient plus pay for performance fees plus 'other' fees such as GP Training practice allowance) was linked to aggregate practice level data describing the demographic characteristics of the population, QOF, CQC and Ipsos MORI GP Patient Survey findings, secondary care utilisation rates. Econometric modelling allowed us to draw conclusions about the associations between funding and outcomes.

Secondary care utilisation

For secondary care utilisation, the current capitation fee formula (based on the Carr-Hill formula) seemed to be broadly aligned to patient need in terms of secondary care usage; there was no significant association between higher funding and reduced secondary care costs. However, one group of practices did have lower secondary care costs. These were the practices in receipt of capitation supplements (so-called 'MPIG payments'). These practices (22% of the total) had historically been practices that invested in larger primary care teams and in clinical excellence, which arguably meant that they had prioritised investment in healthcare and service provision over the taking of large partnership profits.

CQC inspection quality domains and patient satisfaction

For both CQC inspection quality domains (5 quality domains in total) and patient satisfaction (GP Patient Survey scores), higher funding was strongly associated with higher scores. The strength of the association and modelled score increases as ££ per registered patient are summarised in the publications. These findings do suggest that additional funding does result in increased quality of primary care across multiple domains. One of the key findings was that practices investing in larger primary care teams (more salaried GPs, nurses, other healthcare workers, managers) achieved higher quality and patient satisfaction.

Primary care mortality

The findings related to primary care mortality have not yet been published. We would be happy to share preliminary findings with the Committee. We are the only research group in the country to have access to primary care mortality data (following a Data Access Request Service, or DARS, application to NHS Digital). Preliminary findings show that practices with higher funding have lower mortality rates, after adjustment for multiple demographic and multimorbidity factors that might be associated with mortality and with lagged associations to allow for delayed funding effects. These

findings again suggest that additional funding is associated with quantifiable reductions in primary care mortality. The implication is that at least some of this funding has been invested in delivering higher quality primary care services.

Provision of 'additional services'

Finally, analysis of the provision of 'additional services' has provided contrasting findings. The funding of 'additional services' differs from other primary care funding sources. Funding is 'hypothecated' in that it is strictly related to achievement of each component, similar to item-of-service payments (e.g. for service delivery of vaccinations). As such, funding cannot simply be 'diverted' into partnership profits. 'Additional services' might therefore seem a fairer form of funding – 'you pay for what you get'. However, we have identified other problems with this approach to funding: practices in more prosperous areas were in receipt of substantially larger 'additional services' payments. In other words, this approach to funding perversely increased health inequality.

Interpretation of findings

Our findings have led us to the conclusion that the independent contractor status of primary care has hampered both additional investment in primary care and attenuated the outputs from higher funding.

The conflict of interest between partnership profit (GP earnings) and reducing the cost of secondary care (reduced secondary care utilisation rates) or increasing the quality of service is stark. Our findings have demonstrated that practices which invested in larger primary care teams (i.e. those practices historically in receipt of MPIG payments or whose data shows higher staff per 1000 registered patients) had both reduced secondary care costs and higher quality of care.

It is our interpretation of these findings that if the profit motive were removed from the provision of primary care then a service could be developed to more successfully achieve three things: to reduce secondary care costs, to increase the measurable quality of care and to reduce health inequalities. Full integration into NHS secondary and community services would be needed to deliver these goals.

References:

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Feb 2022