Funding primary care

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Recently Charles teased me suggesting I had received a big boost in pay for less work.

'Yes I have but I am not so sure about the less work,' *was my initial reply.* 'We certainly have done better recently but not as well as the GPs!'

'Well' *he said*, **'Whether or not you deserved it, and I think you did, I am not concerned about absolute levels or differentials, but I am concerned about the basis on which primary care is funded.'**

'Why?'

'Let's compare the way you are rewarded with the GPs. You are either paid for doing a job in the NHS or receive a fee in private practice. In the first instance your employer is ultimately responsible to the client for your performance and can reward you accordingly. In the second, the client can judge for himself with the help of his GP.'

'But we all have clinical responsibility to our patients wherever they are seen?'

Charles did not disagree, saying, **'True but that is a moral and professional duty. The financial relationships are very different. The GP is directly responsible for the service, but his client, the patient, does not have any financial clout except the now rather weak one of joining or leaving the practice list.'**

'So how would you handle it, Charles?'

'I think there would be a lot to be said for going back to the old days and pay a realistic capitation fee to cover all professional and administrative costs and little else.'

'I do remember, as a student, a friend of mine got very upset when I was reluctant to register with a GP. He told me that his GP father was only paid extra for vaccinations and confinements and that his living depended on those who were fit and well!'

'That's the core of the matter. The fitter his patients the more he got, and as capitation fees were 90% of his income it did impact if someone moved elsewhere.'

'But surely the funding organisation has responsibility for seeing the service is up to scratch and reward those contractors who perform well.'

'I accept that there is an argument for this but how would you judge the service?'

'I would make sure enough was being done for the patients.'

'How, Coe? Recording arbitrarily selected aspects of clinical activity with all the form filling involved? Rewarding monitoring of chronic disease which may be difficult to separate from normality or barely impairs the health of the individual! This must put temptation in the way of even the most honest practitioner. If in doubt include him? How else do you explain the vast difference in the incidence of the relevant diseases between different practices?'

'So you would go back to funding by global capitation fee?'

'Yes, but weighted for age, gender and social class as determined by postcode. The list limit would be determined not simply by numbers, but by gross-weighted fees ensuring that the level of service reflected the needs of those in the practice.'

'And subject to that, entirely by capitation fees?'

'Nearly, but I would reward success as well.'

'What else would you pay for?'

'As you know from a previous conversation I believe the agencies responsible for treatment of disease and health promotion should be funded separately at government level.[1] Primary care should be mostly paid by the former, but the latter should be allowed to contract services from the GPs.'

'What services?' *I asked.*

'It would be up to the responsible authority, but I would anticipate it would be a small proportion of their budget for treatments where there are clear-cut benefits such as immunisations.'

'But Charles, many would say prevention is better than cure. So shouldn't GPs be involved in primary prevention?'

'If you accept the possibility that primary prevention in low-risk groups may be compromised by the disruption to health that the diagnosis itself or the

medication produces, which we nicknamed the *commoveamus* effect,[2] then that form of prevention might not be a priority.'

I looked doubtful.

'Coe, there would be nothing to prevent GPs deciding where the balance lay and making their own decisions if and when to intervene. That would fit nicely with my bonuses!'

'What do you mean?'

'The commissioner has a duty to the taxpayer to ensure a good service and should reward those who provide it!'

'But that's what the government says it is doing!'

'But how? As we have seen, rewarding process as assessed by volume has its pitfalls. Better to reward outcome!'

It was my turn to ask, 'How?'

'Go to the fundamentals! The aim is to enable a long, healthy and useful life through a caring and responsive service. So first assess bonuses by survival and employment rate, weighted by gender and social class!'

'But wouldn't the effects on mortality take a long time to show?'

'Probably, but one has to start somewhere and one might be rewarding past good practice, not a bad thing! It would also benefit those who chose what actually proved to be the right level of intervention for primary prevention in the real world.'

'Perhaps, you might be right in the very long run' *I replied hesitantly, continuing, thinking of employment,* 'But might not GPs be tempted to sign people off for work too early?'

'Ideally that would be prevented by market forces, as loss of the capitation fees would hurt. Although it should be possible to prevent monopoly practices in cities, I accept that this would be impracticable in rural areas and so the market could not work everywhere. This means that bonuses should be given for accessibility, practice 'atmosphere' and patient morale. The first might be objective but would require form filling. I would like to include the others which are softer, but which an experienced assessor might not be find so difficult to ascertain. Too often nowadays we shy at making judgments that cannot be defended absolutely!'

Charles would be the last to say that all his suggestions were practicable now, but perhaps we should learn from the past. The drift away from capitation fees to practice allowances and other payments has de facto reduced the independence of general practice.

Coemgenus

References

1 *Coemgenus.* Do we need a real health service? *J R Coll Physicians Lond* 2000;34:218.
2 *Coemgenus.* Everyone a patient? Beware the *commoveamus* effect! *Clin Med* 2005;5:665–6.