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Designing general practice for others

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The new GP contract in UK was brought in because there were serious recruitment and morale problems within general practice and pay had fallen behind. Quality and Outcomes framework contains groups of evidence-based indicators, and has continued to evolve, being amended as new evidence becomes available, to improve the diagnosis and management of some of the most prevalent chronic diseases. It has improved quality of care and reduced inequalities.

Flying off to Berne to talk about general practice in the future, I met a GP colleague in the airport. A conversation contrasting theory and reality. Asked to talk to Swiss GPs about the best models of European general practice, with particular focus on the UK, I looked back on the effect of the 2004 GP contract, which was designed to help with poor morale and under payment – and introduced radical new changes with a performance related component to income (Quality and Outcomes Framework – QOF) and major changes to out of hours.

No one can quite make up their mind. Personally, I feel the benefits of QOF outweigh the adverse effects. There is much more systematic evidence based monitoring of chronic disease with greatly improved process measures. On the other hand, chronic care was already improving so it may have supported change rather than created a new direction. In hypertension, for example, there was no real alteration in the trajectory of improved management.

Critics point out that non incentivised conditions haven't done as well and that it altered the nature of the consultation.

GPs responded remarkably to the challenge and although the media have been critical of their increased income, a performance related component was an integral part of the contract. It wasn't a bonus.

GPs were also relieved of responsibility for out of hours care, but the government greatly underestimated the cost and quality of the service previously provided by GPs. With a crisis at emergency departments, they are now keen to hand back responsibility (the newspapers and television have covered it extensively today) but, the demography and lifestyle expectations of the GP community has changed and a return to the previous system may be unrealistic.

Personally, I feel the benefits of QOF outweigh the adverse effects. The day job has also changed. Hospitals have shrunk, patients spend less time as inpatients, investigations and treatment are pushed towards primary care, the team structure has broken down with less support from health visitors, district nurses, community psychiatric nurses, and other community services. And patients' expectations have risen. For GPs, the job is almost unrecognisable to those graduates for whom it was a first choice career in the eighties.

There are still good days – problems sorted, conditions cleared, successful pregnancies, and happy teddy hugging children. A job well done, a contribution to society and a warm feeling at the end of the day.

But, on bad days its thankless – every consultation is hard work, nobody cured, the phone relentless, the extras mounting up, and illnesses multiply. And, as we sat over coffee in the airport, my colleague told me that every GP he knows in their mid fifties has already enquired about their pension. And I also know that there have been so many enquiries that, in our region, GPs are now permitted only one pension estimate request per year. So, I changed my last slide during the flight: Redesign the system, but remember those who work in it …

- Performance related system improves quality of care in clinical practice and reduces inequality.
- It requires investment in systems, staff and organization – and computerisation and works best with multiprofessional teams.
- If you introduce performance related pay, do not criticise doctors if they increase their pay.
- Redesign the system but remember to support those who work in it.

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