

The value of UK general practice: the facts

January 2007

The new GP contract was introduced in full in April 2004 following lengthy negotiations and full agreement by all parties. Ministers were kept informed throughout the process and approved the final arrangements. They spoke in public about the intended value of the contract and their words have turned out to be accurate. Despite this, in recent months, general practice seems to have been under attack from misleading reports in the media and other sources that GPs are overpaid and not pulling their weight. This fact sheet is designed to give GPs and Local Medical Committees (LMCs) the facts to counter these unfair criticisms.

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How much does the average GP earn?

Recent claims by the Association of Independent Specialist Medical Accountants (AISMA) that some GPs are earning up to £250,000 have been widely quoted and misinterpreted by the media. These figures apply only to a tiny minority of GPs working in exceptional circumstances. A usually more reliable indicator of GP income is the Information Centre's Earnings and Expenses Enquiry (EEQ). This recently estimated that, from *all* professional earnings sources (including NHS, private and out-of-hours work), self-employed, non-dispensing GPs would have earned an average net income of £102,388 in 2004/05. It has since become clear, however, that these estimates included the employer's superannuation contributions. This means that GPs are actually earning much less than the EEQ originally led us to believe and that self-employed non-dispensing GPs were earning, on average, around £95,000 in 2004/05 from a combination of NHS and non-NHS sources. This is a UK figure. It should be noted that the earnings of GPs differ significantly across the four countries and will be lower in Northern Ireland, Wales and Scotland. In addition, the earnings of salaried GPs are not included in this figure. On average, salaried GPs earn considerably less than GP principals, partly as a result of reduced responsibilities, particularly those to do with running the practice as a business. The Doctors' and Dentists' Review Body's (DDRB's) suggested range of (minimum) income for full-time salaried GPs in 2006/2007 is £50,332 to £76,464.

The inclusion of employer's superannuation contributions seems to have complicated earnings estimates. Why were these contributions counted as net income?

The 14% employer's superannuation contribution was, misleadingly, included in net income estimates on tax returns this year because, for tax purposes, it is considered to be practice income but not an allowable expense. HM Revenue and Customs (HMRC) is aware of the problem and has now issued guidance for GPs and their accountants on how the employer's contribution should be dealt with. This should make it easier to produce more representative earnings figures in the future. The HMRC guidance can be found through the BMA's website: www.bma.org.uk/ap.nsf/Content/HMRCrecordpen

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How have GP earnings changed since the introduction of the new contract?

Based on earnings estimates for all self-employed GPs from 2004/05, average net income appears to have increased by around 20 percent since the introduction of the new contract. That is considerably less than the increase of 30 percent or more often quoted by the media. It should be remembered that any increase in net income since the new contract was introduced is partly accounted for by the delivery of new work including the Quality and Outcomes Framework (QOF) and enhanced services.

Despite inflation, GPs received no cost-of-living increases in the value of the contract in 2006/07, and Access DES payments, previously paid in full to most practices, are now considerably harder to achieve. In addition, expenses have continued to rise, so most GPs will actually have seen their real earnings, for an increased amount of work, fall over the last year.

The rise in GP earnings since 2003/04 has been an intentional consequence of a new contract, agreed between the GPC and the government with the explicit purpose of demonstrating high quality practice and counteracting well-

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recognised recruitment, retention and morale problems in general practice. In return, the contract has delivered benefits to patients through the improved monitoring and treatment of acute and chronic health problems and the development of nationally determined and locally appropriate enhanced services. The contract deal also changed the working environment for GPs by introducing competition and a more commercially-oriented and businesslike approach.

This increase in income sounds considerably less than the estimated dynamising factors would suggest. Why is this?

It was agreed, under the current contract, that the dynamising factors should be based on the change in actual pensionable profit year-on-year. It was always anticipated that, over time, the total percentage increase in pensions was likely to exceed the percentage increase in net income. One of the reasons for this is that income that was not previously superannuable – for instance, work for out-of-hours providers – is now included in the calculation of NHS pensions.

Is it true that GPs are now taking a greater proportion of gross income home as profit?

Several recent media articles have reported that GPs are taking a greater proportion of practice income as personal profit and the government has said it regrets the fact that GPs have not invested more of the increase in gross income in patient services. Although a small change in the earnings/expenses ratio had been anticipated, these reports are generally misleading because raw figures conceal several changes in the way GPs are paid under the new contract. Although EEQ figures show a fall from 59.5 percent in 2003/04 to 55 percent in 2004/05 in the percentage of overall earnings accounted for by tax-allowable expenses, the reasons for this change are complex and include:

- GPs are no longer responsible for certain elements of their business expenditure, including IT, the purchase, maintenance and upkeep of which is now the responsibility of the primary care organisation.
- The new GMS contract made it possible for practice partnerships to include non-clinical members, many of whom may previously have been employed by the practice. Their salaries would, therefore, be removed from the expenses side of practice budgets thus changing the earnings/expenses ratio.
- The EEQ figures include employer's superannuation contributions in GP net income. If this was considered, as it will be in future years, to be an element of gross income and a practice expense, the expenses to earnings ratio would be closer to its level under the old contract.

The suggested present level of expenses does, in any case, no more than take the percentage back to its level in 1990/91 when the previous contract came into being. It had reached its higher level as GPs were prepared to invest heavily in their practices even when gross incomes were rising more slowly.

GPs have increased investment in their staff and practices since the introduction of the new contract

Contrary to the government's accusations, GPs have increased investment in their staff and practices since the introduction of the new contract. According to the EEQ average expenses rose from £120,064 to £129,926 between 2003/04 and 2004/05. The increase in staff costs in 2004/05 was 17 percent, a massive increase by anyone's standards. The areas where expenses grew slowly or fell were business expenses and car and travel costs together with depreciation on capital assets.

What will happen to GP pay in 2007?

For the year 2006/07, in addition to receiving no inflationary uplift to the contract, the GPC agreed 'efficiency' changes in the QOF, amounting to some 15 percent, and the introduction of additional areas of work, on the explicit and publicly agreed understanding that the government's perceived value-for-money issues would not be revisited in future negotiations. The government is not honouring its agreement that value-for-money issues were dealt with by the 2006/07 negotiations. As a result, the negotiating parties have been unable to reach a negotiated agreement for 2007/08 because of a failure to agree the extent of any inflationary uplift and associated efficiency savings. Although several *potential* offers for 2007/08 have been discussed, all have been inadequate, well below inflation, and most have attempted to introduce new work without sufficient additional funding. Instead, the GPC has submitted evidence to the DDRB and is currently awaiting its decision. The government is disputing the role the DDRB has to play in reporting on GMS GP incomes. The BMA has rejected its arguments and pointed out that for the first three years of the contract the Departments of Health, NHS Employers and the BMA submitted joint evidence to the DDRB.

In addition, as you will be aware, the Secretary of State announced her decision in December to cap, retrospectively, the pensions dynamising factor for GPs over the years 2003-08. We are led to believe that the other three countries are in agreement with this. The GPC is challenging this decision robustly.

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What difference has QOF made to GP income?

The negotiations on the new contract were predicated on the overwhelming bulk of new money being delivered through performance-based income streams and 75 percent of new money was intended to be delivered via the QOF. Since the introduction of the new contract, most of the increase in practice income has indeed been channelled through the QOF as performance-related pay. As the GPC had anticipated, practices have attracted additional resources by demonstrating that they deliver high quality care and work across the range of specific areas identified by the government. In 2005/06 the average practice in England achieved a score of 1,010.5 points out of the 1,050 available. Similarly, GMS practices in Scotland achieved an average of 1,026.2 points, in Wales the average QOF point total per practice was 1,003.3 and practices in Northern Ireland achieved an average of 1027.6 QOF points. These achievements were significantly higher than the government had anticipated and are a great tribute to the work of GPs and their staff.

Weren't GPs already doing much of the work in the QOF?

The government wanted rises in GP incomes to be linked to demonstrating the delivery of high-quality care (see above). Of course, as all parties were aware, GP practices were already undertaking some of the work that now falls under the remit of the QOF. While the government seemed to doubt that GPs would do well in the QOF, the GPC stated that it not only expected most practices to earn 750 points, because they had been delivering quality work for years, but that it fully expected many to top 900 points. The introduction of the QOF has indeed incentivised GPs to employ extra staff and invest in even better services for patients. It has also provided practices with the resources to identify patients with certain conditions before these would otherwise have come to light. Both work that had been initiated prior to the new contract and work undertaken since the introduction of the QOF have contributed to GPs' excellent performance in this area.

What hours are GPs working now?

It is difficult to get accurate figures about the average hours worked by GPs because many work part-time. However, all surgeries are responsible for their patients for 52.5 hours a week from 8am – 6.30pm every weekday. Most GPs will also do work to run their practices outside the hours set aside for seeing patients, and a significant number of GPs continue to work for out-of-hours organisations.

Didn't GPs stop doing out-of-hours work when the new contract came in?

Before the new contract was introduced, GPs were providing out-of-hours care at minimal cost. When the new contract was introduced, the default responsibility of all GPs to provide 24-hour care for their patients ended and the obligation to ensure provision of out-of-hours care was transferred to PCOs. The true cost of providing out-of-hours care has since been demonstrated by the fact that an estimated £100 million of the government's primary care overspend is accounted for by the increased costs of providing out-of-hours services. Problems in out-of-hours care since the introduction of the new contract are a testament to the unrecognised and underfunded work once undertaken by GPs and have not been caused by general practice. Relieving GPs of the obligation to provide 24-hour care was necessary to ensure that general practice remained an attractive option to doctors and that GPs had an acceptable work/life balance. It is important to recognise, however, that many GPs still choose to provide out-of-hours services to their patients either directly or by working for an out-of-hours organisation.

Are GPs going to be forced to extend their opening hours?

The government has emphasised the importance of patient access and, very recently, the Secretary of State reiterated her belief that GP surgeries should be providing extended patient access. Access problems will only be addressed by an expansion of the numbers of GPs. The government's own recent workforce figures confirm this and it is indefensible that the funding for many of the incentives for training, recruitment and retention has been cut or completely withdrawn. GPs have clearly specified hours for providing contracted services to their patients, but PCOs are free to commission extended opening hours, for example on Saturday mornings, through local enhanced services agreements. GPs can not be forced to extend to their opening hours.

GPs remain excellent value-for-money

Are GPs still good value-for-money?

The UK governments expressed some value-for-money concerns following the introduction of the new contract, even though it had been negotiated and agreed by all parties. Although GP income did rise, as intended, following the introduction of the new contract, GPs remain excellent value-for-money. General practice delivers high quality services with fewer doctors per head of population than most of our European neighbours. The Personal Social Services Research Unit at the University of Kent has calculated that, in 2005/06, the unit cost of each face-to-face GP consultation was just £21. This figure compares very favourably with other NHS costs. Increasingly, GPs are providing services which used to be done in hospitals,

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eg minor surgery, at a much lower cost to the commissioner. In the House of Commons on 28 November 2006, the Secretary of State for Health, Patricia Hewitt said that the new GP contract 'has led to primary care services being rated as better in our country than in almost any other advanced country'.

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Is the GP contract responsible for NHS deficits?

The GP contract is not responsible for NHS deficits. At various points in the last couple of years the government seems to have blamed GPs for the financial results of poor central planning but reports of contractual overspends have been significantly exaggerated. The BMA has estimated that the 'overspend' caused by GPs' performance in the QOF accounted for about £140m, not the £300m reported by the government. Financial problems in the NHS are, in fact, the result of many factors including targets, reforms, inefficiencies and structural problems. An Audit Commission report published in July 2006 said that, in the Trusts and PCTs in significant financial difficulty that it had reviewed, the origins of financial failure typically lay in ineffective management and weak or inadequate board leadership. The 'overspend' attributed to the GP contract could also be seen in the context of the estimated £172m that the NHS spent on external management consultants last year.

If GPs are not responsible for NHS deficits, why does the government persist in revisiting value-for-money issues?

GPs can be forgiven for wondering why the government persists in revisiting value-for-money issues in relation to general practice. We can only speculate that in so doing, the government is trying to identify the contract as a scapegoat for the NHS' financial problems. It may also be an attempt to try to discourage the DDRB from making a recommendation on GP pay. Some also believe that it is attempting to pave the way for the wider involvement of private providers in the NHS.

What is the profession doing to resist attempts by the government to denigrate general practice?

The BMA and its General Practitioners Committee works hard to promote the good work of general practice and redress the balance of stories in the media about NHS issues. In recent weeks GPs and LMCs across the country have expressed their anger about negative stories by contacting the local and national press. It is through this frequent, direct contact with the media and MPs that doctors can do most to negate unfounded criticism. The BMA's press office works to promote the views of the profession by continual contact with the media and the BMA's parliamentary unit is always happy to put GPs in contact with their local MPs. The parliamentary unit can help arrange meetings between GPs, LMCs and MPs on a local or regional basis. If you want more information about working with your local MP, please see: www.bma.org.uk/ap.nsf/Content/Puttingpoliticsintopractice or contact Susan Solanki, parliamentary liaison officer, at ssolanki@bma.org.uk For help with the media contact Linda Millington, the BMA's head of media relations at pressoffice@bma.org.uk

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How will the recent negative publicity affect patient perceptions of GPs?

Although it is impossible to predict the impact recent publicity will have on public perceptions of general practice, we believe that levels of patient confidence and trust in GPs remain high. In a Healthcare Commission Survey of 117,000 patients in September 2005, 76 percent reported having confidence and trust in the GP they saw. More than nine out of 10 said the GP treated them with dignity and respect. Patient surveys consistently report that patients like their local GP services and value continuity of care.

General practitioners are represented by a main UK-wide committee, the General Practitioners Committee (GPC), plus three national committees, which work alongside it. The committees represent all general practitioners whether or not they are members of the BMA. The GPC is part of the BMA which provides additional benefits to its members.

For more information on BMA membership and GPC activities visit www.bma.org.uk