The traditional model of a family GP caring for multiple generations from birth to death is long gone but as yet no clear paradigm has come forward to replace it. **Dr Druin Burch**, a consultant at Oxford University Hospital and senior advisor to health and social care strategy consultancy Candesic explores the new models of general practice emerging in the 21st century and asks whether they can prove attractive enough to boost the supply of GPs in England

The new GP

Widespread access to primary healthcare, regardless of income, started in the UK with the 1911 National Insurance Act. Established by a Liberal Prime Minister, it did for Britain what the conservative Chancellor Otto von Bismarck had done for Germany.

The benevolent intention of providing healthcare for all workers was driven by the desire to support the country by making sure workers were healthy.

With the establishment of the NHS by a Labour government in 1948, universal access to primary healthcare came into being.

Again, the aim was two-fold: to support the health of the population and, by doing so, support the health of the nation.

The NHS foundation was backed by the Labour, Liberal and Conservative parties combined. This is not ancient history; the political consensus in favour of the NHS in Britain is long-standing and likely to continue. Internal market reforms were continued by the most recent Labour administrations just as the overall delivery of socialised medicine has been supported by the current Conservative one. Britain knows clearly what it wants and it wants the NHS. It's just not clear what sort of NHS that is.

> INDIVIDUAL GPS THEMSELVES ARE NOW FREQUENTLY OPTING TO AVOID PARTNERSHIPS AND PURSUE A SERIES OF INDEPENDENT TEMPORARY CONTRACTS

From the foundation of the NHS until the late twentieth century, the fundamentals of General Practice remained largely unchanged. Doctors ran practices and provided primary care services to a core group of patients, in and out of hours.

Continuity of care was the norm, and generations grew up knowing who their GP was, having kept the same one most of their life.

From the late twentieth century, the relationship began to change. Out-of-hours cover began to be provided not by each practice individually but by small groups of them, then larger groups operating at county or near-county level. The 111 service was introduced as the first port of call.

Today, GPs in Britain provide a more varied and fragmented service. Much care previously provided by doctors now

falls to nurses, pharmacists and other allied health professionals. Existing practices currently struggle to recruit and many newly qualified GPs have no wish to settle permanently, as older ones have done. The notion of the 'portfolio GP', with a mixed bag of experiences, jobs and special expertise, would once have been viewed with suspicion – now it is the norm.

The picture today

Figure One highlights that there is only a single CCG in England (Hambleton, Richmondshire and Whitby CCG) with the recommended balance in supply and demand in terms of number of GPs per population. The rest of the country shows 'the heat is on' for GPs to care for more registered patients on their books than recommended.

Despite rises in numbers of places at medical schools and in GP training schemes, these stresses are likely to increase. Not only is demand rising inexorably, year-on-year, but the supply of GPs is showing strain. The proportion of doctors choosing to specialise in general practice has fallen and the number of GPs choosing to work in a salaried role (more often part-time) has risen by a factor of ten.

The classic model of general practice is the 'partner model', where experienced general practitioners join and invest money into opening their own practice to serve a local community. They can also employ salaried general practitioners.

Unlike salaried GPs, partners are not on a fixed salary, and are paid from the profits that the practice makes; historically practices were owned by GP partners and few wished ever to be salaried doctors working for others.

A general practice can choose whether to operate independently or as part of a network of general practices, known as a 'federation'. This is a group of general practices that join together with the aim of improving the delivery of care for the local population and increasing efficiency savings via economies of scale, resource sharing and potentially increased specialisation.

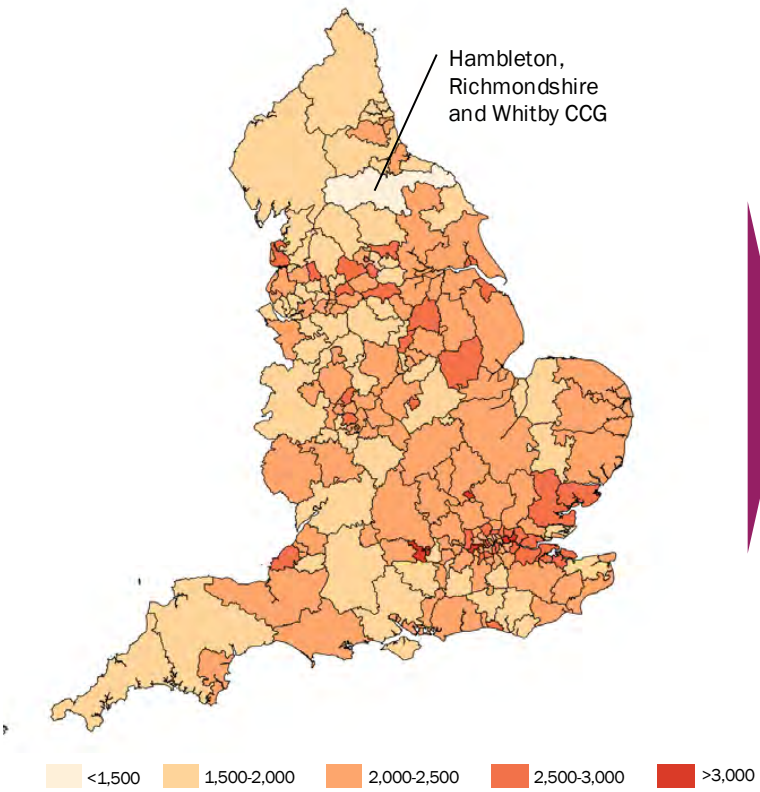
Over 50% of general practices now find themselves as members of federations. 2016/17 NHS Digital data showed that just eight new GP surgeries opened, while 202 GP surgeries closed or merged.

There is the start of a trend of large private corporations taking over local practices. Individual GPs themselves are now frequently opting to avoid partnerships and pursue a series of independent temporary contracts; others are moving away entirely from their traditional environments and going to work in hospital A&E or ambulatory care departments.

General practices are now frequently owned by non-doctors and have the majority of care delivered by allied healthcare professionals and doctors who are not partners in their own business.

From being professionals working long hours with 24/7 responsibility for patients they know well, primary care doctors are increasingly expecting and opting for jobs where they clock in and clock out, with defined responsibilities

FIGURE ONE UNDER-SUPPLY OF GENERAL PRACTITIONERS IN ENGLAND
NUMBER OF PATIENTS PER FTE, 2016



The majority of CCGs exceed the *'less than 1,500-2,000 patients per full time equivalent GP'* recommended by the Royal College of General Practitioners

SOURCE NHS DIGITAL; THE KING'S FUND; ROYAL COLLEGE OF GPS; CANDESIC ANALYSIS

Primary care in 2015/16, England

£10.395bn budget

7,435 General Practices across **207** CCGs

34,242 full-time equivalent General Practitioners

58.5 million registered patients and an emerging trend of practices closing their lists to new patients to focus on 'safer care'

and payments made by the hour. Much of this reflects societal changes that are common also to secondary care and beyond the borders of medicine. These changes are partly behind the movement of GPs out of their community surgeries and into the emergency and ambulatory departments of nearby hospitals. Having lost continuity of care they are open to new roles that don't include it.

An uncertain future

The future of primary care inside and outside the NHS has never been more uncertain. The most effective way to deliver it, and the way in which that can be made attractive to providers, is unclear. Along with an increase in private provision, such as drop-in centres, online services are growing rapidly.

Babylon is positioning itself as a provider of NHS primary care services. The automated service will compete with NHS 111, and is reputed to be equivalent when it comes to triggering hospital referrals but superior in terms of how many face-to-face primary care appointments it provokes. With 'GP At Hand', Babylon is attempting to add something new, with direct access to NHS GP consultations both online and in person.

Doctors themselves have raised concerns. Trained to expect that new interventions are based on good evidence, they will need persuading. Their opinions matter, not only in swaying the tastes of patients-as-consumers.

The unintended consequences of good ideas are not a new part of primary care; the 111 service, designed to reduce workloads, did the opposite.

Babylon, Doctor Care Anywhere, Push Doctor, eConsult and similar services need to find ways of interfacing with the NHS Emergency Care Data Set and with the electronic patient records of primary and secondary care. Doing so will allow them to demonstrate safety and value, thus ensuring that those who plan and deliver primary care come to trust them. It will also open rich new avenues for future development.

Being able to link artificial intelligence and decision-making tools with real-life outcomes will not simply prove a means of demonstrating safety and efficiency, it will allow systems to mine the masses of data produced by the NHS in order to learn and improve.

Evidence and innovation

Investors are dipping their toes into the primary care market just as owner-operating GP partners are withdrawing.

GPs have traditionally been driven by the satisfaction of providing lifelong care for patients they know well. What will their role be, relative to other health professionals and relative to services from hospitals and other providers, with that continuity gone? To what extent can it be preserved, and might online systems support it?

Chasing targets and tariffs may result in new models of care with attractive efficiencies, but such models also have to be attractive to the doctors needed to deliver them. The projected shortage of GPs, despite explicit efforts by the government to increase their numbers, suggests the attraction is not currently there.

Part of the appeal of Babylon is that it doesn't only seem fresh and attractive to younger, healthier patients wanting quick advice and quick prescriptions, it seems fresh and attractive to some doctors. To last, and to win over those who are suspicious, that appeal needs to be backed up by evidence that innovation is driving clinical quality. Gaining that evidence, through linking patient consultations with individual outcomes, would have profound benefits.

What next?

It would be untrue to say that primary care in Britain is at a crossroads: untrue because none of the roads leading forward are clear. Proven clinical effectiveness is needed to support the design of regulations and tariffs, as well as to attract and motivate the required workforce.

There is no going back to the family doctor of the past, but the quality they provided was tightly bound up with what gave them job satisfaction. Innovations and new models of care should look to provide both those attributes if they are to survive and flourish.