Cyflwynwyd yr ymateb i ymgynghoriad y Pwyllgor Iechyd a Gofal Cymdeithasol ar dyfodol ymarfer cyffredinol yng Nghymru

This response was submitted to the Health and Social Care Committee consultation on the future of general practice in Wales

GP56 : Ymateb gan: Unigolyn| Response from: An Indivdual

A personal submission to the Senedd Health and Social Care Committee's Inquiry into the future of general practice in Wales
28/03/2025

[redacted] I am writing in a personal capacity, and not on behalf of my partnership. I would prefer that my name is not published alongside my contribution to your committee's consultation.

I've tried, below, to outline some concerns that I have about general practice in Wales and to do this in a way that is broadly in line with the subject headings under consideration in your consultation.

Underinvestment in primary care

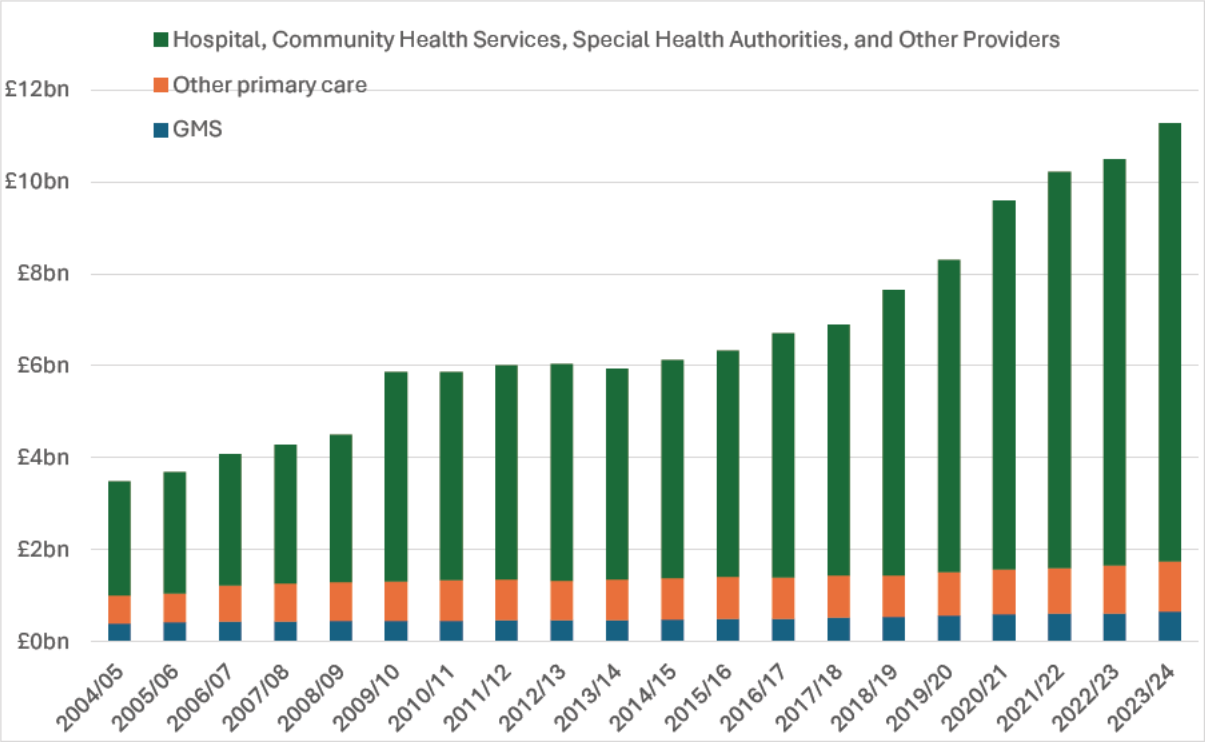
That the Welsh NHS is struggling is not news. It is struggling despite substantial revenue investment: between April 2004 and April 2024 Consumer Price Inflation (CPI) increased 74%; in the same period, NHS expenditure in Wales increased from £3.49 billion (2004/05) to £11.28 billion (2023/24) - a staggering 223% increase, well above inflation.

But that increase is not equally divided between primary and secondary care. In this time, spending on GMS increased 67% whilst NHS spending on all non-primary care increased 283% (this does include some services based in the community). GMS has decreased as a percentage of total NHS spending from 11.12% in 2004/05 to 5.76% in 2023/24: a 48% reduction in the proportion of the NHS budget spent on local GP surgeries. In truth, these percentage changes are not directly comparable because part of this change can be explained by changes in accounting practices which has seen some expenditure brought into NHS accounts from elsewhere. However, the fact remains that proportionally more of NHS spending has been going to secondary care over the last 20 years or so.

Why is this a problem? Because it undermines the Government's stated long-term aim in *A Healthier Wales* to "shift resources to the community". This is what's known to policymakers as "left shift": the idea that concentrating on care in the community allows for better preventative measures and a healthier population, which leads to better economic output and fewer expensive hospital stays. Good primary care is the bedrock of an efficient health system. It's not that a good health system is not possible without good primary care, but it is more difficult to achieve, and more costly overall.

In Wales, the balance of investment in primary and secondary care is so skewed that it would be laughable were it not so worrying. It appears that actions have not matched the policy rhetoric, and we have prioritised technical efficiency (getting more from the resources invested) over allocative efficiency (allocating resources in such a way as to maximise health). Underinvestment in primary care is, therefore, a systemic problem for the NHS.

Figure 1: NHS Wales expenditure



N.B. The large jump in 2009/10 was because of changes in the Financial Reporting Manual, so 2004/05 - 2008/09 is not directly comparable to 2009/10 onwards

This argument can be extended to funding of other sectors under Welsh Government control. Health is, to a large extent, socially determined. I look at what has happened to the funding of local authorities, and the services that we have lost in the last 20 years as they made savings and focussed on statutory services; I can't help but wonder whether the slow decay in the social fabric that was supported by these lost services has contributed to a more expensive, yet less than optimal, health service.

Inflation has been a hard pill to swallow. The Government wanting to drive unfunded costs up further is even harder to swallow.

The majority of GMS work is done by GP partnerships, working as small businesses providing primary medical care services. In many cases the GPs own their practice premises and finance the capital spend on these premises on a private basis. The profit of the business is the partners' income. Calling these small organisations businesses is quite a stretch. In truth, the terms of the GMS contract are restrictive: practices have very little scope to increase their income through activity and surprisingly little control over their costs.

Rising costs are well-documented and have hit practices hard. The NHS at large also faces inflationary pressures from demographic changes: the Science Evidence Advice *NHS in 10+ Years* published in 2023 notes that Wales has the highest proportion of people

aged 65 and over of all the countries of the UK. It also states that the proportion of those aged 70 or over in Wales will have changed from 16.67% of the population in 2000, to a projected 25% by 2038.

Figure 2: Population aged under 65 and over 65 in mid-2021

	Age 65 and over	Age under 65
Northern Ireland	16%	84%
England	18%	82%
Scotland	20%	80%
Wales	23%	77%

Screenshot taken from: ***NHS in 10+ years. An examination of the the projected impact of Long-Term Condition and Risk Factors in Wales (2023)***

The reality of these population changes, particularly in a system that still needs to do more to shift into prevention, is that the cost of healthcare increases. It's likely that the 67% increase to GMS since 2004/05 is a fairly significant real terms cut, taking this into account.

In addition to the wider economic, and health population-specific inflationary drivers, GP practices have had to contend with something else that is entirely driven by the (Welsh) Government. Since 2020/21 the Government has stipulated the minimum pay rise that had to be given to GP practice staff. Prior to this, practices had discretion on how to allocate their funding across their costs. The unfortunate aspect of this stipulation is that the Government neglected to fund those pay rises adequately. The National Living Wage (NLW) increased significantly from £8.21 per hour in 2019/20 to £10.42 per hour in 2023/24 - an increase of 26.9%, whilst the Government uplifted the contract by 16.2% for staff costs (the remaining 10.7% has been paid by the GP partners). In the 2024/25 contract, NLW increased 9.79% but the Government stipulated a pay rise of a further 6% on top of the 9.79% (which equates to a 16.4% pay rise) whilst only providing funding for a 6% pay rise. This means that the lowest paid workers in primary care have seen a 47.7% increase since 2019/20, whilst practices have only received funding for a 23.2% increase (Fig. 3). I applaud the Government's desire to improve pay, and I agree that my GP practice colleagues deserve to be well paid for doing difficult and demanding work, but I don't think that the way to achieve this is by reducing GP partner pay, because many practices are on the brink of becoming unviable.

Figure 3 - changes to National Living Wage since 2019/20 compared to GMS funding

	What was funded		What it actually cost	
	WG % change in funding for staff costs	**NLW that the WG actually funded** **£/hour**	**Actual NLW paid in GP practices** **£/hour**	**% change in NLW**
2019/20		8.21	8.21	
2020/21	2.8%	8.44	8.72	6.2%
2021/22	3.0%	8.69	8.91	2.2%
2022/23	4.5%	9.08	9.50	6.6%
2023/24	5.0%	9.54	10.42	9.7%
2024/25	6.0%	10.11	12.13*	16.4%
	23.2%	**< Difference between funded and actual cost increase >**		**47.7%**

* (WG stipulated a 6% uplift to the actual NLW of £11.44)

There is a clear case for increasing the funding available to primary care and to the GMS contract. There is also a clear case for increasing GP contractor pay: taking 2019/20 as a starting point - the last year before the Government started stipulating minimum pay-rises for staff, CPI has increased 24.1% from April 2019 to April 2024, Resident Doctor pay is up 31.8% and Consultant pay is up 29.1% (on average) as a result of negotiations between the BMA and the Government. Good for them, although there's still some way to go to achieve pay restoration.

In contrast to our hospital colleagues, GP contractor earnings have decreased in real terms since 2019/20, because of inflationary pressures on costs (some of which are the direct consequence of Government policy as outlined above) and suppressive pressures on income (which, again, are the direct consequence of Government policy because we cannot do much about our income under the terms of GMS). Add in the fact that many of us need to pay off loans that have financed the purchase of our surgery buildings, and the fact that these loans are now much more expensive because of Bank Rate increases (my own loan now costs 23% more than it did 4 years ago, for example) and the real decline in GP pay is even more steep. Another bone of contention in contract negotiations has been the reluctance of Government to recognise the need for inflationary pay awards: their stance has been that these awards come with strings attached to them, whereas all of our colleagues in the NHS are awarded these inflationary awards with no strings attached. The BMA has tried, in vain, to separate the contract uplifts to reflect inflationary awards and performance-related awards, so we have often been left with more work for a real terms cut in income. All of this begs the question: why has the Government decided to significantly increase investment in hospital services, and substantially increase the pay of hospital doctors, whilst cutting (in real terms) the GMS budget, and GP partner pay?

The funding model

A GP partnership's GMS funding comes through the Global Sum - the core element of the contract, for services that all practices must provide, Enhanced Services - optional bolt on contracts with additional pay for additional work, and the Quality Improvement Framework (QIF) - payment for work on trying to improve the quality of care in certain key areas of health. There are also Seniority (being phased out) and Partnership Premium payments designed to encourage Partnership work.

I would argue that the Global Sum payment is not adequate to fund a core service that can attract GPs in a satisfactory Patient:GP ratio. Because of this, practices are very dependent on the Enhanced Service, QIF and Seniority/Partnership premium income, but many of these have been largely static in *cash* terms for many years, let alone real terms.

Over the horizon

Looking forward to 2025/26, I see the changes proposed to Employer's National Insurance Contributions (NICs) looming. Here, I steal Dr Helen Salisbury's excellent analogy of us as Schrödinger's GPs: the Westminster Government has decided that GPs are both public sector and private sector, only it's always when it suits them and not us, so as private businesses we have to shoulder the cost of the rise in NICs (whereas hospital budgets will be protected against these). However, a scheme like the Employment Allowance - which allows small employers relief against the cost of employer NICs - is not available to GP practices because we work in the public sector. To my small rural practice, the change in Employer's NICs, alone, will be a five-figure sum - again borne entirely by the partners.

Another example: GP contractors have access to the NHS pension scheme just like hospital doctors. However, GP contractors are liable for both the employee and employer contributions to the pension which means that a GP and a hospital doctor earning the same income will accrue the same pension, but the GP will have paid more than double the pension contributions that the hospital doctor paid. This is part and parcel of being an independent contractor, but is only really acceptable when the contract strikes a balance of mutual benefit. Right now, as was clearly shown by the results of the BMA referendum (where 99% of those who voted rejected the contract that had been offered), the GMS contract is nowhere near what it needs to be for GPs.

I don't want to be writing this. I don't even want to be having to think much about the GMS contract. I want the contract to facilitate me to do my work as a GP for the benefit of my patients, whilst giving me fair remuneration. A good GMS contract would allow me to do this without having to give much thought to it. We do not currently have a good GMS

contract, and 99% of the GPs that voted agree with me so mine is not an outlier opinion. Many GPs are demoralised: we are working extremely hard to run a service in what has been a very challenging economic and clinical environment for many years, and the game feels rigged against us. The Government ought to listen. After all, we don't actually have to contract to GMS: for the first time in my career, I am hearing GPs talk about entering private practice, in a way similar to what Dentists have already done because of the deficiencies of their General Dental Services contract. I think this would be disastrous for the NHS and for public health, and it's certainly not what I - someone who firmly believes in the principles of the NHS - would want to see, but I can understand why it's being discussed. The Government needs to act now, and it ought to be under no illusion that GPs are happy (we are not) or that we will put up with the current situation for much longer.