Practice Funding – a brief overview

A workload formula, the Scottish Workload Formula (SWF), applies to an agreed pot of existing funding streams – approx. £600 million in 2018/19. This covers approximately 85% of GP funding.

Divided up by practice patient list size with weightings for deprivation and old age. List size varies from a few hundred to 43,000. The list is based on geographical practice boundaries which can overlap with each other. Everybody in Scotland should be on a practice list.

The remaining elements of general practice funding are:

- Enhanced Services – additional payment for nationally specified services like vaccinations and the Extended Hours scheme;
- Premises – reimbursement of practice premises expenses based on an estimation of the rental value of the property;
- Seniority Payments – intended to be part of the pay of individual GPs to reflect experience
- Practice Income Guarantee – (£23 million) to ensure no practice lost out under the new formula.

Covered by the statement of financial entitlements https://www.sehd.scot.nhs.uk/pca/PCA2018sfe.pdf and regulations http://www.legislation.gov.uk/ssi/2018/66/contents/made .

Research on practice costs and funding:

https://www.gov.scot/binaries/content/documents/govscot/publications/advice-and-guidance/2017/11/2018-gms-contract-scotland/documents/00527540-pdf/00527540-pdf/govscot%3Adocument/00527540.pdf

https://www.gov.scot/binaries/content/documents/govscot/publications/advice-and-guidance/2017/11/2018-gms-contract-scotland/documents/00527542-pdf/00527542-pdf/govscot%3Adocument/00527542.pdf

https://www.gov.scot/binaries/content/documents/govscot/publications/advice-and-guidance/2017/11/2018-gms-contract-scotland/documents/00527541-pdf/00527541-pdf/govscot%3Adocument/00527541.pdf

A discussion of this research and the development of the Scottish Workload Formula can be found in the background paper.

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Background - Development of the Scottish Workload Formula

Practice funding under the previous Scottish Allocation Formula (SAF)

Prior to the 2018 GP contract, money was allocated to GP practices by way of the Scottish Allocation Formula. Under the SAF the single largest element of practice funding was the Global Sum which accounted for 64% of total practice payments. The SAF allocated, or divided up, the Global Sum to practices on the basis of their patient list size. The allocation was weighted for factors that increase GP workload as measured by consultation rates – including the age/sex profile of patients and deprivation. It was also weighted to compensate for the presumed additional cost of delivering general practice in rural areas.

The remaining elements of general practice funding were:

- Enhanced Services – additional payment for nationally specified services like vaccinations and the Extended Hours scheme;
- Premises – reimbursement of practice premises expenses based on an estimation of the rental value of the property;
- Seniority Payments – intended to be part of the pay of individual GPs to reflect experience
- Correction Factor payments – payments related to the 2004 agreed Minimum Practice Income Guarantee (MPIG).
- Quality Outcome Framework (QoF) payments which represented circa 20% of total general practice funding in 2014/15 – the final year of the operation of QoF in Scotland. The negotiated agreement in 2014/15 was for QoF payments to remain part of the total payments to general practices – renamed as Core Standard Payments. Practices received the average of their three years QoF payments up to the point of its abolition in 2014/15.

The SAF had two dimensions: a workload dimension and a unit cost dimension. Across these two dimensions, there were four elements that determined the share of the Global Sum an individual practice received:

- An age-sex adjustment;
- A deprivation adjustment;
- A market forces factor (MFF); and
- A rurality adjustment.

The size of the practice list, the age-sex composition of the practice population and the relative deprivation of patients' neighbourhoods were the key factors in determining the estimated workload of a practice. The rurality factor and MFF adjusted for variation in the costs of provision (i.e. expenses).

The different demographic and socio-economic characteristics of practice populations tended to influence the funding in different directions. The age-sex adjustment gave a larger weight to practices with an older population as older patients have higher consultation rates. Given higher life expectancy in less deprived areas, this adjustment moved funding to more affluent areas. The deprivation

adjustment worked in the opposite direction, whereas the rurality adjustment, on average, favours less deprived areas.

The overall result of the interaction of these different formula adjustments was a relatively flat per patient funding profile relative to population morbidity and mortality profiles and a mismatch between the funding profile and the consultation rate profile. This pattern is found in other countries, and referred to as the “Inverse Care Law” in academic literature on general practice funding.

There were many historical anomalies of practice funding related to the 2004 GP contract and to earlier national agreements. The Minimum Practice Income Guarantee (MPIG) – which guaranteed individual practices would have the same funding after the introduction of the 2004 contract as before – effectively solidified many historic funding streams at the practice level.

There were other historical funding anomalies, in addition to MPIG. Decisions in previous years, for instance, to maintain a floor of Enhanced Service income under which practices could not fall; and payment of “Paragraph 40” monies (again related to maintenance of income streams when related activity no longer existed) meant that while globally, the SAF broadly allocated the bulk of funding according to both need and presumed cost, locally there could be wide variation.

It was therefore possible, for example, to have two neighbouring practices, serving similar sized populations of similar demographics but with widely different total practice funding. This effectively meant that GPs providing similar care to similar populations over a similar time frame could be paid very different amounts. The perpetuation of these historically based funding differences, therefore, resulted in unfair and arbitrary differences in GP pay.

In light of the above the Scottish Government commissioned Deloitte to undertake a review of the SAF and to carry out statistical analysis to update and improve, where possible, the components of the formula.

Summary of 2016 & 2017 Deloitte Reviews of Scottish Allocation Formula and Review of GP Earnings and Expenses in Scotland (the data underlying the SWF)

The SAF had two broad dimensions: one capturing variation in the relative need/workload for primary care services across different populations; the second capturing variation in the unit cost of providing services across different geographies.

The Deloitte commission was therefore specified as two separate research projects: one analysing the relative need/workload aspect of the formula, the other analysing the unit cost aspect of the formula. The key findings are outlined below.

Review of Scottish Allocation Formula (2016): Summary of Findings

The need/workload research.

The two main determinants of relative need for health care services, or the relative workload facing primary care, are the age and gender profile of the practice population and the morbidity and socio-economic circumstances in the areas where the practice population live. The Deloitte analysis confirmed the continuing importance of these factors using updated data and improved statistical techniques. For example, they estimated that patients aged 75 years or older have up to three times higher need compared to patients aged 10 or younger; and patients in the most deprived areas, with high levels of long-term sick and unemployed and limiting long-term illness, have up to 25% higher need for health care.

The main improvements recommended by the research were:

- the inclusion of patients who had not visited a GP (zero consultation patients) in the calculation of relative need;
- the estimation of age-sex and morbidity effects together, rather than calculating the age-sex effect independently; and,
- the updating of the data and use of new indicators for the morbidity and life circumstances adjustment.

The unit cost research.

The 2016 Deloitte research into the variation in the unit cost of providing primary care services across different geographies made some substantial criticisms of the SAF rurality adjustment. In particular that:

- it was applied to the income element of the allocation as well as to the true underlying costs of providing the service;
- it did not adequately take account of variation in practice list size in rural areas, where there can be large practices achieving economies of scale;
- there appeared to have been weaknesses in the method used to select and estimate the indicators of rurality.

Ultimately, however, lack of practice-level costs data stopped Deloitte from developing an alternative formula unit cost adjustment. The need to have more detailed data on practice-level costs was a major motivation for the commissioning of follow-up research from Deloitte in 2017.

Review of GP Earnings and Expenses in Scotland (2017): Summary of Findings

In 2017 Deloitte was commissioned to undertake a survey of practice earnings and expenses to provide a more informed understanding of the variation in GP income and in the costs of providing primary care services across different geographies.

The commission also instructed Deloitte to engage with sector experts to explore alternative options for remuneration and funding of primary care services.

To generate the data for the review Deloitte sent a request to 600 practices asking for information on levels of staffing and pay and for the practice accounts which provide details of the structure of practice costs. Of the 600 practices contacted, 109

provided the information requested. The key findings for costs and income are set out below.

Key Findings - Costs

Analysis of the sample data suggested that staff costs are the largest component (c.70%) of general practice costs (excluding GP partner salaries). The second largest component is premises costs (16%).

There is considerable variation in total costs between practices. Average costs per patient ranged from £49 (bottom decile) to £109 per year (top decile).

Distribution of general practice costs

	Mean	P10	P25	P50 (median)	P75	P90
Cost (excluding dispensing) per patient	£76.5	£48.9	£55.7	£66.8	£82.2	£109

Once patient case-mix (including deprivation) and location is controlled for, no difference in costs per patient located in areas with different levels of deprivation is identified. Smaller practices tend to exhibit higher costs (both total and staff costs) per patient than larger practices. Even after controlling for scale, remote practices had significantly higher costs per patient on average, however, there was found to be a very large range of costs per patient for remote practices.

Key Findings – Income

Average net income per WTE (whole time equivalent) partner GP is £99,000. However, there is considerable variability in net income, typically ranging between £63,000 (bottom decile) and £128,000 (top decile). In particular remote practices or practices with high numbers of partners tend to have lower net incomes.

There is some evidence that there are higher paid GPs working in urban areas compared with remote areas as the mean income is around 11% higher in urban areas, although median incomes are similar in both areas.

Conclusions on the 2016 and 2017 reviews

The Deloitte research developed an improved version of the workload dimension of the SAF formula. The implementation of that enhanced workload formula (as the SWF) would better recognise and fund the higher workloads in areas of high deprivation or morbidity.

The research also demonstrated that there is considerable unexplained variation in partner income between practices and that there are higher costs in remote practices, although these costs vary substantially between practices in remote areas for reasons that have not been identified.

Background to the negotiations for the new GP contract 2018

The 2018 contract was negotiated against a backdrop of general practice facing unprecedented challenges: increased workload; increased risk relating to staff and premises; and recruitment and retention.

To meet these challenges it was recognised that the future of general practice could not be delivered through the GMS contract alone. There was an imperative to transform how primary care services are configured and delivered including significant investment in primary care workforce and infrastructure. It was critical that the contract was modernised to reflect and address the aforementioned challenges, alongside improving patient access to general practice and making becoming a GP a more attractive career option for medical students.

There was also a recognition that in transforming the role of the GP to be the 'expert medical generalist' in the community - focussing on complex care; undifferentiated illness; and outcomes, quality and leadership - we needed to make the best use of GP skills - managing uncertainty, holistic person-centred care and clinical leadership of an expanded team. To do this non-expert medical generalist workload needed to be redistributed to the wider primary care multi-disciplinary team, ensuring that patients have the benefit of the range of expert advice needed for high quality care.

The 2018 GMS contract offer was designed to meet these challenges, deliver a multi-disciplinary team to support the GP as expert medical generalist and deliver a strong and thriving general practice, sustaining high quality universal healthcare and realising Scotland’s ambition to improve our population’s health and reduce health inequalities.

The new GP contract 2018 - Phase 1 – the methodology of the SWF

Phase 1 involves the application of a new workload formula, the SWF, to an agreed pot of existing GMS funding streams. The workload formula recommended by the Deloitte 2016 review is the most up-to-date and appropriate formula. After negotiation, the BMA agreed that this workload formula should be used.

Previous GMS funding streams were also included in the new pot to be allocated by the SWF (the formula now covers over 85% of total GP funding):

- the previous Global Sum;
- Core Standard Payments; and
- Correction Factor (MPIG).

As with all changes to funding, any change could negatively affect practice funding if carried out with no additional investment. The necessary investment in this case

amounted to £23m recurring, from 2018/19. This additional investment is to improve services for patients in areas where workload is highest.

The new formula (SWF) is a methodological improvement to the previous SAF. It is based on the best available evidence (the Deloitte reviews) and as such it more accurately reflects the workload of GPs. Compared to the workload-related weightings of the original SAF, the SWF gives greater weight to older patients and deprivation.

The analysis to develop the SWF used data from the Practice Team Information (PTI) Dataset. This data set holds data provided by a sample of almost 6% of Scottish Practices covering 363,000 patients. The Deloitte team analysed the data to ensure that it was representative, in particular, with respect to age, gender, deprivation and the urban rural mix. They concluded “overall, the population appears to be well represented by the sample.”

The impact of deprivation on the workload of a practice is better reflected in the SWF than the previous SAF. Methodological improvements mean both deprivation in urban areas and isolated pockets of rural deprivation are now better addressed.