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EDITORIALS

Shortage of general practitioners in the NHS

GPs are a scarce resource that must be deployed more wisely

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Ensuring sufficient primary care doctors is a key challenge for health planners globally because of the important role that primary care plays in supporting cost effective health systems that promote equity in health outcomes. For example, the US is predicted to need 7800 to 32 000 additional primary care physicians by 2025.[1] We know that the UK's NHS is also short of general practitioners,[2] but we do not know the size of the shortage or how many additional general practitioners it needs to provide comprehensive primary care services.

In its plan for general practice published in 2016, NHS England set a target of 5000 additional general practitioners by 2020.[3] However, no data were presented to show that this would be enough to meet the country's needs. An analysis from Imperial College suggests that NHS England has substantially underestimated the current shortage of general practitioners and the numbers required to plug the gap.[4] It estimates that in 2016, the NHS in England was already around 6500 general practitioners below the ideal number, rising to 12 100 short by 2020.[4] Given that recruitment to general practice training schemes in England remains below target, shortages of general practitioners will inevitably continue into the foreseeable future.

Workforce planning is hindered by the lack of accurate and timely data on workload in primary care and the lack of accurate information on the number of general practitioners working in the NHS.[5] The NHS does not routinely collect or publish information on the workload of general practices (in contrast to hospital activity, where workload statistics are published regularly). Information on the number of general practitioners working in the NHS is also limited. Improving these data would be a useful start. But more radical solutions are also required.

One important step to aid recruitment would be to link primary care funding to workload through the implementation of workload based funding for general practices. Since the NHS was established in 1948, core funding of general practice has been capitation based.[6] However, this model increasingly looks unfit for the 21th century. With activity based funding, general practices would be paid for the work that they do, and practices would take on new work only if the funding met the full costs of providing the service.

Activity based funding would be considerably more costly to the NHS than the current method of funding. The government would therefore have to decide whether to fund NHS general practice entirely from taxation; part fund it from taxation and allow general practices to charge patients to make up the difference; or scale back the services that general practices offer to fit in with the public funding that was available.[7] All these options are problematic but as the current situation is not sustainable, a decision is urgently needed.

The NHS should also examine the extent to which work done by general practitioners could be carried out by other professionals such as nurses, physician assistants, healthcare assistants, pharmacists, and physiotherapists. For example, programmes that allow patients to see physiotherapists directly without requiring a referral from a general practitioner can help reduce demands on general practices and provide an alternative, cost effective care pathway for patients with musculoskeletal problems.[8] More NHS services should be accessible by patients without a referral from a general practitioner—for example, exercise and weight reduction programmes, antenatal services, podiatry, termination of pregnancy services, and services for drugs and alcohol misuse.[9]

An increasing administrative burden on physicians is a global phenomenon,[10] a barrier to primary care recruitment in the UK and elsewhere, and a brake on efficiency. Reducing it should be a government priority, starting with a detailed review of all non-clinical tasks done by general practitioners with the aim of removing as many as possible to free up more time for clinical work.

The NHS must also do more to encourage doctors to return to clinical practice after career breaks for family or other commitments. We cannot afford to waste the skills and commitment of this important group, or write off the public investment in their training. Key barriers to return to work include the high indemnity payments that doctors now must pay, which can be unaffordable for doctors working part time or considering out-of-hours work, and the inadequate child care support offered to doctors with families.

Since the current shortage is set to continue, general practitioners should be treated by the NHS as a scare resource and must be deployed in a manner that makes full use of their skills and training. In parallel, measures must be taken to remove barriers to recruitment and retention while we put the systems in place

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to measure, track, and ultimately fix this threat to the sustainability of the health service.

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