A profile of PMS salaried GP contracts and their impact on recruitment

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Background. Personal medical services (PMS) pilot sites aim to use salaried GP schemes to improve GP recruitment and retention and enhance the quality of service provision, particularly in underserved areas.

Objectives. Our objectives were to (i) compare the work incentives of salaried compared with standard GP contracts; (ii) assess recruitment success to salaried posts; and (iii) describe the types of GPs attracted to these new posts.

Method. All first wave PMS pilot sites with salaried GP posts known to be ‘live’ in October 1998 were included in the analysis of employment contracts and job descriptions. Information on recruitment was obtained by a questionnaire survey of PMS sites that were intending to recruit a salaried GP.

Results. The mean full-time equivalent salary was £43 674 with additional benefits in terms of sick leave, maternity leave and paid expenses. Eighty-nine percent of posts were eligible for the NHS pension scheme. Posts were mainly full time (40.8 hours per week). GPs were responsible for providing services equivalent in scope to general medical services. One-fifth of contracts freed GPs from out-of-hours responsibility and most freed them from practice management. Forty-three of the pilot sites actively recruited to fill 63 salaried posts, which involved a total of 51 recruitment ‘rounds’, with some pilots advertising more than once. There were 291 applications. The median number of applicants per post was three and the median time to recruitment was 6 weeks. Eighty-five percent of sites were satisfied with the quality of their applicants and 64% with the quantity. Eighty-five percent of applicants previously had been working in general practice, most in locum or salaried posts. Applicants tended to be young and male. Sixty posts were filled.

Conclusions. Salaried contracts offer positive incentives to recruitment in terms of reduced hours of work and freedom from administrative responsibility. Recruitment success was similar to that achieved by inner city practices generally. This modest achievement might be enhanced by the addition of professional development schemes and increased flexible/part-time working.

Keywords. Contracts of employment, personal medical services, recruitment, salaried doctors.

Introduction

The majority of GPs in Britain are ‘independent contractors’ who agree to supply general medical services to the National Health Service (NHS) under an agreed national contract. Remuneration is based mainly on capitation supplemented by allowances, fee-for-service and target payments. The NHS (Primary Care) Act\textsuperscript{1} of 1997 introduced a new voluntary scheme, which freed general practice from the constraints of these standard contractual arrangements. Instead, local health service provider organizations (namely general practices and community NHS trusts) were able to propose local service contracts, designed to meet the needs of local populations. GPs could be employed on a salaried basis to provide ‘personal medical services’ (PMS) alongside other services needed in the locality.
From 567 initial expressions of interest, 123 proposals were developed and 87 PMS pilots went ‘live’ in the first wave.\(^2\) Salaried GP schemes formed part of the strategic plan of many of these PMS pilots. As of 25 May 1999, there were 46 salaried sites (54%), although the situation has continued to fluctuate, with salaried sites and posts being added or dropped. The aim of many of the pilots was to use salaried GP schemes to improve GP recruitment and retention, and to enhance the quality of service provision in under-served areas by targeting activities.\(^2\)

From the recruitment and retention perspective, many of the disincentives to working in under-served areas are unlikely to be affected by the salaried option. Deprivation is among the most important factors deterring GPs from practising in a community,\(^3,4\) and it is difficult to see how a salaried contract might free GPs from the obligation to care for needy families or resolve problems with poor community amenities. Other deterrents to practice might, however, be ameliorated. For example, many GPs have expressed a desire for more flexible working hours and freedom from administrative responsibilities.\(^5\) Increased remuneration might prove an additional attraction. Whether salaried contracts are able to effect a more favourable balance between such modifiable and un-modifiable disincentives will be a key factor in determining their success. As GPs may vary in the importance they attach to various (dis)incentives, it will be important additionally to estimate the potential size of the constituency for such schemes within the workforce.

Our aim was to evaluate the impact on GP recruitment of salaried schemes within PMS pilots, as part of a wider study within the Department of Health’s national evaluation. Here we (i) compare the work incentives of salaried compared with standard GP contracts; (ii) assess recruitment success to salaried posts; and (iii) describe the types of GPs attracted to these new posts.

**Methods**

**Salaried GP contracts and job descriptions**

Contracts of employment and job descriptions were requested from each of the 46 PMS salaried GP sites identified as having gone ‘live’. Contracts were allocated to pairs of reviewers and a purpose designed data extraction form completed independently by each reviewer. The following information was extracted from these documents: salary and details of other payments; type of employer; management and out-of-hours responsibilities; performance appraisal and training arrangements; contract length; employment benefits; hours of working; and whether patient subgroups or clinical services were to be targeted. Areas of disagreement were resolved, if necessary, by referral to a third reviewer, and the final data were coded and entered into SPSS for analysis.

**Recruitment**

Information on recruitment was collected by means of two postal questionnaires dispatched in October 1998 to all 46 PMS sites that were intending to recruit a salaried GP. The first questionnaire collected data for each salaried post and requested: the number of applicants; the number short-listed and interviewed; the time taken to recruit; where advertised; and satisfaction with the quality and quantity of applicants. The second questionnaire was completed for each applicant and requested information on age, gender, medical training and employment history. This information was anonymized. Non-responders were followed-up by letter after 4 weeks and subsequently by telephone. Data were coded and analysed using SPSS.

**Results**

**Salaried GP contracts and job descriptions**

Forty-six employment contracts were received from 41 of the 46 PMS sites with a salaried GP post. Thirty-one job descriptions were received from 31 of these sites. Reasons for non-compliance were: that the documents had not yet been drafted (one contract and 10 job descriptions); they were not made available to the researchers (four contracts and four job descriptions); or the site was not in the process of recruiting (one job description).

In 22 (48%) of the contracts, the stated employer was a trust and in 13 (28%) a GP practice. In the remaining three (7%) which stated the employer, these were described as a nurse, a limited company and a multi-agency pilot. Seventeen contracts were for between 2 and 3 years duration.

Table 1 summarizes the main characteristics of contracts and job descriptions. Salary levels were generally below target GP remuneration of £52 600 for 1999. The mean full-time equivalent salary was £43 674, based on the 27 contracts which provided this information. Additionally, in six contracts, the salary was based explicitly on the NHS consultant scale and, in a further three contracts, the post was described as ‘consultant’ without explicit reference to a salary scale. Nine contracts were based on Whitley Council scales but did not state the spinal point. Of the two remaining contracts, one stated that the salary was comparable with that of health authority staff and the other set the salary at the level of a ‘senior hospital appointment’. Few contracts offered financial rewards or bonuses \((n = 5)\), or specified financial penalties \((n = 2)\).

Salaried contracts generally offered good employment benefits. Employers tended to assume responsibility for expenses such as vehicle mileage and out-of-hours cover. Many offered maternity and paid sickness leave. Forty-two contracts specified annual leave, which ranged from 25 to 41 days. Thirty contracts specified leave for
education, training and personal development, which ranged from 2 to 10 days. Only four arranged mentorship for personal training and development. The majority of contracts stated that the post was eligible for the NHS pension scheme.

In nine job descriptions, salaried GPs were responsible for providing PMS equivalent to the full range of general medical services (GMS), and in 10 they were responsible for providing additional services (referred to as PMS plus). Five job descriptions specified clinical services to be targeted, and seven mentioned particular patient groups to be targeted. Most contracts offered full-time posts, with only seven offering part-time work. The mean hours contracted per week was 40.8 (where time commitment was stated in sessions per week, we assumed 3.5 hours per session). Eight contracts freed GPs from out-of-hours responsibility. Staff management was the most common administrative responsibility specified in job descriptions, and this was required in only five sites.

**Recruitment**

Forty-three (93%) of the 45 PMS sites actively recruiting a salaried GP returned completed questionnaires. There were 51 recruitment ‘rounds’ (i.e. employer declared attempts at recruitment) for 63 posts across these 43 sites, with some sites advertising more than once. A total of 291 applications were received. Table 2 shows that the median number of applicants per post was 2.8 and the median number interviewed per post was 2.0. Eighty-five percent of sites were satisfied with the quality of applicants and 64% were satisfied with the quantity of applicants. The median time to recruitment was 6 weeks, and 60 posts were filled. London posts differed from others in having a higher number of applicants per post (median five in London versus two elsewhere; Mann–Whitney U = 122, P < 0.01). No other geographical differences were found.

Table 3 provides information on the characteristics of GPs who applied for salaried posts. The majority were...
male (66%). The median age was 38 years, with male applicants being significantly older than females. Information on the employment background of each applicant indicated that the majority (85%) had previously been working in general practice. Of these, most were either GP registrars (26%) or locums (31%). Only 14% had moved from a GP principal post. London posts differed from others in having older applicants (median 41 years versus 35 years elsewhere; Mann–Whitney U = 1124, \( P < 0.05 \)). No other geographical differences were found.

Only three posts were unfilled. We could find nothing distinctive about these in terms of contracts of employment or job descriptions.

Discussion

We set out to evaluate the ability of PMS salaried GP schemes to solve problems with GP recruitment, particularly in underserved areas. Our conclusions are tentative as the early experience of first wave pilots may change with time. The employment contracts and job descriptions, on which much of our analysis was based, provide only limited insight into the employment experience of salaried GPs. An added difficulty is the absence of appropriately matched sites for comparison with salaried PMS pilots. Here we have used national statistics for comparison.

Compared with standard GP contracts, salaried PMS contracts tend to offer lower pay but more employment benefits (e.g. sickness leave, maternity leave, travel and other expenses, etc.). The monetary value of these benefits to some GPs might more than offset the lower pay. An added potential advantage is that pay is stable and does not fluctuate with practice profits. For locums, the relative security of tenure (usually 3 years) and eligibility for an NHS pension might be additional benefits. For GPs wishing to avoid long-term commitment to a partnership, the fixed duration of tenure may have proved attractive. Whether PMS salaried contracts prove financially more attractive than other GP contracts will, therefore, depend on the circumstances of the individual and his/her attitude to risk. Given that PMS sites were mostly located in deprived areas, where it can be difficult to earn a high income, salaried contracts might be preferred.\(^6\)

The main incentives offered by salaried PMS contracts were reduced hours, and freedom from out-of-hours and administrative responsibilities. As out-of-hours work and practice administration appeal to a diminishing proportion of the GP workforce,\(^3\) these job characteristics will enhance the attraction of salaried posts. Other non-financial incentives desired by GPs are opportunities for professional development through sabbaticals, linked academic posts and structured personal development initiatives.\(^7\)\(^8\) Little use was made of such incentives by first wave PMS sites. Given the marked trend towards part-time working in the GP workforce generally,\(^9\) it was also surprising to find that the majority of salaried PMS contracts were full time.

The impact of these (dis)incentives on recruitment to salaried posts appeared modest. Time to recruitment was shorter than the national average for GP principal posts,\(^10\) possibly because sites had identified suitable candidates prior to advertisement. Employer satisfaction with the quality and quantity of applicants was comparable. The number of applications per vacancy was lower than the national average and slightly below that for practices in urban deprived areas.\(^10\) However, given that PMS sites are concentrated in deprived areas, it seems likely that recruitment to PMS salaried posts may not be worse than that in inner city sites generally. The response to salaried GP contracts was geographically differentiated, with significantly more applications per post in London. The reasons for this finding are uncertain, but it reinforces the suggestion that London is unusual in terms of GP recruitment and retention.\(^11\)

The constituency for salaried PMS posts appears broad. Approximately 1 in 6 were recruited from previous employment in medicine, other than general practice, and therefore constitute a real gain to the GP workforce. One in four were recruited from GP registrar posts, supporting other research, which suggests that many newly qualified GPs now prefer to delay entry into principal posts.\(^12\) The largest group, however, was drawn from GPs in other types of posts, particularly locums. Whether such moves effectively increase workforce size is unclear. However, it could be said that salaried posts offer better opportunities than locums for effectively managing GPs’ contribution to primary care provision. Only 1 in 6 GPs transferred from principal posts—a move which could be regarded as neutral with respect to workforce size.

While salaried GPs were drawn from all age groups and both sexes, the majority tended to be young and male. The appeal to younger doctors might be expected as more recent generations of GPs have expressed a growing disillusionment with principal status and a desire to be free of practice administration.\(^5\) The preponderance of males was unexpected, given the rising proportions of women in the GP workforce and the excess of women in locum and other salaried posts.\(^13\) It may be that women are less willing than men to experiment with such innovative posts and that this gender imbalance will change with time.

Overall, these findings suggest that salaried PMS posts have the potential to ameliorate problems with GP recruitment in underserved areas. Reduced hours and freedom from practice administration and out-of-hours work are key incentives. The benefits in terms of improved recruitment are, at present, modest, but might be enhanced by the addition of professional development schemes and flexible/part-time working.
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References