MPIG

(minimum practice income guarantee)

Dr Peter Holden

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Executive Lead for Practice Finance, Rural Affairs and Emergency Preparedness

General Practitioners Committee

British Medical Association

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Dr Peter Holden

- GPC UK Executive Lead with special responsibility for
  - Urgent, Unscheduled and Emergency care
  - Emergency Preparedness
  - Finance, VAT,
  - Technical Steering Committee Lead
  - New Contract Infrastructure
  - **Rural practice** and community hospitals
  - Practice premises
  - Dispensing , P.A., Stock order
  - “Special services”
- **STILL a WORKING GP 6 sessions per week + OOH shifts!**
- **The only person left from either side which negotiated the new 2004 GP contract**

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Dr Peter Holden declarations of interest

- GPC UK negotiating team and Executive Lead – 15 years
- GPC UK – 32 years
- BMA Council , voting member and Director 22 years
- Emergency Preparedness Lead, British Medical Association
- Member, Emergency Preparedness Resilience & Response CRG DH UK
- Lead member, Technical Steering Committee, NHSIC/DDRB
- External Advisor, The Health Service Ombudsman
- Examiner, Royal College of Surgeons of Edinburgh
- Chairman BASICS Education Ltd – The British Association for Immediate Care
- Medical Aircrew Lincs. & Notts. Air Ambulance
- HEMS Physician MAGPAS Helimedix East Anglian Pre-Hospital Critical Care & Retrieval Team
- Regional Major Incident Advisor, East Midlands Ambulance Service NHS Trust
- Senior partner Dr PJP Holden & Partners, Matlock

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Background 1- General

- MPIG is part of the 2004 GP contract deal
- Need to understand practice finance
- GP practices are independent contractors
  - **But GP practices are not like any other small business**
    - Micromanaged by many bodies in a way no other small business would tolerate
    - Cannot adjust their offering
    - Cannot adjust their pricing
    - Cannot decline service to those who are a financial loss-makers for the practice
    - Extremely tightly priced contracts – NHS expenses calculated to within £50 pa
    - Financially a hand to mouth existence. Late payment = bank loan guaranteed by GP
    - 95%+ of their business is for the NHS –consequently totally dependent upon it
    - Cannot outsource. They have to locate where their patients live
- GPs pay for their premises staff and overheads only a proportion of which are reimbursed directly by the NHS
- GPs are personally liable for the debts of the practice and the acts errors and omissions of their staff

Background 2 - pre 2004

- GP net pay RATE recommended by DDRB
- Gross turnover(IAGR) minus NHS expenses = GP pay (IANI)
- AVERAGE NHS Expenses determined by
  - Analysis of 100% sample of Inland Revenue returns
  - NHSIC Technical Steering Committee report to DDRB
- Computer calculation such that
  - Theoretical average practice undertaking theoretical average spread of work with average expenses receives IANI clear of expenses
  - **Hence individual item pricing does not bear relationship to actuality as the price is designed on a weighted average activity basis to deliver IAGR**

IAGR = Intended average Gross remuneration. IANR = Intended average NETT remuneration
DDRB= Doctors & Dentists Pay Review Body (set up after the Royal Commission)

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Origins of MPIG 1 in 2004

- 2004 contract was a 14 year CORRECTIVE pay deal
  - 14 years of pay standstill and constant DDRB interference by governments of the day
  - Recruitment had collapsed (as now)
  - Many practice partnership vacancies (as Now)
  - It was bound to be large settlement!
  - Change to capitation based Global Sum to run essential services
- Gershon Principles in force and influenced the negotiations
  - Same bangs fewer bucks, More Bangs same bucks
- Pre 2004 "John Wayne contract"
  - A *"GP's gotta do what a GP's gotta do"*
  - Financially exploitative of the profession with workload shift from hospitals to GP
  - GPs *"- provide the type of services usually provided by GPs…"*
- Government insisted that all new money went into new work into QoF **<u>which over-delivered as the GPC said it would at the time</u>**

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Origins of MPIG 2

- Carr Hill funding formula for Global sum (GS) based on
  - Age & Gender (Nursing Homes also)
  - Market Forces Formula
  - Rurality (aka distance to practice)
  - Diseconomies of Scale REMOVED BY BLAIR **hence the need for MPIG!**
  - Too late in the day to recalculate
- Monies from old contract mapped across to Global Sum
- **GLOBAL SUM IS TO FUND ESSENTIAL SERVICES ONLY**
- **Negotiating team DELIBERATELY sought not to find out the GS impacts upon their own practices prior to announcement**
- Black Wednesday 13 March 2003

Black Wednesday 13/03/2003

- Practices faced genuine bankruptcy
- GS too low because NO NEW MONEY IN IT!
- Global Sums delivered 25% cuts in some instances
- Concept of Correction Factor which varied over time to deliver MPIG
- Correction factor funded by raiding the £250m recurrent premises budget because government refused to allocate the agreed new money to it
- (Next time bomb is the premises issue. If leftward shift of care is to occur then premises in general practice are needed to deliver it!)
- MPIG should erode over time as value of GS rose (tide and boats in harbour analogy)
- **But Global Sum has never risen since 2004!**
- **Hence continuing need for MPIG**

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MPIG post 2004

- All political parties want to get rid of MPIG
- Sum is trivial within the NHS £116million or <2% of GP budget
  - **(cf. £500 million locum cost for A&E!)**
- IMPACT IS HUGE on affected practices
- **2014 GP contract workload is being delivered at 2004 prices with GP partners bearing PERSONALLY the costs of expenses inflation from their own pay which has fallen roughly 25% Most partners now earn less per hour than their salaried assistants!**
    - Currently average circa £92,000 pa for 52.5 hours contracted 60 hours actual
    - (on a like for like basis circa £55,000pa based upon a 40 hour week)
- For a long time rural practice has been subsidised by dispensing
- NOT ALL RURAL PRACTICES DISPENSE
- PwC report indicates dispensing no longer profitable
- Media consistently **and knowingly mislead** the public regarding GP earnings by not allowing for a 40% longer working week BEFORE Out of Hours work(40% of GPs partake) nor differentiating
  - Gross Turnover from
  - Nett Profit from
  - Take home pay
- **GP RECRUITMENT HAS COLLAPSED. 28% of GPs are over 58, 40% over 50 years of age**
- **GPs take 12 years to train.**

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