

**Royal College of General Practitioners**

**Changing Partnerships**

Discussion Paper  
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**March 2009**

The Royal College of General Practitioners was founded in 1952 with this object:

*'To encourage, foster and maintain the highest possible standards in general practice and for that purpose to take or join with others in taking steps consistent with the charitable nature of that object which may assist towards the same.'*

Among its responsibilities under its Royal Charter the College is entitled to:

*'Diffuse information on all matters affecting general practice and issue such publications as may assist the object of the College.'*

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## INTRODUCTION

It is reported that there are now over a hundred applications for each advertised partnership<sup>1</sup> and in 2008 it is unusual to see a partnership being advertised at all; the vast majority of new positions are for salaried options only.

Is this lack of partnerships just a passing stage in a cycle of general practitioner (GP) workforce or a continuing, inexorable process that began with the 1990 reforms and accelerated with the new General Medical Services (GMS) contract? Will the change in configuration of general practice risk losing the entrepreneurial spirit of GPs and lead to the end of professional autonomy? Or will the current changes bring new opportunities for doctors, patients and the health service? Will the general practice of the future be run by a small number of corporate GPs and/or private sector organisations? And will it employ a much larger workforce of doctors, nurses and other health professionals within tightly controlled structures – analogous to the Health Maintenance Organisations found in the United States?

If the future entails smaller and slimmer partnerships containing more salaried positions, does it matter? For decades the profession has been fighting for greater flexibility in its working practices, which some argue is addressed by the salaried option. There is also a view, growing in support, that the profession should move away from the small-business ‘partnership’ model and instead work within larger primary care organisations and networks.

This paper will attempt to explore what partnership is, the forces that are driving the loss of partnerships in general practice and some of the issues that this may herald for our profession. Finally, it will end with some recommendations as to what we, the Royal College of General Practitioners (RCGP), should be doing to address this new and rapidly growing salaried workforce of GPs.

## ROYAL COLLEGE OF GENERAL PRACTITIONERS AND THE INDEPENDENT CONTRACTOR STATUS

In 2000, the RCGP published a discussion paper *Is There a Future for Independent Contractor Status in UK General Practice?* setting out arguments for and against independent contractor status.<sup>2</sup> In favour of independent contractor status, the College concluded that doctor involvement in the running of a practice helped streamline management and was highly cost-effective. When compared with other models of payment systems across Europe and North America, the UK model (of independent contractor status) satisfied the essential attributes of primary care and ranked highly in terms of satisfaction with the system, health outcomes and value for money. Many of the innovations in general practice, for example practice nurses, nurse practitioners and primary care informatics, were developed by enthusiastic GPs who invested time, money and energy to ensure their existence. It is unlikely, the College argued, that salaried doctors could or would be expected to invest either their time commitment or personal financial stake in a practice that the self-employed independent contractors have hitherto provided.

The publication went on to outline the advantage, to patients, of GPs as independent contractors:

From the patient perspective, the model of the GP principal having a personal investment in a practice leads to stability in terms of both geography and length of tenure in post which contributes to continuity of care and the principles of personal doctoring. The patient advocacy role of GPs, especially in deprived and vulnerable communities, is strengthened by independent contractor status.

Doctor involvement in the running of the practice was also seen to have disadvantages:

It could be argued that the model of independent contractor status, with its financial and managerial responsibilities, together with the clinical commitment of 24-hour responsibility for patient care, is in itself a major contributor to work stress. Also if an independent contractor has a period of absence from work, due to illness or natural life events such

as childbirth, they will find themselves at a disadvantage. Although principals can claim some re-imbusement from health authorities for the cost of a locum for sickness or maternity leave, the bulk of these costs are met by the GP's practice or by the affected doctor.

The College publication concluded that the different requirements of patients, doctors and society could be well served by independent contractor status but there needed to be recognition that other ways of working in general practice were equally valid and acceptable.

The College publication was written following changes in the organisation of primary care (NHS (Primary Care) Act of 1997) and the introduction of Personal Medical Services (PMS). Under a PMS contract individual GPs, whole practices, or groups of practices could negotiate terms and conditions of service locally with their health authority, though following national rules, with payment based on meeting set quality standards and accounting for population needs. The aims of PMS were to improve GP recruitment, particularly in deprived areas, by offering GPs more flexible forms of employment. With a PMS contract, GPs could maintain their personal patient lists and keep their independent contractor status, but they also had the option of becoming salaried employees.

## **THE RISE OF THE SALARIED DOCTOR**

### **1990–2004**

Before the late 1990s most GPs working in general practice did so in partnership arrangements, working as self-employed contractors known as principals. There was however a number of vocationally trained GPs who, for one reason or another, did not wish to make the transition to partnership. The reasons for this were complex and multi-factorial, including feeling inadequately prepared for partnership, concerns about workload – particularly out-of-hours work – and the fear of being trapped for life in a single place after obtaining a partnership.<sup>3</sup> Others blamed their reluctance to become partners on the 1990 GP contract.<sup>4</sup>

These doctors chose instead to work in salaried<sup>i</sup> positions, either employed by a practice (under PMS or GMS arrangements), or by the PCT under a PMS contract.

By the end of 2000 over half of the pilot PMS schemes were for salaried employment<sup>5</sup> and more and more practices were advertising salaried vacancies rather than partnerships. Whilst not a panacea for all the problems of recruitment and retention, the salaried option, especially under PMS arrangements, was seen at the time as an effective employment option popular amongst doctors, practices, primary care organisations and politicians, and appeared to deliver high-quality care. However, salaried employment also had some significant disadvantages over partnership arrangements for the individual doctor, in particular the variability of contracts offered in terms of content and quality. At worst, GPs were offered open-ended probationary periods, poor maternity rights, no entitlement to sick leave and notice periods of one month irrespective of the duration of service. Entitlement to study leave was generally not recognised and, if it was, then it was without financial support by the practice as there was no entitlement to postgraduate education allowance for locum/salaried doctors. In many cases GPs undertook salaried posts ‘with a view’ only to find that at the end of a fixed-term period their services were no longer needed. PCT PMS contracts provided more stability and, although average full-time pay was lower than that for GP principals, this lower pay was offset by good employment benefits (e.g. paid sickness leave, educational leave, maternity leave, travel and other expenses, NHS pension, etc.). Other benefits were stable pay that did not fluctuate with practice profits and relative security of tenure.

To iron out inconsistencies in contract arrangements, the General Practitioners Committee (GPC) produced a model contract for sessional GPs in 2004, designed for salaried doctors employed under GMS practice or PMS PCT arrangements.

## **2004–current**

If the flexibilities allowed under the 1997 NHS Act were the catalyst for a

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<sup>i</sup> Also known variably as sessional, retainer, locum, peripatetic, assistants or other doctors.

rise in salaried doctors, then the 2004 GP contract<sup>6</sup> provided the driver for all practices to engage salaried doctors. The contract was negotiated at a time of crisis. Recruitment and retention were poor and a predicted retirement bulge of GPs originating from the Indian subcontinent was adding to problems in the workforce. Against this background was an increasing workload and responsibility for new aspects of care (for example health promotion, addiction, minor surgery). The growing workload meant that many GPs were willing to commit to only 'core work' and to relinquish their 24-hour responsibility. The new contract signified the end of the GP monopoly for primary care services – a process that had started with the 1997 Primary Care Act. From April 2004 contracts were now negotiated between PCTs and general practices, not between the Secretary of State and individual GPs through the BMA. To establish a level playing field of other providers, the government abolished the Medical Practices Committee mechanism for securing fair distribution of GPs and primary care services. A consequence of this was linking money to the patient and not to the number of GPs in a practice. This meant money could be saved by employing fewer partners and replacing outgoing partners with 'cheaper' salaried GPs or other clinicians. The new contractual arrangements allocated practices a single global budget, to include staff and premises costs.

Since 2004 the number of salaried GPs has increased. A survey of GPs carried out in 2005 found that 88 per cent of the 33,380 GPs were principals and 4040 (12 per cent) were salaried. By 2006 figures showed that the number of salaried doctors had doubled and the number of new GP partners fell by 5.6 per cent.<sup>7</sup> Over the same period there was a net increase of salaried/sessional GPs of 58.6 per cent. The 2007 GPC survey involving the UK GP workforce (including GP registrars) has shown that the trend towards salaried employment has not diminished and that around one third of all respondents were a mixture of different salaried positions.

It is not just the new GP contract that has stimulated this change; a significant contributory factor to the large number of salaried doctors has been the increase in the number of women entering the workforce. Women make up 60 per cent of medical school places and 75 per cent of GPs under 30.<sup>8</sup> A recent review of the UK medical workforce showed that general practice has a higher proportion

of women compared with hospital medicine, both at career grade and at specialty training/registrar group levels. However, within general practice only one-third of contractors are female compared with two-thirds of salaried GPs.<sup>9</sup> This contrasted with previous research that had found that younger men – those more noted for their risk-taking behaviour – predominated when salaried posts were introduced.<sup>10</sup> Changing social trends towards work/life balance and new national legislation for equal opportunities, disability discrimination, flexibility, part-time workers<sup>1</sup> and NHS Improving Working Lives standards<sup>2</sup> have also contributed to the rise of salaried doctors. Other significant changes have been, first, the change in employment law such that employees gain employment rights after 12 months and, second, the new GMS contract, which allows practices to recruit additional salaried doctors when partners leave without the financial disincentive of years gone by.

### **Independence in context**

The lack of partnerships and rise of salaried doctors begs a number of questions, including: What does it mean to be a partner? Are doctors currently working as partners deluding themselves that they are truly independent?

First, then, what does it mean to be a partner? There are a number of definitions. In civil law systems, a partnership is an arrangement between individuals who, in a spirit of co-operation, agree to carry on an enterprise, contribute to it by combining property, knowledge or activities, and share its profit. In medical practice a partnership is a voluntary contract between two or more doctors who may or may not share responsibility for the care of patients, with proportional sharing of profits and losses.

Successful partnerships are based on trust, equality and mutual understanding and obligations.

Then what about ‘independence’? Are GPs working today truly independent contractors, or have successive market reforms eroded this independence, rendering all GPs essentially salaried?

An independent contractor is generally taken to refer to a self-employed person who has entered into a contract for services with another party. This contract for services is fundamentally different from the contract of service, which governs an employee–employer relationship. A key test, often used to distinguish between these two types of contract, relates to the question of ‘control’. Generally, the more control A exercises over B’s work, the more likely A is to be the employer and B the employee. Thus, if A can tell B not only what job to do but also how it is to be done, A has sufficient control to make him or her B’s employer.<sup>11</sup> The main advantages of an independent contractor service in general practice are perceived to be its flexibility and adaptability, and the fact that it can offer a more personalised model of care. It also provides opportunities for innovation and diversity without interference. However, as more of what a GP does is dictated outside the surgery, the perception of independence and flexibility is beginning to wear thin. A plethora of NHS reforms has introduced more and more controls over GPs. The government has always dealt with GPs as independent contractors, but the way in which it treated them in 1990 was entirely different from the way in which they were treated in 1966. In 1966 the profession’s independent contractor status effectively served to protect professional autonomy. In 1990, with the change in the form of government towards a ‘contract state’, GPs were treated as independent contractors more in the sense of business entrepreneurs.

Though voluntary, the new GMS contract with its 1000 indicators is perhaps the most controlling contract of any NHS employee. At the time of writing, GPs are now required to report at least bi-annually to the PCT, giving information as diverse as the number of referrals done using Choose and Book, referral data, prescribing data, number and type of significant events and so on. Practices also have to provide a detailed statement of the hours they are available to patients for surgery consultations; they must provide an annual practice development plan, clinical governance plan, and a prescribing audit; the most recent requirement is an annual declaration on the use and storage of controlled drugs. Practices have to adhere to PCT prescribing and referral guidelines, and the introduction of Practice-Based Commissioning is adding exponentially to the information that needs to be submitted to the PCT and the requirements to adhere to targets. GPs are even beginning to be performance-managed as to

their patients' use of A & E, and current demand reduction targets further limit GPs' clinical freedoms.

Successive GP contracts and NHS reforms have therefore eliminated the vagaries of the previous contracts where 'A doctor is required to render to his patients all necessary personal medical services of the type usually provided by general practitioners.'<sup>12</sup> Indeed, as has been commented,<sup>13</sup> until 1990 the GP contract was essentially a 'gentleman's agreement'.

### **Advantages and disadvantages of salaried options**

As with every aspect of the new reforms there are advantages and disadvantages. Salaried GPs may help reduce the workload and burden on busy, pressurised practices.<sup>14</sup> New blood can bring fresh ideas that ultimately should benefit both practices and patients by producing a new group of confident, clinically astute GPs willing to continue in lifelong learning and development. This may have a 'knock on' effect and encourage older principals to further their education and development. In addition there are – and have been – many doctors working in salaried positions, for example in academic practice, who have provided high-quality care and commitment, as well as leading innovation, whilst their independent colleagues in neighbouring areas have been performing poorly. Contractual status does not always equate with performance, commitment and innovative practice, and there is no relationship between the contractual status of an individual and his or her performance, commitment or inclination to innovate. The quality of service provided by the salaried workforce has been found to be comparable with that provided by general practice principals,<sup>15</sup> reflected by higher Quality and Outcomes scores.<sup>8</sup>

On the other hand, the predicted lack of partnerships may lead to fewer and less able candidates entering general practice, to the detriment of the inherent entrepreneurial talents of the men and women working in small business. There is also the risk of creating a 'jobsworth' culture of doctors, working within their contracted working-time-directive hours and unable or unwilling to participate in the wider non-clinical aspects of general practice. Already there is a lack of new recruits to GP education and GP involvement in training and medical politics. This situation will only deteriorate as the existing numbers of partners

become older and less able to continue leading their profession. Anecdotally, salaried doctors are talking about ‘dead-end’ careers and ‘staff-grade general practitioners’, and feel undervalued.

The legal position of a salaried doctor is no different from the legal position of a salaried employee in any organisation. It follows that it may be more difficult for doctors in salaried positions to express independence or to challenge current policies, including, as is evident within the current climate of the NHS, policies around rationing, demand management and commissioning decisions. In the present conditions of over-supply of doctors, salaried employees may be reluctant to challenge their employers about, for example, their pay or conditions, or other practice issues.

Over time, the loss of the traditional GP partner may result in a gradual diminution of the role that the GP has in his or her practice community – such that having a personal investment in a practice leads to stability in terms of both geography and length of tenure in post, which contributes to continuity of care and the principles of personal doctoring. The patient advocacy role of GPs, especially in deprived and vulnerable communities, is strengthened by independent contractor status and could be irrevocably lost with the expansion of the salaried model.

### **Forces of change**

The forces of change in medicine have, over the last decade, led to greater control over doctors, especially GPs, by the state. The Bristol Inquiry led to far greater scrutiny over the performance of hospital doctors and Shipman likewise GPs.

For practices, the trend over the years has been towards larger, more bureaucratic organisations<sup>16</sup> run by smaller numbers of GP principals, and increasingly private providers employing large numbers of salaried GPs, nurses and other staff. Nurses and pharmacists are being encouraged to take on new roles – for example prescribing and diagnostics. At the time of writing the prospect of polyclinics has been proposed, servicing populations of up to 50,000. The consultation paper *Consulting the Capital*<sup>17</sup> proposes that every hospital A&E

department would have a polyclinic as its ‘front entrance’ so that patients who did not need to go to A&E or be admitted would be seen there. Though not stated, it is thought that generalist practitioners would run these polyclinics, although some Foundation Trusts have expressed an interest.

At the time of writing, the private sector has begun to deliver primary care services. Private providers contracting to provide NHS services will have almost all of their GPs working as salaried doctors. Again, there will be an overarching management structure with corporate and clinical governance arrangements, and the expectation of adherence to clinical guidelines and protocols. Private organisations will vary as to the extent in which they seek and heed the opinions of their clinicians, but in some organisations GPs will feel disenfranchised and disregarded. Increasing reliance on skill mix change and making better use of the skills of other healthcare professionals may mean that some private organisations employ relatively fewer doctors and more nurses and healthcare assistants, and that GPs’ jobs are threatened as a result. Some GPs fear exploitation by the private sector. However, there is evidence that some private employers offer better terms and conditions to their employees than some traditional general practices.

### **The impact of continuing change**

Yet again the profession is facing enormous change, this time with the fundamental future of its contractual arrangements. The forces of change over the last decade have been against maintenance of the independent contractor status of GPs; successive GP contracts have placed more and more control for GPs to work with outside health organisations (health authorities and Primary Care Trusts). Pooled practice budgets have led to the incentive to replace ‘expensive’ partners with ‘cheaper’ salaried doctors, or even to replace doctors completely. The increasing number of women in the profession is leading to greater demand for part-time, flexible and largely in-hours working patterns. A three-tier structure is appearing: a smaller, older workforce of GP principals; a growing, currently younger group of salaried doctors; and an unknown number of freelance GPs. Meanwhile the machinery of privatisation, put in place in 1997 (it could be argued that the 1990 contract started this), has continued apace – meaning that, in time, the current workforce will be enticed to work for

new primary care providers, salaried forever. Unlike at other times in the history of general practice, salaried options certainly appear at the present time as the *only* option available to doctors. Headlines and leader articles in the GP press talk (again) about *a crisis in the profession* – the loss of partnerships leaving the door open to the private sector to entice the salaried doctors into what may appear to be attractive positions, which in turn would destabilise the current model of traditional general practice. For salaried doctors, they are fearful that they have lost the chance of ever being able to shape general practice and have lost the opportunity, maybe forever, to become masters of their own destiny; some talk about the ‘ladder being pulled up’. A collective helplessness and confusion is pervading the profession, with those in the lucky position of being partners being set against the ever-growing workforce of salaried doctors.

### **The third way**

Despite many gloomy protestations, general practice still remains a desired career option for young doctors, providing a satisfying career combined with a good quality of life and, still, a large degree of personal autonomy. Amongst the public, GPs still command the most respect of all the professions. GPs are good at adapting to change and using opportunities presented to them for the best. Maybe it is time for the profession’s leaders to promote a third way, of small community-based teams continuing care across the physical, social and psychological domains.

The RCGP’s *Roadmap*, published in November 2007, introduced the concept of federations of general practices providing NHS services.<sup>16,18</sup> Federated practices or consortia would share resources, expertise and services. This model would favour the continuation of the independent contractor, though practices would become more uniform and, whilst retaining some independence, would be part of a corporate overarching management structure, providing IT, HR and other high-level functions to all the constituent practices. The federated model fits well with the challenges of commissioning. Holding the budget will allow the federation to move services and create the funding to increase the number of services provided by practices. The relationship and power balance between

the federated and constituent practices is the difference between a partnership and a managed organisation. The overarching management structure would specify a set of rules, such as referral pathways, opening hours, skill mix and allow individual practices autonomy as to how this can be achieved. A more sophisticated understanding of how to lead *primary care organisations* and *networks* must replace the traditional *small business* model from which our present use of the term ‘partnership’ finds its origins. This new federated model of working will necessitate new roles for GPs working together as ‘*teams*’ and replaces the current ‘salaried’ and ‘partner’ divisions. Federated practices, with GPs having differing roles and responsibilities (see below), would also compete with private firms, who are enticing GPs with the promise that they can retain control of their practice whilst receiving back-office, financial and IT support from the private sector partner.

### **General practitioner roles**

New ways of working demand new roles for GPs not based on ownership of a particular property but instead on the function that each provides to his or her organisation. Simplistically these roles can be seen as falling into three domains:

#### ***Traditional GPs***

Quality primary care needs GPs to provide traditional general practice (continuity of care, local involvement, home visiting, nurturing the extended primary care team). This role should not be viewed as somehow secondary in importance to any management or leadership role, but as the backbone of quality general practice. GPs with other professional commitments will also do this work, but not necessarily lead, even though they may be more experienced.

#### ***GPs with other interests***

Examples of these are academic GPs, GPs leading commissioning, or GPs holding local leadership positions. GPs who hold multiple part-time posts have valuable insights about different parts of the whole system. They are well placed to provide leadership across whole areas and work across boundaries, including with secondary care, to produce guidelines and whole-system pathways.

### ***Primary care directors***

Every competent general practice, and (soon) federation of general practices, will need doctors who take responsibility for organisational concerns, including clinical and corporate governance, risk, finances, strategy, workforce and disciplinary matters. As well as good managers they must be respected as experienced practitioners and retain a clinical workload. This has traditionally been the responsibility of partners, but in this federated model there is no reason to exclude salaried GPs solely by virtue of their contractual status from assuming the roles of responsibility of management in these areas, recognising the professionalism of salaried GPs, and thereby fully utilising the wide range of skills and expertise that are available within the workforce.

We believe that using this way of analysing the present crisis has the merit of distinguishing GPs by role rather than levels of importance. The roles can overlap as much as any practice wants. It is open to many different financial arrangements to suit different preferences. It clarifies the training and professional support needed of different GPs, as well as highlighting team-working between them. It also goes some way to safeguard NHS general practice for future generations.

## SUGGESTED RECOMMENDATIONS FOR DISCUSSION

1. To acknowledge and respond to the changes in structure of general practice.
2. To continue to promote the values of general practice.
3. The College and GPC need to engage with the new workforce, taking their needs into consideration in their deliberations, in particular career and developmental needs.
4. The College and GPC must work together to help develop career pathways for salaried GPs.
5. The need for the development of robust workforce figures and monitoring. This should be properly integrated to include all providers, and should include sessional GPs as well as principals. Future workforce planning should be able to inform the numbers required to enter specialty training, and aid and assist in achieving the career aspirations and developmental needs of the future workforce.
6. Liaison with the Committee of General Practice Education Directors (COGPED), so that the changing career aspirations and developmental needs of the future workforce can be reflected in specialty training (as an ongoing review process).
7. Engagement with other stakeholders, for example Primary Care Organisations (PCOs) and Strategic Health Authorities (SHAs), to inform the changing nature of general practice. With the development of the federated model and GPs working as ‘teams’, moving away from the hierarchical approach adopted by some of these organisations.
8. Work to develop systems that will recognise the expertise and experience of salaried GPs as highly qualified, skilled fellow professionals.
9. A need to ensure equity of process in the provision of terms and conditions of employment and provision of NHS pensions between GMS and Alternative Provider Medical Services (APMS)/PMS providers. GP federated models that necessarily use the model terms and conditions of employment, and are members of the NHS pension scheme, should not find themselves at a disadvantage compared with other provider organisations.

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