

Under pressure

What the Commonwealth Fund's 2015 international survey of general practitioners means for the UK

Sara Martin, Edward Davies, Ben Gershlick











Acknowledgements

A number of people contributed to the development of this report and the authors would like to thank the peer reviewers and a range of colleagues at the Health Foundation for their comments and advice.

We would also like to thank The Commonwealth Fund for their work in conducting the survey.

Errors or omissions remain the responsibility of the authors alone.

Contents

Overview	2
GP satisfaction	5
Coordination of care	14
Electronic medical records	23
Discussion	31
References	35

Overview

Every three years, the US-based Commonwealth Fund coordinates a survey of general practitioners (GPs) and primary care physicians across 11 countries. This report provides UK-focused analysis by the Health Foundation of the 2015 survey, which included several UK-specific questions funded by the Health Foundation. The report centres on three topics of particular interest: GP satisfaction, care coordination and use of electronic medical records.

The survey provides insight into how GPs perceive their working lives and practices at a time when health services across the UK are seeking to develop more services in primary care. The Commonwealth Fund website will publish the full survey data set, along with those from previous years.*

Key points

- The Commonwealth Fund surveyed 12,049 primary care physicians across 11 countries between March 2 and June 8 2015. This included 1,001 GPs from the UK.
- The survey findings show that there are certain aspects of care where the UK performs strongly. Indeed, in some cases (such as the use of electronic medical records) the UK is an international leader. However, the survey also highlights a number of areas of concern, in particular that UK GPs find their job more stressful than any of their international counterparts.
- Of particular concern is that 29% of GPs in the UK want to leave the profession within five years. These findings show that holding on to existing GPs by improving their working lives should be as great a priority as recruiting new ones.

GP satisfaction

- GPs in the UK report higher levels of stress and lower satisfaction with practising medicine compared to primary care doctors in other countries. 67% of UK GPs report being satisfied, compared to an average of 79% across the other 10 countries featured in the survey. 59% of GPs in the UK describe their job as extremely or very stressful, higher than anywhere else.
- UK GPs report similar levels of satisfaction with their income to primary care physicians in the other countries featured in the survey – 67% in the UK and 72% internationally. When comparing their incomes to specialist colleagues, UK GPs are **more** satisfied than their counterparts internationally – 58% of GPs in the UK are satisfied, compared to just 38% in other countries.

* www.commonwealthfund.org/interactives-and-data/surveys/2015/2015-international-survey
Please contact the Health Foundation (info@health.org.uk) for the UK-specific data.

- A key area of dissatisfaction among GPs in the UK is the length of appointment times, where the UK is a significant outlier. 92% of UK GPs report spending less than 15 minutes with patients per appointment, compared to an average of 27% across the other countries featured in the survey. Only 26% of UK GPs are satisfied with the amount of time they spend with patients, compared to an average of 59% across the other countries.
- There is a clear correlation between those who want to leave general practice and high stress levels. Of the UK respondents planning to leave medicine for a different career, 77% said their role as a GP was extremely or very stressful, compared to 49% of those who plan to stay.

Coordination of care

- Primary care doctors in all countries featured in the survey appear to be struggling to coordinate care. Within this context, the UK compares favourably in terms of communication between health care providers. For example, 36% of GPs in the UK always receive information about changes made to a patient's medication or care plan, more than in any other country featured in the survey except France.
- However, this comparative strength does not extend to coordination with social services or community providers; 70% of UK GPs find it somewhat or very difficult to coordinate their patients' care with these providers.
- In addition, the communication between UK GPs and other providers does not always appear to be translating into better experience for patients. 79% of UK GPs reported their patients experienced problems in the past month because care was not well coordinated. This is 15 percentage points higher than in the next highest country (Australia), and 31 percentage points higher than the average across the other countries featured in the survey (48%).

Electronic medical records

- The UK is a leader for the use of electronic medical records (EMRs), with 98% of GPs routinely using an EMR in their daily practice. This compares to an average of 86% across the other 10 countries featured in the survey. Despite this, the UK performs less well in terms of practices offering patients the option to email a medical question or concern, at 38%. This compares to an average of 49% across the other countries.
- The small UK sample size means care is needed when making comparisons within the UK. However, there is clear variation in the use of EMRs across England, Scotland, Northern Ireland and Wales. For example, 91% of GPs in England routinely or occasionally use electronic ordering of laboratory tests within their practice, compared to only 31% of GPs in Wales.

Box 1: About the survey

The Commonwealth Fund's 2015 international health policy survey of primary care doctors

Countries surveyed: Australia, Canada, France, Germany, the Netherlands, New Zealand, Norway, Sweden, Switzerland, United Kingdom and United States

Sample: General practitioners/primary care physicians (GPs). Data from each country were weighted to ensure the final outcome was representative of GPs in that country based on their demographics (gender, age – and region for the UK) and selected specialty types. This procedure also accounted for the sample design and probability of selection.

Sample size: The final unweighted samples included 12,049 primary care physicians, of which 1,001 were GPs from the UK. Of these, 475 were from England excluding London, 200 were from London, 136 were from Scotland, 110 were from Wales and 80 were from Northern Ireland.

Method: The GPs were recruited through a variety of methods including postal mail, email, fax and online. In the UK 2,540 GPs were asked to complete the survey either online or via phone. 1,001 participated, a 39.4% response rate. In addition to the international set of 44 questions, these GPs were asked an additional set of UK-specific questions, funded by the Health Foundation.

Uncertainty: The majority of the survey results provide comparisons between countries. The overall margin of error (for a 95% confidence level)* ranges from 1.8% (Sweden) to 5.1% (Germany). For the UK it is 3.7%. This includes the 'design effect' (error introduced due to the weighting procedure); without this, the UK's margin of error is 3.1%.

These are the theoretical margins of error if the percentage of respondents giving a certain answer is exactly 50%, where margins of error will be highest. They therefore give some indication of where particular caution should be taken with results. A margin of error is a relationship between sample size and the percentage of respondents giving a certain answer: it does not take into account how the survey was conducted. Sampling error is only one type of error that affects survey outcomes.

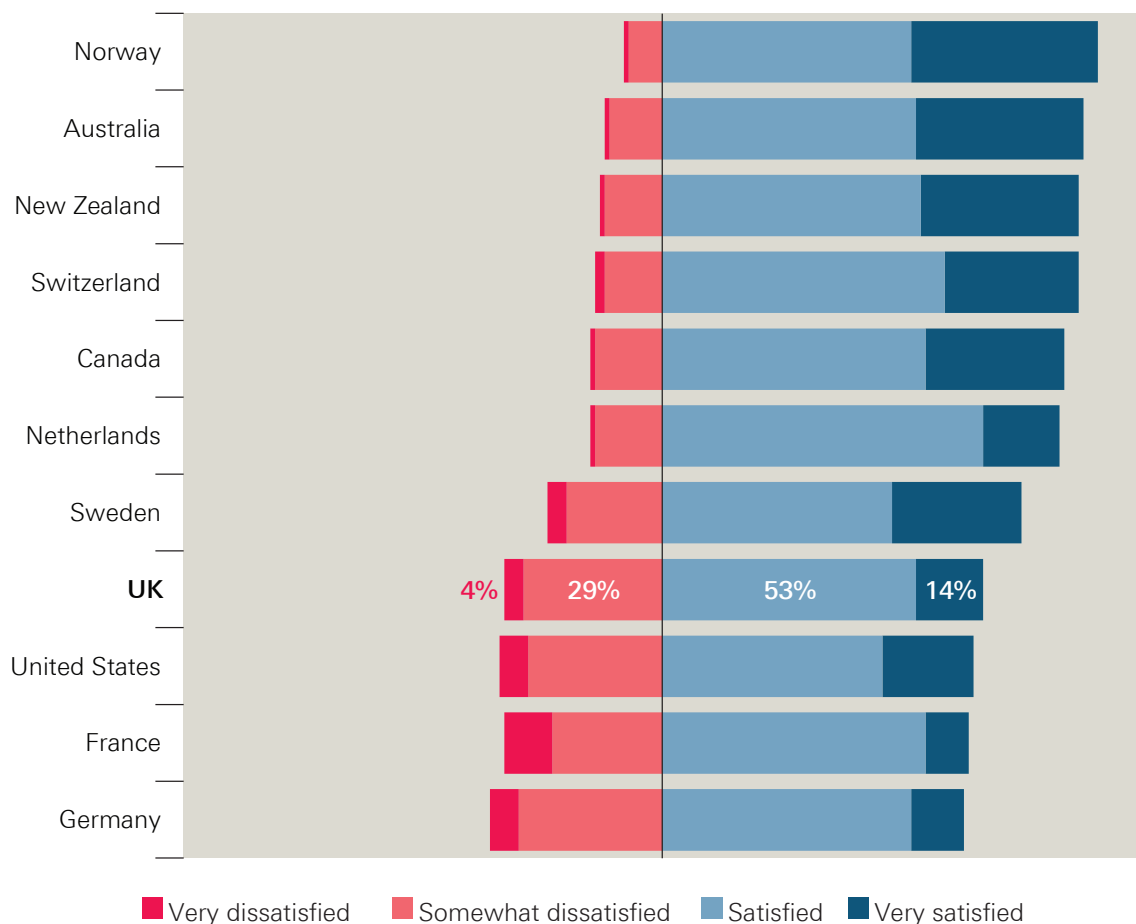
This report includes a small number of sub-analyses between the different countries of the UK, or within different subgroups of respondents. Not all the results of these sub-analyses are significant at the 95% level, but we have included them as they may be of interest as part of a wider trend.

* The margin of error is one side of a confidence interval. So a margin of error of 3.7% for a 95% confidence level means that if the survey were conducted 100 times, you would expect the data to be within 3.7 percentage points above or below the percentage reported in 95 of the 100 surveys.

GP satisfaction

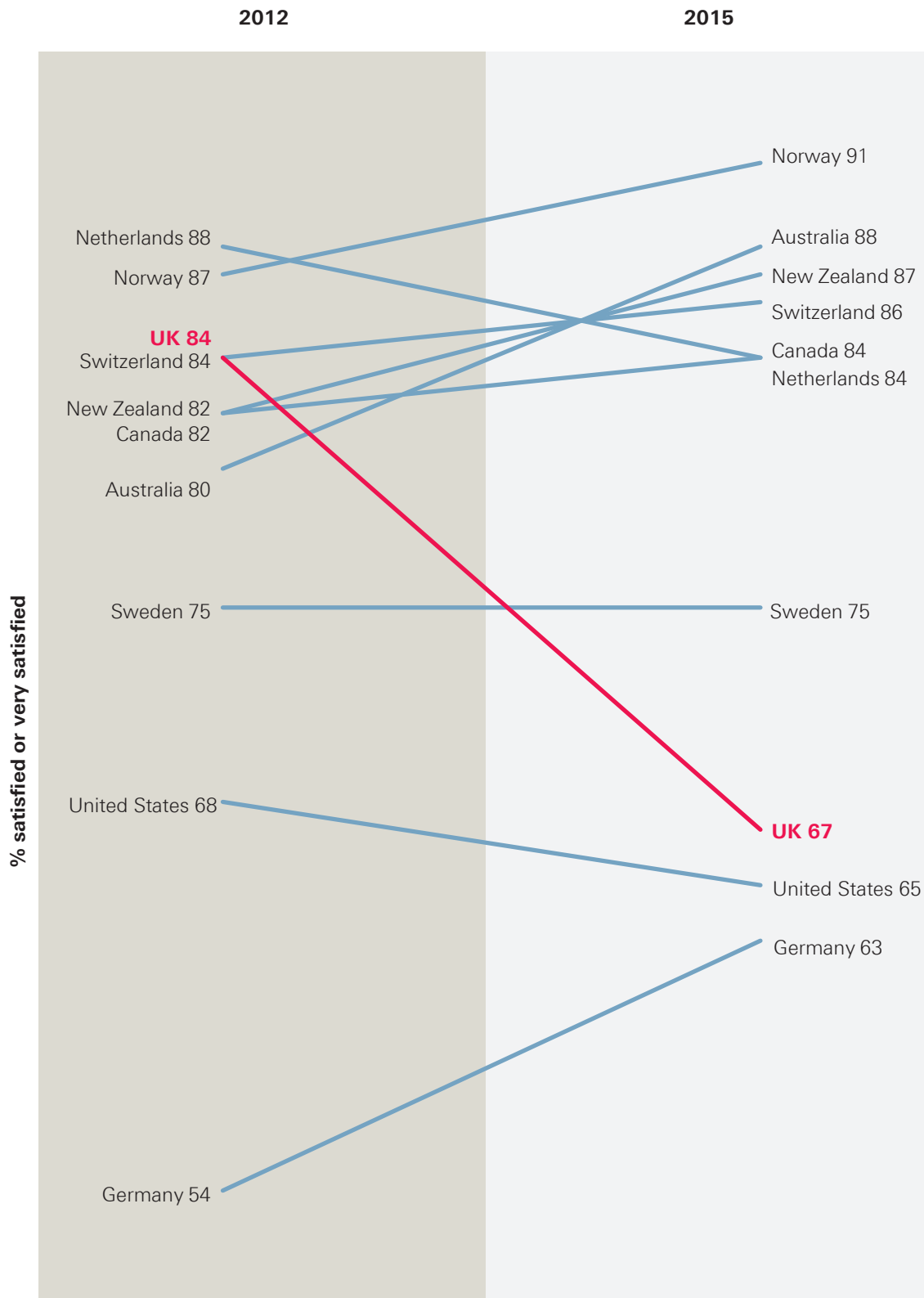
The public in the UK regularly express high satisfaction with GP practices. For example, in the 2014-15 GP patient survey, 85% of respondents reported a good overall experience.¹ However, this contrasts with GPs in the UK themselves, who report one of the lowest satisfaction rates internationally. In the 2015 Commonwealth Fund survey, 67% of GPs in the UK report that they are either 'very satisfied' or 'satisfied' with practising medicine, compared to an average of 79% of primary care doctors in the other 10 countries featured in the survey. Only the United States (65%), France (64%), and Germany (63%) have lower satisfaction rates (Figure 1).

Figure 1: Satisfaction with practising medicine



This marks a decline from the 2012 Commonwealth Fund survey,² when 84% of UK GP respondents reported they were satisfied or very satisfied with practising medicine (Figure 2). It should be noted that the 2012 survey had a different sample size and methodology, so any comparisons must be made with caution.

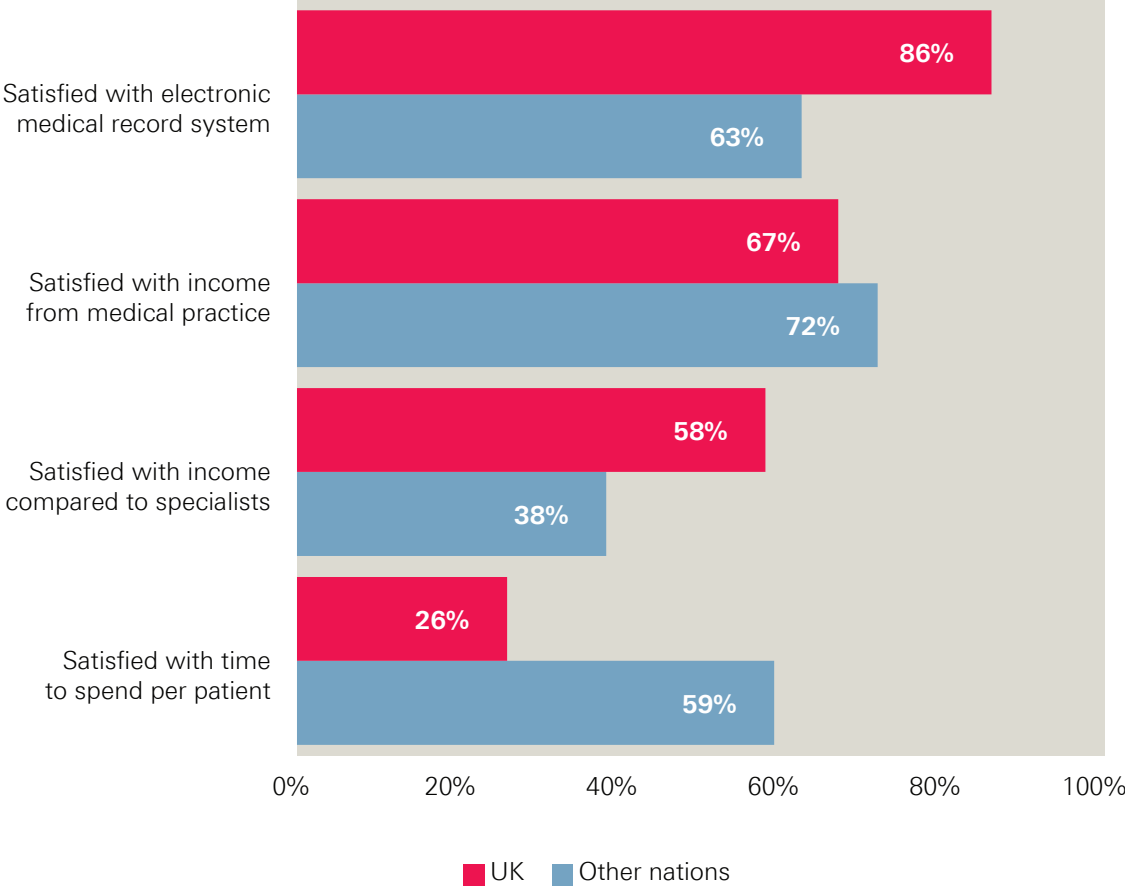
Figure 2: Change in satisfaction with practising medicine, 2012-2015



In the 2015 survey, when asked about their satisfaction with four aspects of their practice, UK GPs were more satisfied than the average across the other countries on two aspects (electronic medical record systems, income compared to specialists). They reported broadly similar satisfaction with their income from medical practice.

In contrast, the level of satisfaction with the time they spend with patients showed a big difference: only 26% were 'satisfied' or 'very satisfied', compared to an average of 59% satisfaction in the other countries featured in the survey (Figure 3).

Figure 3: Respondents' satisfaction with different areas of general practice

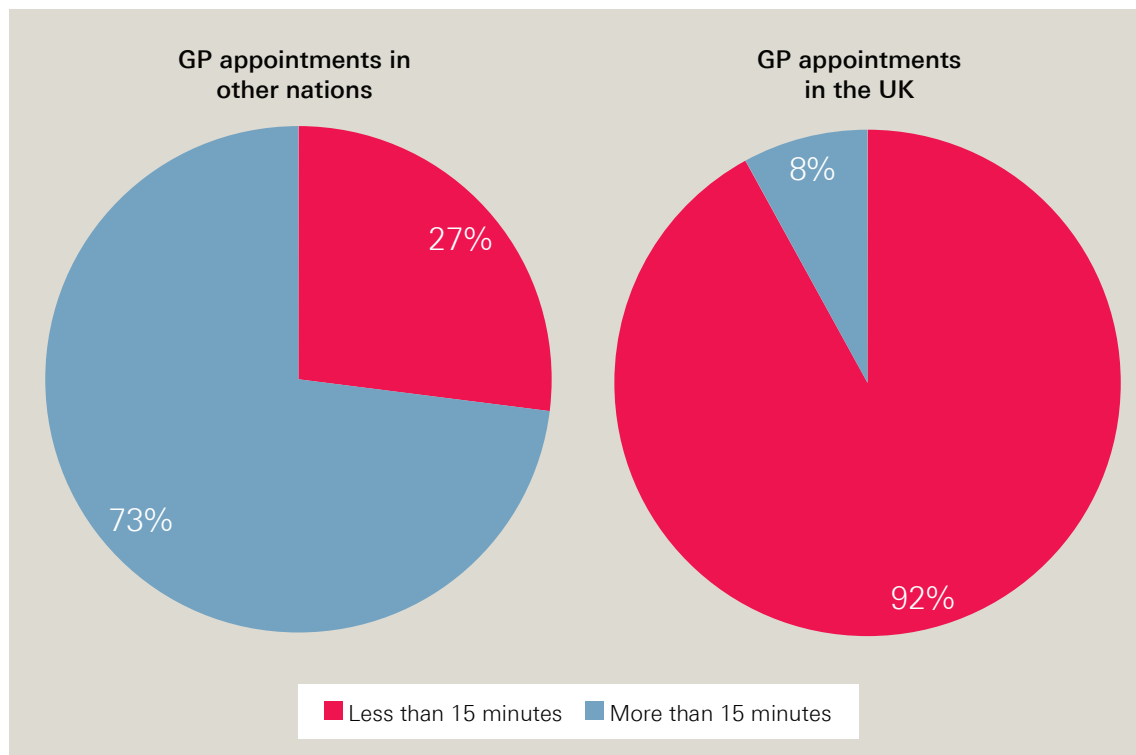


The survey only sought views on four aspects of practice – there are likely to be other factors contributing to GPs’ dissatisfaction. For example, a study by the University of Manchester found the top five stressors for GPs were: increasing workloads (92%), the requirements of external bodies (87%), patient demand (86%), paperwork (85%) and insufficient time to do the job justice (85%).³

However, the Commonwealth Fund survey indicates that the UK is a clear outlier in terms of length of appointments (Figure 4). In the UK, 92% of GPs reported that appointments involved less than 15 minutes of face-to-face time with patients – the highest rate among all countries featuring in the survey.

This is consistent with wider evidence: UK GPs spent an average of 11.7 minutes with their patients in 2006/7⁴ and more recent reports from other sources suggest shorter averages.⁵ There is widespread practice of a ‘ten-minute rule’ within the UK, which was originally mandated as a minimum for booked appointments in the 2004 GP contract.⁶

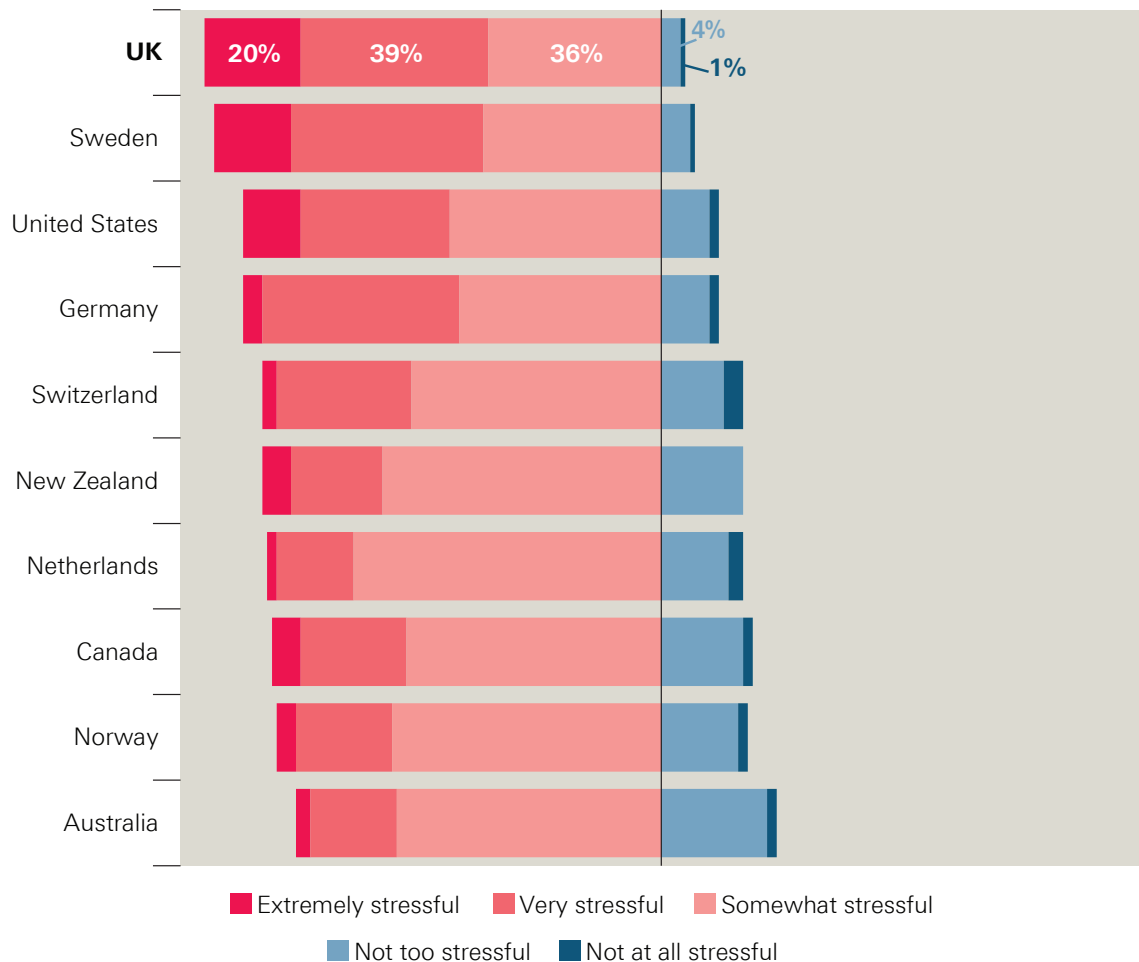
Figure 4: Percentage of consultations taking less than or more than 15 minutes



Perhaps unsurprisingly, when looking across all 11 countries featured in the survey, longer appointments are associated with greater GP satisfaction with time spent with patients.

Dissatisfaction with the amount of time spent with patients is likely to be one contributor to the number of UK GPs finding their work stressful; 59% of UK respondents reported that they found practising in primary care ‘very stressful’ or ‘extremely stressful’. This is higher than any other country surveyed (Figure 5).

Figure 5: Percentage of respondents finding general practice very or extremely stressful

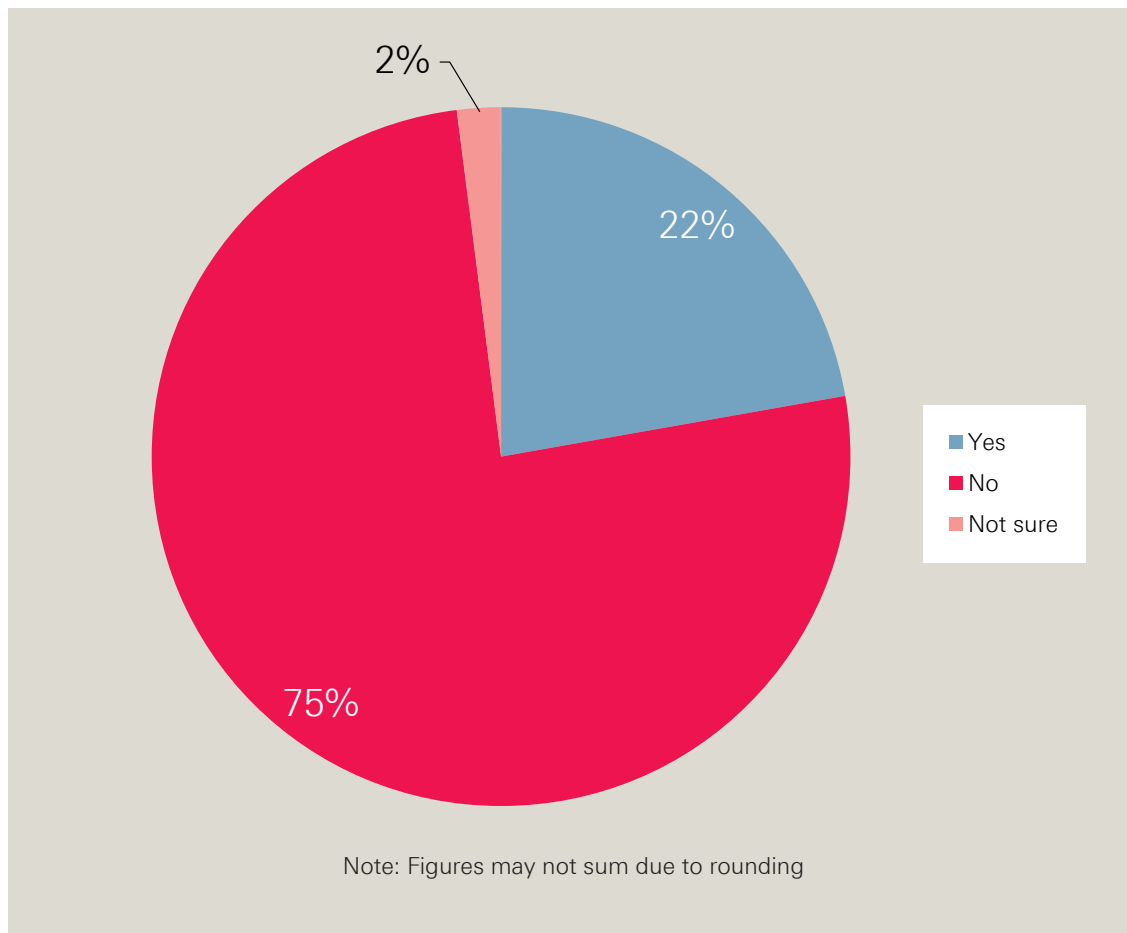


In addition to the link to GP stress and dissatisfaction, the length of consultations could also have implications for recruitment and retention of GPs,⁷ as well as improved care outcomes, especially of preventive care.^{8,9}

Further work is required to develop a better understanding of why consultations are shorter in the UK than the international average – as well as identifying opportunities for change.

In a UK-only question, more than one in five (22%) of GPs reported being made ill by the stress of work in the past 12 months (Figure 6).

Figure 6: Percentage of respondents being made ill by the stress of work in the past year

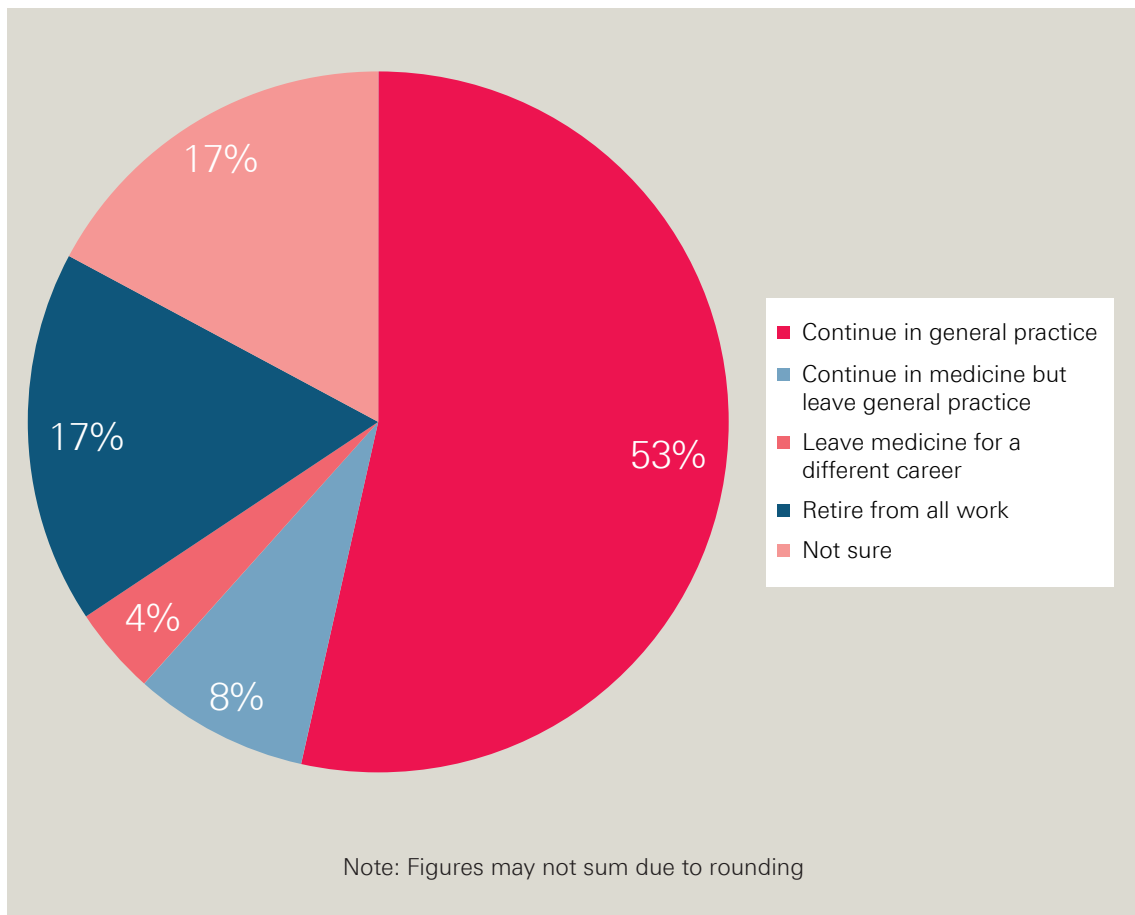


The 2014 NHS Staff Survey asked a similar question – if stress had made staff feel unwell. They found higher rates of ‘unwellness’ among most other NHS staff – for example 37% of staff within acute trusts reported that they had felt unwell as a result of work-related stress.¹⁰ However, comparisons between the Commonwealth Fund and NHS Staff Surveys are not straightforward because the questions asked were slightly different (‘unwell’ as opposed to ‘made ill’).

Implications for GP retention

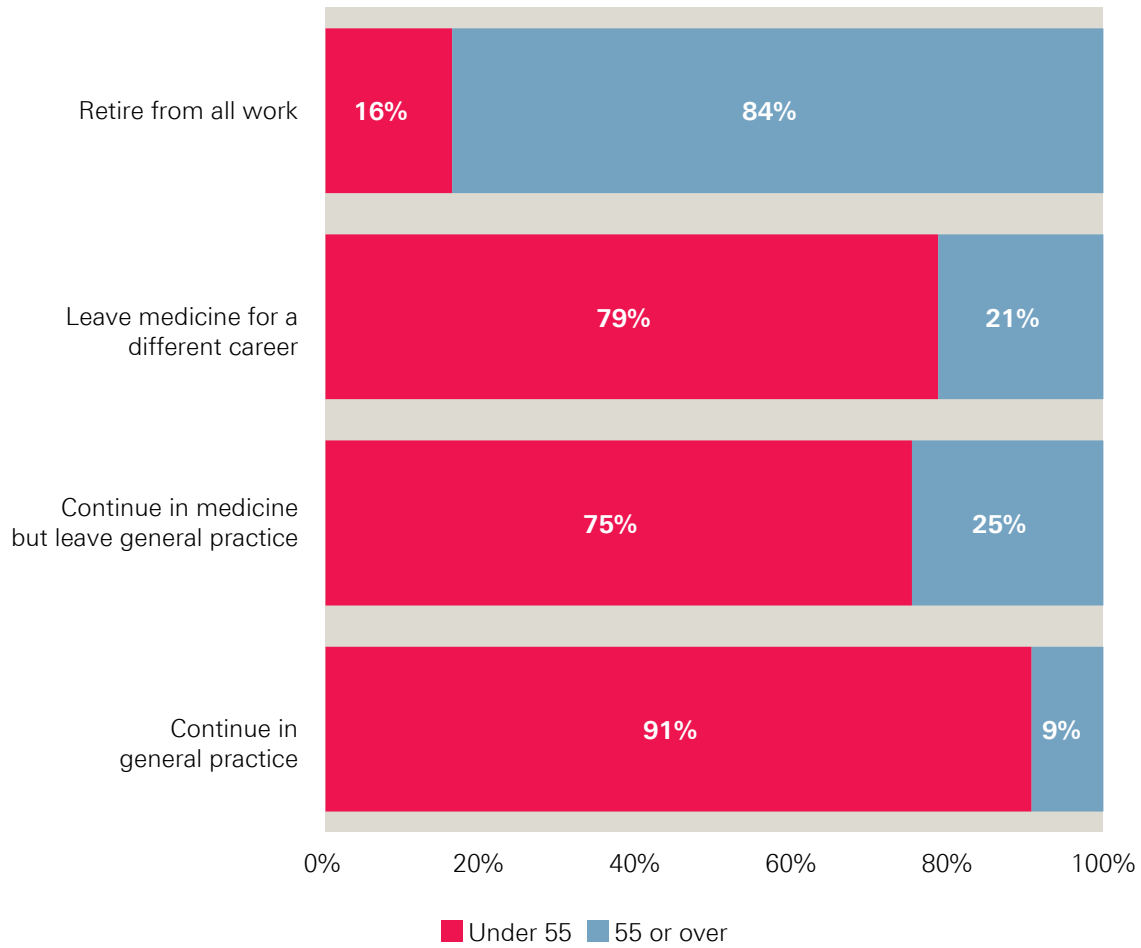
Nearly 30% of UK respondents reported that they plan to leave general practice within five years. This includes those planning on switching careers completely (4%), staying within medicine but switching specialisms (8%) or retiring (17%) (Figure 7). A similar survey in 2015 of 1,192 GPs in central England found that 42% intended to leave general practice within the next five years.¹¹

Figure 7: UK respondents' intentions in the next five years



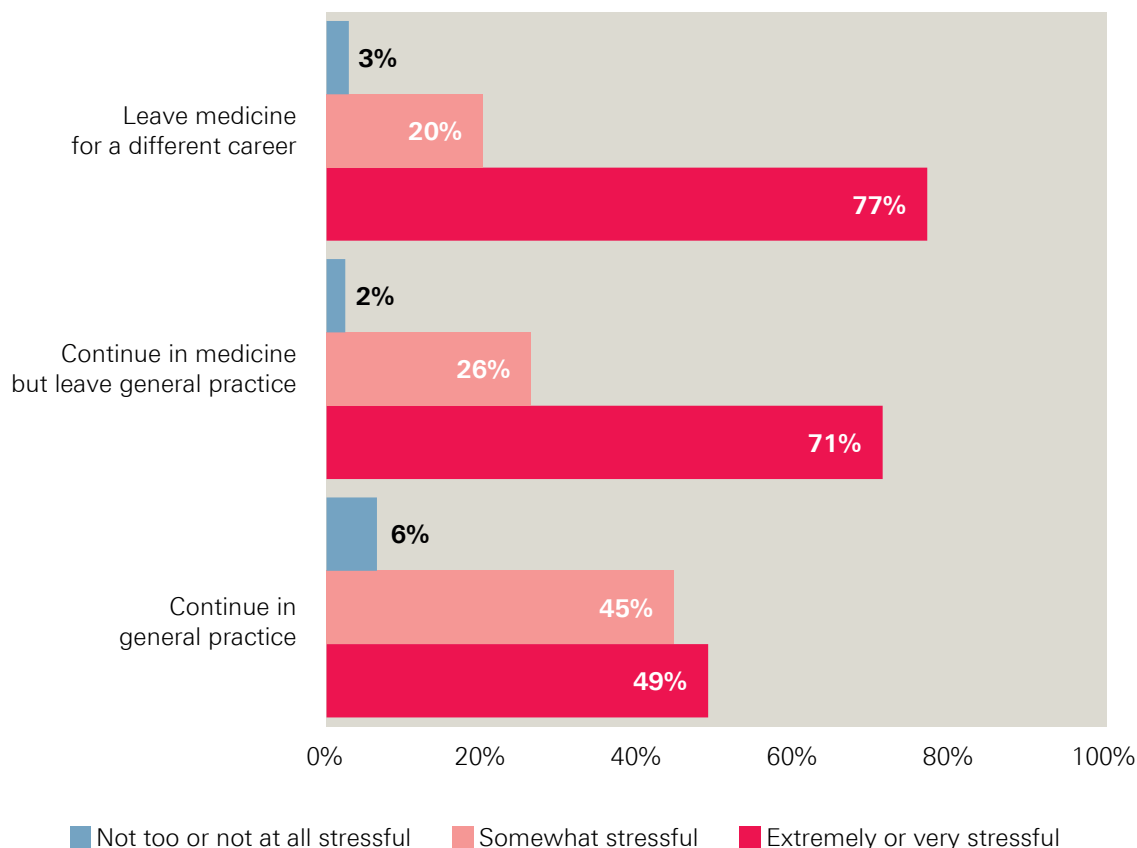
In the Commonwealth Fund survey, of the 12% of GPs planning to switch careers (4%) or specialisms (8%), 77% are younger than 55 years of age (Figure 8).

Figure 8: The relationship between age and respondents' intention to leave general practice



The survey indicates a clear correlation between stress and a desire to leave general practice (Figure 9). In a 2016 study, Doran and colleagues utilised mixed methods to examine the reasons GPs leave direct patient care. They found that, while the reasons are ‘cumulative and multifactorial’, the main reason is that the ‘increase in administrative tasks and overall workload’ was perceived by the GPs as having ‘fundamentally changed the patient-doctor relationship.’¹²

Figure 9: The relationship between stress level and intention to leave



There is evidence to suggest that respondents are likely to follow through with their expressed intention to stop providing direct patient care. In 2010, the University of Manchester did a follow-up study on a 2001 survey which found that 10% of GPs under 50 years of age planned to leave direct patient care within five years.¹³ In the follow-up study, they found that 16.5% of GPs under 50 had actually left direct patient care, and that job satisfaction and intention to leave both correlated with actually leaving.

However, it is unlikely the full 8% reported in the Commonwealth Fund survey will switch from general practice to another medical specialty, given how difficult it is for physicians to change specialties.¹⁴

Coordination of care

For a number of years, national policies across the UK have aimed to improve coordination and communication between health and care services.

For example, the Public Bodies (Joint Working) Act in Scotland aims to further joint working between health boards and local authorities in order to ‘integrate care’.¹⁵ In Northern Ireland, health and social care has been organisationally integrated since 1972, but since the 2011 Compton Review (*Transforming your care: A review of health and social care in Northern Ireland*)¹⁶ there has been an increasing focus on integrating primary and acute care.

In England, the *NHS Five Year Forward View* (Forward View) stated: ‘The traditional divide between primary care, community services, and hospitals – largely unaltered since the birth of the NHS – is increasingly a barrier to the personalised and coordinated health services patients need.’¹⁷ Similarly the Welsh government’s five year plan for the NHS states, ‘The integrated NHS bodies will accelerate the development of new simplified, integrated services. Confusing, disconnected services fail people and do not make best use of scarce resources.’¹⁸

Despite this range of efforts across the four nations of the UK, there is still uncertainty about the extent to which care coordination is happening at scale.¹⁹

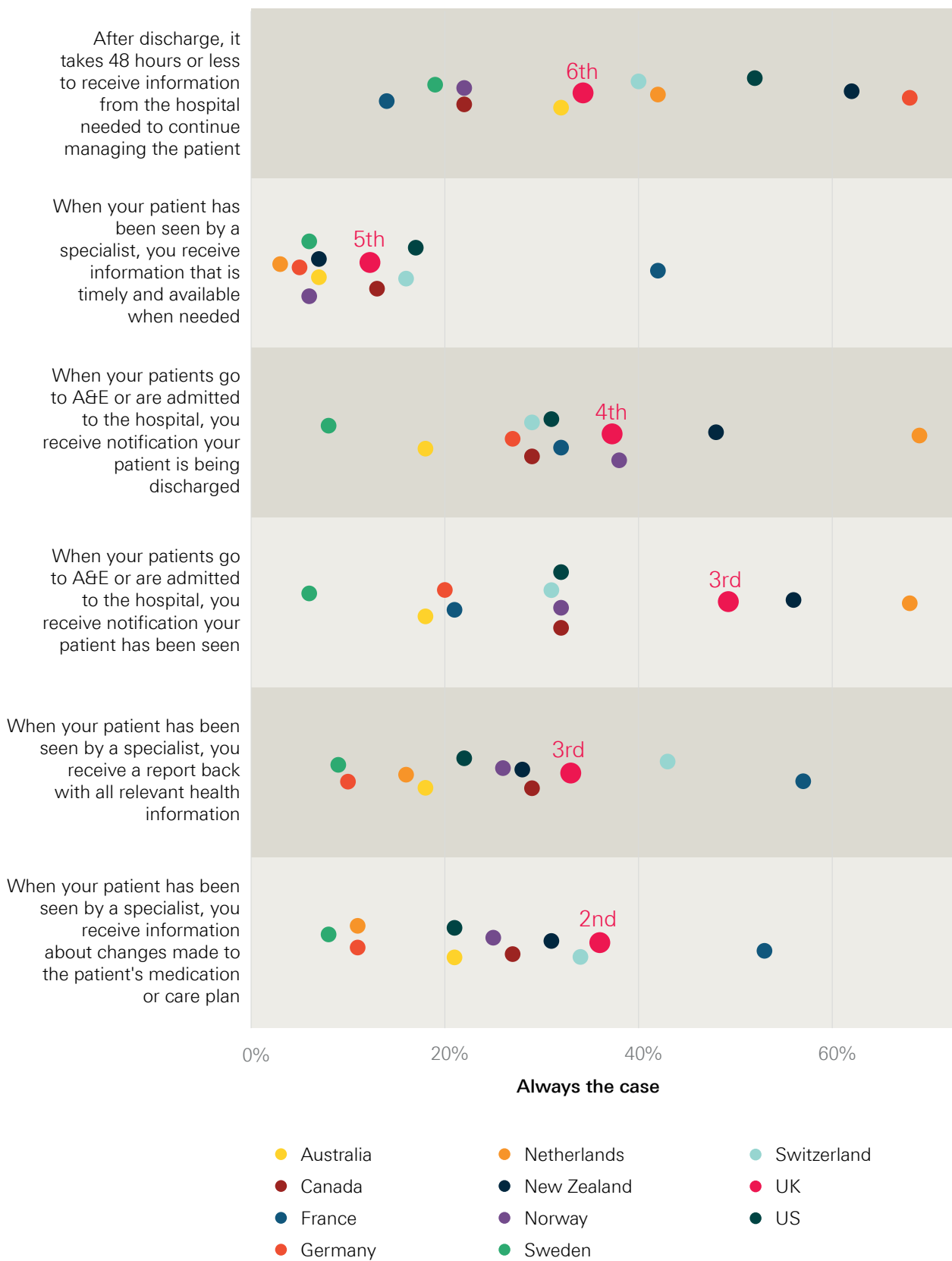
Communication between GPs and other providers

The survey indicates that the UK performs relatively strongly in terms of communication between GPs and acute providers. As shown in Figure 10, the UK consistently rates in the top half of the 11 countries featured in the survey, generally performing less well than the Netherlands or New Zealand, but significantly better than Sweden or Australia. This comparative strength echoes the Commonwealth Fund’s 2014 *Mirror, mirror on the wall* report, which ranked the UK first on coordinated care measures.²⁰

However, the survey also indicates significant room for improvement, across all countries, including the UK. Increased care coordination is a policy priority throughout developed health care systems, with many countries with traditionally fragmented systems trying to support better working between different parts of the system.²¹ For example, while the UK trails only one other country (France) in terms of GPs receiving information about changes made to a patient’s medication or care plan, only 36% of GPs in the UK reported this was always the case (compared to 53% in France).

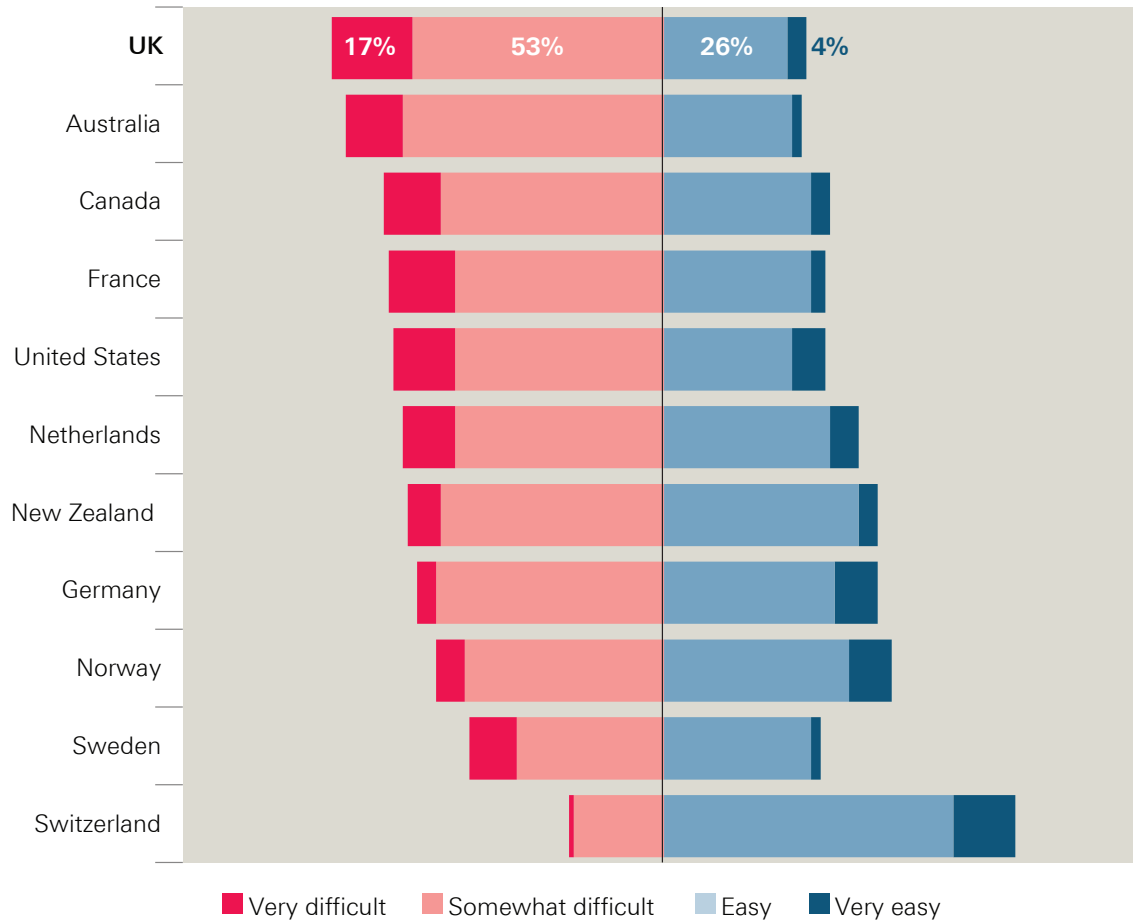
The UK compares less favourably on GPs receiving timely information after discharge of the patient from hospital. Only 34% of UK GPs reported that, after discharge, it takes 48 hours or less to receive from the hospital the information needed to continue managing the patient; this is nonetheless sixth of the 11 countries featured in the survey. This is also an improvement since the 2012 Commonwealth Fund survey, when only one in five (21%) GPs in the UK received timely information from the hospital after discharge.

Figure 10: Percentage of respondents always able to communicate in certain ways



However, UK GPs reported far greater challenges coordinating with non-acute providers. 70% of GPs in the UK find it somewhat or very difficult to coordinate their patients' care with social services or community providers (Figure 11). This is the highest of any country featured in the survey. In contrast, 74% of GPs in Switzerland find this coordination easy or very easy.

Figure 11: Percentage of respondents finding it somewhat or very difficult to coordinate care with social services or other community providers



While the UK's performance on coordination between specialists and GPs is a relative drop since 2012 (see Table 1), this trend is seen across the board. Comparative performance has not changed considerably.

Table 1: The UK's performance on communication between GPs and specialists, 2012 to 2015

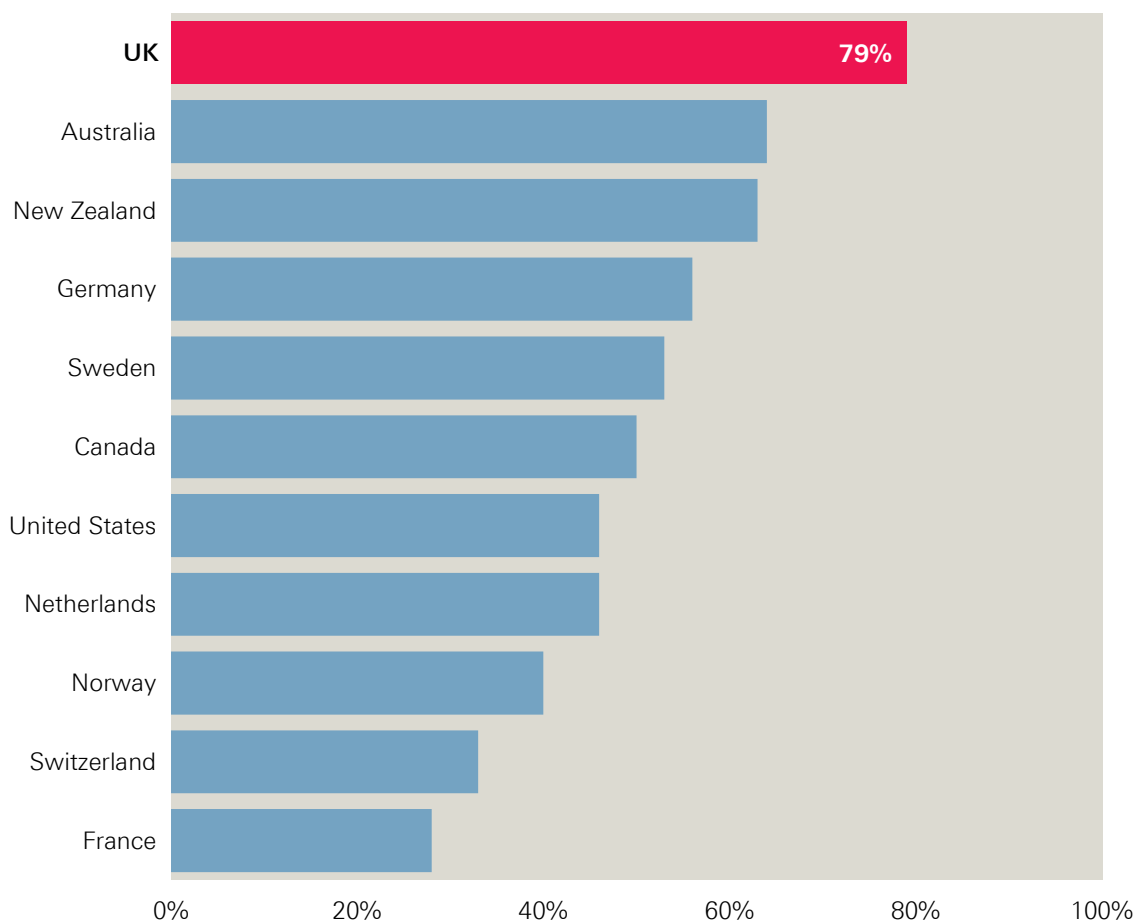
	2012	2015*
GPs receive the information needed to manage a patient's care within 2 days after they were discharged from the hospital	21% (ranked 7th)	34% (6th)
Doctor receives alert or prompt to provide patients with test results	70% (2nd)	65% (1st)
After referring patient to a specialist, GPs always or often receive:		
a report back with all relevant health information	87% (7th)	84% (7th)
information about changes to a patients medication or care plan	88% (4th)	86% (5th)
information that is timely and available when needed	63% (7th)	49% (10th)
GPs always or often receive:		
notification that patient has been seen in emergency room	86% (3rd)	86% (3rd)
notification that patient is being discharged from hospital	79% (3rd)	67% (8th)
* Statistically significant changes are indicated in bold		

Impact on patients

Despite comparing positively with the other countries on communication with acute providers, the UK is a significant outlier in terms of the impact of poor coordination on patients; 79% of UK GPs reported that, in the past month, one of their patients experienced a problem because care wasn't well coordinated. This compares to an average of 48% across the other countries featured in the survey. As shown in Figure 12, the rate in the UK is 15 percentage points higher than the next highest country (Australia). Even within the UK there is variation, with 58% of Scottish GPs reporting patients experiencing problems due to poor coordination, compared to 81% in London.

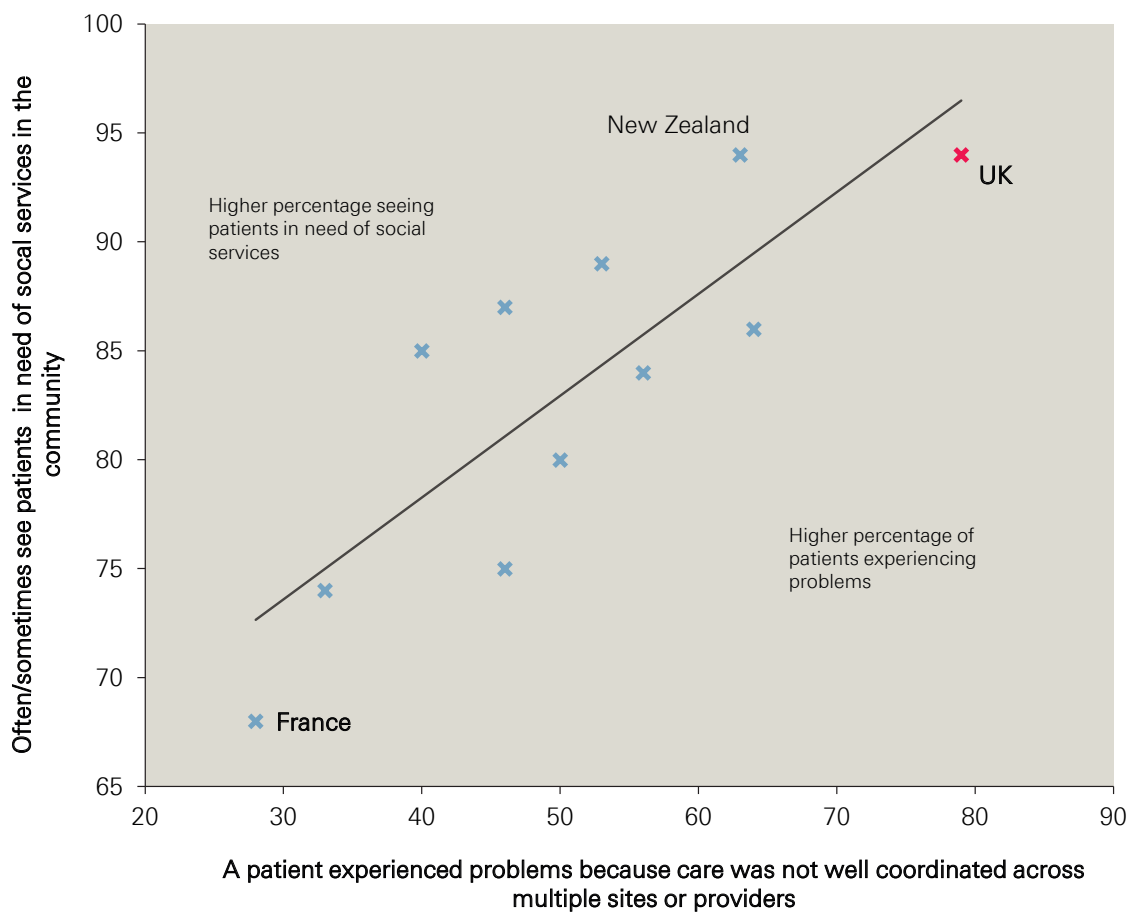
The differences in the reported impact of poor coordination could be explained by the UK having better systems for capturing patient problems, or different understandings of what a patient problem is. Nonetheless, it seems clear that, in the view of survey respondents, poor coordination is adversely affecting patients.

Figure 12: Percentage of respondents whose patients experienced problems in the past month because care was not well coordinated across multiple sites or providers



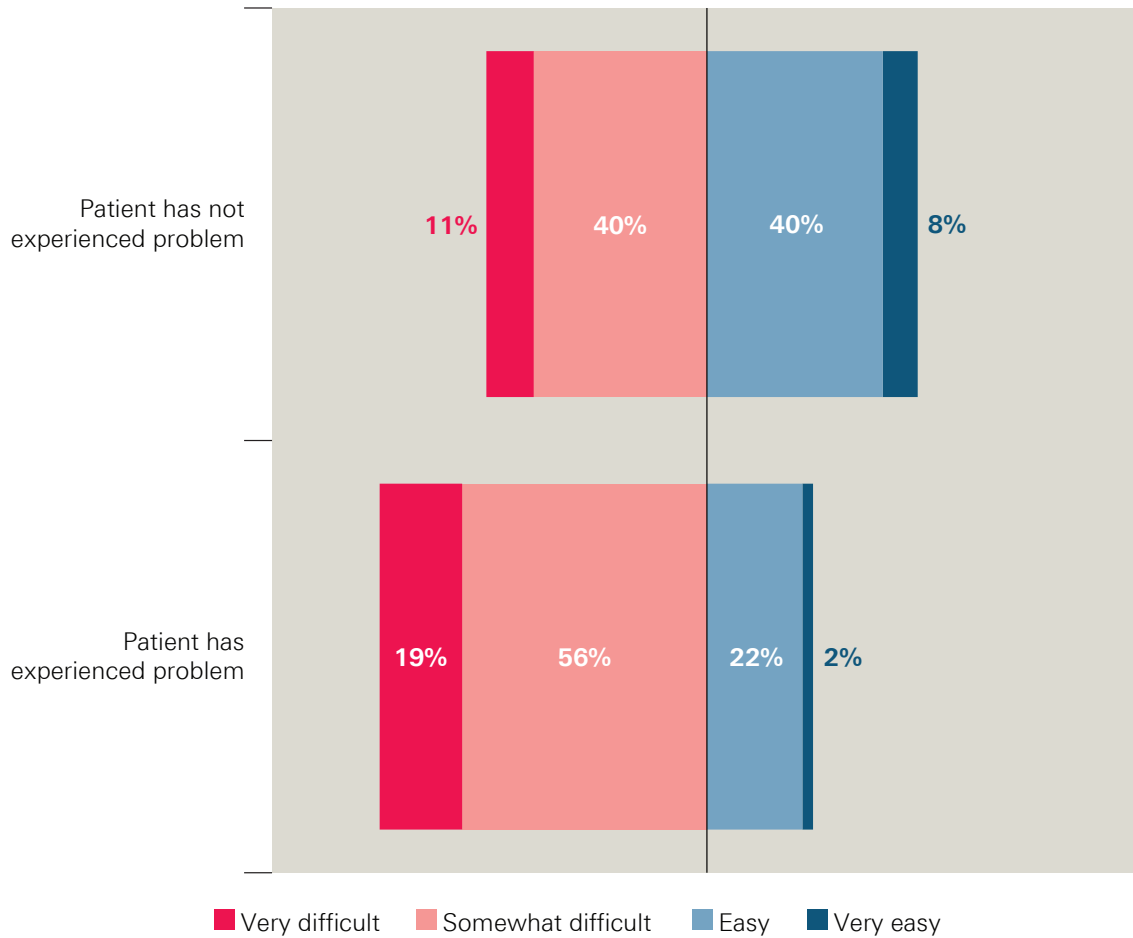
Another factor influencing this variation is that, in some countries, GPs more frequently see patients who require this kind of coordination. This relationship can be seen in Figure 13. The UK has high levels of GPs reporting that they often or sometimes see patients in need of social services in the community. Understandably, the more frequently GPs see these patients, the more likely it is that one of their patients will experience a problem. However, the UK still stands as an outlier, especially when compared to New Zealand, which has the same level of ‘need’, but 16 percentage points fewer patients experience problems due to poor coordination.

Figure 13: The relationship between often seeing patients in need of social services and patients experiencing problems



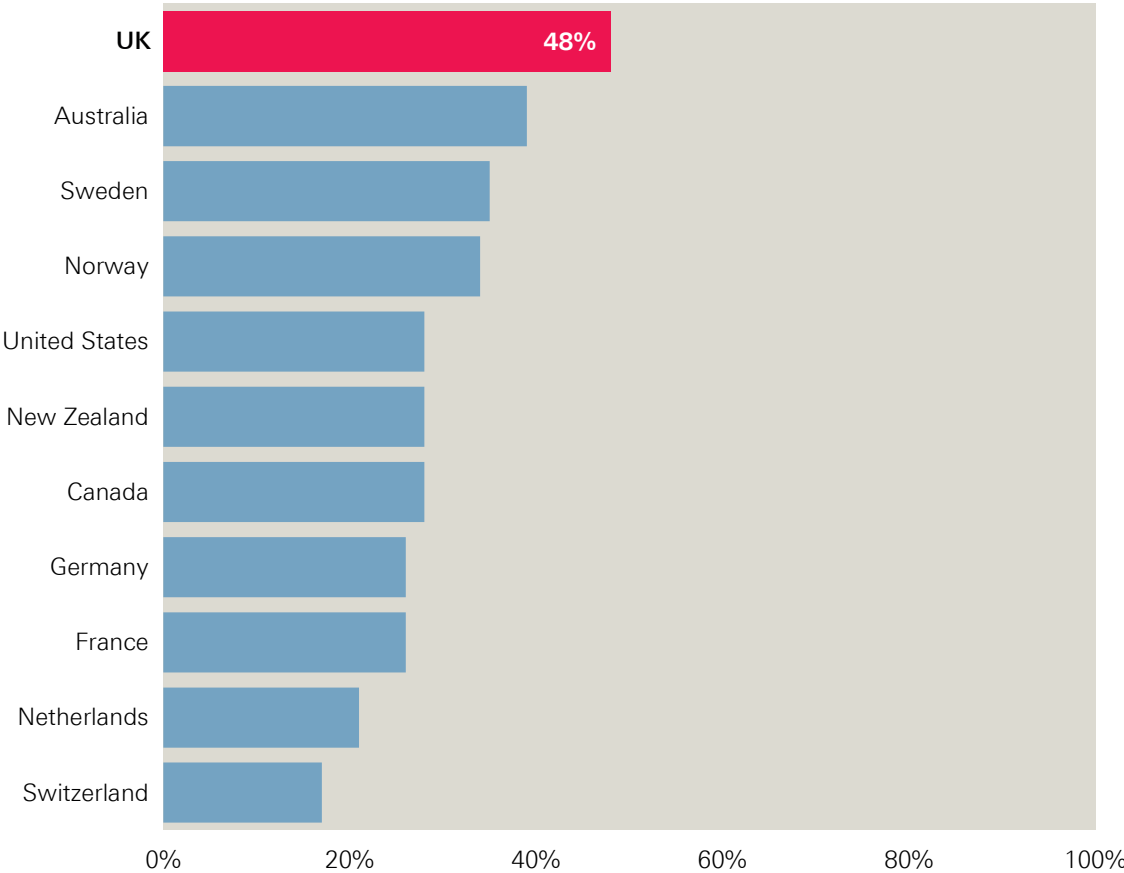
In the UK, there is a clear relationship between difficulty coordinating care and this impact on patients. As Figure 14 shows, of GPs who reported that a patient experienced problems in the past month, 75% find it difficult or very difficult to coordinate care. For GPs where a patient has not experienced problems, this figure is 51%. Conversely, 48% of the GPs where a patient has not experienced problems describe coordinating care as ‘easy or very easy’, exactly twice the percentage of those GPs where a patient has experienced a problem (24%).

Figure 14: The relationship between the patients experiencing problems and GPs’ difficulty coordinating care across providers



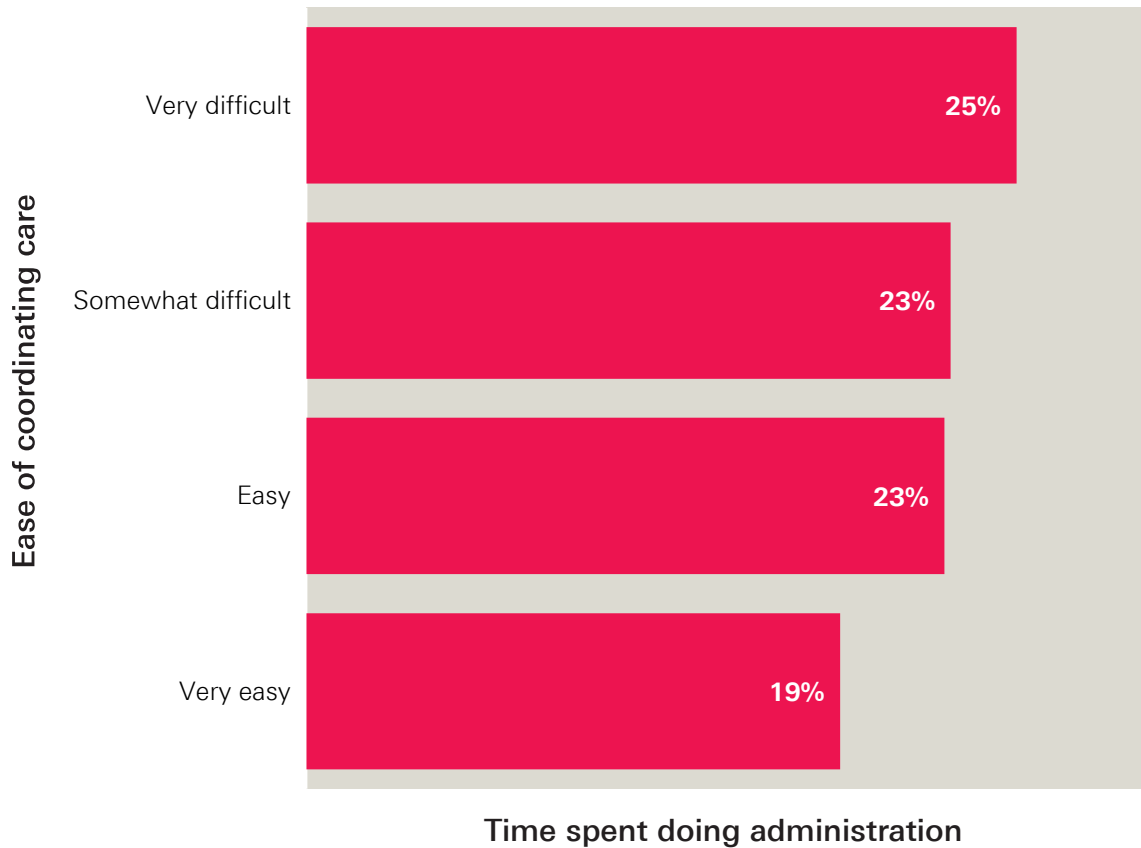
The UK also has the highest rate (48%) of respondents reporting the need to repeat tests due to lack of availability of test results (Figure 15). This suggests an impact on the patient due to poor coordination, but it is unclear if these problems are within or between organisations.

Figure 15: Percentage of respondents who had to repeat tests or procedures because results were unavailable



Across all the countries featured in the survey there is an association between GPs reporting difficulty coordinating care and the amount of their time spent doing administrative tasks. This may indicate poor internal processes within the primary care setting, affecting both coordination and time required for administrative work (Figure 16).

Figure 16: The relationship between difficulty coordinating care with other providers and time spent doing administration



The survey’s contains clear messages about care coordination in the UK:

- While the processes for GPs to communicate with acute providers are good relative to those in the other countries featured in the survey, there is clear room for improvement when it comes to communicating with other kinds of providers.
- The difficulty GPs are having in trying to coordinate care is impacting on patients.

This is in line with the findings from other international reviews, with a recent report from the Health Foundation suggesting that ‘the UK’s health system has strong foundations to work with. However, more could be done to prevent and treat ill health, both within and outside of the remit of the NHS’.²²

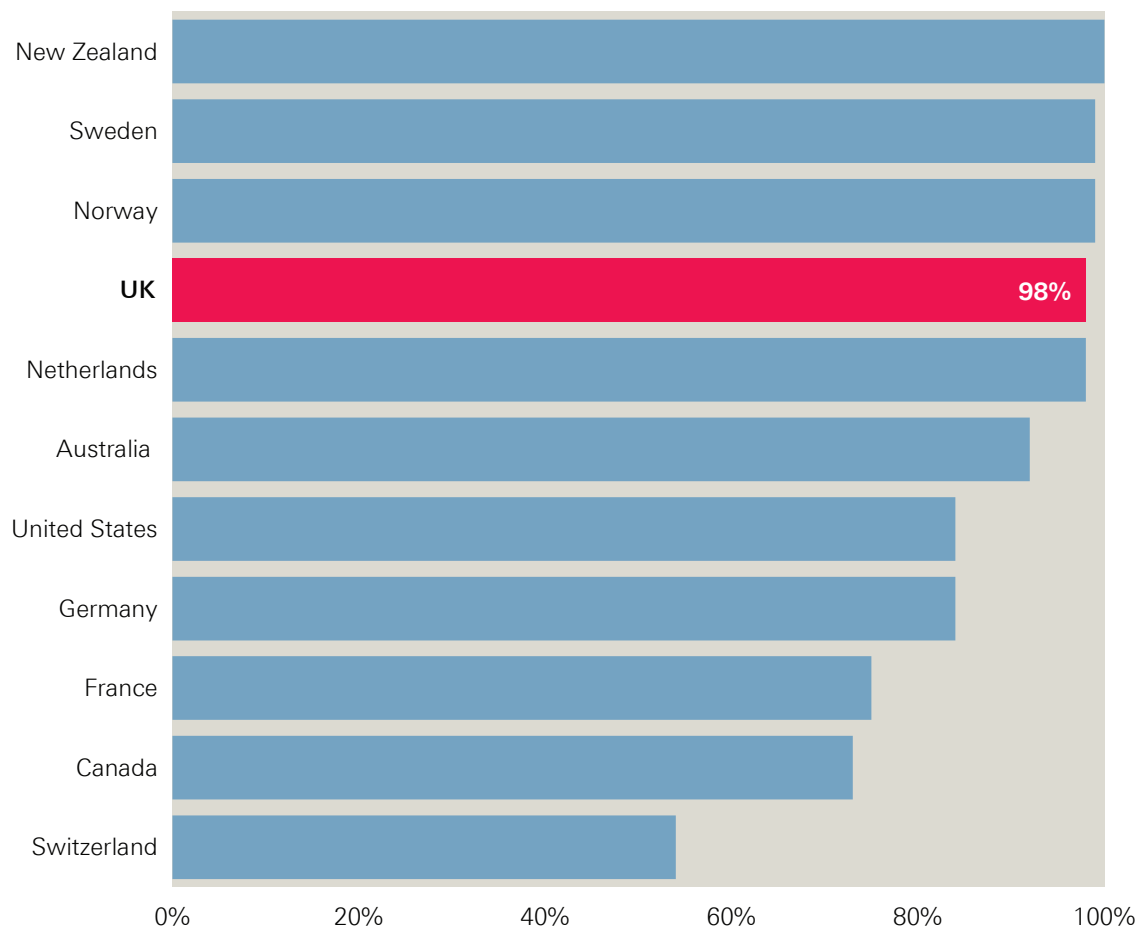
Electronic medical records

In previous surveys by the Commonwealth Fund, UK general practice has tended to be more advanced in the use of information technology than other countries.²³ Despite some high profile difficulties in the area, such as the National Programme for IT,²⁴ the UK has often been at the forefront of use of information technologies on a national scale.

In England, the *NHS Five Year Forward View* (Forward View)¹⁷ states an intention to ‘exploit the information revolution’, particularly through the development and use of electronic patient medical records (EMRs). The Forward View set out an approach where the national focus is to provide ‘electronic glue’ to enable systems to work together, and local areas are free to innovate.

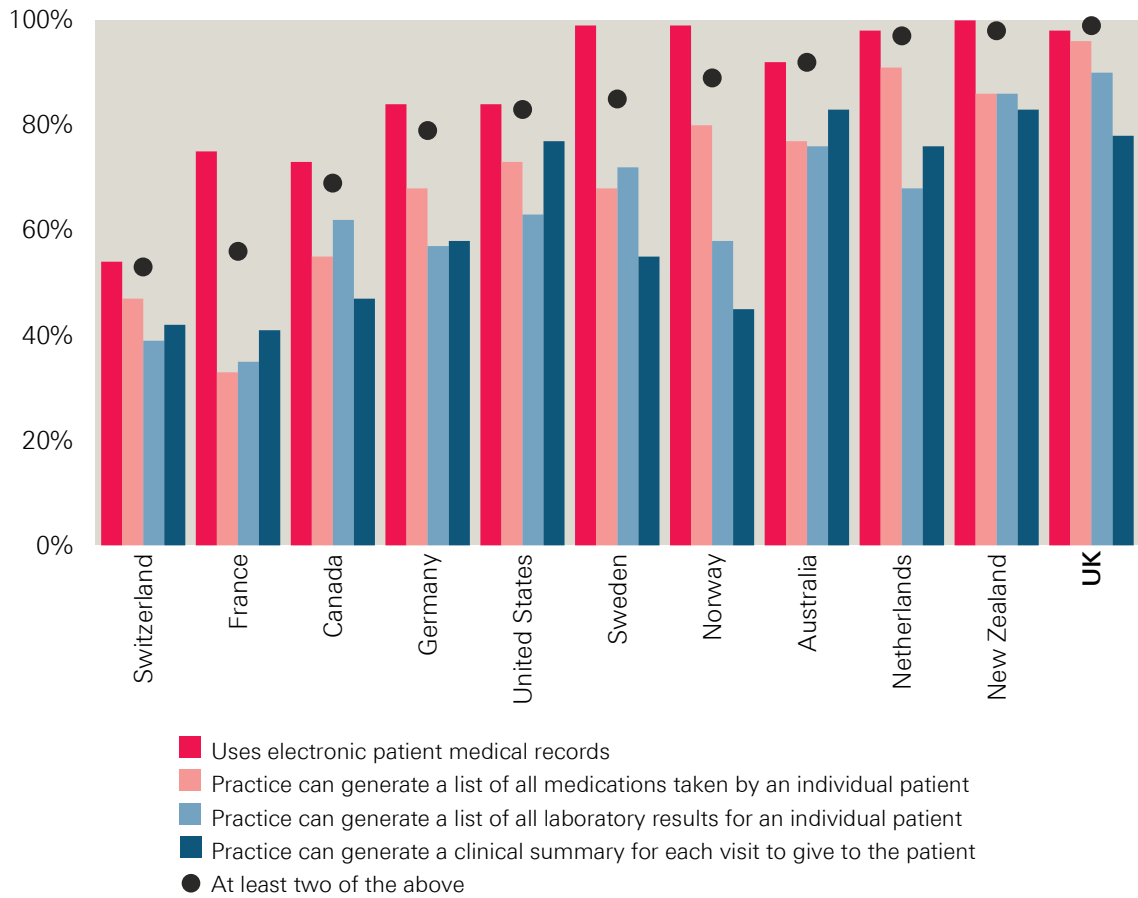
The Commonwealth Fund survey shows that the UK consistently performs well against other countries in its use of EMRs. Just 2% of GPs do not routinely use EMRs in their daily practice (Figure 17); down from 11% in a similar study conducted by the Commonwealth Fund in 2006.²⁵

Figure 17: Percentage of respondents who use electronic patient medical records in their practice (not including billing systems)



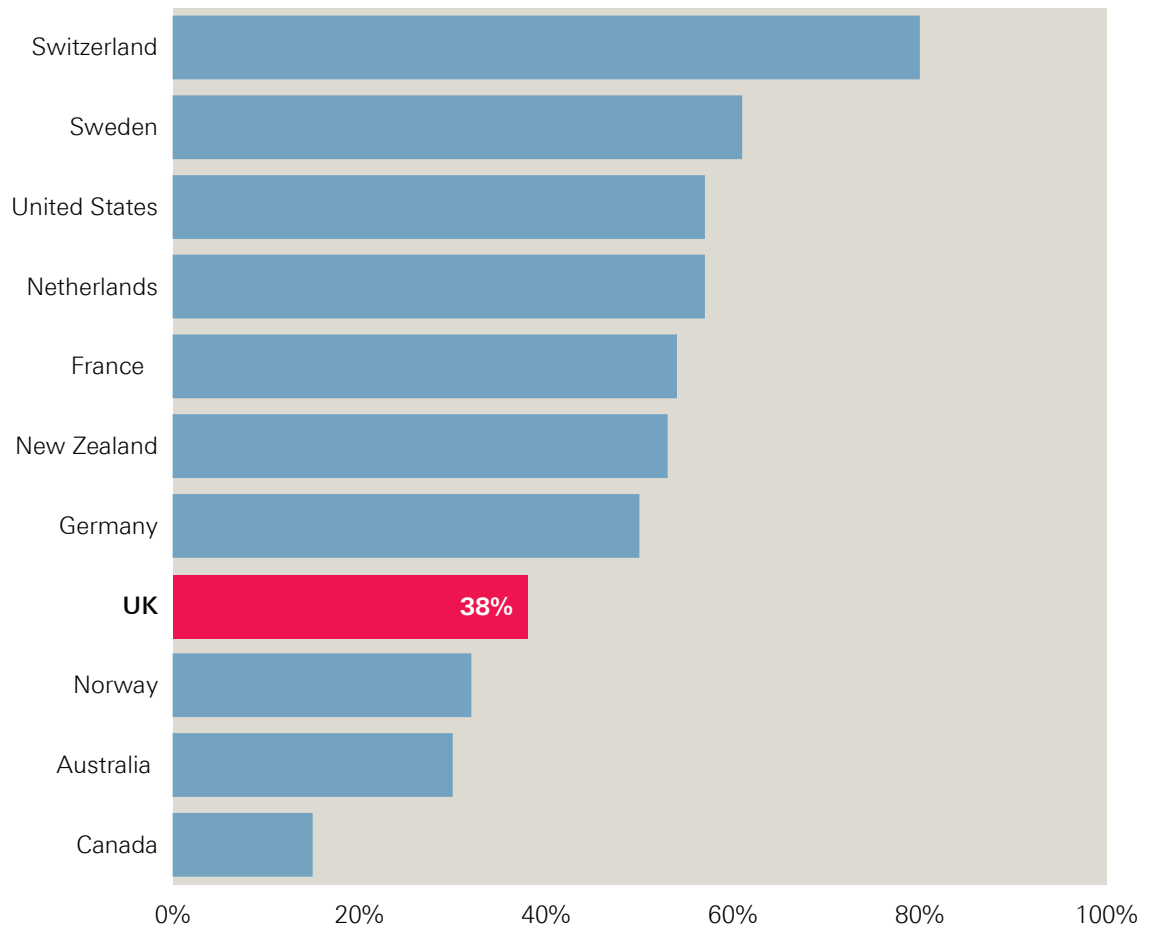
How the EMR is then used varies within the UK but again compares well with other countries. Figure 18 breaks down how the EMR is used by different GPs in the UK compared with primary care physicians in other countries featured in the survey. In almost every area the UK is leading or close to leading the rest of the world. The majority of GPs can generate a list of medications taken by a patient (96%), a list of laboratory results (90%) and a clinical summary for each patient (78%). There is no uniform EMR system for GPs so, for example, while some EMRs may provide prompts to alert patients about test results, others will not.

Figure 18: The percentage of electronic systems with advanced capabilities



However, the UK lags behind a number of other countries when it comes to GPs reporting that patients can email them with a question or concern (38%, Figure 19).

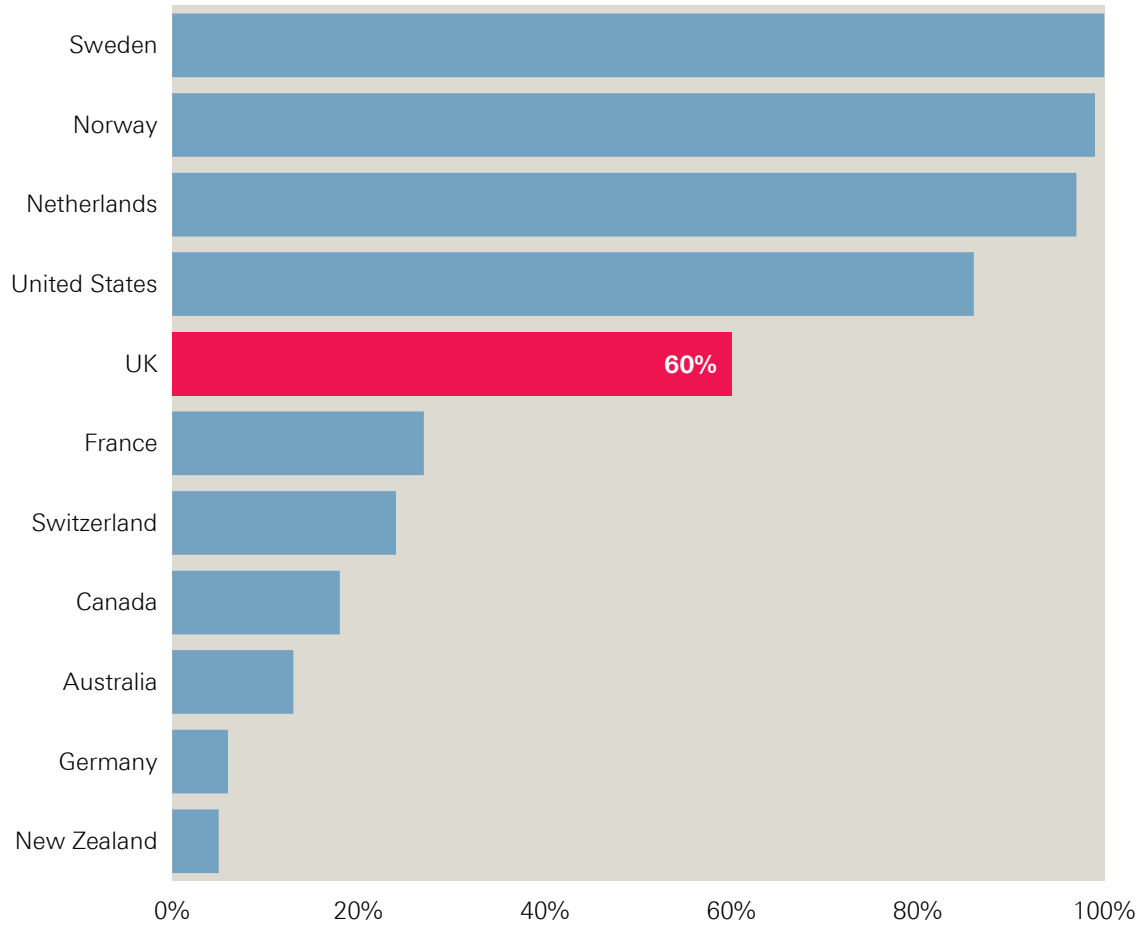
Figure 19: Percentage of practices where patients can email with a question or concern



Some of this may be due to the different functions different EMRs have, although cultural resistance – such as a fear of being swamped with email – could also be a factor.

Figure 20 shows the variability of practices being able to transfer prescriptions to a pharmacy electronically, with the UK some way behind leading countries.

Figure 20: Percentage of practices able to transfer prescriptions to a pharmacy electronically

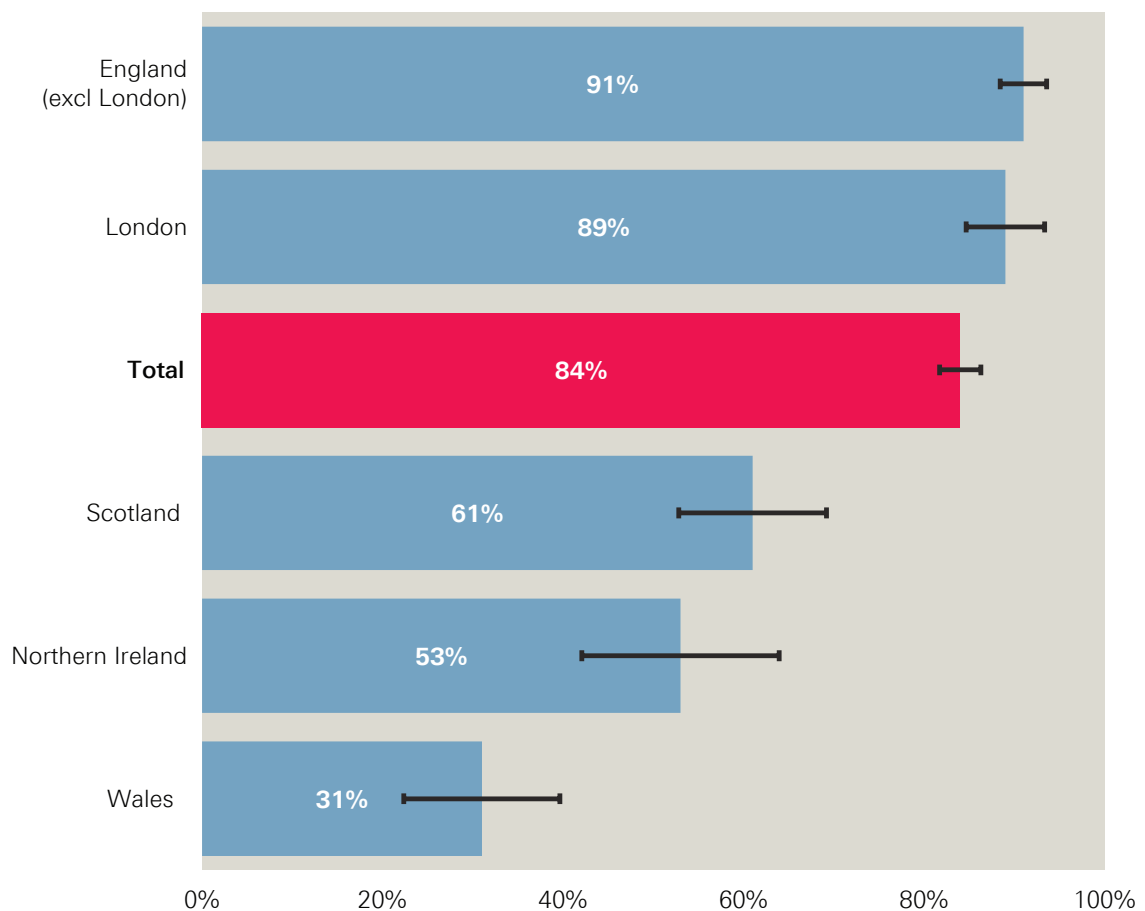


Variation within the UK

While EMRs are widespread across the UK, there is significant variation in how they are used in different regions and countries. Some of this may be due to growing differences between the health care systems in the four countries of the UK (England, Scotland, Northern Ireland and Wales).

There is a need for some caution in comparing the different parts of the UK as the needs of primary care in London (which is reported separately from the rest of England) may be very different from those in Scotland. The small number of GPs interviewed for the survey in some countries (see Box 1 on page 4) also means there is a danger of drawing too much from the data. To highlight this, margins of error are displayed on Figures 21-23, which show regional variation.^{*} However, even allowing for these caveats, in several instances the variations appear stark. For example, the difference between the ability of GPs in England and Wales to order laboratory tests electronically (Figure 21) are pronounced: 31% in Wales and 91% in England.

Figure 21: Percentage of practices routinely or occasionally using electronic ordering of laboratory tests

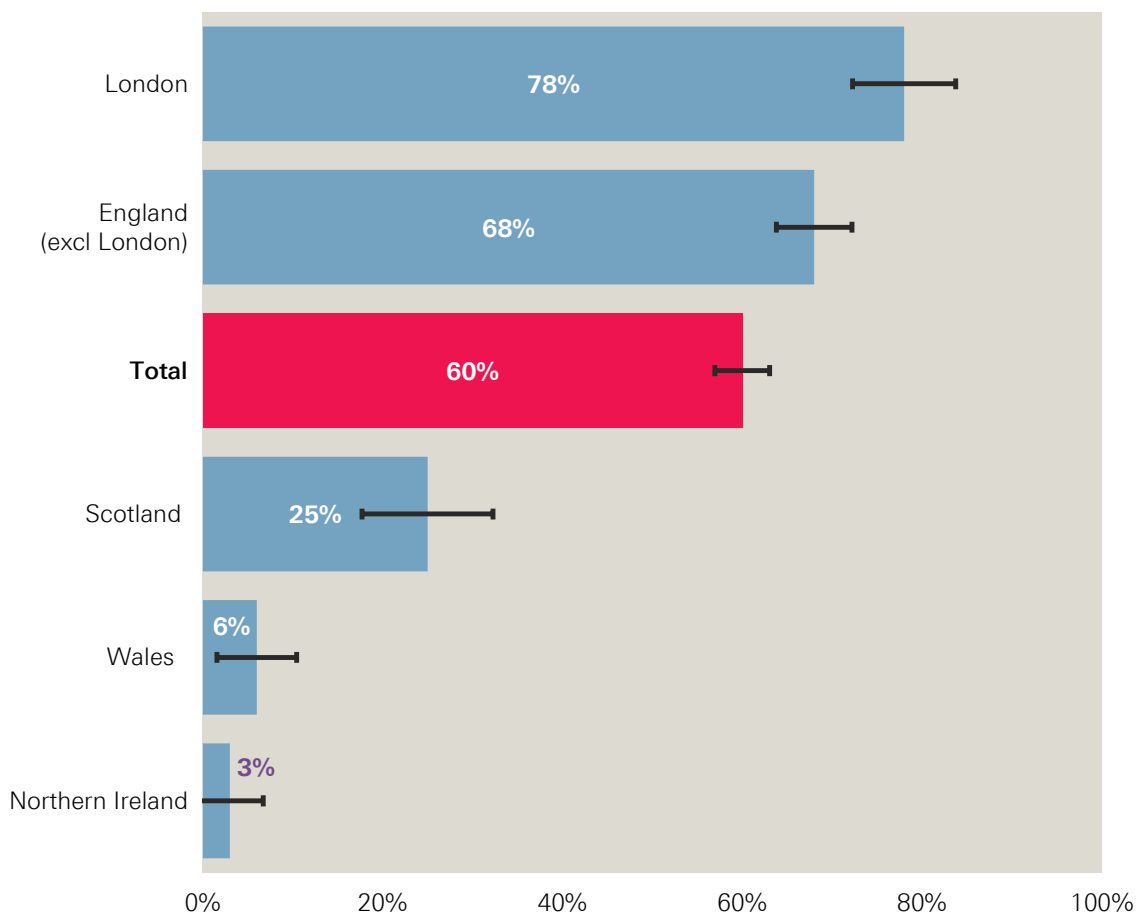


^{*} For more details of these margins of error, see Box 1 on page 4.

There is again a need to be careful in how these results are interpreted – for example, it could be that more laboratory testing is done within GP practices themselves in some areas, eliminating the need for electronic ordering and skewing results in certain parts of the UK. Patients may actually receive a better service when ordering is not done electronically. However, such stark variation does demand a better understanding of what is happening in each area.

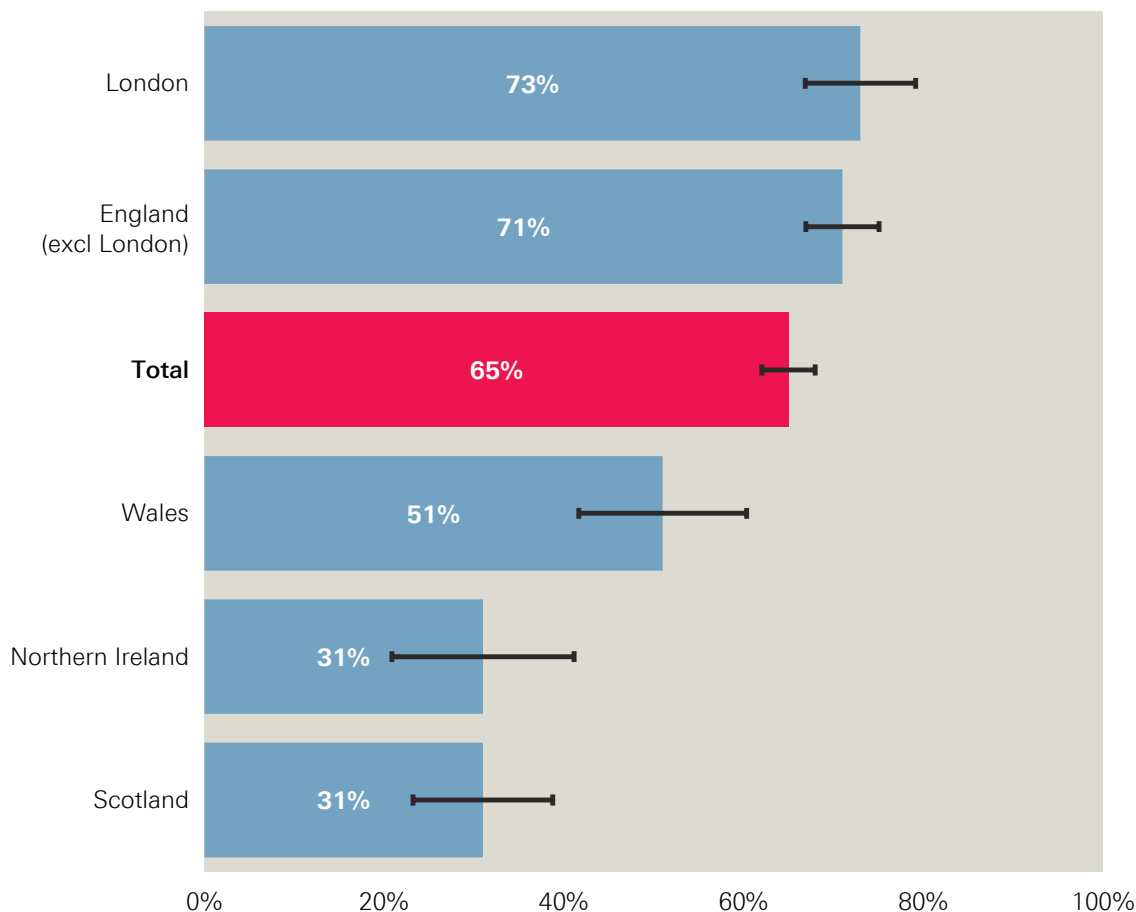
There is an even sharper variation in electronic transfer of prescriptions. While almost four-fifths of London GP practices can electronically transfer a prescription to a pharmacy, in Northern Ireland the GPs surveyed reported that it is very rarely possible. This does again come with a caveat about sample sizes and error margins but, even so, the variation seems notable.

Figure 22: Percentage of practices able to electronically transfer prescriptions to a pharmacy



The survey also found wide variation in practices receiving an alert or prompt to provide patients with test results (Figure 23).

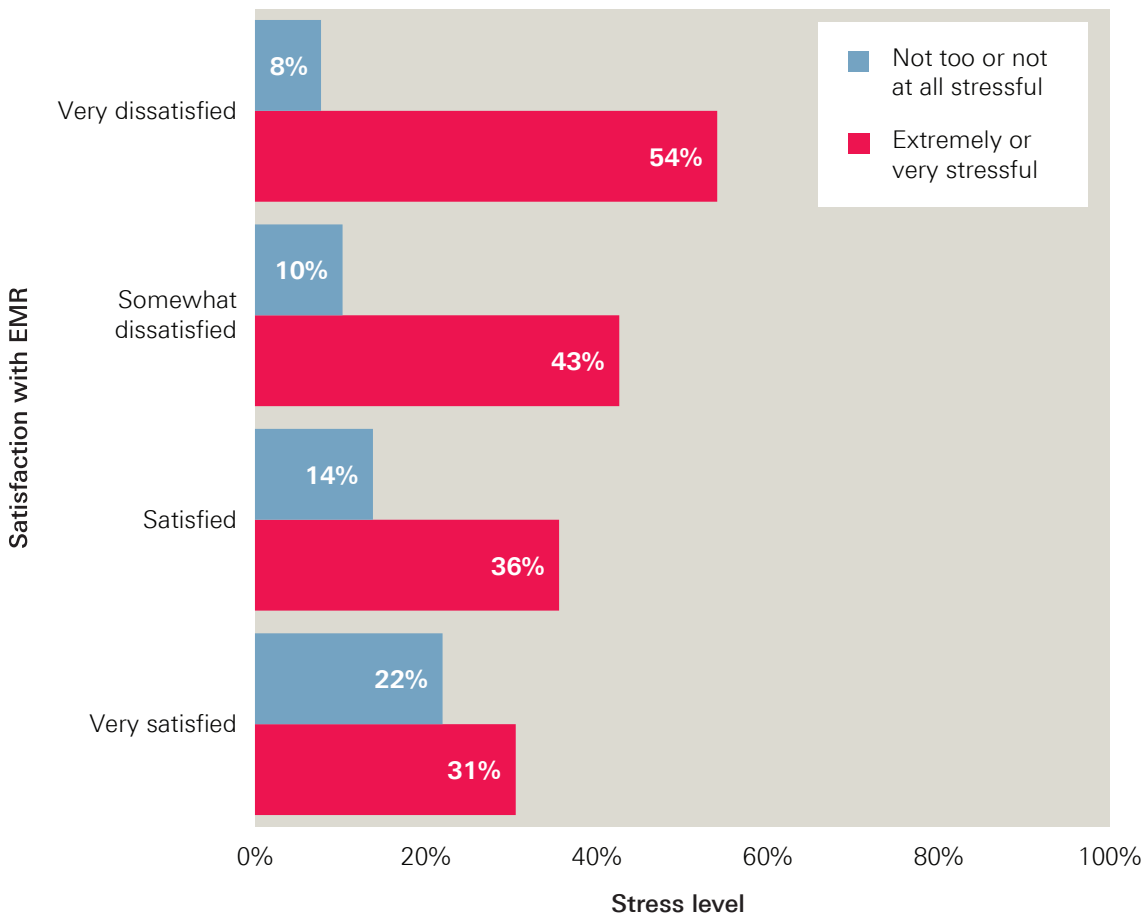
Figure 23: Percentage of practices receiving an alert or prompt to provide patients with test results



There is little empirical research as to why these variations exist. A 2015 study that spoke to pharmacists working with EMRs suggested reasons including: technical problems, a resistance to changes to routine work practices and fear of weakened interpersonal communication.²⁶ It is also possible that eliminating variation is largely a matter of time. EMR systems are comparatively new and it simply takes some years to roll out best practice. The increased use of EMRs over the last recent years would point to this.

This variation in use and function of EMR systems is important to understand better as it could have implications for the coordination of care and GP stress, discussed earlier in this report. Across all the countries featured in the survey, there was a correlation between GPs' satisfaction with their EMR and how stressful they find their job (Figure 24). A strong, functioning EMR would seem to be integral to a strong primary care system.

Figure 24: The relationship between GPs' satisfaction with their EMR and how stressful they find their job



Discussion

General practice, like other areas of health care, is constantly developing and subject to national reform.

For example, the desire to expand the range of primary care services and the role of general practitioners is evident in 1997's *The new NHS: modern, dependable*;²⁷ it takes centre-stage in 2006's *Our health, our care, our say*;²⁸ it runs throughout 2014's *NHS Five Year Forward View*.¹⁷ Jeremy Hunt's first major speech following the 2015 election was to announce a 'new deal' for GPs. 2011's *Together for health: A five-year vision for the NHS in Wales* gives just one example of how a focus on primary care is not just an English phenomenon.¹⁸

The 2015 Commonwealth Fund survey provides an insight into the development of aspects of general practice in the UK, relative to international peers. There are some positive findings: the UK's performance on using electronic medical records, and a number of communication processes relating to coordination of care, is comparatively strong.

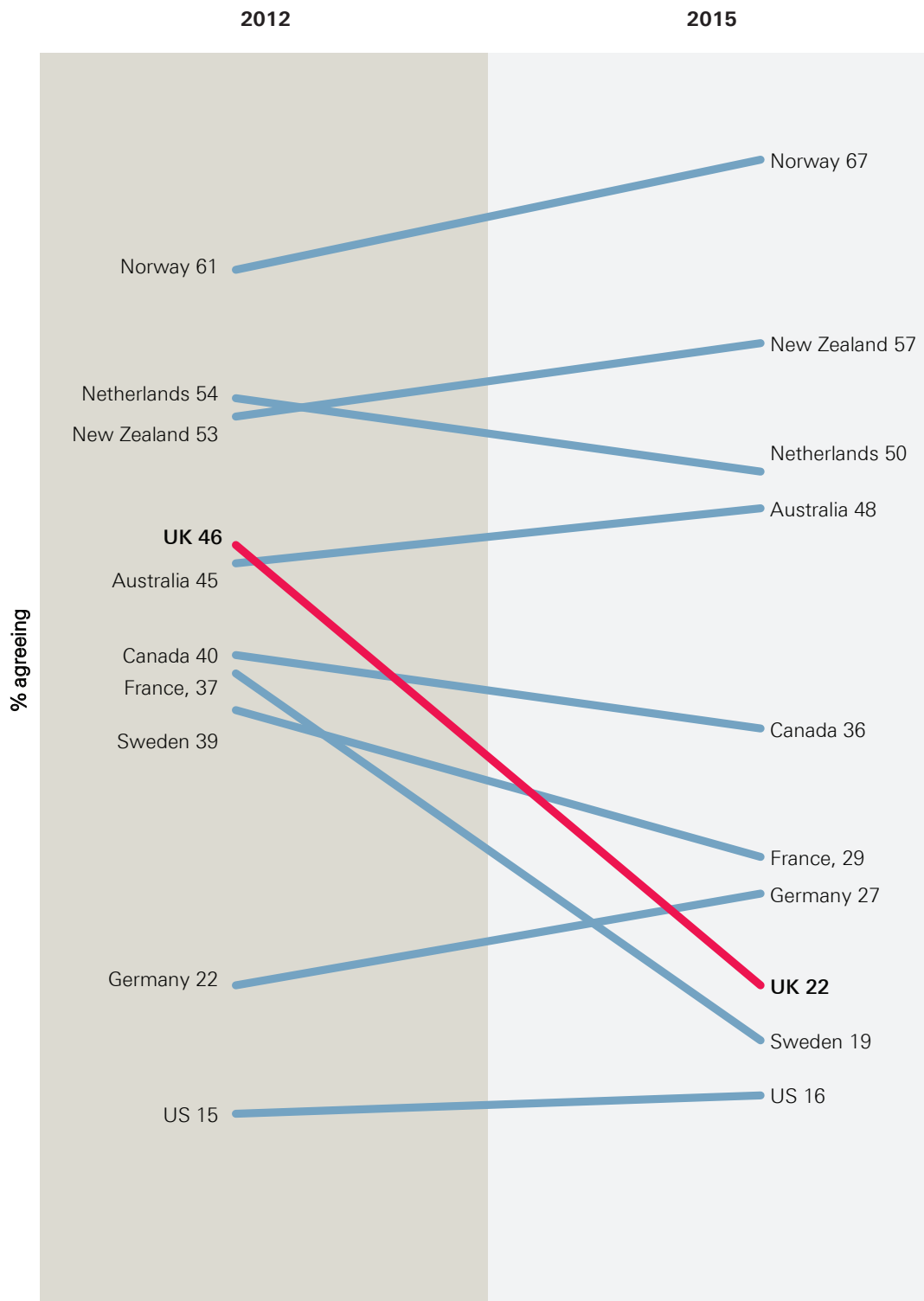
However, the survey also portrays a picture of GPs in the UK who are more stressed, both compared to their international counterparts and also to previous years. UK GPs increasingly think that the system requires change: in the 2012 Commonwealth Fund survey, 46% of UK GPs felt that the system worked well and only minor changes were needed. By 2015 this had collapsed to 22%, the biggest decline of any of the countries featured in the survey, and only higher than the US and Sweden (Figure 25).

The level of stress, and the high proportion of GPs who intend to leave practice in the next five years, is worrying for two major reasons.

The most pressing issue is likely to be the impact on the number of practicing GPs in the workforce. The NHS in England has set great store in seeking to recruit 5,000 more GPs by 2020. However, the Commonwealth Fund survey indicates retention is likely to be as great a challenge – if not more so – than recruitment. Of the 29% of current GPs who say they intend to leave general practice within five years, a third are under 55 and not looking to retire. This group, representing around 10% of current GPs, should become a special focus for initiatives to retain GPs.

In addition, any vision for developing primary care will only happen if GPs actively support its aims, and have the capability and capacity to deliver it. The work now needed by GPs to develop new care models needs time and energy; the survey casts doubt on the amount of 'headspace' UK GPs have to plan significant changes to their services. GPs in the UK, more than in any other country surveyed reported stress at work, with the limited amount of time they are able to spend with patients likely to be a key contributing factor.

Figure 25: Change in whether GPs feel the system works well and only minor changes are needed, 2012-2015



Action is needed to address both of these issues. The survey suggests the following four areas policy makers should explore further.

- **Consider longer appointment times.** The Commonwealth Fund survey identified an association between higher dissatisfaction and shorter time spent with patients on direct patient care. On average, 92% of GPs in the UK report appointments of less than 15 minutes per patient, compared with 27% of GPs in other countries featured in the survey.

Addressing this imbalance will not automatically restore satisfaction among GPs and will not be right for every appointment. The association between stress and short appointment times is not necessarily causal. However, the findings show the UK as an extreme outlier on this issue and so it would be unwise to ignore it. One option is to encourage greater experimentation and learning between areas; potentially across the four UK countries, or within England, building on the Vanguards, or Prime Minister's GP Access Fund.

- **Confront other GP stressors, particularly 'external requirements'.** There has been interest at a national level to reduce the burden of bureaucracy on general practice from cumulative external demands (for example from the Department of Health, NHS England and regulators). This is unfinished business.

At practice level, increasing demands for care from patients could be improved with better use of IT and scheduling of appointments.³

- **Understand variation in use of EMRs.** Although the UK is an international leader when it comes to availability and use of EMRs, there is wide variation in how they are used around the UK. For example, 91% of GPs in England order laboratory tests electronically, compared to just 31% in Wales. The variation has implications for the coordination of patient care, as well as the stress experienced by GPs.

The causes of the variation could be many and varied – and, indeed, quite legitimate based on local circumstance. But there is a need to identify more clearly the reasons for variation so they can be tackled if necessary. Previous research on this is sparse but some areas to consider are technical problems, changes to routine work practices and overcoming fears of weakened interpersonal communication.²⁶

- **Improve coordination with services beyond the NHS.** The survey shows that no single country has 'solved' care coordination. While the UK performs reasonably well with regard to how processes of care operate between GPs and hospitals, this is against a low international base, and against much lower reported coordination between general practices and community services. In addition, the survey implies that any structural advantages in the UK are not always feeding through to a better experience of care by patients: despite some strong processes, the UK is a clear outlier performing badly in terms of patients experiencing specific incidents of poor care because that care was not well coordinated.

There is no clear reason for this breakdown of coordination in patient care but something is going wrong between our comparatively good processes between GPs and hospitals and the problematic patient experience. The reasons for this need to be further researched and better understood and much better data is required. With increasing focus across the UK on coordination as a way to improve quality and reduce costs, it is important to build on the infrastructure already in place.

Above all, the survey highlights the interrelated nature of the challenges facing GPs. To excel internationally, the UK urgently needs strategies which take into account and seek to address the multiple interwoven factors at work in primary care.

References

1. NHS England. *GP Patient Survey 2014-15*. Available from: www.england.nhs.uk/statistics/2015/07/02/gp-patient-survey-2014-15/ (accessed 8 January 2016).
2. Commonwealth Fund. *2012 Commonwealth Fund International Survey of Primary Care Doctors*. Available from: www.commonwealthfund.org/interactives-and-data/surveys/2012/nov/2012-international-survey (accessed 8 January 2016).
3. Gibson J, Checkland K, Coleman A, Hann M, McCall R, Spooner S, Sutton M. *Eighth National GP Worklife Survey*. Policy Research Unit in Commissioning and the Healthcare System (PRUComm), 2015.
4. HSCIC. *2006/07 UK General Practice Workload Survey*. Available from: www.dhsspsni.gov.uk/gp_workload_survey_2006_07.pdf (accessed 8 January 2016).
5. NHS Choices. *GP appointments - Patient choice*. Available from: www.nhs.uk/choiceintheNHS/Yourchoices/GPchoice/Pages/GPappointments.aspx (accessed 8 January 2016).
6. NHS England. *No. 291 General Medical Services Contracts Regulations*. NHS England, 2004.
7. Kassler WJ, Wartman SA, Silliman RA. Why medical students choose primary care careers. *Academic Medicine*, 1991;66(1): 41–43. Available from: www.scopus.com/inward/record.url?eid=2-s2.0-0026065158&partnerID=40&md5=40994f8badc82b1726b1541d4657911e (accessed 8 January 2016).
8. Dugdale DC, Epstein R, Pantilat SZ. Time and the patient-physician relationship. *Journal of General Internal Medicine*, 199;14 Suppl 1, S34–40. Available from: www.pubmedcentral.nih.gov/articlerender.fcgi?artid=1496869&tool=pmcentrez&rendertype=abstract (accessed 8 January 2016).
9. Wilson A, Childs S. The effect of interventions to alter the consultation length of family physicians: A systematic review. *Br J Gen Pract*. 2006;56(532):876-882.
10. NHS Staff Surveys – 2014 Results. Available from: www.nhsstaffsurveys.com/Page/1042/Past-Results/Staff-Survey-2014-Detailed-Spreadsheets/ (accessed 7 January, 2016)
11. Dale J, Potter R, Owen K, Parsons N, Realpe A, Leach J. Retaining the general practitioner workforce in England: what matters to GPs? A cross-sectional study. *BMC Family Practice*, 2015;16(1), 140. <http://doi.org/10.1186/s12875-015-0363-1> (accessed 8 January 2016).
12. Doran N, Fox F, Rodham K, Taylor G, Harris M. Lost to the NHS: a mixed methods study of why GPs leave practice early in England. *Br JGenPract* 2016;DOI: 10.3399/bjgp16X683425 (accessed 8 January 2016).
13. Hann M, Reeves D, Sibbald B. Relationships between job satisfaction, intentions to leave family practice and actually leaving among family physicians in England. *European Journal of Public Health*. 2011; 21(4), 499–503. <http://doi.org/10.1093/eurpub/ckq005> (accessed 8 January 2016).
14. Oxtoby K. *Switching specialty*. Available from: <http://careers.bmj.com/careers/advice/view-article.html?id=20000184> (accessed 6 January, 2016).
15. Public Bodies (Joint Working) (Scotland) Act 2014. Available from: www.legislation.gov.uk/asp/2014/9/contents/enacted (accessed 8 January 2016).
16. Compton Review (Transforming Your Care). Available from: www.transformingyourcare.hscni.net/wp-content/uploads/2012/10/Transforming-Your-Care-Review-of-HSC-in-NI.pdf (accessed 8 January 2016).
17. NHS England. *NHS Five Year Forward View*. NHS England, 2014. Available from: www.england.nhs.uk/ourwork/futurenhs/ (accessed 8 January 2016).
18. NHS Wales. *Together for health: A 5-year vision for the NHS in Wales*. NHS Wales, 2011. Available from: <http://gov.wales/docs/dhss/publications/111101togetheren.pdf> (accessed 8 January 2016).
19. Ernst & Young LLP. *National Evaluation of the Department of Health's Integrated Care Pilots*. RAND Europe, 2012. Available from: www.gov.uk/government/uploads/system/uploads/attachment_data/file/215103/dh_133127.pdf. (accessed 18 January, 2016).
20. Davis K, Stremikis K, Squires D, Schoen C. *Mirror, mirror on the wall*. Commonwealth Fund, 2014.
21. Nolte E, Pitchforth E. What is the evidence on the economic impacts of integrated care? European Observatory on Health Systems and Policies, 2014. Available from: http://www.euro.who.int/__data/assets/pdf_file/0019/251434/What-is-the-evidence-on-the-economic-impacts-of-integrated-care.pdf?ua=1 (accessed 8 January 2016).
22. Berry N. *How does the NHS compare with health systems in other countries?* The Health Foundation, 2015.
23. The Commonwealth Fund. *International Health Policy Surveys*. Available from: www.commonwealthfund.org/topics/current-issues/international-surveys (accessed 8 January 2016).
24. House of Commons Committee of Public Accounts. *The Dismantled National Programme for IT in the NHS*. House of Commons, London: The Stationery Office Limited, 2013. www.publications.parliament.uk/pa/cm201314/cmselect/cmpubacc/294/294.pdf (accessed 22 January, 2016).
25. Commonwealth Fund. 2006 International Health Policy Survey of Primary Care Physicians. Available from: www.commonwealthfund.org/interactives-and-data/surveys/2006/2006-international-health-policy-survey-of-primary-care-physicians (accessed 8 January 2016).

26. Hogan-Murphy D, et al. Healthcare professionals' perceptions of the facilitators and barriers to implementing electronic systems for the prescribing, dispensing and administration of medicines in hospitals: a systematic review. *Eur J Hosp Pharm* 2015;22:358–365. doi:10.1136/ejhpharm-2015-000722 (accessed 8 January 2016).
27. Department of Health. *The new NHS: modern, dependable*. Department of Health, 1997. Available from: www.gov.uk/government/uploads/system/uploads/attachment_data/file/266003/newnhs.pdf (accessed 8 January 2016).
28. Department of Health. *Our health, our care, our say*. Department of Health, 2006. Available from: www.gov.uk/government/uploads/system/uploads/attachment_data/file/272238/6737.pdf (accessed 8 January 2016).

About the Commonwealth Fund 2015 International Health Policy Survey of Primary Care Doctors

The Commonwealth Fund's 2015 International Health Policy Survey of Primary Care Doctors was undertaken by the Commonwealth Fund with core funding and co-funding from the following organizations: Bureau of Health Information; Health Quality Ontario; the Canadian Institutes of Health Research; the Canadian Institute for Health Information; Commissaire à la Santé et au Bien-être du Québec; La Haute Autorité de Santé; the Caisse Nationale d'Assurance Maladie des Travailleurs Salariés; BQS Institute for Quality and Patient Safety; the German Federal Ministry of Health; the Dutch Ministry of Health, Welfare and Sport; the Scientific Institute for Quality of Healthcare, Radboud University Nijmegen; the Norwegian Knowledge Centre for the Health Services; Swedish Agency for Health and Care Services Analysis; the Swiss Federal Office of Public Health; the Health Foundation; and any other country partners.

An additional UK sample for the survey was funded by the Health Foundation.

About the authors

Sara Martin joined the Policy Team at the Health Foundation after completing her training at Harvard Medical School. She has an MSc in Comparative Social Policy (focusing on health policy) from the University of Oxford. Previously she was a medical director and founder of a school-based health centre and a high school chemistry teacher. She has also been involved in research and grant-writing activities for several health charities.

Edward Davies is a Policy Fellow at the Health Foundation. Edward has spent the majority of his career working as a health journalist. Most recently, this saw him working as a North American Editor for the *BMJ* and, prior to that, writing for a range of trade and general publications from *Medeconomics* to *the Guardian*.

Ben Gershlick is an Economics Analyst at the Health Foundation. Previously he was a Policy and Economics Analyst and a Strategy and Policy Officer at the Health Foundation. Before joining the Health Foundation, Ben was at the Department of Health and Channel 3 Consulting. Ben has an MSc in International Health Policy (focusing on health economics) from the London School of Economics and Political Science, where he also spent his time as an undergraduate.

The Health Foundation is an independent charity committed to bringing about better health and health care for people in the UK.

Our aim is a healthier population, supported by high quality health care that can be equitably accessed. We learn what works to make people's lives healthier and improve the health care system. From giving grants to those working at the front line to carrying out research and policy analysis, we shine a light on how to make successful change happen.

We make links between the knowledge we gain from working with those delivering health and health care and our research and analysis. Our aspiration is to create a virtuous circle, using what we know works on the ground to inform effective policymaking and vice versa.

We believe good health and health care are key to a flourishing society. Through sharing what we learn, collaborating with others and building people's skills and knowledge, we aim to make a difference and contribute to a healthier population.

The Health Foundation

90 Long Acre, London WC2E 9RA

T +44 (0)20 7257 8000

E info@health.org.uk

🐦 [@HealthFdn](https://twitter.com/HealthFdn)

www.health.org.uk

ISBN: 978-1-906461-75-1

Registered charity number: 286967

Registered company number: 1714937

© 2016 The Health Foundation