Inflation - its impact on GP Practice Finances

At the GPC England meeting on 19 May 2022 I was tasked to look at the consequences of inflation on general practice finances. Two of us are sufficiently senior that we remember what it was like to run a practice during periods of high inflation. You may think 10% is bad but at one point we touched 22% inflation and had 15% mortgage interest rates. We had the protections of a DDRB and in 1980 we got a straight 44% (Forty four percent) pay rise, in 1991 26%.

It is important to understand that general practice financing has changed particularly since 2004 and means that general practitioners are much more exposed to inflation than they were prior to 2004. First, our expenses ratio was in the middle 50% region - it is now touching 70% and simple mathematics will demonstrate that once the expenses ratio goes much beyond 60% small increases in overheads can result in large falls in net disposable income UNLESS GROSS turnover is increased to compensate.

When general practitioners came into the National Health Service in 1948 along with all other doctors their pay was based upon the average of their 1936, 37, 38 tax returns upgraded to take account of wartime inflation. By 1952 general practice was in trouble because societal post-war reconstruction had produced significant inflation and there was no mechanism to increase doctors pay nor more importantly to estimate their practice expenses. Matters came to a head very rapidly and the BMA took the government to judicial review and Mr Justice Dankwerts gave GPs a 100% pay rise overnight but more importantly stated the principle that the expenses of the profession must be reimbursed to the profession in full. That principle has existed for 70 years.

Despite the 1952 judgement by 1957 the profession was in trouble again and the Pilkington Royal Commission was set up to look at doctors and dentists pay and resulted in the Pilkington report in 1960 which amongst other things set up the Doctors and Dentists Pay Review Body (DDRB but also set out many principles concerning the fair adjudication of pay for doctors given that the government controlled both supply and demand. It included mechanisms to secure reimbursement of expenses for GPs which are still true today. **The only problem is that most people have never read the Pilkington report especially government ministers**. From 1960 GPs moved from an implicit cost-plus contract arising from the Dankwerts judgement to an explicit cost-plus contract arising from the setting up of the DDRB. (Cost plus refers to costs of delivery of service i.e., expenses plus whatever income is deemed appropriate for each grade of doctor)

To inform the DDRB regarding expenses a technical steering committee (TSC) was set up. The TSC still exists in modified form and is made up of four groups of members, operating behind a Chinese wall, under the purview of the government chief statistician and operating to his professional standards meaning he is answerable only to Parliament. TSC consists of the statistical civil servants who originally existed in the Office of Manpower Economics, moving over to the NHS becoming eventually part of NHSI. The statisticians have total professional independence. Also represented at TSC are the four Departments of Health and representatives nominated by the BMA from the UK negotiating team with at least one member from each of the four nations. The TSC used to meet once a month for most of the day. It produced an annual report based upon crunching statistics from a wide variety of sources but most importantly from an anonymized and ultimately 100% sample of GP practice accounts. Over the years to 2004 it managed to estimate practice expenses to within £50 per principal despite periods of very high

inflation and over the period 1966 to 2004 was only £3000 adrift per principal – a truly remarkable scenario. The outputs of TSC were regarded by governments, the profession the Departments of Health and the DDRB as being beyond reproach and as close to scientific fact is it was possible to get. (Declaration of interest I was a member of TSC from 2000 to 2014 and led the delegation from 2006)

The result of this was that even during periods of high inflation (inflation rarely fell below double digits from 1970 to 1992) the profession always at least received automatic increases in what today would be termed the global sum but in those days was called IAGR (intended average gross remuneration) albeit about 12 months behind the relevant period of inflation. TSC became quite expert at estimating what the previous 12 months outturn would be and there was an interim expenses payment made which then became subject to a balancing mechanism in subsequent years. Even so, pre 2004 and particularly pre 1990 the largest single expenditure which GPs incurred was their borrowing costs reimbursements formerly known as cost rent. Cost rents were adjusted every time the bank rate changed which sometimes could be as frequently as monthly although in latter years the cost rent was fixed quarterly and even annually. Pre-2004 each GP principal was directly reimbursed for 70% of 2×37.5 hours per week ancillary staff and there were few high earners amongst that group as they were mostly receptionists. This was the reason that the expenses ratio was low enough that GPs could cope, albeit with some discomfort, periods of high inflation especially as the DDRB was fiercely independent of government rather than the puppet of government which it has become in the last 10 years

In 2004 the profession moved away from an explicit cost-plus contract back to an implicit one a policy decision which was not unanimous amongst the negotiators particularly those who were financially savvy because they felt it would only be a matter of time before the government ceased to properly reimburse increasing expenses and it would only be a matter of time before inflation would pick up again. Indeed, it took less than five years for the government to break its part of the bargain with the profession and that is why even before the current problems, we have lost 30% of our income since 2010.

We no longer have the protections of an explicit cost-plus contract and nor do we have a UK contract and nor do we have a truly independent DDRB. What we now have are multiple sources of money, often hard to track, local variations resulting in differential awards for the same piece of work around the country, a partially dislocated expenses calculation mechanism and no longer the ability to generate UK wide statistics because we now have four separate contracts. Much more importantly our businesses are more highly geared and as a proportion of our annual income we have a much greater investment in our businesses without any real reward for those risks and lost opportunity costs.

As general practice has become more complex and more difficult to manage coupled with local variations in demands made of general practice both by patients, commissioners and, increasingly trusts dumping work upon us, it is increasingly difficult to determine that GPs are universally paid a fair income and fair expenses for the same piece of work wherever it is undertaken. In short, we have pay anarchy and practice expense chaos. This is compounded by the fact that many GPs are not business savvy, many NHS managers have little experience of running a business in the commercial world, have even less experience of the world of general practice and no experience of having to put their house up as collateral to pay the monthly wages of staff when the NHS is simply forgotten or omitted to pay a practice!

Whenever one goes out to negotiate a fee for doctors we are faced with ignorance and also the public sector concept of "you are being paid more than the Prime Minister" by an ignorant management cadre who fail to recognise the difference between gross turnover of the business with the net reward after tax for the practitioner undertaking the work.

As we move into this period of inflation GPs very urgently need

1. to become much more efficient at working out what things cost to produce
2. learn to say no to work which does not turn a profit on its own without cross subsidy from other work.

The origin of the BMA fee engine is designed to precisely to educate doctors as to what a piece of work is likely to cost.

Turning to the issue of inflation itself for those on a salary inflation is effectively the reduction in buying power of a fixed salary so 10% inflation means you have 10% less buying power all other things being equal.

For GP principals if the turnover of the business is fixed (and it is for NHS general practice because government controls the price) then inflation is a nasty pincer movement because not only does the expenses ratio rise and therefore profits fall but what is left in profit has reduced buying power additionally, so it is a double whammy. It is very important to try and get a handle on what inflation means for your practice because there can be massive falls in liquidity and therefore drawings over a very short period even with quite modest inflation.

One cannot simply with any degree of accuracy apply the CPI or RPI to practice finances as the basket of goods which makes up these indexes may not mirror the basket of goods purchased in the running of practices. For example, most GP practices energy bills fall outside the government's caps, and we heard of energy bills tripling or quadrupling yesterday and such bills are a very significant part of the non-staff pay element of general practice finance. Therefore, it is important to try and work out the different weightings of the different categories of expenditure within your practice overhead envelope and it is hoped that we will provide further guidance on this shortly

In the meantime, attached is a simple calculator which will show you in general terms the impact of inflation on your drawings and your personal buying power but in very round terms for every 1% of inflation at a 70% practice expenses ratio you will lose 3% of your income. But it does not rest there. If we were to get subsequent years of 10% inflation without an increase in our gross turnover your income over we would have no income at all by the end of year 4 and by the end of year 2 we would have lost half our income

We would not survive beyond year 2 as I suspect that banks would call in loans which support our premises by that point.

This highlights the dangers of 5 year fixed deals with out explicit compulsory balancing mechanisms regarding practice expenses. The profession needs urgently to understand what steps are to be taken to sort this out

It is entirely UNFAIR and fles in the face of Dankwerts and Pilkington for GP principals to be expected to fund a 2% tolerance in expenses from their own pockets

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