

IS GENERAL PRACTICE IN CRISIS?

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HEADLINES ABOUT A 'CRISIS' in English general practice seem to have become a regular fixture. There are reports of some practices faced with closure, and many others staffed by a dwindling number of hard-pressed GPs, struggling to meet growing demand on reduced budgets. Many GPs are reported to be considering leaving the profession due to burn-out and low morale. Patient groups point to evidence of significant numbers of people finding it harder to get appointments when they need them.

ON THE OTHER SIDE OF THE DEBATE, critics of general practice in politics and the media argue that GPs have enjoyed disproportionately large pay increases in the past decade. They also claim that more patients have been driven to attend overloaded hospital A&E departments because GPs are no longer required to directly provide out-of-hours care.¹ As a result, many GPs feel besieged by hostility from the media and from political leaders who are driven to demand more and more from a stretched service.

CAN WE GET A CLEARER PICTURE by looking at the facts? And what can politicians do to help improve it? This briefing provides an evidence-based overview of the current state of general practice in England, and offers some potential solutions. It examines demand for GP services, the GP workforce, funding, and standards of access and quality of care. It then presents four ideas to help solve the problems facing general practice – and the wider NHS.

KEY POINTS

In terms of standards of care, there is no crisis yet in general practice.

Patient satisfaction with appointments remains high, and there is no clear sign of falling clinical quality. However, patient satisfaction with opening hours and appointment waits has been falling steadily for the last three years, suggesting access to GPs is getting worse.

However, a GP workforce crisis is emerging. Not enough GPs are being trained, more trainees now work part-time, and more existing GPs plan to retire early. Numbers are not keeping up with hospital doctors.

The number of small or single-doctor, traditional GP practices has been falling. The numbers of larger GP practices, and larger organisations like GP networks and practices with multiple sites, have been rising.

Despite the rhetoric of shifting care out of hospitals, general practice funding has lagged behind. GP proprietor earnings remain high, but they have been falling steadily. In the face of rising demand, general practice will need more money, general practice will need more money if it is to improve its ability to coordinate patient care.

New funding will not be enough on its own: it must help change and improvement. The trend towards larger organisations and networks should be supported by money to enable organisational development. This will allow GPs to achieve economies of scale and better, more efficient care through sharing clinical roles across practices; fostering effective links between practices, other professionals and organisations; and strengthening their management capacity.

Politicians should move away from top-down control and targets in general practice. Instead, they should design standards and contracts that let local GPs experiment and innovate, as long as they deliver certain outcomes for patients and the public.

There is a worrying lack of basic information about how many consultations general practices do, and who is doing them. Most estimates are still based on data from 2008. This must change so that taxpayers, policy-makers, and GPs themselves can understand what is happening in the sector.

WHAT HAS HAPPENED TO DEMAND FOR GP SERVICES?

Although an estimated 90 per cent of NHS contacts take place in general practice, no public body records how many consultations take place, or which practices or staff groups undertake them. Over the course of 2014, the debate on the pressure facing GPs has been based on workload figures from 2008.² The frequently cited figure of 340 million GP consultations a year suggests a rise of 13 per cent in four years. However, this is a projection from the 2008 data, which were based on a sample of practices.

This absence of up-to-date and comprehensive activity data in general practice is a serious problem: it reduces planning to guesswork and the debate on pressures on general practice to exchanges of anecdotes. It also represents a lack of accountability for the use of public money by the bodies that plan and pay for primary care, the ‘first-point-of-contact’ services that include general practice alongside dentistry and community pharmacy.

Demand is likely to have grown since 2008: the population has increased, people are living longer, and more long-term illnesses like diabetes are affecting people of all age groups. It is not clear whether the reports of increased workload are due to more consultations, more patients with complex and time-consuming problems or other reasons, such as increased administrative requirements in general practice. The Nuffield Trust plans to publish analysis later this year on trends in GP consultations. In the absence of analysis of actual trends, we would advise policy-makers to be cautious about existing estimates of increased consultations.

WHAT HAS HAPPENED TO NUMBERS OF STAFF IN GENERAL PRACTICE?

‘During the period 2006–13, the total GP workforce increased by four per cent’

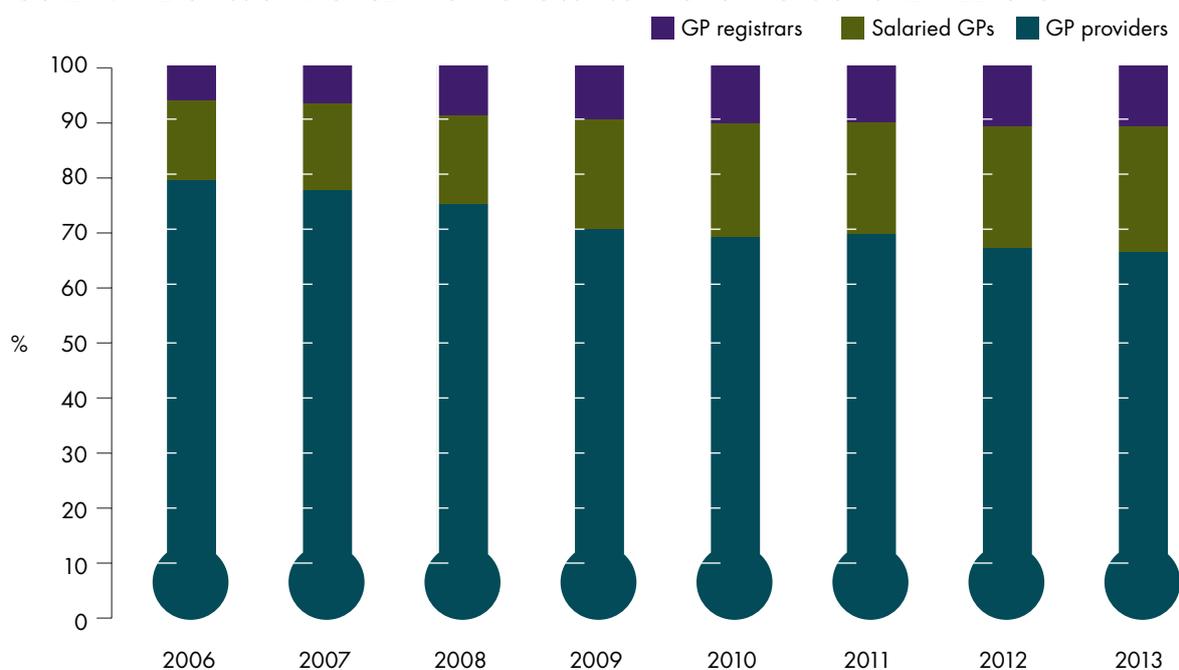
Although there is uncertainty about the scale of increase in demand for GP appointments, there are grounds for concern about whether there are adequate levels of staff, now and in the future:

- During the period 2006–13, the total GP workforce³ rose by four per cent, representing an increase of 1,144 (total number in 2013: 32,075). However, from 2010 to 2013 the number of GPs per 100,000 population in England fell slightly, from 60.5 to 60.⁴
- The growth in GP numbers has lagged behind other qualified clinical staff. Between 2006 and 2013, the number of consultants in hospital and community services grew by 27 per cent.
- From 2010 to 2013, numbers of general practice nurses in England increased by two per cent⁵ – although this followed 10 years of generally more rapid growth.⁶

- Over the same period, the number of administrative and clerical staff in general practice increased by four per cent.⁷ This could reflect moves to divert administrative tasks to free up doctors' time for patients. It could also be a sign of growing demands on practices to collect data and complete reports on the quality of care for a range of outside bodies.
- The number of GPs stating that they intend to 'quit direct patient care in the next five years' rose from six per cent in 2010 to nearly nine per cent in 2012 among those under 50 years old – and from 42 per cent to 54 per cent among the over-50s. One reason may be that GPs in 2012 reported the lowest job satisfaction for a decade.⁸
- Up to last year, almost all the slots for new GP trainees in practices were still being filled – but figures for 2014 suggest that more than one in ten was left empty.⁹
- Health Education England, responsible for doctors' training, has a target for half of all medical students to choose general practice as their specialty by 2016.¹⁰ But that target has already had to be put back a year: only 40 per cent chose general practice in 2013.¹¹
- The demands on GPs' time for participation in clinical commissioning groups and other external work has grown.

The characteristics of GPs and the way they work are also changing. There is a trend towards part-time working, with 12 per cent of GP trainees now working in this way.¹² A driver of this is the increasing number of women who are more likely to work part-time.

FIGURE 1: THE GP WORKFORCE HAS A GROWING PROPORTION OF SALARIED GPs¹³



Source: HSCIC, General and Personal Medical Services, England 2006–13

'The number of one-doctor practices almost halved between 2006 and 2013'

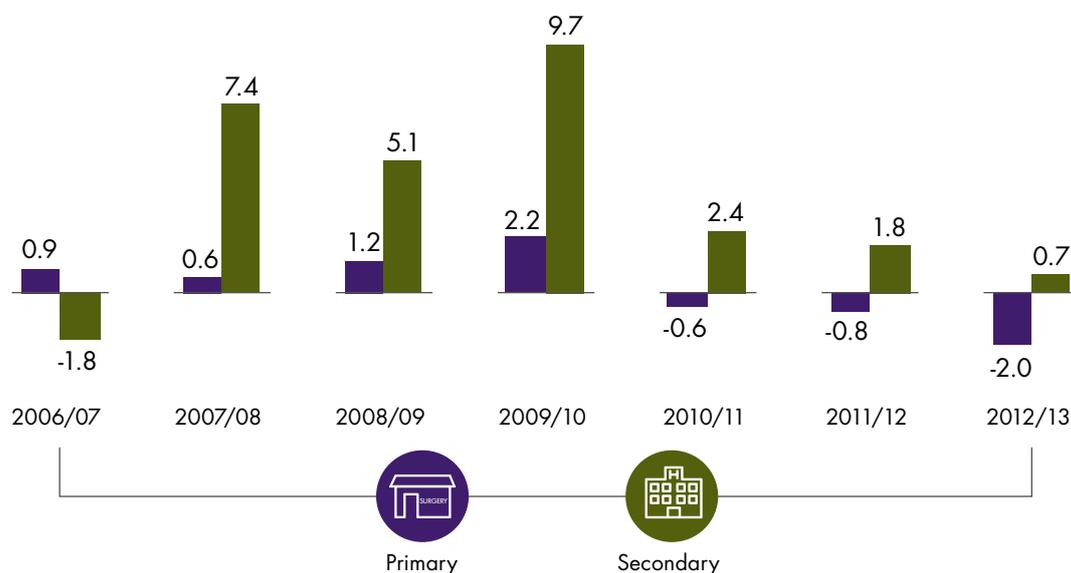
There has been a shift in the profession from being dominated by GP partners working as independent contractors,¹⁴ to one where many doctors work as salaried employees, usually within GP partnerships. In 2013, GP 'providers' who held their own contracts accounted for 66 per cent of the GP workforce, down from 79 per cent in 2006.¹⁵

This change from GP owner-operators towards salaried GPs is accompanied by a trend towards fewer, bigger GP practices. The total number of practices in England has fallen by four per cent, and the number of one-doctor practices almost halved between 2006 and 2013. Meanwhile, the number of practices with 10 or more GPs increased by 76 per cent to 510 in 2013, over the same period.¹⁶ This is part of a wider trend within GP organisations seen in many other European countries. Larger, multidisciplinary, primary care organisations or networks have been highlighted by European primary care policy experts as more suited to care for older people and those with complicated or multiple illnesses, when more specialised treatment from a wider team of professionals is increasingly needed outside hospital.¹⁷

HOW TOUGH IS THE FINANCIAL SQUEEZE?

Although health care spending has risen by 22 per cent in the last seven years,¹⁸ much of this has gone to the NHS' secondary care services, to which patients are referred by general practice and other areas of primary care. In particular, it has gone to fund hospital care.

FIGURE 2: ANNUAL PERCENTAGE CHANGE IN SPENDING ON PRIMARY AND SECONDARY CARE SINCE 2006/07 (REAL TERMS)



Source: Primary care trust annual accounts data, 2006/07 to 2012/13.

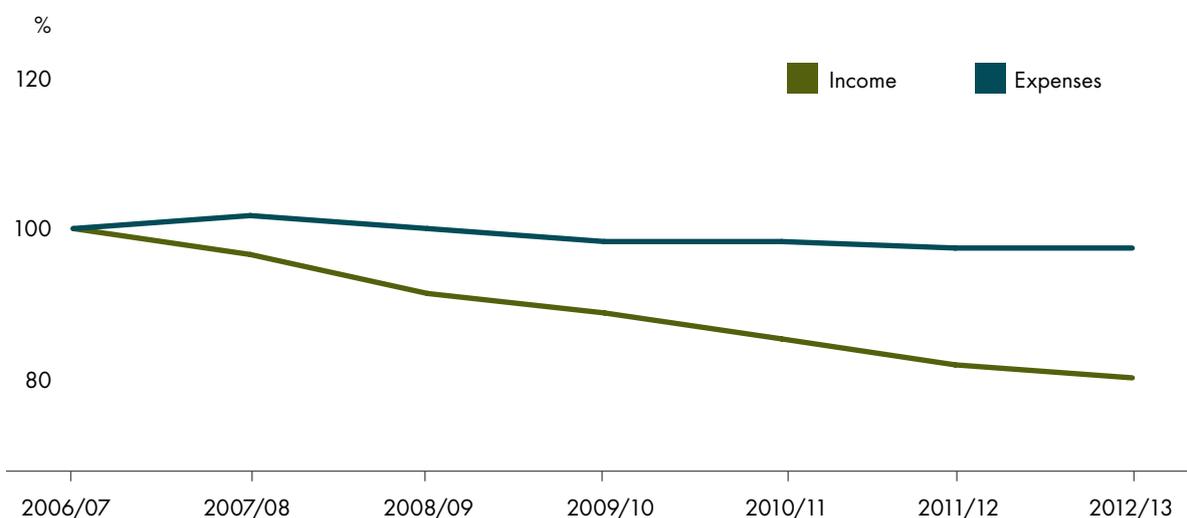
Figure 2 shows how secondary care received the lion's share of growth during the generous years of spending from 2006 to 2010. The proportion of the total health care budget directed to primary care services – which are the first point of contact for patients, including GPs, dentists, optometrists and community pharmacists – shrank from 27 per cent in 2006/07 to 23 per cent in 2012/13.¹⁹

Within the overall NHS primary care budget, general practice has also seen a real-terms decrease. Last year, spending on GP services fell by 3.8%. Department of Health accounts show that while £7.84 billion was spent on GPs in 2012/13, in 2013/14 this fell to £7.55 billion.²⁰

Individual UK GPs have also been feeling the squeeze. They have seen a real-terms fall in their average income before tax, while their expenses (which consist of practice staff salaries, equipment and building costs, and so on) have risen. Overall, average income before tax decreased by 2.4 per cent between 2011/12 and 2012/13, from £96,859 to £94,502.²¹ However, this is against a backdrop of real-terms wage decreases in every part of the economy following the downturn in 2008/09.^{22,23}

Internationally, figures from the Organisation for Economic Co-operation and Development (OECD) show that the UK's independent contractor GPs are the best paid among OECD countries – although the growing number of salaried GPs fare worse in this respect than their counterparts overseas.²⁴

FIGURE 3: CHANGES IN GP EARNINGS AND EXPENSES, 2006/07 – 2012/13 (BASE YEAR: 2006/07)



Source: GP earnings and expenses data, 2006/07–2012/13

Income can have an effect on the number of practices, because GPs may decide to quit in response to falling income. GP groups have recently been warning that the abolition of the Minimum Practice Income Guarantee (MPIG) could lead to a spate of practice closures, especially in deprived areas. This guarantee was introduced in the 2004 GP contract to ensure

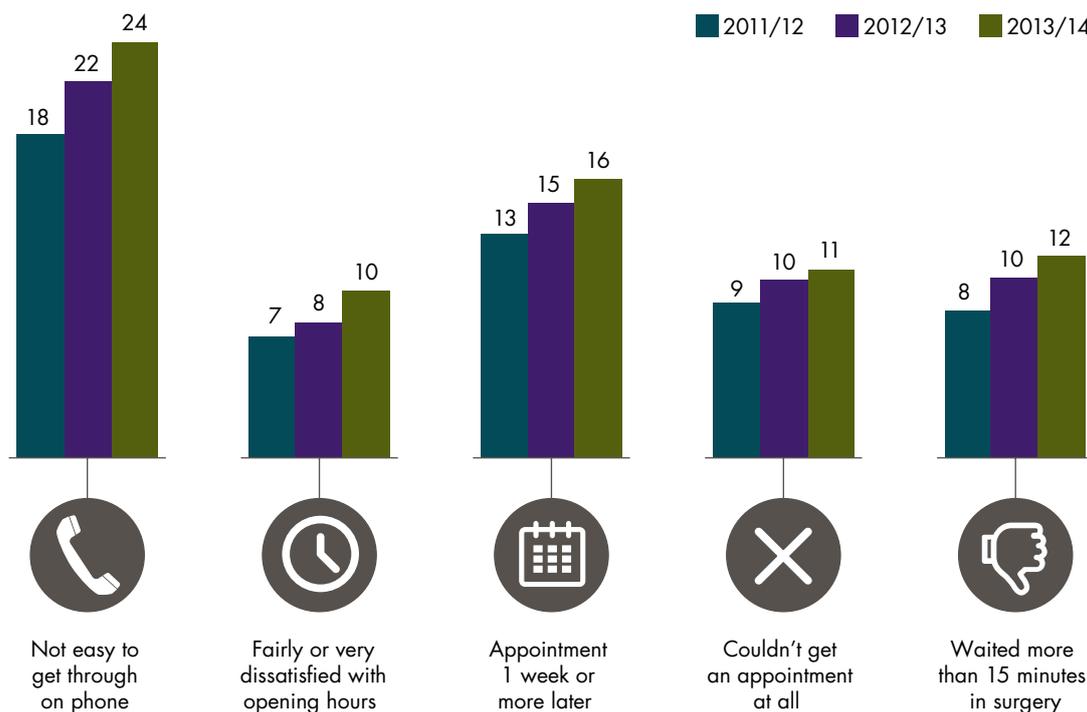
that the basic income of a general practice would never fall below its level before the introduction of the 2004 contract. NHS England is now phasing out the MPIG, and it estimates that for 98 English practices (about 1.2%) this will mean a drop in income equivalent to more than £3 per patient each year, adding up to a substantial proportion of the roughly £70 per patient that GPs receive as part of their funding.^{25,26}

ARE STANDARDS OF CARE AND ACCESS SUFFERING?

With talk of a crisis in general practice, it can be easy to forget that most people continue to report a good experience when they visit their GP. Patients appear to be at least as satisfied with general practice as they are with A&E and inpatient hospital services.^{27,28} A closer look, however, reveals some key indicators moving in the wrong direction.

From 2011/12, the national GP Patient Survey shows a year-on-year increase in patients reporting difficulty getting through to their practice on the phone, longer waits for appointments, and dissatisfaction with opening hours.²⁹

FIGURE 4: PATIENT EXPERIENCE OF ACCESSING GP SERVICES, 2011/12 – 2013/14 (%)



Source: Ipsos MORI.

Some commentators have linked worsening general practice access ratings to the Government dropping the 48-hour appointment target in 2010.³⁰ However, the only major rise in people reporting a wait longer than 48 hours came in 2009/10 while the target was still in place.

No change was seen during 2010/11.³¹ The rate of reported access to a GP within two days has since fallen very slightly, from 50 per cent in 2011/12 to 49 per cent in 2013/14. Patient ratings of their experience remain high once patients have accessed their GP. Eighty-eight per cent of patients say their doctor was good at listening to them, and 83 per cent say he or she treated them with care and concern. These figures show no signs of a recent decline.³²

For clinical and organisational quality, English GPs are assessed by the Quality and Outcomes Framework (QOF). This measures whether they meet a wide range of standards of care, and part of their income is allocated accordingly. Scores across the whole range of 148 indicators improved between 2010 and 2012, but fell slightly in 2013 – by 0.8 percentage points.³³

However, these trends may partly just reflect the QOF's changing criteria. For example, measures of how well GPs treat osteoporosis were added for the first time last year, and it may take some time for practices to apply the new standards.³⁴

Internationally, general practice in the UK compares well. A 2012 survey by the Commonwealth Fund, a US research foundation, suggests that the UK is slightly above average in people's ability to see a doctor within two days when they need care.³⁵ On measures relating to care for people with chronic conditions, where the role of general practice is crucial, a 2014 survey shows the UK performing very well.³⁶ However, some researchers have raised concerns about whether the current UK model of generalist primary care is still fit for purpose, especially in relation to the identification of serious illness in children³⁷ and the early diagnosis of cancer.³⁸ Such analyses point to a perceived need for new models of generalist/specialist joint working in primary care.

HOW CAN GPS ADAPT AND SURVIVE?

Crisis or not, general practice is under great pressure from falling funding, workforce problems, and the growing needs and rising expectations of an older, sicker population. However, research by the Nuffield Trust and others, and the experiences of people leading change within general practice organisations, show how the sector can reform to meet evolving needs.

Some innovative practices are already tailoring their services to the needs of different patient groups, and this should become the norm. A generally healthy person needs a different kind of appointment from an older person with several long-term conditions. For the former, rapid access through telephone and e-mail consultations is already available in some areas for common ailments. This needs to become the norm, while longer

appointments offering continuity with a GP must also be available for patients with complex problems like diabetes, dementia or lung disease.

For those with the most complex problems of all, like frail older people or homeless people, there could even be specialist practices, or specific GP lists within a wider network of practices, dedicated to their care. These practices or lists would be supported by a team of GPs, specialists such as geriatricians, psychiatrists and renal physicians, pharmacists, nurses, social workers and others.

Achieving this would mean accelerating the move away from the traditional model of small, free-standing general practices, towards larger GP organisations or networks. GP teams across the UK and internationally are already finding ways to collaborate and scale up, typically by forming federations and networks, or merging to form ‘super-partnerships’ and multi-site practices.³⁹

‘GP networks and partnerships could take on direct responsibility for other services outside hospitals’

Collaborating in this way allows GPs to pool resources and increase scale, improving their ability to invest in staff and infrastructure, and build links with the wider health system and take on new and extended clinical and managerial roles. This does not mean that the familiarity of local practices need be lost. Network structures can allow the advantages of scale while keeping their neighbourhood presence.

In the longer term, networks and larger partnerships could take on direct responsibility for the other services that patients rely on outside the hospital setting, like district nursing and elements of mental health care. These are currently part of separate NHS trusts, but in some areas it might be more logical for them to be run by larger general practice organisations. NHS England’s Forward View for the future of the NHS suggests GPs taking this role could make a major contribution to higher productivity and standards across the entire health service.

Equally, larger-scale general practice will be able to develop strategic and operational management capacity to a level well beyond that of current practice management, which tends to focus largely on day-to-day administration. These skills in turn can allow them to run a broader range of services, and make proper use of technologies that are complex to get up and running, but which have the potential to transform care.

WHAT CAN POLICY-MAKERS AND POLITICAL LEADERS DO TO HELP?

AVOID 'TOP-DOWN' CONTROL

First, politicians should resist the temptation to create new targets or specify models of general practice to be replicated everywhere. There are no 'one size fits all' solutions for general practice and targets can divert clinical work away from patient priorities. NHS England's Forward View, welcomed across the political parties and NHS professional groups, makes the case that many different ways of working need to be tested in the NHS, so that good solutions can be identified for different local areas.

'General practice should be held to account for how it spends its money, through real-time data collection'

There is a significant degree of change already being undertaken in general practice. This is often driven by primary care organisations that have been established by local GPs, as in many of the federations, networks, super-partnerships and other GP-owned entities. In some cases, change is being led by clinical commissioning groups, GP-led bodies that plan and fund hospital care, but also have a legal duty to improve general practice. Many clinical commissioning groups are using local contracts and incentive schemes to improve general practice. These need to be given a chance to work and should be evaluated carefully, to ensure that desired outcomes are achieved.

ENSURE STANDARDS AND CONTRACTS ARE READY FOR NEW IDEAS

Second, contracts should be used to support the vision of general practice working at scale and closely linked to other professionals – including community nurses, mental health professionals, specialists in hospitals, pharmacists and social care staff. There may also be a case for special contracts and lists for groups with intensive health needs, like frail older people and homeless people. In agreement with central bodies, practices focusing on these could work to different priorities and include medical specialists within the care network or organisation.

Holding GPs to account for their taxpayer funding will need a number of clear national expectations, while avoiding targets and micro-management. These could focus on areas such as preventative care, adequate access to treatment, and coordination with other parts of the NHS. The Nuffield Trust and The King's Fund have suggested a set of 'design principles',⁴⁰ which include organisational improvements. These principles are designed so that solutions can be developed locally rather than be imposed from above.

MAKE BETTER USE OF DATA

Third, good use of data will be vital. Nationally, general practice should be held to account for how it spends its money through a requirement to collect and report robust activity and consultation data in real time, in the way that hospital services are required to do. Locally accessible

patient records must be available to everyone that patients rely upon, including hospital specialists, pharmacists and social care workers. Without the ability to link data and share records, many of the improvements in care that are needed will not be possible.

PAYING FOR PROGRESS

Fourth, as the population grows and ages and more is asked of general practice, funding will need to keep pace. With the NHS ambitious about delivering better, more efficient care by treating more patients in the community, it makes sense that primary care's share of the budget should grow rather than shrink.

Public concern about losing services means that the capacity to care for people at home needs to be well developed before any money can be taken out of hospitals. This is likely to require careful investment over the 2015 to 2020 Parliament for a period of 'double running' and to enable support to practices and their staff as they design, plan and implement new models of care and organisation.

There needs to be a parallel and integrated workforce plan, which is not just training and retaining more GPs and bringing back GPs who have left, but also training and deploying practice nurses, pharmacists, specialists and others to take on more of the workload. This plan should also address the ways in which the management of primary care practices and organisations can be strengthened.

BACKING GPs TO DO THINGS DIFFERENTLY

Lastly, political leaders should try to counter the sense of alienation among many GPs and general practice staff. Government, taxpayers and patients all need and want general practice to change. So do GPs. Helping and supporting them to do things differently is likely to be a better approach than criticism and confrontation.

NOTES AND REFERENCES

1. Clinical commissioning groups (which are led by local GPs), while not having to provide these services directly, are obliged to make sure out-of-hours cover is in place.
2. Sippitt A (2014) 'Will millions of patients miss out on GP appointments this year?'. https://fullfact.org/health/patients_miss_out_gp_appointment-29743
3. Excluding registrars and retainers. All figures are 'full-time equivalent'.
Note: The retainer scheme enables GPs with other commitments to undertake a limited amount of general practice (that is, on a very part-time basis) to maintain their skills until returning to more substantive general practice in the future.
4. Health & Social Care Information Centre (2014) *General and Personal Medical Services: England 2003–13*.
www.hscic.gov.uk/catalogue/PUB13849/nhs-staf-2003-2013-gene-prac-rep.pdf
5. HSCIC General and Personal Medical Services, England – 2003–2013, as at 30 September: Bulletin tables [xlsx] full-time equivalent.
6. The Information Centre (2008) (via www.kingsfund.org.uk/sites/files/kf/general-practice-in-england-overview-sarah-gregory-kings-fund-september-2009.pdf).
7. Health & Social Care Information Centre (2014) *General and Personal Medical Services: England 2003–13*.
8. Hann, M, McDonald J, Checkland K, Coleman A, Gravelle H, Sibbald B and Sutton M (2013) *Seventh National GP Worklife Survey*. University of Manchester. www.population-health.manchester.ac.uk/health/economics/research/FinalReportofthe7thNationalGPWorklifeSurvey.pdf
9. careers.bmj.com/careers/advice/view-article.html?id=20018042
10. Department of Health (2013) *Delivering High-quality, Effective, Compassionate Care: Developing the right people with the right skills and the right values: A mandate from the Government to Health Education England: April 2013 to March 2015*.
11. Health Education England (2014) *GP Taskforce Report*.
12. Centre for Workforce Intelligence (2014) *In-depth Review of the General Practitioner Workforce*.
13. 'Salaried' includes retainers but excludes registrars. 'GP providers' refers to contract holders.
14. 'Most GPs are independent contractors to the NHS. This independence means that in most cases, they are responsible for providing adequate premises from which to practise and for employing their own staff' (NHS Careers, www.nhscareers.nhs.uk/explore-by-career/doctors/careers-in-medicine/general-practice).
15. HSCIC General and Personal Medical Services, England – 2003–2013.
16. HSCIC General and Personal Medical Services, England – 2003–2013.
17. Expert Panel on Effective Ways of Investing in Health (EXPH) (2014) *Definition of a Frame of Reference in Relation to Primary Care with a Special Emphasis on Financing Systems and Referral Systems*. European Commission.
ec.europa.eu/health/expert_panel/opinions/docs/004_definitionprimarycare_en.pdf
18. Primary care trust annual accounts data from 2006/07 to 2012/13. All the figures are in real terms, using the HM Treasury GP deflator at 27 June 2014.

19. Primary care trust annual accounts data from 2006/07 to 2012/13. All the figures are in real terms. Detailed explanation about the data is provided in Lafond S, Arora S, Charlesworth A and McKeon A (2014) *Into the Red? The state of the NHS' finances: An analysis of NHS expenditure between 2010 and 2014*. Nuffield Trust.
www.nuffieldtrust.org.uk/publications/red-state-nhs-finances
20. Department of Health (2014) *Annual Report & Accounts 2013–14*. Available at www.gov.uk/government/uploads/system/uploads/attachment_data/file/335166/DH_annual_accounts_2013-14.pdf
21. Health & Social Care Information Centre (2014) *GP Earnings and Expenses 2012/13*. www.hscic.gov.uk/catalogue/PUB14924/gp-earn-ex-1213-rep.pdf
22. Office for National Statistics (2012) 'Real wages up 62% on average over the past 25 years'. www.ons.gov.uk/ons/dcp171776_286266.pdf
23. Health & Social Care Information Centre (2014) *NHS Staff Earnings Estimates to December 2013, Provisional Statistics*.
www.hscic.gov.uk/catalogue/PUB13831/nhs-staf-earn-est-to-dec-2013.pdf.pdf
24. Organisation for Economic Co-operation and Development (2013) *Health at a Glance 2013: OECD indicators: Remuneration of doctors, ratio to average wage, 2011 (or nearest year)*. OECD.
25. NHS England (2014) *Implementing the 2014/15 GP Contract. NHS England changes to Personal Medical Services and Alternative Provider Medical Services contracts*. www.england.nhs.uk/wp-content/uploads/2014/03/gp-cont-change-fin.pdf
26. NHS England (2014) *Impact of Phasing Out the Minimum Practice Income Guarantee: 'Outlier' GP practices*. NHS England.
www.england.nhs.uk/wp-content/uploads/2014/02/gp-gms-practices.pdf
27. Care Quality Commission (2012) *Accident and Emergency Survey 2012*. www.cqc.org.uk/content/accident-and-emergency-2012
28. Care Quality Commission (2013) *Inpatient Survey 2013*. www.cqc.org.uk/public/reports-surveys-and-reviews/surveys/inpatient-survey-2013
29. Ipsos MORI (2014) *GP Patient Survey: National summary report, July 2014*. gp-survey-production.s3.amazonaws.com/archive/2014/July/1301375001_Y8W2%20National%20Summary%20Report_FINAL%20v1.pdf
30. *The NHS Plan* promised that patients would be able to see a primary care professional within 24 hours, and a GP within 48 hours: Department of Health (2000) *The NHS Plan: A plan for investment, a plan for reform*. The Stationery Office.
31. Ipsos MORI (2011) *The GP Patient Survey April 2010 – March 2011 Summary Report*.
32. Ipsos MORI (2014) *GP Patient Survey: National summary report, July 2014*.
33. Health & Social Care Information Centre (2013) *Quality and Outcomes Framework Achievement, Prevalence and Exceptions Data, 2012/13*. www.hscic.gov.uk/catalogue/PUB12262/qual-outc-fram-12-13-rep.pdf
34. Health & Social Care Information Centre (2013) *Quality and Outcomes Framework Achievement, Prevalence and Exceptions Data, 2012/13*.
35. Commonwealth Fund (2012) *2012 Commonwealth Fund International Survey of Primary Care Doctors*. www.commonwealthfund.org/publications/surveys/2012/nov/2012-international-survey
36. Commonwealth Fund (2014) *Mirror, Mirror on the Wall, 2014 Update: How the U.S. health care system compares internationally*. www.commonwealthfund.org/publications/fund-reports/2014/jun/mirror-mirror

37. Wolfe I, Thompson M, Gill P, Tamburlini G, Blair M, van den Bruel A, Ehrich J, Pettoello-Mantovani M, Janson S, Karanikolos M and McKee M (2013) 'Health services for children in Western Europe', *The Lancet*, 381, 1224–34.
38. Incisive Health (2014) *Saving Lives, Averting Costs: An analysis of the financial implications of achieving earlier diagnosis of colorectal, lung and ovarian cancer*. Cancer Research UK.
39. Smith J, Holder H, Edwards N, Maybin J, Parker H, Rosen R and Walsh N (2013) *Securing the Future of General Practice: New models of primary care*. Nuffield Trust and The King's Fund.
www.nuffieldtrust.org.uk/publications/securing-future-general-practice
40. Smith J, Holder H, Edwards N, Maybin J, Parker H, Rosen R and Walsh N (2013) *Securing the Future of General Practice: New models of primary care*. Nuffield Trust and The King's Fund.

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