Preferences of healthy and ill patients for style of general practitioner care: implications for workload and financial incentives under the new contract

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SUMMARY. Seven hundred and sixty patients from four general practices in an urban health centre were asked to evaluate the relative importance of 20 statements describing different aspects of general practice. Significant differences were observed between sub-groups of the patients, in particular those who would be likely to make greater use of the general practitioner — the elderly and the ill. Patients who reported not good or poor health status were more likely to value second opinions and, conversely, undervalue efficient prescribing, and an emphasis on vaccinations, cervical smears and check ups. Elderly patients placed greater emphasis on second opinions, protection in their relationship with the hospital, routine visits to the elderly and friendly staff, and similarly undervalued an emphasis on vaccinations, cervical smears and check ups.

This means that practices which increase their list size to benefit from higher capitation payments might, depending on their characteristics, attract predominantly healthy people and increase patient numbers without a commensurate increase in workload. Other facets of the payment system, in particular fees for health promotion work, further support this bias against ill patients.

Introduction

TRADITIONALLY general practitioners have obtained their income through a variety of methods: a series of 'allowances' which were largely independent of specific patient care activities, fees for certain items of service and capitation fees for registered patients. In the new contract for general practitioners, the allowances are diminished, fees are more clearly focussed on services which prevent illness and promote health (and are often related to population rather than individual targets), and there is a greater emphasis on capitation as a method of payment. There is thus financial encouragement to provide a wide range of services for healthy people and to increase list size: in the government's view the latter will have the effect of providing competition for patients and hence, for the enticed patient, a wider consumer choice.

It has been assumed that each extra patient registered has roughly the same implication for additional workload, since 'ill' patients — who provide most of the workload — and 'healthy' patients are fairly randomly distributed in any practice community. However, it is possible that practices which enthusiastically endorse health promotional activities may be selectively encouraging 'healthy' patients to choose to register. Could this mean that general practitioners who respond to the new contract in this way might unwittingly be biasing their services against those ill patients who have the greatest need of their care?

Recently, Smith and Armstrong[1] showed that patients have rather different ideas than government about the characteristics of good quality general practice; and, in addition, that these preferences varied to some degree with the patient's age and sex. This finding is important because under a system of capitation payments it is possible that, if a general practitioner were to emphasize different facets of the practice, 'healthy' low consulting patients might be encouraged to register and, conversely, 'ill' high consulting patients might be discouraged from registering.

This study was carried out, using methodology similar to Smith and Armstrong, to investigate the possibility that 'low user' healthy patients prefer different characteristics of a general practitioner than do the traditional vulnerable groups of the elderly and the ill.

Method

The study was carried out in a health centre in Liverpool which houses the only four general practices in the locality. These practices range from single-handed to a group training practice closely affiliated to the university department of general practice. The population is typical of the city as a whole in terms of demographic and social characteristics but does not contain significant numbers of ethnic minority patients. The catchment areas of the practices score about average on Jarman's scale of social determinants of workload and pressure on general practitioner services.

Audio-taped open-ended interviews with an average length of 30 minutes were carried out with a stratified sample of 20 people, selected to represent a wide range of characteristics. Interviewees were asked 'How can good general practice be achieved?' and prompted to explore their views of the general practitioner's role, attributes, services and range of knowledge.

From transcripts of the interviews, common themes were identified and 20 verbatim statements selected to represent these themes. These statements were arranged in unique pairs (190 in total). There were thus 19 questionnaires, each comprising 10 pairs of statements. In addition, the order of appearance of each statement in every pair was reversed, bringing the total number of questionnaire combinations to 38.

The questionnaire asked respondents to imagine a hypothetical situation in which he or she was about to choose a new doctor. They were asked to choose from each pair of statements which one best reflected their own criteria for the selection of a general practitioner. The questionnaire also asked for the patient's age, sex, and perceived health status on a four point scale ranging from poor to excellent.

A quota sample of 760 was obtained by inviting consecutive patients approaching the reception desk at the health centre to participate in the study. If a patient declined to participate, the next patient was recruited to complete that particular questionnaire. Demographic information about those declining to participate was collected from the general practice records.

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The data were examined in four sub-groups of the total population of respondents: women between the ages of 16–44 years because these are known to be relatively high users of general practitioner services; patients over the age of 65 years, as these too are recognized to be relatively high users of the service; people who scored their health as 'not good' or 'poor'; people who scored their health as 'excellent' or 'good'.

Data from the questionnaires were computerized and analysed using a statistical package (SPSS/PC). From each completed questionnaire a preferred statement was given a score of 1 and the paired statement a score of 0. Where no preference between paired statements was made explicit each received a score of 0.

Results

Sixty two patients (7.5% of the total sample of 882 patients) declined to complete a questionnaire. No significant difference could be found between these patients and those who did respond in terms of the demographic variables which had been collected.

The statements were ranked according to the number of times each was preferred to a paired statement. Table 1 shows the results for the whole of the sample and demonstrates the value placed on the 'traditional' qualities of good general practice.

Table 2 shows the rankings for the four sub-groups of the population. All four rankings were similar, the main exceptions being those services such as cervical smears, routine visits to the elderly and check ups which appealed more to those groups who received them.

To explore these differences further each statement was cross-tabulated with the patient's perceived state of health and their age group. Tables 3–6 show those statements for which significant differences between sub-groups were identified.

Table 3 shows that a higher percentage of people who rated their health as 'not good' or 'poor' preferred a general practitioner who allows an early second opinion. However, for people rating their health as 'good' a higher proportion preferred a general practitioner with an emphasis on preventive measures and 'cost-effective' prescribing.

The age of the respondents was found to affect significantly their preferences for eight of the statements. These are given in Table 4. In summary, more older people preferred a doctor who

Table 1. Overall rank order of statements for 760 respondents.

Rank	Statement about general practitioner	No. times preferred
1	GP is easy to talk to	594
2	GP offers treatment through personal attention rather than drugs	470
3	GP is kind and attentive	465
4	GP sees things from the patient's point of view	453
5	GP allows early second opinion	398
6	GP guides and protects you in your relationship with the hospital	387
7	GP's staff are friendly	385
8	GP has special emphasis on vaccination and smears	382
9	GP provides routine visits to the elderly	380
10	GP provides regular physical check ups for the healthy	378
11	GP offers longer consultation time	373
12	Minor surgery is performed in the practice	334
13	GP knows when not to refer	326
14	GP attends refresher courses	323
15	GP works from adequate and comfortable premises	293
16	GP's surgery around the corner from your home	274
17	GP has fewer patients on the list	267
18	GP at your bedside if you are terminally ill	257
19	GP prescribes inexpensive drugs	125
20	Aspects of GP's personal life known to you	64

NB: Some patients were unable to choose between some of the pairs offered.

Table 2. Rank order of statements by sub-groups of the respondents.

	Rank by patient sub-group			
Statement	Women aged 16–44 yrs (n = 300)	Elderly aged 65+ yrs (n = 132)	Health status not good (n = 256)	Health status good/ excellent (n = 479)
Is easy to talk to	1	1	1	1
Gives personal attention not drugs	3	4 =	3	2
Is kind and attentive	5	2	2	3
Sees patient's viewpoint	4	6	4	4
Allows early second opinion	8	7	5	7
Guides and protects in relationship with hospital	11	9	7	9
Has friendly staff	7	3	6	10
Has emphasis on vaccination and smears	2	17	10	6
Visits elderly routinely	10	4 =	9	8
Has regular check ups for healthy	9	12	14	5
Offers longer consultation time	10	8	8	11
Does minor surgery	14	11	11	12
Knows when not to refer	12	10	12	14
Attends refresher courses	13	14 =	13	13
Has good premises	16	14 =	15	15
Has convenient access	15	13	16	16 =
Has fewer patients on list	18	16	17	16 =
Supports in terminal illness	17	18	18	18
Prescribes inexpensive drugs	19	19	19	19
Home life known to you	20	20	20	20

n = total number of respondents.

Table 3. Preferences of patients by self-reported health status.

	Percentage of patients preferring statement, by health status				
Statement	Excellent (n = 115)	Good (n = 343)	Not good (n = 189)	Poor (n = 40)	
Allows early second opinion	47.4	57.1	62.0	61.0	**
Prescribes inexpensive drugs	22.6	19.2	14.3	15.0	*
Has emphasis on vaccinations and smears	58.0	57.3	49.7	45.0	*
Has regular check ups for healthy	50.9	60.2	45.6	34.1	**

n = total number of respondents. Kendall's tau: **P<0.01; *P<0.05.

Table 4. Preferences of patients by age.

	Percentage of patients preferring statement, by age group			
Statement	16–44 years (n = 387)	45–64 years (n = 207)	65+ years (n = 110)	
Allows early second opinion	53.8	60.3	65.1	**
Guides and protects in relationship with hospital	50.9	60.9	54.8	*
Is kind and attentive	61.9	65.7	74.6	**
Has friendly staff	53.0	50.5	71.8	*
Visits elderly routinely	49.6	56.6	64.3	**
Has emphasis on vaccinations and smears	64.2	46.6	36.0	***
Has regular check ups for healthy	56.3	52.7	45.1	*

Kendall's tau: ***P<0.001; **P<0.01; *P<0.05.

allows an early second opinion, who gives guidance and protection in their relationship with the hospital, who is kind and attentive, has friendly staff and provides routine visits to the elderly. On the other hand, a higher proportion of younger people preferred a doctor who has a special emphasis on preventive measures, such as immunization and cervical smears and the provision of regular check ups for healthy people.

The relationship between health status and preferences was further examined in those aged 65 years and over to see whether self-reported health status had an effect independent of age. Table 5 shows that within this group it was those with the poorest health who expressed the greatest preference for a doctor who allows second opinions. Furthermore, while regular physical check ups for the healthy were poorly valued by the over 65 years group in general (see Table 4), this service was valued even less by those elderly people who perceived themselves to be unhealthy.

In the younger age group (16–44 years), it was found that perceived health status significantly affected the group's preference for style of treatment; a higher proportion of those with poor self-rated health preferred a doctor who offers treatment through personal attention rather than drugs (Table 6). This sub-group also preferred a doctor who provides minor surgery in the practice.

Table 5. Preferences of patients aged 65 years and over by self-reported health status.

| Statement | Percentage of patients preferring statement, by health status | | | |
	Excellent (n = 7)	Good (n = 43)	Not good (n = 44)	Poor (n = 12)
Allows early second opinion	42.9	58.1	70.5	83.3**
Has regular check ups for healthy	40.0	60.0	38.0	23.1**

Kendall's tau: **P<0.01.

Table 6. Preferences of patients aged 16–44 years by health status.

| Statement | Percentage of patients preferring statement, by health status | | | |
	Excellent (n = 87)	Good (n = 209)	Not good (n = 80)	Poor (n = 6)
Gives personal attention not drugs	58.6	66.5	71.3	83.3*
Performs minor surgery	37.6	48.8	51.9	50.0*

n = total number of respondents. Kendall's tau: **P<0.01; *P<0.05.

Discussion

The sample in this study was drawn from attenders at a health centre: this is likely to have introduced a bias in the sampling as high attenders in the population are more likely to be represented. Nevertheless, since the study was examining the implications of patient preferences for general practitioner workload this bias is more acceptable than a sampling frame of the practice population which may have had much smaller proportions of the ill and elderly.

The study set out to try to see whether vulnerable groups such as unhealthy and older patients exhibit different preferences for style of health care provision: the results show that to some degree they do, and that both age and perceived health status

make independent contributions to these preferences. This suggests that according to its characteristics a practice could in theory attract more young and healthy patients and fewer old and unhealthy patients. A practice of this kind would have the following deterrent characteristics for the old and sick: the doctor did not encourage early referral for a second opinion; was less kind and attentive; had unfriendly staff; and made poor provision for routine visits to the elderly. To attract more of the healthy population the practice would place more emphasis on prescribing inexpensive drugs and would have a special interest in check ups for the healthy, and the provision of immunizations and cervical smears.

Of course it is highly unlikely that a general practitioner would deliberately plan to build a distinct form of practice, especially as some criteria such as 'general practitioner is easy to talk to' were uniformly valued while others such as 'aspects of general practitioner's personal life known to you' were consistently ranked lowest by all groups. In addition, there are increased capitation fees for elderly patients and a weighting based on the Jarman score to try and compensate for workload differences between geographical areas.[2] Nevertheless the new contract may be biased towards greater proportionate rewards to practices which attract 'healthy' patients. Certainly evidence from the USA — and anecdotal evidence from the UK — does suggest that the method of payment explicitly or implicitly influences the selection of patients: in the case of a fee-for-service system it is the ill who are selected; in a capitation system, the healthy are selected.[3]

The biases introduced by overemphasis on capitation as a method of payment need to be tempered by other incentives. However, of the characteristics listed above which might be pursued by a 'profit-maximizing' practice, only one, namely routine visits to the elderly, is directly countered in the new general practitioner contract. On the other hand, four of the characteristics are actually encouraged by the new arrangements. These are: a disincentive for budget holding practices to make referrals; a move to less expensive prescribing through the new indicative drug budgets; an emphasis on immunization through target payments; and an emphasis on illness prevention and health promotion through additional payments for specialized clinics. In addition the general practitioner has the opportunity to gain additional income by achieving the population targets for healthy screened groups.

In the final analysis the basis of good quality care lies in professional commitment to the task and not in remuneration. However, the latter can influence the form and emphasis of service provision. It would be a pity if, in the new entrepreneurial environment, the effect of financial incentives for general practitioners were to encourage concern for the healthy at the expense of care for the ill.

References

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