CORRESPONDENCE

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Health promotion in general practice

SIR,—The new general practitioner contract introduced a system of payments for health promotion clinics. Health promotion in general practice should be organised, audited, and guided by protocol and should make use of the clinical and organisational skills of the whole team, with practice nurses playing an increasingly important and responsible part. If by a "clinic" is meant a fixed day, single subject clinic seeing at least 10 people then clinics are the wrong way to organise most health promotion work in most general practices. Clinics thus defined are an inefficient, inflexible, inconvenient, and "inverse caring" way to organise much of our health promotion.

Clinics are certainly appropriate if (*a*) the patients need to see a number of health workers who are not usually in the same place at the same time—for example, a diabetic clinic with doctor, nurse, dietitian, and chiropodist; (*b*) the patients are coming to see a health worker with special skills who does not normally work in the practice—for example, audiologists, dietitians; and (*c*) the clinic necessarily involves group work. But health promotion that consists of one patient meeting one member of the practice team is often better integrated with our routine work. For this we should be offering health promotion consultations rather than health promotion clinics, and we need to have the time and flexibility to be able to provide such consultations opportunistically. Such an arrangement is more convenient for patients (it is not confined to fixed days and times), less stigmatising (for example, for patients with alcohol problems), more likely to reach those most in need, more efficient (the default rate on appointments for health promotion activities tends to be high), and more comprehensive—allowing any practice to provide a full range of health promotion and structured chronic disease management consultations rather than a limited number of clinics.

If specific remuneration of health promotion in general practice is to continue then it should be extended to cover health promotion work organised as individual consultations. Family health services authorities could require practices to submit protocols for each health promotion activity offered, to specify a minimum duration for health promotion consultations, and to identify by date and practice record number each consultation making up a claim—thus allowing verification by reference to practice records that the consultations took place. The authorities' medical advisers could decide on minimum necessary standards of record keeping for the continued allowance of claims.

As they stand, the provisions in the new contract for remuneration of health promotion clinics threaten to have an adverse effect on services to patients by encouraging the devotion of disproportionate amounts of staff time and energy to activities that can be made to qualify as clinics and for which sufficient numbers of patients can be persuaded to attend. Such a distortion of service provision is inefficient and probably, in the context of limited resources for health care, unethical. As pointed out by Al-Bashir and Armstrong, the new contract risks creating a "bias against ill patients."[1]

Furthermore, the variable interpretation of the regulations governing remuneration of health promotion clinics by family health services authorities is giving rise to large differentials in practices' earnings from this source, which do not necessarily reflect the quality of service provided or the conditions and constraints under which different practices operate.

The Royal College of General Practitioners and the General Medical Services Committee should give urgent consideration to these issues in their representations to the Department of Health over possible revisions to the new general practitioner contract.

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1 Al-Bashir MM, Armstrong D. Preferences of healthy and ill ptients for style of general practitioner care: implications for workload and financial incentives under the new contract. *Br J Gen Pract* 1991;41:6-8.

Jarman index

SIR,—The three articles on the underprivileged area score[1-3] came as a complete surprise to me: none of the authors had sent me their articles before publication. I have covered many of the points raised in them elsewhere.[4]

The underprivileged area score attempts to develop a measure of general practitioners' opinions of factors that increase their workload or pressure on their services. It was not developed as a "deprivation" index as such but it does have a high correlation with other indices that were developed to measure social deprivation[5-7] and also with measures of illness levels in different areas.[4] It was used at the time of the Acheson committee[8] in 1980 and later in an attempt to identify, by objective measures, areas where general practitioners were more likely to have greater workloads or pressure on their services.

It will always be difficult to measure something so vague as social deprivation, but this does not mean that an attempt should not be made to identify deprived areas. There are strong correlations between all of the deprivation indices, and it would be possible to define electoral wards or enumeration districts that were above, say, one standard deviation of all of the indices. This would, in effect, mean modifying the choice and weighting of the variables used in the indices.

All of the indices have been constructed in a similar manner. Variables that are thought to be associated with social deprivation are chosen from the national census. They are transformed to make the distribution of the variables in wards or enumeration districts more symmetric; the transformed values are weighted by a weighting thought to represent the importance of the variable; and the weighted transformed values are added to give the score. The underprivileged area score differs from the three other indices whose choice of variables and weightings is determined by their originators. For the underprivileged area score the variables and weightings were chosen initially as a result of evidence to the Acheson committee from about 200 organisations connected with primary care and later by a survey of one in 10 general practitioners in the United Kingdom, with a 77% response rate and a high level of agreement regarding the factors (and their weightings) considered important by general practitioners.[9]

This short letter cannot deal with all of the points raised. For instance, the underprivileged area score does explain 44% of the variation of the age-sex standardised admission rates in the English district health authorities, whereas standardised mortality ratio to age 75 explains only 42%; the combination explains 51%—all significant at $p<0.0001$.

I agree that deprivation payments to general practitioners do not guarantee that they will be used to help patients in deprived areas. This is a feature of the entire capitation system of payments for general practice. If deprivation payments were to be extended or increased I believe there would be a case for requiring evidence of their use—for example, for achieving immunisation or cytology targets.

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3 Carr-Hill RA, Sheldon T. Designing a deprivation payment for general practitioners: the UPA(8) wonderland. *BMJ* 1991;302:393-6. (16 February.)
4 Jarman B. *Social deprivation and health service funding.* London: Imperial College, 1990. (Papers in science, technology and medicine No 22.)
5 Department of the Environment. *Urban deprivation.* London: DoE, 1983. (Information note No 2.)
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