The new general practitioner contract: Is there an alternative?

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> The National Health Service at its best is without equal. Time and again the nation has seen just how much we owe to those who work in it.
>
> But major tasks now face us, to bring all parts of the National Health Service up to the very high standard of the best, while maintaining the principles on which it is founded and to prepare for the needs of the future.

There is evidence of widespread agreement with these statements from the Prime Minister, among both the receivers and providers of health care. The increasing negative reaction that has been generated by the white paper *Working for Patients*[1] and the new general practitioner contract[2] does not appear to have been based on a reluctance to consider change but rather on a deep concern that the proposals will not only fail to achieve their stated objectives for patient care but, on the contrary, will be harmful to the functioning of the health services. There is no place for complacency about the delivery of health care in the United Kingdom, and the publication of these documents provides a valuable and perhaps necessary stimulus for urgent rethinking. The challenge that faces all of those concerned with the delivery of health care is to ensure that the result of this process is an improvement in the services provided.

The Secretary of State has indicated that, although he will not accept procrastination, he will accept positive proposals, and it is with this in mind that I make the following proposals from the perspective of general practice.

The role of general practice

The general practitioner is concerned with providing care for populations of individuals who have registered with him or her for primary care. This care includes:

- Responding to new requests for care from patients by identifying their problems and taking appropriate management decisions, which may include giving advice, prescribing treatment, or referral to secondary care
- The continuing care of chronic disease and aging processes and the care of terminally ill and bereaved patients
- Appropriate screening and health education
- Prevention—primary, secondary and tertiary.

Good quality general practitioner care demands:

- Provision of adequate premises for the delivery of care and appropriate equipment
- Maintenance of good records of the care provided
- Age and sex registers of the population for which the doctor is responsible with the facility to identify particularly vulnerable groups in the population
- Provision of services for patients with special needs, such as antenatal care, contraceptive care, well baby clinics, and immunisation, and care of the elderly and supervision of those with certain chronic disorders, such as diabetes, hypertension, etc
- Development of a team approach to providing comprehensive primary care services.

Good quality general practitioner care does not demand:

- Responsibility for the control of peoples' behaviour, be this concerned with excessive eating, smoking, sexual promiscuity, or drug taking. These are the responsibilities of society at large, and to impose such a responsibility on the general practitioner is to condone the medicalisation of social behaviour, warned against by Ivan Illich.[3]
- Provision of routine medical examinations for healthy adults. These have not been shown to improve health, and there is some evidence that they increase anxiety, morbid preoccupation with disease, and absence from work.

The new contract for general practitioners must be viewed with these basic principles in mind. Certain standards of performance have been determined that are concerned almost entirely with preventive care, some of which is of questionable benefit. Some of these standards seem to ignore the rights of patients to accept or reject care. Other aspects of the contract with respect to preventive services totally ignore the problems of calculating appropriate denominators in order to measure the percentage response to care. Overall, the contract is imbued with the belief that "good care" as it defines it will attract more patients to the doctors providing this care, and the doctors will consequently receive greater financial rewards through a system of payment based largely on capitation. It ignores perhaps the most crucial aspect of primary care, which is concerned with the time doctors can devote to listening to and identifying their patients' problems and to providing counselling, advice, health education, and appropriate management.

The doctor trained to provide care under the new contract will employ an array of nurses and health educators. Patients entering the consulting room will be screened, advised about their weight, smoking habits, stress level, immunisation state, etc. Unfortunately some of these patients may have illnesses that can be diagnosed and treated appropriately only if the doctor takes time to listen to their problems, examine and investigate them, and respond to their current needs. The competition for capitation fees may make it difficult for the doctor to respond in this manner.

Is there an alternative?

On the whole, doctors in general practice sympathise with the government's objective of bringing all parts of the NHS "up to the very high standard of the best." This is a standard that the Prime Minister herself acknowledges is without equal in the world, and it has been achieved with the current contractual arrangements. It is how NHS staff members can be encouraged to achieve this standard that is the

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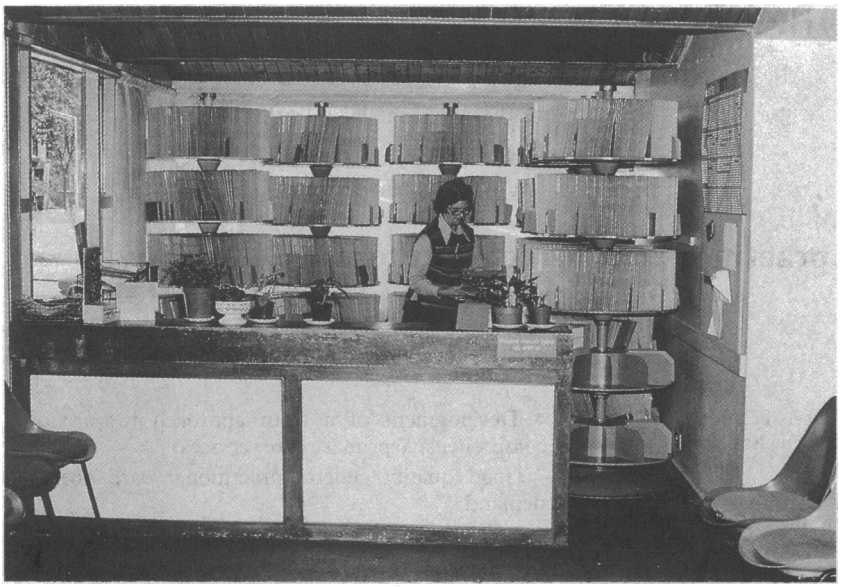

A4 filing system in an inner London practice

issue that must be debated. Will the radical changes proposed in the new contract really have the effect of bringing inferior standards of practice up to the level of the best? This is questionable. The emphasis on income derived from capitation fees will encourage the development of large lists of patients. The emphasis on prevention means that doctors who wish to earn maximum fees for their services will be constrained to show adherence to totally unrealistic indicators of performance. Doctors who provide a caring and compassionate service, which takes time but is much less easily audited, will have an appreciable disincentive to provide the care that patients value.

Improvements in general practice could be achieved by simple changes that do not entail a radical overhaul of the present contract. These changes, however, do demand a change of heart in the profession but not one that will in any way threaten clinical freedom. They can be achieved by accepting the concept that general practitioners should contract with the family practitioner committee to provide services for a defined community of patients to a standard defined by the committee in consultation with the profession and consumer associations. In return for this agreement the general practitioner would be paid a basic practice allowance for the services provided and a capitation fee for each registered patient, with a higher fee for elderly patients. Rather than reducing the basic practice allowance it should be increased, but it should be dictated by the services provided. As part of the contract each practice would be constrained to provide the family practitioner committee with an annual report of the services provided, which could be audited by comparison with items of service payments, and each practice would be visited at intervals of two years by an audit committee. The facts provided in the annual report, together with the report of the audit committee, should lead to a grading for each practice from poor to excellent, on the basis of which the basic practice allowance for the next two years could be calculated.

Auditing services

In order to obtain the mean basic practice allowance general practitioners should be expected to provide those services that have been shown to be or by common consent may be accepted as necessary for providing good quality medical care. Extra services that may enhance the basic practice allowance should also be restricted to services that have been shown to enhance patient care, either directly or through the efficient use of resources. Services that are conducive to the development of general practice, the health service, research, or education should be given due recognition. Services such as routine medical examinations for healthy adults that have not been shown to enhance the quality of health and, indeed, in some studies have led to a deterioration in health should not be included in evaluations. New services should not be provided unless they are established on a sound research footing.

Services to be evaluated by the audit committee

A prerequisite for paying any basic practice allowance would be the provision of an annual practice report. From this basic and extra services would be identified and graded, and these may subsequently be verified by visitors from the audit committee. I suggest that the following services should be considered when the grading for the basic practice allowance is judged. My suggestions are based on a combination of common sense and research evidence concerning the provision of good quality general practitioner care. Because the main concern in this audit is with raising the quality of the most inferior services the standards proposed are not particularly demanding.

Premises—Good and sympathetic care cannot be provided in the absence of adequate consulting and waiting rooms. These should include: adequate waiting space determined according to the number of registered patients; adequate heating and lighting; toilet facilities for patients; a consulting room of defined minimal size; an examination couch and washing facilities; facilities for sterilising instruments and disposing waste; and storage of emergency drugs and equipment.

Equipment—Basic diagnostic equipment, including an auroscope, an ophthalmoscope, a vaginal speculum, a proctoscope, a peak flow meter, and a weighing machine should be available. Equipment for simple surgical procedures, such as scalpels, scissors, and forceps, and for simple diagnostic procedures, such as diagnostic strip tests for urine, syringes, needles, laboratory containers, and cervical cytology equipment, should be basic to any practice. The possession of extra equipment, such as an electrocardiograph, an electric cautery, a cryocautery, and a nebuliser, should be expected in practices with an above average grading.

Records—Each practice should have an age-sex register that is updated properly. Each consultation should be entered in the medical records, with details of the patient's problem, its management, and drugs prescribed. All practices should provide drug records for patients receiving repeat prescriptions. There should be evidence in the records that patients who are receiving treatment with steroids, antihypertensive drugs, diuretics, or hypoglycaemic drugs are seen at least once every six months. All above average practices would be expected to keep routine blood pressure records for at least 50% of the patients over the age of 40 and have computers with call and recall systems for immunisations and cervical smear tests.

Team work—A team approach, either by attached nursing and health visiting staff or by well developed liaison with nurses and health visitors, should be evident. This could be confirmed in auditing by consulting the community nursing services. The provision of a practice nurse, a dietitian, and a psychologist might be looked for in practices graded above average.

Services—In addition to services provided on demand and continuing care for chronic disease, practices should provide well baby and immunisation services, out of hours care, antenatal care (either on a community or a shared care basis), and family planning

services. The provision of these services can be confirmed by item of service payments. Special screening for the elderly, community obstetric or diabetic care, community psychiatric services, etc, might be expected in practices given an above average grading.

Teaching and research—Practices selected by peer review to provide undergraduate teaching and vocational training and to carry out research might expect a higher than average grading.

Services to the health service—General practitioners committed to work designed to advance general practitioner care nationally, such as members of district committees, Royal College of General Practitioners committees, BMA committees, etc, might expect a higher than average grading.

Patterns of prescribing—Prescribing profiles for practices will be available to the family practitioner committee, and practices in which the profile indicates prescribing costs of 20% or more above the district average should be investigated. The results of the investigation could influence the grading for the basic practice allowance of such a practice.

Inner city and rural practices—Some practices, particularly in inner cities, experience a very high turnover of patients, which leads to an increased workload. Wide dispersal of patients in rural areas also presents special problems. These factors should be taken into account when practices are graded.

Evaluation of services provided

On the basis of annual reports, item of service payments, visits by the audit committee, and prescribing profiles, practices could be graded from poor to excellent on a scale of 1 to 5. Those graded 1 would receive no basic practice allowance; those graded 5 would receive twice the average allowance. In this way the services provided could be related to remuneration.

As a result of supervision the services might be expected to improve and costs would go up. This is entirely in keeping with the government's aims for a better service. In time, however, all practices might be expected to have computers and practice nurses, and it may be necessary to modify the basic service expected in general practice to attract the mean basic practice allowance. In due course new initiatives in prevention and services may be proved to be desirable, and these could then be incorporated into the services expected in order to attract a mean basic practice allowance. With advances in information systems all practices will probably need a computer, and an initiative by the government to provide this facility will become necessary.

The audit committee

The appointment of the audit committee will be crucial to the success of this programme, and it is important that people appointed to this committee are trusted by the doctors working in the community. At the same time it is important that the government should see the members of the audit committee as independent assessors of the services being provided. I propose that the audit committee should be appointed by the family practitioner committee and should include a general practitioner nominated by the local medical committee, a community nurse, a manager from the family practitioner committee, a community doctor (with special responsibility for organising and interpreting data), and a lay chairman. All members appointed to this committee should be agreed by the local medical committee; they should be paid for their services and be expected to devote one day each week to committee work. This should make it possible for them to visit each practice every two years. A mechanism for appeal should be available to doctors who disagree with their grading, but this should be based only on questions of fact, which should, however, include questions concerned with the age and sex structure of a practice. Practices with totally inadequate premises would have to be supported by loans to improve the premises if they are to be protected from a vicious circle of lack of finance and further deterioration in grading.

This system of audit will meet most of the government's wishes to improve the quality of general practitioner care, bringing all parts of the NHS "up to the very high standard of the best." It would not challenge the doctor-patient relationship by introducing financial factors to decision making. Above all it would not allow financial considerations to interfere with the day to day conduct of general practitioner care; nor would it encourage general practitioners to provide care for very large lists of patients in order to satisfy their greed.

Conclusion

I have described ways in which general practitioners may be constrained to provide care that is sensitive to the quality of the services provided. Individual items of service would continue to attract remuneration and thus encourage good practice. Basic clinical care would be encouraged through audit of records and prescribing. Seniority payments could be linked to postgraduate training. The overemphasis on prevention in the new contract, which is just a part of the general practitioner's normal services, could largely be delegated to nurses and would be balanced by good general care and not constrained by unrealistic targets related to unreliable denominators.

Such a system would achieve the objectives of *Working for Patients*. If the profession supported this it would be seen to be behind the objectives of the new contract. If the profession is not prepared to accept some form of external audit after years of failing to provide a satisfactory internal audit then it probably deserves the treatment the government is proposing. If the government rejects the system it would clearly indicate that its prime concern is with an ideology concerned with the market place, a misunderstanding of the principles on which general practice is founded, and a total disregard for patient care. The electorate has then a clear decision to make. To someone who has dedicated a professional lifetime to studying and developing the role of the general practitioner and improving his or her status this would be profoundly disappointing.

1 Secretaries of State for Health, Wales, Northern Ireland, and Scotland. *Working for patients*. London: HMSO, 1989. (Cmnd 555.)
2 Department of Health and Welsh Office. *General practice in the National Health Service. A new contract*. London: DHSS, 1989.
3 Illich I. *Medical nemesis: the expropriation of health*. London: Calder and Boyars, 1975.

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