Controlling the gatekeepers: the accountability of general practitioners

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ONE of the key words of the 1980s has been accountability. Throughout the public sector there has been new interest in making those responsible for delivering services answerable for what they do and how they spend the taxpayers' money. It is part of the new managerial revolution in public administration. Providers of professional services, be they teachers or doctors, are increasingly being called to account. New institutions, such as the National Audit Office and the Local Audit Commission, have been created and the Government has introduced a new style of management into the public sector which revolves around setting objectives and measuring progress towards their achievement, and which requires that the managers should be held accountable for their performance.[1] The key words in all this are, to quote the Government's document setting out this strategy, 'monitoring efficiency and effectiveness'.

All this may seem a long way from present problems in primary care, but primary care is likely to be increasingly affected by this new public philosophy, and by the current preoccupation with accountability, efficiency and effectiveness. We suggest that general practitioners may, over the coming decade, have to reconsider their status as independent contractors or, at the very least, redefine what is meant by this concept in order to make it compatible with the rapidly changing political, economic and institutional context in which they are working.

In arguing this case we make two assumptions. The first, which general practitioners will have no problem endorsing, is that primary care is likely to become more important over the next decade. The growing emphasis on treating the whole person, the increasing recognition that social and medical factors cannot be neatly separated, the reaction against expensive, high technology medicine — all these are factors calculated to give extra prominence to the role of the general practitioner. The second assumption, which doctors may find somewhat less acceptable, is that as the role of primary care expands there will be increasing demands for more information about the activities of general practitioners and growing pressure to make them accountable for the way in which they use public resources.

The central paradox of the next decade it is therefore likely to be that general practitioners will move increasingly into the focus of National Health Service (NHS) policy-making but the price of growing prominence will be loss of autonomy in the traditional sense. With increasing resources available general practitioners may have more freedom to do more interesting things but they may have less freedom from external constraints in that they may have to be more answerable to others.

The central role of primary care

Since the start of the NHS there has been a shift in activities and resources from the primary to the secondary sector of care.[2] For example, the number of general practitioners increased by only 20% between 1950 and 1980, while the number of hospital doctors rose by nearly 400%. And the best reason for predicting a switch in priorities is, quite simply, that the historic growth in the resources devoted to the hospital sector cannot continue and indeed there has in recent years been a sharp reduction in the rate of growth,[3] even though the demands made by an ageing population are increasing and new procedures continue to be developed. If the demands on the hospital sector are to be accommodated by what will at best be only a modest annual increment in state resources (under any government), then ways will have to be found of channelling these demands in different directions or diverting them elsewhere. And, if it is assumed that there is only modest scope for channelling them in different directions, for example, towards the private sector,[4] then the only other policy option would seem to be to divert them back into primary care — to strengthen the general practitioner's role both as a service provider and as a gatekeeper.

The logic of this scenario seems irresistable. But there are problems. To describe the general practitioner as the gatekeeper is a familiar cliché but the trouble with clichés is, all too often, that we do not think through their implications rigorously enough. The gatekeeping role of the general practitioner has two faces. The first is that of the patient's agent — as gatekeeper to the rest of the NHS the responsibility of the general practitioner is to maximize his or her patient's chances of getting the best possible treatment. The patient relies on the doctor for information about what is available, and to act as advocate. But the other face of gatekeeping is that of the rationer — the general practitioner must ensure that sensible use is made of public resources and that patients are not referred to hospital or for expensive diagnostic tests if there are no serious grounds for doing so or if the local clinical resources cannot cope with the demands. In short, general practitioners must be two-faced, caught between their responsibilities to individual patients and to the need for effective use of collective resources.

But to stress the gatekeeping role of the general practitioner in deciding who goes where in the hospital sector of the NHS is to give a very incomplete picture. The gatekeeping role of the general practitioner is more extensive than this. If we think of health and social support as a system — where different kinds of services and programmes of cash benefit complement each other and indeed may be substituted for each other — then the general practitioner (and his or her team) forms the centre of the system. It is the general practitioner who may determine whether or not a particular patient gets rehoused by the local authority or receives help from the social services or gets certain social security entitlements, such as invalidity benefits or an attendance allowance.

In all this the general practitioner has a multiple role. He or she may certify certain claims to entitlements or services, act as the agent or advocate of the patient in putting the case for services or cash and provide the information required by citizens if they are to find their way through the maze of entitlements and services. For this reason, Professor Brian Jarman has developed a computer package designed to allow people to work out their social security entitlements.[5] Indeed, it could be argued that the best way of distributing information about social security entitlements (in the widest sense) is through the doctor's surgery, since more people are likely to visit the surgery routinely than almost any other location. Much of this may not have much to do with health care in the narrow sense. But if it is conceded that health and social care form part of the same system of support and that very often they may substitute for

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each other, then it is clear that if we are concerned about the effectiveness of the system as a whole, we must also be concerned about the effectiveness of the general practitioner in distributing information and acting as the guide and agent of the citizen in addition to his prime role as a direct provider of health care in the strict sense. A simple and obvious example will make the point. Given the current emphasis of public policy on sustaining the ability of the elderly to live in their own homes for as long as possible, in order to avoid both the trauma and expense of institutional care, then obviously much depends on the effectiveness of the general practitioner (and his or her team) in coordinating amd mobilizing the various forms of support, ranging from home helps to home nurses.

So much for the arguments in support of our first contention — if health care and social support are thought of as a system, then the role of the general practitioner is not only central but will become ever more important if the aim of public policy is to strengthen the various forms of community and primary care required to reduce the rate of growth in demand for secondary, institutional care. It is not the aim of this paper to explore the complexities, difficulties and ambiguities of this role — problems stem from the fact that the general practitioner is usually a facilitator, promoter and coordinator, rather than in the position of being able to command resources, and from the fact that as the role of the general practitioner expands in the way described so his or her dependence on a team increases.

The case for more accountability

To stress the role of the general practitioner as a gatekeeper and a rationer, as the man or woman who helps to determine what people get out of the system of health and social support, is also to stress that the general practitioner plays an important role in determining not only how much public money is spent but whether or not it is spent efficiently. This is most evident in the case of prescribing. If a doctor prescribes too much of a given drug, then he or she is prescribing inefficiently. If a doctor prescribes an inappropriate drug, then he or she is prescribing ineffectively. So much is obvious, and generally accepted. But precisely the same point can be made about hospital referrals or diagnostic tests. In both instances, the way in which a general practitioner practices has implications not only for the quality of medical care but also for the quantity of public resources spent. Moving beyond the NHS, it can similarly be argued that if a general practitioner is inefficient or ineffective in acting as the patient's guide and advocate through the maze of social security benefits and social support services, then the system as a whole will not be delivering value for money — more expensive fórms of treatment or support may become necessary because inadequate or belated use is made of alternative ways of meeting needs.

From this flows the central dilemma of public policy. There is indeed as has been argued, a powerful case for putting more resources into primary care: for meeting, for example, the medical profession's demand for smaller lists — a demand which could well be met over the next decade given that we appear to be moving into an era where options are no longer constrained by a shortage of doctors and given, also, that an increasing proportion of the graduates from medical school are women with a bias towards general practice.[6] But why should governments concede these demands unless they can be sure that putting in more resources will result in increased efficiency and effectiveness of practice; the evidence for this is inconclusive at best.[7]

The only sensible strategy for any government concerned about value for money in public expenditure would therefore be to insist that the price of increasing resources must be greater accountability for outcomes. It might be argued, for example, that the objective of primary care should be to minimize the demands made on the more expensive secondary system of care. In which case, the performance of primary care in any given district might be measured by the extent to which it increases or reduces the number of referrals over a period of time, and by the proportion of the population that ends up in some form of institutional care. In short, the question would be: are general practitioners efficient and effective in their gatekeeping and rationing role in the widest sense? Clearly, allowance would have to be made for factors outside the control of general practitioners, such as the availability of various forms of social support. However, while such factors complicate the task of evaluating the performance of doctors, it remains legitimate to ask how they perform in the light of environmental constraints.

This kind of approach complements, but does not replace, the more familiar emphasis on assessing the performance of doctors in terms of the professional quality of their practice: at present a major concern of the Royal College of General Practitioners.[8] It also raises a series of other questions. For example, an evaluation of primary care might examine the frequency with which doctors see the most vulnerable patients, such as the elderly, and the extent to which they themselves are responsible for the health of their patient population as a whole as distinct from those individuals who happen to come to see them.

These are complex questions and the conceptual difficulties involved have not been addressed in detail. But the argument of this paper is that they will inevitably have to be addressed if there is to be a move towards expanding the role of primary care. Indeed, there is already some evidence of a movement in this direction. In the case of regional and district health authorities, a complex system of performance indicators and performance reviews is already in operation.[9] In other words, the first, faltering steps towards assessing the outputs — if not yet the outcomes — of health services have already been taken. In the case of family practitioner committees a similar system is in the process of being established — as yet, the performance indicators only cover administrative performance. But given the requirement that family practitioner committees should produce regular 'profile and strategy statements',[10] setting objectives and policies, it would seem to be only a matter of time before attention focusses on the performance of primary care itself — on the performance of the general practitioner as a coordinator, mobilizer and user of scarce public resources.

So the prospect for the next decade is one of opportunity and challenge for general practitioners. The opportunity is the chance to play an ever greater role in an expanding system of primary health and social support. The challenge is how best to reconcile traditional views of clinical autonomy with the demands of public accountability to demonstrate both efficiency and effectiveness.

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