personal care, for which the local authority or individual patients must pay.[7]

These definitions of categories of care are therefore of equal importance in domiciliary care, particularly as the guidance allows hospitals to discharge patients home if either they or their carers have rejected other options such as nursing homes. Many of the people covered by the guidance already live at home, receiving few statutory services and being cared for principally by relatives and other informal carers. For many carers, domiciliary and day care facilities are crucial in the management of the precarious balance between their caring and other domestic and employment responsibilities.[8,9] Where health and social care resources are tight, however, domiciliary services may be pared down to the absolute minimum.[10] This is particularly the case in intimate personal care, which is so crucial to the core values of dignity and quality of life, which rightly underpinned *Caring for People*.[11]

Long term care has historically been associated with inappropriate institutional arrangements and inadequate provision "in the community." The new priority accorded to the NHS's responsibilities for meeting continuing health care needs is welcome. Those responsibilities, however, will be properly fulfilled only by the investment of adequate resources and commitment in models of services that reverse existing imbalances of provision and promote choice and independence for users and carers.

MAGGIE PEARSON
Professor of health and community care
Health and Community Care Research Unit,
University of Liverpool and North West Regional Health Authority,
Liverpool L3 6AL

GERALD WISTOW
Professor of health and social care
Nuffield Institute for Health,
University of Leeds,
Leeds LS2 9PL

1 Department of Health. *NHS responsibilities for meeting continuing health care needs*. London: Department of Health, 1995. (HSG(95)8.)
2 National Association of Health Authorities and Trusts. *The National Health Service: responsibilities for long-term care. Response by National Association of Health Authorities and Trusts to the draft guidance of the NHS Executive*. Birmingham: NAHAT, 1994.
3 Health Service Commissioner. *Failure to provide long-term NHS care for a brain damaged patient*. London: HMSO, 1994. (HC197.)
4 Wistow G. Charges at the interface. In: Balloch S, Robertson G, eds. *Charging for social care*. London: National Institute for Social Work and Local Government Anti Poverty Unit, 1994.
5 Hobbs R. Rising emergency admissions. *BMJ* 1995;310:207-8.
6 Wistow G. Aspirations and realities: community care at the crossroads. *Health and Social Care in the Community* (in press).
7 Wilson G. Assembling their own care packages: payments for care by men and women in advanced old age. *Health and Social Care in the Community* 1994;2:283-91.
8 Phillips J. The employment consequences of caring for older people. *Health and Social Care in the Community* 1994;2:143-52.
9 Pearson M, Bogg J, Pursey A, Quinney D. *Users' and carers' views of NHS day hospitals for older people*. London: National Audit Office, 1994.
10 Richardson R, Pearson M. *Suffering in silence? Unmet health and social care needs in an inner city area*. Liverpool: Health and Community Care Research Unit, 1994.
11 Department of Health and Social Services Inspectorate. *Care management and assessment—Managers' Guide*. London: HMSO, 1991.

# Performance indicators for general practice

## *Will lead to league tables of performance*

Some family health services authorities are now producing performance indicators for the general practices they administer.[1-3] With the move towards a primary care led NHS,[4,5] these indicators will become an important management tool. League tables of practice performance are a possibility: for example, practices could be ranked by rates of uptake of cervical smear tests and the proportion of drugs prescribed generically. Many general practitioners, particularly those who work in deprived communities, will find this development threatening and may think that league tables will unfairly label their practice as performing poorly. Family health services authorities must therefore ensure that performance indicators are interpreted appropriately.[6]

Performance indicators may be used to identify and reward high performing practices with increased allocations for staff and premises. Conversely, if resources are allocated according to health need rather than performance, then less well developed practices (which are often located in areas with high need) may receive more resources. Because such practices may not have the capacity to use additional resources effectively this may lower the morale of the more innovative practices. Performance indicators should not therefore be used uncritically when resources are allocated to practices.[7]

General practitioners can benefit from performance indicators. They can use them to identify how their practice deviates from the norm and where scope for further investigation and audit may exist. For example, a practice with a high proportion of technically unsuitable smears may want to investigate this further. Performance indicators can also help practices to identify priorities for improvement and to monitor how well they address them over time. Finally, performance indicators can be used to carry out descriptive research into variations in medical practice in primary care.[8]

The most important limitation of performance indicators is that they measure only certain aspects of performance. For example, they can tell us what a practice's referral rate is but tell us nothing about the appropriateness of these referrals. Performance indicators also tell us nothing about what most general practitioners would consider to be their most important role: the clinical care of individual patients. Secondly, performance indicators could create perverse incentives, with general practitioners concentrating on improving the indicators rather than improving the quality of their care. Thirdly, performance indicators are constructed from routine

**Examples of performance indicators for general practices available to family health services authorities**

| | |
|---|---|
| Patient data | Number of patients per partner |
| | Demographic breakdown of practice population |
| | Census derived social variables |
| Target payments | Cervical smear uptake rate |
| | Percentage of smears that are technically unsuitable |
| | Immunisation uptake |
| Items of service | Night visiting rate |
| Prescribing | Prescribing cost per patient |
| | Percentage of items prescribed generically |
| | Ratio of inhaled steroids and cromoglycate to bronchodilators |
| Employed staff | Numbers and categories of employed staff |
| Hospital referral rates | Referral rates for inpatient care |
| | Referral rates for outpatient care |

data, and there are errors in these data, especially in age-sex registers (inflation of lists), census data (under enumeration), and data on referrals (inaccurate coding). Finally, indicators of prescribing are derived from prescribing analysis and cost (PACT) data; with the steadily increasing cost of NHS prescriptions, more drugs will either be prescribed on private prescriptions or be bought over the counter, making prescribing indicators derived from PACT data less useful.[9] Family health services authorities need to be aware of these limitations when they use performance indicators to assess practices' performance.

To improve the limited information available to patients (for example, in practice leaflets) when they choose a practice, some family health services authorities may wish to make performance indicators available to the public. Although many general practitioners will oppose the publication of performance indicators, we already have league tables for schools and hospitals, and the publication of league tables for general practices may be inevitable. But, because of the controversy raised by league tables elsewhere and the lack of consensus between general practitioners and managers over what constitutes "good" performance, this is a development that family health services authorities should handle sensitively. General practitioners should therefore be involved at all stages in the development and implementation of performance indicators.[1] Even if the indicators are not released to the public, the new health commissions will make much greater use of performance indicators in monitoring general practices.[3,4] General practitioners should therefore collaborate with family health services authorities to improve the quality and usefulness of performance indicators, and they should start to discuss with their local health commissions how they intend to use performance indicators in the management of primary care services.

F AZEEM MAJEED
Lecturer in public health medicine

Department of Public Health Sciences,
St George's Hospital Medical School,
London SW17 0RE

SIMON VOSS
Consultant in public health medicine

Southampton and South-West
Hampshire Health Commission,
Southampton SO16 4GX

1 Old P, Voss S, Davidge M. Performing arts. *Health Service Journal* 1994;104:28-9.
2 Payne N, Jones G, Norris J, Robinson J, Hodgkin P. Profiling general practices. *British Journal of Healthcare Computing and Information Management* 1994;11(9):12-3.
3 Hanlon A, Hargreaves S. Performance indicators for general practice. *J Epidemiol Community Health* 1994;48:502.
4 NHS Executive. *Developing NHS purchasing and GP fundholding.* Leeds: NHSE, 1994. (EL(94)79.)
5 NHS Executive. *Towards a primary care led NHS: an accountability framework for GP fundholding.* Leeds: NHSE, 1994. (EL(94)92.)
6 Majeed FA, Cook DG, Anderson HR, Hilton S, Bunn S, Stones C. Using patient and general practice characteristics to explain variations in cervical smear uptake rates. *BMJ* 1994;308: 1272-6.
7 Iliffe S, Munro J. General practitioners and incentives. *BMJ* 1993;307:1156-7.
8 Baker D, Klein R. Explaining outputs of primary health care: population and practice factors. *BMJ* 1991;303:225-9.
9 Heath I. The creeping privatisation of NHS prescribing. *BMJ* 1994;309:623-4.

# Reviewers chosen by authors

## *May be better than reviewers chosen by editors*

We are always looking for ways of improving our processes of peer review, and over the next few months we will be exploring the option of using reviewers nominated by authors. We therefore ask all researchers to suggest two or three potential reviewers for papers they submit for publication. The reviewers can come from anywhere in the world, and we especially welcome reviewers from outside Britain.

This policy could improve the quality of peer review in two important ways. Firstly, authors are often better placed than editors to know whom to approach for a considered, balanced, and credible opinion in their field of research. The best reviewers are not those with the most experience or eminence[1] and may be unknown to anyone outside the subject. This is a particular problem for editors of general journals, who peer review manuscripts from a wide range of disciplines. Secondly, nominated reviewers will enrich the *BMJ*'s database, keeping us in touch with young active researchers and giving us a broader population of reviewers. An audit in 1990 showed that most of our reviewers were male academics from London or other university cities, and most were senior doctors who had been qualified for a median of 24 years. We had few general practitioners, few from overseas, and very few women.[2] Things have improved since then—after a recruiting drive aimed at overseas reviewers—but we want to continue to make progress.

The worry about using nominated reviewers is that peer review will become a cosy process of endorsement by friends and colleagues. We hope, however, that our quality control measures will guard against obvious bias. Reviewers are graded for each report. Brief, unsubstantiated, and uncritical reports are given low grades and have little impact on our decision. Low scoring reviewers are not used. We also ask reviewers to declare personal and professional connections with the authors of a manuscript so that we can make up our own minds about the potential for bias.[3] Many journals are already using reviewers nominated by authors and an informal survey conducted at *Gut*, for example, suggests that they write better reports than reviewers selected by editors.

About half the material sent to the *BMJ* is externally peer reviewed, the rest being rejected after scrutiny by at least two medical editors. We may not use the nominated reviewers for a particular paper, but we will enlist all those who agree into our existing population of reviewers. For now, we will continue with anonymous refereeing. Open review—unmasking the identity of reviewers to authors—may be the next step in the modernisation of peer review, but it remains unpopular with many reviewers.[4] Any readers who would like to review manuscripts for us are also welcome to volunteer and should write to the papers secretary, Sue Minns, at the *BMJ* for details.

We hope eventually to assess the impact of using nominated reviewers on the quality of published papers. As a first measure we will be performing a controlled trial to examine its effect on the quality of referees' reports and their influence on the editorial decision.

ALISON TONKS
Assistant editor

*BMJ*,
London WC1H 9JR

1 Evans AT, McNutt RA, Fletcher SW, Fletcher SH. The characteristics of peer reviewers who produce good reviews. *J Gen Intern Med* 1993;8:422-8.
2 Lock S, Smith J. What do peer reviewers do? *JAMA* 1990;263:1341-3.
3 Smith R. Conflict of interest. *BMJ* 1994;308:4.
4 Fabiato A. Anonymity of reviewers. *Cardiovasc Res* 1994;28:1134-9.