risk groups and their medical and nursing attendants must be carefully monitored.

Another major influence on the attitude towards infected patients is the cost of their care. Enormous sums of money have already been spent caring for patients with AIDS and even conservative projections of future costs quickly assume astronomical proportions.[3,4] This money may be seen to be lost from other areas of patient care. How many hip replacements or renal transplants will not take place because AIDS patients are receiving zidovudine? Prescribing plastic syringes for diabetics may only have become possible because of the outcry following the free distribution of needles and syringes to injecting drug abusers but a similar extension to other areas of expenditure seems unlikely. Some tough decisions lie ahead for doctors when deciding priorities. In reaching these decisions they must take care to avoid unfair discrimination. 'Discriminate (transitive verb) — to treat differently because of prejudice'.

R.T.A. SCOTT
General Practitioner, Alexandria, Dumbartonshire

References

1. Communicable Disease Surveillance Centre. *The acquired immune deficiency syndrome: 1985. CDR 86/15.* London: Public Health Laboratory Service, 1986.
2. Pinching AJ. The acquired immune deficiency syndrome: with special reference to tuberculosis. *Tubercle* 1987; **68:** 65-69.
3. Wells N. *The AIDS virus: forecasting its impact.* London: Office of Health Economics, 1986: 35-48.
4. *Report of the National Working Party on Health Service Implications of HIV infection.* Edinburgh: Scottish Home and Health Department, 1987: 83.

Medical manpower planning: factors influencing workload in general practice

GENERAL practice is constantly changing and the effect of present trends is to increase the workload of the general practitioner. These trends, which are discussed below, must be taken into consideration when planning medical manpower.

The majority of patients with chronic disease are now cared for in general practice; for example only about 10% of patients with epilepsy are followed up by hospital outpatient departments.[1,2] For patients with chronic disease there are times when care in hospital is essential, and this has led to shared care programmes being set up. These involve cooperation between general practitioners and primary care nursing colleagues, liaison nurses and consultant physicians. The workload involved in this liaison is considerable and is increasing.[3,4] Many practitioners are setting up disease registers, and organized call and recall systems for patients with chronic diseases. This not only increases administrative time and costs, but also the number of consultations with each patient. The use of computers can reduce administrative work and make it more efficient, but new services require additional resources. Some of the increased work involved in caring efficiently for the chronically ill could be carried out by practice nurses and nurse practitioners and there is evidence that they wish to take on such tasks.[5] However, the extent to which these team members can take on this work will depend on the degree to which general practitioners are permitted to delegate and on the acceptability to patients of this change.

As large mental hospitals close, patients with chronic mental illness and mental handicap are moved into the community and become the responsibility of general practitioners. Their care requires a high degree of skill, and also the ability to organize and coordinate community resources. Such work is time consuming, and does not receive serious attention in the debate about the community care of the mentally handicapped.

There is no evidence that the rationing of health care and costs in the National Health Service by waiting lists will be abolished in the near future. Patients who are waiting for appointments in specialties such as neurology and ophthalmology or for operations are often anxious and sometimes in pain. They are therefore likely to consult their general practitioner and increase his workload. Attempts to shorten waiting lists by the increased use of day surgery and the early discharge of patients postoperatively results in general practitioners providing care previously provided by the hospital. This policy increases both the range and quantity of work undertaken by the primary health care team.

More general practitioners are now screening their patients for hypertension, diabetes, high alcohol intake and hyperlipidaemia and this trend is strongly encouraged by the government. It has been found that preventive care is more common in training practices and practices which have low lists where there is better than average medical manpower.[6]

The rapid increase in the number of cases of the acquired immune deficiency syndrome will dramatically increase the number of people in the community who need long term and sometimes frequent care. General practitioners will be expected to play a major role in providing care at all stages of the illness.

More women are now being trained as doctors — in 1984 46% of medical students were women.[7] The majority of women doctors get married and have children, resulting in absence from work, disruption of their career and a need to combine work with domestic commitments on a long term basis. As the proportion of women general practitioners increases, the implications for medical manpower planning must be considered.

One in 10 general practitioners is a trainer and the trainer's contract requires two sessions to be put aside for teaching and supervising the vocational trainee. Many practices also teach medical students, and the trend is for medical students to spend more time in general practice. The General Medical Council recommends that hospital doctors should spend some of their time in training in general practice.[8] Thus, the amount of time that general practitioners spend in teaching is likely to rise.

Many doctors value the time they spend working as school, occupation or prison medical officers and many also serve on professional committees. Although it would seem likely that this work would erode the amount of time the doctor has available for patients, it has been found that doctors who work for more than three hours outside the practice also spend more time in contact with patients in the practice.[9]

Doctors who spend longer with each patient might be expected to see fewer patients in each consultation session and this might reduce the total number of patients that they could care for. A survey comparing the care of patients allocated at random to surgeries booked at 5.0, 7.5 and 10.0 minute intervals by analysing tape recordings of the consultations[10] found that in surgeries booked at 10 minute intervals the doctor identified more problems, carried out more preventive procedures, and spent more time listening to patients and explaining their

management. There was an improvement in patient satisfaction in surgeries booked at 10 minute intervals.[11]

The number of elderly people in the community is increasing. They consult more frequently than younger people and their consultations take longer. It has been suggested[12] that doctors should visit the elderly more frequently, and be willing to fit them into surgeries, perhaps without an appointment. If implemented, these suggestions would increase the amount of time that doctors spend in caring for elderly patients. Elderly patients who in the past would have been admitted to geriatric wards are now moving into residential homes and thus remain under the care of general practitioners. The care of these disabled and chronically ill elderly patients is demanding and time consuming, and in some areas of the country this work comprises a large percentage of the general practitioner's total workload.

There are particular parts of the country where an increase in the number of general practitioners is particularly necessary. Preventive health care has been found to be less frequently implemented among patients in social classes 4 and 5.[6] Preventive care for these patients is difficult and requires longer consultations, and possibly extra consultations specifically for preventive care.

Patients from ethnic minorities may have cultural difficulties in obtaining primary care. For instance, Muslim women may not wish to consult the doctor without their husbands, who may be at work all day. In addition, there may be language difficulties and difficulties in understanding because of different cultural norms. All of these problems increase the amount of time that doctors need to spend with these patients.

The above are just some of the factors which will increase the workload of general practitioners. It is difficult to quantify the effect of these factors but the cumulative impact makes it essential to reduce the average list. In order to ensure that such a reduction is matched by increased activity in areas such as prevention it will be necessary for general practitioners to provide information on their performance. Information from general practice is patchy at present and this makes it difficult to create a rational policy for the appropriate medical manpower in each health district.

EDWIN MARTIN
General Practitioner, Bedford

References

1. Goodrich DMG, Shorvon SD. Epileptic seizures in a population of 6000: demography classification and the role of the hospital services. *Br Med J* 1983; **287:** 641-644.
2. Hopkins A, Scambler G. How doctors deal with epilepsy. *Lancet* 1977; **1:** 183-186.
3. Durno D. *Activity analysis in general practice (MD thesis).* Aberdeen: University of Aberdeen, 1972.
4. Fleming DM. Workload review. *J R Coll Gen Pract* 1982; **32:** 292-297.
5. Greenfield S, Stilwell B, Drury M. Practice nurses: social and occupational characteristics. *J R Coll Gen Pract* 1987; **37:** 341-345.
6. Fleming DM, Lawrence MSTA, Cross KW. List size, screening methods and other characteristics of practices in relation to preventative care. *Br Med J* 1985; **291:** 869-872.
7. Universities Central Council on Admissions. *Statistical supplement to the twenty third report 1984–85.* London: UCCA, 1986.
8. General Medical Council Education Committee. *Draft recommendations on the training of specialists.* London: General Medical Council, 1987: para 64.
9. Wilkin D, Metcalfe D. List size and patient contact in general practice. *Br Med J* 1984; **289:** 1501.
10. Roland MO, Bartholomew J, Courtenay MJF, *et al.* The five minute consultation: effect of time constraint on verbal communication. *Br Med J* 1986; **292:** 874-876.
11. Morrell DC, Evans ME, Morris RW, Roland MO. The 'five minute' consultation: effect of time constraint on clinical context and patient satisfaction. *Br Med J* 1986; **292:** 870-873.
12. Harrison S, Martin E, Rouse S, Wilson S. Assessing the needs of the elderly using unsolicited visits by health visitors. *J R Soc Med* 1985; **78:** 557-561.

Health service costs and the general practitioner's role in relation to prescribing

WHEN the National Health Service was introduced in 1947 it was based on the principle that the health services should be available to everyone regardless of financial means, age, sex, employment or place of residence.[1] Need for health care would be the only criterion for its use. It is this concept which still attracts the admiration of many countries in the world, and is, I believe, the reason why so many doctors, health care workers and patients would defend it against any attack, and all political parties pay at least lip service to the support of the principle.

Sadly, even now, the NHS fails to deliver as good health care to the poor as to the affluent. 'The availability of good medical care tends to vary inversely with the need of the population served. This inverse care law operates most completely where medical care is most exposed to market force, and less so where such exposure is reduced' wrote Julian Tudor Hart in 1971.[2] This hypothesis was backed up by Don Forster in 1978,[3] who analysed nine available health indicators for the 10 standard economic regions in 1972–73. The tendency towards inverse care in the service has been exacerbated today.[4]

The problem is made more difficult by the increasing cost of health care in real terms and as a proportion of gross national expenditure, and this applies particularly in the area of prescription medicine. In 1974–75 prescriptions cost £297 million or 8.6% of overall health expenditure; in 1983–84 they cost £1430 million or 11.1% of expenditure and the trend continued in 1985–86 to an overall cost of £1700 million which was 11.3% of total NHS costs.

Various methods of improving prescribing and reducing costs have been proposed in the Hinchcliffe report,[5] and more recently in the Greenfield report, which recommended that pharmacists should substitute generic drugs for proprietary products on prescriptions.[6] This was opposed by the profession, but, undeterred, the government imposed a list of limitations on prescribing in certain therapeutic categories in April 1985. Another method of offsetting some of the cost of prescriptions is by the prescription charge, which has risen from 20p in 1979 to £2.40 today. Although 70% of people receiving prescriptions are exempt from charges, there is a small group who fall into the poverty trap just outside the exemption level. There is no doubt that fear of being given a prescription they cannot afford prevents some of these patients from visiting the doctor or if they do consult they do not cash all the items on their prescription, and often choose the wrong ones — perhaps a cough linctus and not the antibiotic for a chest infection.

It is not surprising that in the current economic climate the use of the market mechanism to reduce the cost of prescribing is being discussed, and Dr David Green, a political scientist and sociologist has written a booklet called *Medicines in the*