fees will make up 60% of the total remuneration of a general practitioner. The aim of these changes is to encourage general practitioners to take on new patients and so compete with other doctors in their locality. Linked to these changes are the intentions of the government to take direct control of the entry of new doctors into general practice and to allow doctors to advertise the range of services which they offer. This is a coherent logical approach to increasing choice for patients but experience in the early 1950s does not suggest that improved patient care results from intense competition between general practitioners.

The government's policy assumes that increasing choice for patients will improve health care. To suggest otherwise appears unfashionably paternalistic. Many aspects of health care, however, are not immediately popular, for example health promotion, and responding to demands rather than needs may lead the NHS even further into being a sickness rather than a health service. Most of the patients seen by general practitioners are suffering from self-limiting disorders and efforts to shift the emphasis in general practice towards prevention could be undermined by the proposals on patient choice. The white paper's proposals may also damage the coordination of general practice and community services. An effective primary health care team requires at least rough comparability in the territories covered by individual members. This point was strongly advocated in the report of the community nursing review.[7]

The choice of hospital care will be more problematic in future than it is at present. At the moment general practitioners have the right to refer their patients to any specialist. Geographical inconvenience and waiting lists modify this open system but costs do not intrude directly into the decision making of the doctors or of the patient. Hospital costs dominate the health budget and although the government is reticent about the financial implications of their proposals, 'value for money' is the *leit motiv* which runs through the whole white paper.

Budget management and competition are the means envisaged to achieve value for money in the health service. The unique arrangements set out in the white paper will create an internal market within the NHS, with money following the patient and both general practitioners and hospitals encouraged to manage their own budgets. This system is so novel that no one can predict the consequences. Some see the proposals as damaging the doctor–patient relationship by placing a price tag on the decision making of the doctor. Supporters of the government see it as a way of directing resources to the services which are successful in meeting the needs of patients in a locality. The only certainty is that there will be an increase in administrative and accountancy staff and that the NHS will be a magnet for health economists from all over the world who will wish to observe the service as it grapples with this massive experiment in health care.

Some of the uncertainties about the future of the health service may be reduced by the publication of the promised working papers but, whatever the outcome of the detailed negotiations, health care in the United Kingdom is journeying into unknown territory. Optimistic general practitioners who work in areas where fierce competition is unlikely should remember that cost limits are being applied to primary care for the first time. Pessimists should remember that in the past 40 years general practitioners have been improving the care they provide to patients while working to a contract which penalizes investment of time and equipment for better patient care. Our contract and the terms and conditions of our service do have a major effect on the care we provide in general practice but our professional responsibility is to act at all times in what we believe to be the best interest of the patients we serve.

E.G. BUCKLEY
Editor of the Journal

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Quality of care in general practice — lessons from the past

SINCE 1911, general practice has evolved under three policy regimes: the panel system (1911–48), the early National Health Service (1948–65) and the family doctor charter (1965 onwards). With negotiations now under way for a new framework of policies and economic incentives, the time is right to examine what these developments in general practice show about policy choice. It may be unwise to look for lessons about specific areas, but the historical record may give some guidance on broad issues such as the relative effects of professional as against economic incentives.

Family doctors are clinicians, but they also have to be businessmen. Their clinical commitments have been affected by their ability to attract and use resources. In this respect it was the panel system rather than the NHS which represented the real break with the past in providing improved rewards for initiative. Recent research covering both the panel system and the period since the family doctor charter has looked at the decisions which doctors faced and how they reacted to incentives.[1]

The panel system was based on the state health insurance scheme that was introduced by the national insurance act of 1911 and came into effect in 1913. The panel doctor was paid a capitation fee for providing services and drugs to panel patients. Initially the act covered wage earners aged between 16 and 70 years employed in manual labour or in non-manual jobs with an income less than £160 a year, although the limits were made less restrictive over time. Dependants and the better off were not covered. It was in effect a two-tier system with half the population covered by the panel system and the rest having to pay

privately, with consequent restricted access for the poor.

The panel era has usually been seen as a time when general practitioners gradually moved towards civil servant status with an increasing dependence on the state for income. In fact income from panel practice was a base from which doctors were able to expand earnings from private practice. This new study of the basic data[1] has shown a much greater improvement in medical incomes between the two world wars than expected. With some justice it could be said by the late 1930s that 'more doctors are of the £1000 a year class than men of any other profession'. The cost of living fell by some 7–10% between 1924 and 1936, so that in real terms, general practitioners were almost 50% better off at the end of the period and the prosperity was shared as differentials between doctors narrowed.

The panel doctor was faced with a range of decisions on business strategy. He could expand his list by employing an assistant. He could use a telephone and a car — or even two — and carry out his own dispensing by employing a dispenser. Most important of all he had to divide his time effectively between panel and private patients. Private patients were usually thought to deserve more time and in fact an agreement between the Ministry of Health and the British Medical Association explicitly allowed for this. It was settled in 1924 that although on average the income from panel patients would make up one half of a doctor's total net income only two sevenths of his time was assumed to be devoted to them.

The panel system provided incentives for working-class patients to consult the doctor much more frequently than hitherto. The average number of surgery attendances and home visits per patient rose from 3.8 in 1922 to 5.1 in 1934–36. Such heavy demand for consultations produced particular problems in the older industrial areas where the system seemed to encourage a superficial type of treatment based on the bottle of medicine. The inability of panel doctors to deliver care of a consistent quality or to use new technology led to increasing criticism; in particular there were controversies about maternity care and about the treatment of fractures. The system also made access difficult for poorer patients and their dependants many of whom were treated in local authority clinics or by chemists. The panel system created a serious conflict between the interest of the patient in better treatment and the interest of the doctor in higher income. The main incentives were towards cost minimization and towards a restriction in the quality of service. Changes in technology and in treatment methods were concentrated in the hospital service.

The early period of the NHS from 1948 to 1965 represented a policy vacuum where the payment system and practice arrangements carried over from the panel system. The main early effect of the NHS was to increase demand through giving free access to dependants while making little change in the incentives for improving the services supplied by general practitioners. Even the gains made under the panel system in terms of security of income were lost during bitter arguments about pay levels. The real change came in 1965 with the family doctor charter. This stabilized income and gave doctors a generally good level of real income: but it was linked to new policies for investment in premises, for encouraging the employment of nurses, secretaries and receptionists by general practitioners and for encouraging vocational training.

The family doctor charter provided direct assistance with practice costs: it also included professional as well as economic incentives. A recent survey has looked at the effects of the charter 20 years on using an interview survey of 260 practices in seven different areas of England chosen as representative.[2] The study developed a model by which personal characteristics, the local environment and the payment system determine decisions on practice strategy covering such issues as partnership size, investment in premises and staffing. The survey results identified a distinct group of innovators who have taken interrelated decisions to invest in premises, employ nursing staff and take part in the training scheme. Innovative practices were also more likely than the rest to employ practice managers, to own computers and to provide special clinics. Innovation was clearly related to area, proportions of innovators varying from 68% in the affluent east of England rural area to 23% in the midlands urban area.

The family doctor charter has provided conditions in which the measurable quality of service has improved for about 50% of practices: but it has had little more success than the panel system in raising standards in practices in the older industrial areas. The survey suggested that general practice is now divided between larger practices which have the capital, the staffing and the management to develop a wider range of services and small partnerships facing high patient demand with inadequate resources in the older industrial areas.

What does the pattern of practice response over the three periods suggest about policies for the future? The balance between economic and professional incentives has varied. Under the panel system most of the pressures were economic and acted towards increasing income, minimizing costs and shifting more complex work towards the local authorities and the hospitals. The incentives to improve professional performance were very weak. Under the family doctor charter there were incentives both to reduce costs through increasing partnership size and to improve professional performance through the vocational training scheme. Current proposals for an increase in competition between general practitioners needs to be balanced by complementary policies for professional development. The panel system shows that increased competition might operate in ways that drive standards down. The pattern of developments since the family doctor charter is one of quality emerging as a result of professional cooperation rather than economic competition. Incentives which encourage competition need to be related to programmes for encouraging continuing professional development.

The historical record also shows that the problem of standards of service in older industrial areas has been a persistent and intractable one. The standard of panel practice in such areas was very poor and recent research[2] has shown that the charter was not very effective in encouraging innovation in these areas. Any improvement is only likely to follow from coherent and targeted policies. As they stand, the proposed new incentives in the white paper[3] are unlikely to produce better results. Greater reliance on fee for service and on capitation fees is likely to be most important in raising income in more affluent areas, where larger innovative practices will have the management resources to develop services to an expanding population. There is a case for new types of primary care funding which would be targeted on practices in the older industrial areas.[4]

The record of the past shows how easily family doctors can become trapped in a situation where it is difficult for them to invest in new technology and new methods of treatment. Under the panel system and under the first stage of the NHS, family doctors came increasingly to be seen as the poor relations of medicine. Ideas about quality of care change over time and investment is required to keep up with them. The ability of family doctors to carry out this investment is not helped in specific ways by the white paper. New investment in information technology and working capital will be required over the next few years in order to raise the quality of care and it is not clear how this is to be financed. Family doctors have to invest or they

will come to be seen as professionally backward. Competition may stimulate action and response by practices, but the agenda for action has to be set by professional commitment rather than by the crude economic forces which operated to lower standards under the panel system.

Finally, the panel system has lessons about the dangers of a two tier system divided between NHS and private patients. Standards were planned to be lower for panel patients and they were forced down further as the system developed. Under a two-tier system there is bound to be a diversion of energy to the paying customers: then general practice will be trying to resolve problems of access as well as of quality.

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Drug defect reporting

ADVICE on the reporting of adverse drug reactions is readily available to health care professionals in the *British national formulary* and the *ABPI data sheet compendium.* The Committee on Safety of Medicines recommends that all adverse reactions should be reported for new drugs, but that for established drugs only serious suspected reactions should be reported.[1] Serious reactions are those which are fatal, life threatening, disabling, incapacitating, or which result in prolonged hospitalization. Administratively, the reporting of adverse reactions is easy, using the yellow card which is found in the back of the *British national formulary,* the FP10 prescription pad and the *ABPI data sheet compendium* or by dialling 100 and asking for CSM freephone.

It is right that prescribing doctors should be acutely aware of the possibility of adverse reactions to recently introduced drugs. Experience with thalidomide and benoxaprofen has shown that a rapid and effective reporting system is vital. It is also important that all doctors should bear in mind that, apart from having adverse reactions, drugs may be relatively inactive therapeutically, which is just as serious to the patient. Advice for the doctor wishing to report a possible drug defect is not readily available. The agreed procedure when a drug defect is suspected is to inform the local chief administrative pharmaceutical officer in Scotland and Northern Ireland, or the regional pharmaceutical officer in England and Wales, who passes the complaint to the defect centre at the Department of Health and Social Security medicines division, who are responsible for investigating the possible defect (Medicines Testing Laboratory, personal communication). Investigations are usually performed by the medicines testing laboratory of the Pharmaceutical Society of Great Britain. Information can be difficult to extract from this system. An alternative method of reporting suspected defects is to inform the manufacturer of the drug directly.

A major concern in this area relates to generic prescribing. This assumes greater importance with the implementation of part 1 of the consumer protection act 1987. The *Drug and Therapeutics Bulletin*[2] has listed the advantages of generic prescribing — the generic name indicates the chemical class to which the drug belongs, the use of a single name reduces confusion and facilitates teaching, pharmacists can reduce stocks, and prescribing costs can be reduced. The disadvantages are also listed — brand names are simpler, the quality of the generic drug is less predictable than the proprietary drug, the appearance and the excipients used may differ between different generic preparations of the same drug, and the source of the generic product may not be known. The concerns about the quality and the uncertain source of generic drugs are important and now have particular relevance to general practitioners because of the new laws on product liability. Reports by Levy[3] and Wyllie and colleagues[4] show that the therapeutic risks involved in switching between different brands of the same drug are real and perhaps occur more frequently than is usually recognized.

The new laws on product liability impose a considerable burden of record keeping if doctors are not to find themselves legally liable for the supply of a defective drug or other medical product.[5] Unless the supplier of a drug is able to identify accurately the producer, together with batch numbers, the supplier is liable. If accurate records are not kept, general practitioners could be liable for any defect in a drug directly dispensed or administered to a patient.

The General Medical Services Committee advises that doctors are unlikely to be at risk if they adhere strictly to labelling regulations, which apply to all dispensed medicines, and ensure that every instance of supply is recorded in the patient's records. The medical defence societies have said that members will be indemnified in the usual way, providing the goods are supplied in connection with the doctor's professional activities[6] and that accurate records of sources and supply are retained for 11 years.

Generic drugs are supposed to be subject to the same rigorous scrutiny as branded products, but if the medical profession is to continue to prescribe generically with confidence we need more information about the sources of generic products and the routine tests which are carried out to ensure their consistently high standards. As part of this process, it is essential that the DHSS publicizes more widely the procedure for reporting drug defects and the details of those defects which have been found, whether they are in proprietary or generic drugs.

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