TALKING POINT

Sharing primary care: lessons from Medicover

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In 1980 a private subscription scheme, Medicover, offering home visits by doctors, was launched in the London area. Subscribers could buy 24-hour cover for their households for £60 a year, or night and weekend cover for £30. An additional fee of £5 a visit was charged.

The scheme was widely advertised as a means of ensuring a doctor's visit, and of avoiding delays and difficulties in seeing a National Health Service general practitioner in his surgery. There was strong opposition from doctors' representatives on the grounds that it put the patient at risk of being treated by doctors who did not have access to their full medical history.

Medicover operated until 30 November 1981. It was then suspended until a date in 1982 when it was to restart as part of a system of private primary care in which the clients would de-register from their NHS doctors.[1 2]

Who subscribed and why did they do so? In what circumstances did they use the service, and what was the outcome? Did it fulfil their expectations? To what extent was the provision of primary care and information about it shared? What impact could such a service have on the unmet needs for primary care in inner cities? These and similar questions were explored in a study of the first six months' subscribers.

Method

Data about the subscribers and other residents of the household covered by the subscription, and about consultations in the first 12 months of cover, were transcribed from the Medicover company records, coded, and entered into computer files.

Subscribers were asked by the company about their willingness to take part in a postal questionnaire survey, details of which were explained. Those who registered objections were not contacted further. The structure and distribution of a questionnaire were tested in a pilot study using the first month's subscribers. The final version included questions on the reasons for subscribing, the passage of information to the GP, experience of the household's use of Medicover, and other medical services during the period of subscription, and the subscriber's occupation. Consenting subscribers who enrolled between the second and sixth months were sent the questionnaire immediately after the end of their first year of cover. A reminder letter was sent to non-respondents after two weeks and a second reminder and questionnaire after a further two weeks. After this, those still not responding were telephoned if their telephone numbers were known. The questionnaire data were coded and transferred to another computer file.

Results

MEDICOVER RECORDS

There were 276 subscribers in the first six months, most of whom lived within a wide area of London north of the river; relatively few lived in inner London.

The 276 household subscriptions covered 782 residents. The structure of the households covered was similar to that in the south-east region in general,[3] with 32% having at least one child under 16 and 11% a sole resident aged 60 or over.

Seven subscribers said that they did not have a general practitioner; 13 others did not name a GP. The 256 other subscriber records identified 230 different GPs. The subscribers were not, therefore, concentrated around a few GPs; 34% of these GPs worked singlehanded compared with 27% for Greater London as a whole in 1980 (DHSS, personal communication), suggesting that this type of practice organisation was not a strong selective factor in determining Medicover's clientele.

During their first year of cover 341 calls were received (though 16 were later cancelled) on behalf of 188 (24%) of the 782 residents covered. The calls were spread fairly evenly throughout the week; 44% were received between 18 00 and 07 00 the next morning.

The advertised benefits of Medicover included speed of response and personal convenience. The doctor arrived within one hour of being called in 54% of the cases. In one in eight cases the doctor took two hours or longer to arrive, but these included a few in which the caller requested the doctor to visit only after a certain time. Most patients visited (87%) were supplied with drugs or given a private prescription. One in five were advised to go to see their own doctor subsequently. Six per cent were referred to hospital.

After one year, by which time the cheaper "nights/weekend only" option had been dropped, 153 subscribers (55%) renewed their subscriptions. The more use of Medicover by a household the less likely was the subscription to be renewed (table I).

TABLE I—*Renewal of subscription*

No of calls from household in year	Total No of households	No (%) renewing subscription
0	134	93 (69)
1	72	35 (49)
2	32	13 (41)
3 or more	38	12 (32)
All calls	276	153 (55)

QUESTIONNAIRES

There were no important differences in the characteristics of the 82 subscribers used in the pilot questionnaire survey and the 194 May-September subscribers. Of the 190 of the latter who did not refuse to be contacted, 147 (77%) responded when approached. Proportionately more of those who responded renewed their subscriptions after one year (61%) than of the non-respondents (28%). They were otherwise apparently similar.

The clientele was drawn predominantly from professional and managerial groups: 67% of respondents were in the Registrar General's social class I or II.

Of the 147 respondents, 135 (92%) said that they had a NHS GP; of these, 96 (71%) stated that they had not told him of their subscription, usually because it was considered to be unnecessary (63 cases) or they feared his disapproval (19). The GP's reaction was reported by 33 respondents: 11 GPs commented favourably on Medicover, another 11 were indifferent, four considered that Medicover was unnecessary, and seven disapproved, one of these removing the patient from his list. One respondent in five had a private GP, usually as well as a NHS GP.

Asked what experiences, if any, had led to their subscribing to Medicover, half (73) of all respondents reported one or more. The commonest of these was unavailability of the GP or delay before the GP visited (52 cases). Some respondents were dissatisfied with the GP'

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attitude or skill (23) or with some aspect of the practice organisation (13), or had experienced difficulty in registering with a GP (five). Fifteen respondents reported adverse experiences of contact with other Health Service personnel.

Apart from personal experiences, other reasons for first subscribing were given by 100 respondents. The commonest was to provide an insurance against being unable to obtain medical attention (50 cases); others (39) quoted occasions in which a home visit might be needed—for example, those living alone, the elderly, or those with small children. Further reasons included a general dissatisfaction with the NHS (25), the desire for convenience (12), for a speedy response (10), or for a back-up system for the NHS (nine).

Of the 147 respondents, 78 (53%) reported having received at least one visit to the household from Medicover during the previous 12 months. Questioned about the most recent visit, these respondents gave one or more reasons why Medicover rather than some other source had been contacted. The reasons included: outside surgery hours (26), need for quick visit (25), and GP unavailable (17).

Shared care was a reality: in about half these 78 instances at least one other source of medical care was consulted (table II), 10 respondents consulting two or more other sources.

TABLE II—*Last Medicover visit: other agencies consulted by 78 subscribers calling Medicover at least once**

Other agencies consulted	No (%)
NHS GP	23 (29·5)
Private GP	7 (9·0)
Accident and emergency department	9 (11·5)
Agency not shown above	9 (11·5)
No other agency	41 (52·6)

*More than one agency sometimes consulted.

The passage of information about a consultation corresponded broadly with whether or not the NHS GP had been told about the subscription to Medicover. Twenty-nine of these 78 respondents were known to have told their GP of their subscription and, of these, 22 had passed on the record of their last consultation, left with them by the Medicover doctor, compared with 14 out of the 43 known not to have told their GP.

When asked if any aspect of the most recent Medicover consultation for a member of their household had been unsatisfactory, 17 of the 78 levelled one or more criticisms: clinical management (seven instances); doctor's attitude (five); waiting time (four); and cost of medicines prescribed (three).

Finally, the subscribers were asked which source of medical care had been consulted first on the most recent occasion on which a member of the household had needed a doctor. Of the 147 respondents, 103 had experienced such an illness while covered by Medicover. Of these, 63 (61%) had turned first to their NHS GP and 25 (24%) to Medicover, the remainder having consulted other doctors in hospital or the community. The 78 who had not turned first to Medicover were asked why not, and the main reasons were: "not an emergency" (25); "during surgery hours" (16); and "Medicover regarded as a back-up service only" (16).

Discussion

Advertising and selling primary medical care direct to the public is something new to Britain.

Studies of NHS primary care over the past two decades have, in general, shown that patients are satisfied with most aspects of the general practitioner services.[4-7] In the main, these are easily accessible whatever aspect of accessibility is considered.[5] Even so, patients are now finding their GPs' surgeries slightly less accessible than they used to be, and think that the service has deteriorated with regard to doctors visiting them when asked.[6] In both inner and outer London general practitioners may be difficult to contact,[8] so that the promise of guaranteed medical attention from a doctor, like the private service offered by Medicover, will appeal to some people. This is borne out by the reasons given in this study for subscribing. These reasons and the circumstances in which the subscribers chose either to call Medicover or to use another source show that they regarded it as their own deputising service.

It is understandable that Medicover subscribers were drawn mainly from those best placed to meet the fees. In the 1977 national study 63% of patients in social class V were "very satisfied" with their NHS care but only 35% in social class I.[6] Nearly one patient in three would prefer to have a private GP if they could afford one.

The possibility of being removed from the lists of GPs opposed to Medicover must have been a deterrent to subscribing, so that an indeterminate level of demand was suppressed, and to disclosing subscription to it. Medicover can have made little impact on London's unmet needs for primary care at the low level of subscription we found.

A minority of subscribers were dissatisfied with the service provided by Medicover, but nearly half did not renew their subscriptions. This may reflect a reappraisal of the need for the standby service, or of its cost benefit. Those who used Medicover a lot were less likely to have renewed their subscriptions than those who used it rarely or not at all. The implications of this are not clear.

Professional resistance to Medicover stemmed largely from the risk to the patient assumed to be inherent in receiving treatment from two or more people who do not share full knowledge of the patient's medical history and whose therapeutic actions may conflict. The study showed that sharing care without sharing information was not uncommon.

Is a private patient-initiated visiting service ever likely to flourish if used in conjunction with the NHS GP service? Almost certainly not. Medical treatment may have unforeseen, harmful consequences. Where two or more agencies provide treatment concurrently the risks may be increased, particularly in cases such as those described here, when full information is not passed between the agencies. Furthermore, whenever some harm does occur it is difficult to disentangle legal responsibility unless accountability has been clearly established from the outset, as in the case of general practitioners and their deputies. So it seems inevitable that registration with two agencies who may provide concurrent treatments, such as registration with Medicover and a NHS GP, or with both a private and a NHS GP, will always be fraught with difficulties. One way of avoiding the problem of accountability would be for general practitioners to insist that their patients are not registered with other practitioners or services, and vice versa.

While this step would protect the doctors' interests it would restrict the individual patient's ability to obtain an alternative medical opinion. This seems a harsh imposition, given the deterioration perceived in some aspects of the NHS GP service by a public whose expectations are rising, and given the manifestly poor standards of NHS practice in some areas.

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References

1 Ferriman A. Health firm to set up private clinics. *The Times*. 1981 November 13:4.
2 Collier S. Dial-a-doctor chief halts service. *Daily Mail*, 1981 November 28:9.
3 Office of Population Censuses and Surveys, Social Services Division. *Report of the general household survey* 1978. London; HMSO, 1978:12.
4 Cartwright A. *Patients and their doctors*. London; Routledge and Kegan Paul, 1967.
5 Ritchie J, Jacoby A, Bone M. *Access to primary health care. An inquiry carried out on behalf of the United Kingdom health departments*. London; HMSO, 1981.
6 Cartwright A, Anderson R. Patients and their doctors 1977. *J R Coll Gen Pract* 1979;**29**:261-3.
7 Royal Commission on the National Health Service. *Access to primary care*. (Research paper No 6.) London; HMSO, 1979.
8 London Health Planning Consortium. *Primary health care in inner London*. Report of a study group. London: LHPC, 1981.

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