a birthweight <1500 g tend to be born to women who do not regularly attend antenatal clinics, and studies in the USA indicate that half of parents would refuse consent if it was negotiated in advance.

Ethics committees have a role in protecting infants, but to do this adequately they must have sufficient expertise to make judgements on the scientific validity of a trial—badly designed trials are ipso facto unethical. Public awareness of the controversies in randomised trials is growing. Criticism by the editor of the bulletin of Institute of Medical Ethics of the conduct of MRC trials of treatment for prostate cancer and leukaemia[1,2] was picked up by the *Guardian*.[3] It can only be a matter of time before a pressure group is formed.

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For Debate . . .

The doctor, the patient, and their contract

II A good practice allowance: is it feasible?

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In our first paper (17 May, p 1313) we looked at the function of the existing contract in relation to the quality of care and the rewards which general practitioners receive for their work. The government's discussion document, *Primary Health Care*, proposes the introduction of a "good practice allowance" as a means of encouraging the quality of patient care by selectively rewarding those who are able to show that they achieve desired standards.[1] In this second paper we explore this proposal.

What is good practice?

The range of services offered by British general practice has been implied and described in a growing number of publications over the past 25 years.[2,3] But the emphasis on one or other aspect of care changes in relation to rapidly changing perceptions about health care needs. For example, the increasing proportion of people aged over 75 in the population, the policy of shifting responsibility for the care of mentally ill and handicapped people from institutions to the community, the early discharge of patients from hospital, and a new emphasis on preventive medicine and anticipatory care have all had an influence on redefining priorities and creating new imperatives for standards of care. Standards themselves will rise over time. The priority given to a particular aspect of the services to patients will also change. Good practice must therefore be seen not as the achievement of fixed goals, which will be static over long periods of time, but as a dynamic movement.

Here we can only indicate a tentative framework for looking at current standards, which might be used in allocating a good practice allowance. We suggest that standards could be created under three headings: clinical performance, anticipatory care, and the organisation of the practice.

Clinical performance

The Joint Committee for Postgraduate Training in General Practice recognises that good records are a prerequisite for good clinical standards (Letter to regional advisers, 1984). For example, training practices are expected to show that continuation sheets, hospital letters, and investigation results are attached in chronological order. Standards of care could be agreed and monitored in relation to a number of important acute and chronic conditions. Similarly, criteria for good prescribing, including monitoring long term medication, are being devised. Communication between general practice and the hospital is widely regarded as a sensitive component of the quality of care. Criteria might be agreed about the content of referral letters and the information which ought to be clearly stated. Criteria for referral might be agreed and could be audited.

Anticipatory care

For years preventive measures such as immunisation and cervical cytology have been part of public policy, and items of service payments have been made for them. It is a logical step now to make additional criteria for these same activities in terms of the proportion of the relevant population on the doctor's list for whom these services have been provided.

Anticipatory care is an integral part of clinical performance, but we believe that each activity may be differently assessed. Good anticipatory care will demand the use of a reasonably accurate age-sex register, disease or problem registers, and effective systems for call and recall. Standards could be devised for obstetric care, cervical cytology, paediatric surveillance, case finding and control of hypertension, health surveillance for people over 75, immunisation cover, and similar programmes.[4]

Organisation of the practice

Criteria for the standards of premises are already emerging: these could be extended to include equipment. The principle of information sheets for patients has already been accepted by the General Medical Services Committee and the Royal College of General Practitioners. Standards could be created in relation to accessibility: the elapse of time between the request

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and the consultation, the availability of individual practitioners, and the flexibility of consulting hours. It should be possible to agree on standards of accessibility for practices in all localities, for practices with or without appointment systems, and for practices of all sizes and with personal lists of patients or shared partnership lists. We might expect to see practice policies which take into account the preferences of the consumers. Practices might be expected to produce an annual report. Criteria for the acceptance of patients, for facilitating change of doctor both within the practice and between practices, and for removal of patients from the list could be examined and audited.

A good practice is likely to be innovative: new and extended roles for nurses and others might be introduced; group care for patients at risk from obesity, cigarette smoking, and alcoholism; other health education classes; and the presence of an influential patient participation group would all be examples.

The items listed above might form a framework for professional negotiation. Detailed statements would be made in relation to each standard and targets set. For example, "By the age of 5 years all children will have been offered immunisation against *n* conditions: there will be full documentation (clinical contraindications or parental choice) in relation to those children not immunised."

Any practice applying for the good practice allowance might choose to be judged in relation to six out of perhaps 10 "markers" under each of the three major headings. Providing choice is important, but we believe that each of the three major headings must be separately assessed. The creation, updating, and negotiation of standards and targets would necessarily derive from objective research. The needs of consumers and the views of medical experts outside general practice would also be relevant.

There are, of course, serious potential weaknesses in such a system. It is difficult to measure many of the most important aspects of general practice: the style of the receptionist when she answers the telephone, a welcoming atmosphere in the reception area, a consultation which gives time for the patient to develop his or her history, and a sense of commitment to the individual and the community which a good general practitioner imparts. Many aspects of general practice that we value most highly are not amenable to direct measurement. This, however, does not diminish the importance of the aspects that we can measure.

None the less, the danger exists that in the pursuit of the good practice allowance a practice may put all of its effort into achieving the desired targets and conceal a heartless practice or a practice that is incompetent in clinical activities that are not measured for the purposes of the allowance. We believe that these dangers are theoretical rather than real. The achievement of these targets will be impossible without positive attitudes and good clinical and organisational skills. It seems to us unlikely that doctors would choose or even be able to channel these attitudes and skills only into the prescribed standards specified for the allowance.

The allowance: introduction, size, distribution, and funding

A good practice allowance could not be introduced suddenly. Its introduction would need to be phased for two major reasons. Firstly, the funding would almost certainly have to be found in part from a redistribution of current payments: it would be unreasonable not to allow some time to elapse while general practitioners adjusted to new schedules of payments. Secondly, it might take some years to implement a range of standards similar to those which we have described. Even given the necessity of starting with relatively modest standards, it would be essential to give the profession reasonable notice of the intended changes.

Although in the current financial climate part of the funding would result from a redistribution of the moneys presently paid to general practitioners, we believe that substantial new moneys would be needed for a substantially new contract. This would be essential both to prime the pump and to purchase professional good will. Ideally, this new money would be earmarked to provide the additional resources which would be necessary for practices to enhance the quality of their care.

In the government's discussion document it is suggested that some allowances now being paid may have already served the purpose for which they were originally designed: the designated area allowance and the vocational training allowance are given as examples. There are other components of the basic practice allowances which might be reconsidered. Seniority payments currently cost some £58m a year. Because they reward experience they may be regarded as an indirect reward for quality. But there is little evidence that quality of care and length of service are correlated. The group practice allowance currently costs some £27m a year. This was intended to encourage the formation of partnerships, but again the link with quality of care is at best uncertain. The vocational training allowance currently costs £10m a year. The current cost to government of these allowances is some £100m a year. Apart from the additional moneys which we believe to be imperative, such a sum would not only fund the payment of good practice allowances to a substantial proportion of practices but might also provide the funds for increases in capitation and items of service, which we discuss later.

The size of the proposed allowance would, we think, have to be substantial enough to become an important component of the general practitioner's income: perhaps valued at no less than 20% of the present target income for general practitioners. Inevitably, the size of the proposed allowance would relate to the number of allowances which might be awarded and to other changes in the existing elements of the doctor's remuneration.

A good practice allowance might be paid either to individual doctors or to a practice as a whole. The advantage of paying the allowance to the practice is that those partners who are motivated to improve the quality of care would find themselves with a powerful financial argument for progress. The allowance might be paid on the basis of either the number of doctors or the number of patients on the practice list. The former method would tend to contain or diminish the doctor-patient ratio. This would have the advantage of providing more time per patient, without which vitally important but unmeasurable aspects of the quality of health care are difficult to attain. On the other hand, by linking the allowance to capitation (as proposed in the government document) the financial "value" of each patient is increased. In our third paper we discuss the relevance of capitation to quality of care.

A practice or a singlehanded practitioner with a much larger than average list of patients may come to the conclusion that the criteria for the allowance can be achieved only if the doctor-patient ratio is reduced. In most instances this can only come about by taking in an additional partner. The entry of new principals into practice is controlled by the Medical Practices Committee. If, however, there was a shift from the present basic practice allowances to capitation, items of service, and the good practice allowance the need for government to continue to control the introduction and distribution of new principals would diminish.

The agreed criteria for the allowance, which should be published, might in the early years be achieved only by a minority of practices. The intention, however, must be that all general practices would eventually meet the criteria. Since the intention of the allowance will be to stimulate an appreciably rapid improvement in the quality of care it would be self defeating to set the standards in relation to present norms: they must be set in relation to the best models which currently exist. There is a danger in this. We could, by accelerating the rise in standards and tying this to substantial monitary rewards, widen the gap between the good and the indifferent. The practices that were in receipt of the good practice allowance would not only benefit in terms of status, money, and professional satisfaction but would be more likely to recruit the ablest new partners and to benefit from participation in vocational training, other teaching, and research. Those that failed to meet the criteria might in the process become demoralised and disheartened from the task of continuing to strive for better standards. We would have created two nations of general practice.

This may be too gloomy a view. Standards which until recently were applied only to vocational training practices are now being more widely adopted and achieved. The achievement of good quality care in one part of general practice affects the whole of the profession, not least because doctors are most motivated by factors other than money. At the moment general practitioners approach

parity of income in the first few years of practice. This income is reviewed annually in relation to other professional incomes and is more or less pegged to inflation. The pension, too, is proof against inflation. General practitioners are relatively protected from competition from specialists and in large part from each other. They have tenure for life.

Given this degree of protection, the wonder is not that the quality of care in general practice is so uneven, but that so much good quality has been achieved. This must be achieved by the workings of professional good conscience. It might therefore be argued that the demonstration of good quality demanded by the good practice allowance will encourage most general practitioners by setting new and higher norms. Clearly, if the new allowance is to enhance the quality of care in all general practices the relation between the size of the allowance and its distribution will be a matter for fine judgment.

How might it work?

A variety of mechanisms might be envisaged for operating the allowance. Here we describe one possible model, based on two stages and three administrative tiers. The first stage in the process of determining eligibility for the allowance would be an analysis of returns of data which would already be held by district health authorities and family practitioner committees. These data are already being collected by district health authorities and family practitioner committees. General practice needs to prepare itself for the likelihood that they will be published at some time in the future. The nature of these hard data, and the criteria to be applied, would need to be agreed between government and the profession. Their publication, in itself, might encourage a general improvement in standards. Those practices which meet the "hard" data criteria might then elect to be further assessed.

The second stage of the assessment would be based on a visit to the practice, giving an opportunity for the practice to demonstrate the services which it offers to patients and to have these examined and discussed by experienced and competent assessors. Clearly, the analogy here with present day practice is the visit organised for the assessment of trainers.[5]

Successful practices would continue to receive the allowance for five years, and would then reapply for further evaluation and assessment. This happens now with the trainer's grant. At the end of each five year period we might expect to see the standards reviewed in the light of advancing research and experience and some variation in the range of "markers" to be assessed.

Administration

We can envisage a three tier administration. The first would be a national coordinating body that would be concerned with developing national criteria and reviewing regional performance and responsible for training the assessors. The second tier would be a regional organisation, not part of the regional health authority, but perhaps matching it geographically. These regional organisations would hold lists of assessors which would include doctors nominated by local medical committees, faculties of the Royal College of General Practitioners, and other appropriate bodies. All would be practising general practitioners, and once the scheme was fully established all would be currently in receipt of the good practice allowance. The government's document refers to visits by doctors. It seems likely to us that there will be public pressure to include non-doctors, and these may perhaps be nominated by family practitioner committees or community health councils. Each team might consist of three persons, one of whom would not be a doctor, and the assessors would be answerable to the regional organisation. Although nominated by other bodies, they would in no sense be seen to represent them. The team would of course be recruited from assessors practising in health districts other than that of the applicant practice.

The third tier of the system would be the family practitioner committees, which would be responsible for collecting and monitoring the hard data. They would, however, have no part to play in organising the visit, communicating the results, or handling appeals. All of these activities would become the responsibility of the regional body.

Drawing on the experience of the Royal College of General Practitioner's experimental "What sort of doctor?" project,[6] we envisage that practice visits would be thorough and therefore time consuming. It would be important to limit the number of assessors so that each would obtain a sufficient level of experience, in order to achieve comparability of standards. They would also be required to take part in training workshops and conferences. Because of this level of commitment we believe that it would be necessary to pay an economic fee for these services.

Would it be fair?

Any system of rewards must be seen to be fair. But what do we mean by this? Firstly, the good practice allowance ought to be attainable by different types of practice from large groups to singlehanded practices. The largest practices may be disadvantaged because of the need to achieve a consensus view and a concerted effort from a number of different general practitioners. Singlehanded practitioners will face no such problem from partners but may be disadvantaged because of a relative lack of resources.

Secondly, the good practice allowance should be equally attainable by practices in different localities. In particular, practices in disadvantaged areas of the United Kingdom, where morbidity rates and health care utilisation rates are likely to be high, should not be disadvantaged. Clearly, it would be wrong to apply lower criteria for the good practice allowance in areas of social deprivation. This would simply increase the cycle of deprivation and condone poorer quality care where the highest quality of care is most needed. It would be fairer, therefore, to expect the same standards but to concentrate additional resources for primary health care where those resources are most needed. The General Medical Services Committee already has a working party looking at the needs of underprivileged areas. Using a technique such as that suggested by Jarman it would be possible to boost the capitation fee paid for patients in such areas.[7] A contract for doctors who practise in such areas might include a range of benefits and repayments, designed to facilitate better premises, lower doctor-patient ratios, and higher staff-doctor ratios.

Thirdly, the system would have to be seen to be fair to individual doctors and their patients. Inevitably, any system of rewards based on the sort of judgments described here will sometimes administer rough justice. The question to be asked is not whether the new system would be absolutely fair, but whether it would be relatively fairer than the system of rewards now in place. We believe that it could be much fairer. It must also be asked whether the present contract is fair to society at large. In the last analysis a reward system must be judged on its ability to provide society with value for money from its expenditure on health care.

In our final paper we propose to look at a variety of alternative forms of contract between doctors and patients. We shall examine the likely relation between these alternative contracts and the quality of care. It is in relation to these other alternatives that the government's suggestion for a good practice allowance must be judged.

This is the second of three articles.

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