Certification—continuing arguments

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Many doctors condemn sickness certification as a bureaucratic imposition that swells surgery attendances to no good purpose. Too often the certificates may be medically worthless as the doctor can do no more than record what the patient says is or has been wrong with him because no firm diagnosis is possible. To challenge a patient's veracity or to refuse him a certificate on demand can often lead to a breakdown in the doctor/patient relationship. So it is no surprise that GPs resent the requirement to issue certificates—officially "doctor's statements"—to support claims by employees that they are genuinely unable to work because of illness. Nor is it surprising that certification features prominently in negotiations between the DHSS and the profession's leaders—and the arguments continue.

Over the years the Conference of Representatives of Local Medical Committees, which represents all NHS GPs, has varied its policy. At present its aim is the abolition of all short-term certification by GPs for periods of seven days or less and a fee for any certificates issued.¹ The number of National Insurance certificates issued by GPs has been reduced as a result of changes in the rules negotiated from time to time by the General Medical Services Committee. The latest change, which came into effect on 14 September 1980, should reduce the number by about 500 000 a year. Since that date a patient no longer has a right to demand a certificate unless he has already been ill for at least three days—that is, he is in at least his fourth consecutive day of illness.² Before this change a patient could theoretically demand a certificate on the first day of illness as he might have needed proof of that sickness episode to link up with other periods of incapacity under the complex linkage rules for claiming social security benefit.

NI certificates are clearly marked "For social security purposes only," but since 1966 the medical profession has accepted that they might also be used by patients as evidence of illness to show to employers. This was agreed at that time in discussions with representatives of the TUC and the CBI³ in an attempt to show to all concerned that the profession was seeking an overall reduction in the burden of certification (as part of the 1964-6 general practice charter negotiations) and not just a shift from NI to private certificates. This year's LMC conference reversed this policy, but the decision has not so far affected the normal practice of using NI certificates for both purposes.

Government's radical proposals

In April 1980 the Government published a Green Paper, *Income During Initial Sickness: A New Strategy*,⁴ which contains radical proposals for restructuring social security sick pay provisions. The main change proposed is that employers would take over responsibility for sick pay for up to eight weeks in a tax year for, broadly speaking, anyone on their payroll who would at present be entitled to National Insurance sickness benefit. The Green Paper states that the Government "have in mind" to propose to the medical profession an amendment to doctors' terms of service whereby certificates would be available without charge to people claiming benefits from their employers. The LMC Conference in June and the BMA's

Annual Representative Meeting in July passed resolutions making clear that it would not be acceptable to place a statutory obligation on GPs to provide certificates for employers. Furthermore, it was resolved that these should attract a fee if a voluntary agreement were to be reached between the profession and employers to provide certificates under employers' sick pay schemes.

The General Medical Services Committee has also expressed reservations about including any clinical details on certificates for employers. But employers already see medical certificates issued for National Insurance purposes and these normally include a diagnosis. The confidentiality safeguards are that the certificates are given by doctors only to patients and not direct to third parties and that in some cases doctors can use the "vague diagnosis" procedure when they do not wish to disclose the nature of the patient's illness. Both safeguards could continue to operate, the only complication being that under the present "vague certificate" rules the true diagnosis is made available to the DHSS's regional medical service. If the RMS was not concerned then it would have to be made clear that the true diagnosis would be available only to the company's medical officer or to some other doctor nominated by the employer.

If the Government accepted that that new scheme could operate without an obligation on GPs to issue the new certificates the scheme would not work unless each certificate attracted a fee. Even then some GPs would probably refuse to issue certificates as a matter of principle. If the Government decided to impose a statutory obligation on GPs against their wishes the GMSC would no doubt consider whether to advise GPs to refuse to comply. In 1970 GPs stopped issuing certificates for three weeks after the Review Body report on their pay had been referred to the Prices and Incomes Board. This had little effect on the system, but over a longer period there would no doubt be gross abuse by some employees with a rapid rise in sickness absence. There are alternatives to GPs issuing certificates but it would take some time to change over to a new system of policing claims for sick pay.

Inclusion in fees and allowances?

If GPs are to be paid for issuing certificates how could this be done? There are three possibilities. Patients could pay (with possible reimbursement by the DHSS or employer), the GP could charge employers for each certificate issued, or fees for certificates could be included with NHS remuneration and paid to GPs by the family practitioner committee (health board in Scotland). The Minister of State for Social Security, Mr Reg Prentice, has already declared that the Government would oppose patients being charged even if they were reimbursed. The Government is not opposed in principle to employers being billed directly for each certificate if a scheme could be worked out with the CBI, but the administrative arrangements required for both employers and GPs would be complicated. The simplest solution would be for FPCs to pay a fee for each certificate along with the other fees and allowances. A system on these lines operates in the Channel Islands. Each certificate has a tear-off claim slip, and the GPs collect these together and submit them once a month for payment. The NHS could be reimbursed the additional cost from National Insurance funds.

Any new system of payment for issuing certificates immediately raises the likely reaction of the Review Body. In assessing

average net remuneration the Review Body takes into account the issue of certificates free of charge. It would be naive to expect that the Review Body would not offset the fees for certificates, irrespective of the source, against average net remuneration. In other words, if GPs were to earn, say, £20m (at a rate of £1 per certificate) the Review Body would almost certainly consider deducting this sum from the global remuneration for GPs before allocating the remainder to the existing structure of fees and allowances. Whatever the Review Body's attitude, Mr Prentice has stated that only a "nil cost arrangement" would be acceptable to the Government, and he has already asked his officials to notify the Review Body secretariat of these possible changes.

The Government sees its Green Paper proposals as another step along the road of disengaging the State, wherever possible, from activities which firms and individuals could perfectly well perform for themselves. Nevertheless, it will be interesting to see whether these proposals survive. They are notable not so much for the criticisms, which have been many, but for the total lack of enthusiasm on the part of all concerned. No one except the Government can see that this new system would have any advantages over the existing arrangements. For once trade unions and employers are speaking with one voice, albeit with different motives.

Extension of self-certification

Whether or not these changes go ahead, the GMSC is still faced with the task of removing from GPs any responsibility for sickness certification for seven days or less. The Government already accepts self-certification by patients for the first three days of illness even when benefit payments are due under the modified linkage scheme. Self-certification for the first seven days could be introduced without too much difficulty as has been done in some other countries. As a deterrent against abuse the regional medical service has the right to examine claimants to verify incapacity. With some additional help, possibly by employing some GPs on a part-time basis, the service should be able to cope with this change. All GPs could then be freed from this unnecessary chore and have more time to treat patients who really need medical care.

References

- 1 Anonymous. National Insurance certification. *Br Med J* 1980;281:161.
- 2 Anonymous. Less NI certification for doctors. *Br Med J* 1980;281:760.
- 3 Anonymous. New rules for certification. *Br Med J* 1966;i:188.
- 4 Department of Health and Social Security. *Income during initial sickness: a new strategy*. Cmnd 7684. London: HMSO, 1980.

Survey of trainees by RCGP—continued from page 1154

single region. However, this paper is concerned only with the overall picture presented.

There are obvious dangers in extrapolating from a 50% self-selected sample. Yet, insofar as those who responded are likely to be at least as well (or as badly) "organised" as their colleagues who did not, certain conclusions are perhaps justified. The returns may overestimate the proportion of trainees who are in formal schemes; and possibly also the number who are married. Nevertheless, with already one-third of trainees being women (and the proportion bound to increase to one-half or more) and with the high proportion of both men and women trainees who are married, this merely reflects a more general trend in the face of which it is difficult to see how the low figure for part-time training can be sustained for long. It almost certainly reflects availability rather than demand.

The survey confirms points which have frequently been elicited in the course of inspections of individual training schemes carried out by the Joint Committee on Post-graduate Training for General Practice, notably:

Inadequate teaching and monitoring of trainees in all phases of their training (including the release course).

The desire of trainees while in hospital for closer identification with their chosen career (through relevant teaching, release to the weekly half-day course, loose attachment to a training practice) as well as for an initial orientation period in general practice before entering hospital.

The low level of their expectations and their astonishing lack of awareness.

Undoubtedly some regions are severely disadvantaged by reason of geography, local medical tradition, educational resources, or in other ways. But many of the shortcomings revealed by the survey might be regarded as reflecting on the leadership displayed by some

regional advisers because their responsibility includes ensuring the soundness of the intermediate links in the training chain.

The combination of trainee apathy and lack of effective adviser leadership could create a pernicious downward spiral which would be difficult to arrest by RCGP exhortations or by pronouncements from the joint committee. Many other bodies besides these two, may feel there are urgent implications for them arising from the survey and from ideas expressed by trainees at the national conference which followed it. Trainees seem to have a greater sense of identity than before and have declared an intention to make more impact at regional level. At the same time they evidently feel the need for a national association to give voice to their sentiments and

through which they can co-ordinate their regional activities. The creation of yet another consumer organisation should occasion no surprise: it is in the spirit of the times. But it introduces a new and at present unassessable factor into the overall organisation of vocational training.

There is one further reflection which must weigh with everyone involved in this re-appraisal. The disquiet thus far expressed has emanated for the most part from committed, if not always articulate, trainees who have voluntarily accepted a period of special preparation for their chosen career in general practice. In a year or two their ranks will be swollen by less highly motivated colleagues some of whom can be expected to be even more apathetic, others even more critical.

Fees

Local authority fees

The BMA has concluded the agreement with representatives of local authorities for payment of revised fees for 1980. These increases apply to police surgeons with effect from 1 July 1980, medical referees at crematoria in England and Wales with effect from 1 October 1980, and medical services directly remunerated by local authorities with effect from 1 April 1980. The agreement with regard to mileage allowances takes effect from 1 September 1980. The agreement also includes fees and allowances payable by coroners under Section 25 of the Coroners Act 1887. These increases are back-dated to 1 April 1980. Retrospective claims must be made by 31 January 1981.

Copies of the handout listing the new fees

are available to members from the Secretary of the BMA. Please quote reference Fees 7.

Increase in fees for ambulance associations

The BMA has negotiated a revision in the fees payable by the ambulance associations for lectures and examinations carried out normally in connection with the Health and Safety at Work Act. These fees are effective from 1 January 1981.

Members can obtain details from the BMA Secretary by quoting the reference Fees 10. A stamped addressed envelope (9" × 4½") would help speed dispatch. Individual inquiries should be made to regional offices.