The authors assessed the cost effectiveness of general practice and its potential for expansion within the NHS. They saw general practitioners as increasingly important in supporting the elderly and other groups at risk in the community, including the growing number of patients on hospital waiting lists. Able to operate flexibly, general practitioners can more easily arrange times of surgery hours and of clinics to suit patients. They can also develop premises to meet changing local demands and to extend their services according to the needs of patients. Because of their independent contractor status, they have a direct and personal incentive to control their own running costs and administration, and this, the consultants believed, results in substantial overall savings for the NHS.

Coopers and Lybrand also looked at some examples—described in case studies of individual practices included in the report—of where general practitioners could provide specific services more economically than other parts of the NHS: paediatric surveillance, minor surgery, and hypertension screening. They suggested that these services require support and development funding by the government.

Commenting that general practice is held back by lack of finance, the report's authors examined in detail the argument for providing funds to permit specific general practitioner services to be extended. "The allocation of resources within the National Health Service is," the report stated, "a complex process requiring a balance between the many different objectives of prevention of suffering and death, clinical effectiveness, service to patients, and cost efficiency. There has not been and probably cannot be, a single measure against which the effectiveness of all health services can be measured. Nevertheless, there are certain services which general practitioners provide, of a similar nature to those provided in hospital outpatient departments and community health clinics. Furthermore, many services provided by GPs can result in direct cost savings to other elements of the National Health Service. In these areas at least, it is useful to establish a principle for the allocation of resources to general medical services."

Lower marginal costs

Assessing the long run marginal cost of extending general medical services, the authors believed that this is likely to be lower than the current level of average costs, because basic facilities and services such as the surgery, receptionist, and medical records system can be used more intensively to provide more services to existing patients. "The main constraint on the extension of general medical services," stated the report, "is likely to be the hours of work of general practitioners. The cost generated by an increase in the number of GPs is likely to be below the average cost of current general practitioner services, since in many cases increases result from the addition of a further doctor to a group practice. In the case of hospital services access is controlled by waiting lists, thus the marginal cost of providing new hospital services is likely to include the cost of extending premises and equipment.

"The hospital sector has attempted to reduce the marginal cost of services by developing larger hospitals, to make more effective use of central services. However, it would appear that hospitals have experienced the same diseconomies of scale as many other large institutions established over the past 20 years, which have found that the cost of managing and administering such large institutions can outweigh the apparent economies of scale. By contrast, while practices have grown, with a change of emphasis from one and two doctor practices to three to five doctor practices, they still remain small and manageable units."

The management consultants went on to argue that the flexibility with which general practitioners operate makes it possible to extend their service more cheaply than hospital and community health services. The available evidence, they claimed, supports the contention that under the present capitation based system of remuneration the short term cost of expanding existing general practitioner services is likely to be low. It should be possible, they believed, to encourage general practitioners to provide additional services by setting the fees for services above the level of the long run marginal costs to the practitioners, who "respond readily to incentives" with the result that in practice the NHS "gets more than it pays for."

The report also discussed some of the ways in which general practice could be extended. In particular the authors looked at ways of increasing levels of patient contact and the provision of preventive health care; of providing additional services which are currently provided in hospitals or by community health clinics; and of extending general practitioner services in deprived areas.

Committee "receives" report

After a short debate the committee agreed to "receive" the report, but not before some speakers had criticised it, one reason being that the figures were now out of date. Dr M J Oldroyd believed that the report diminished the case that general practitioners had to make rather than improved it, but Dr Peter Kielty saw the discussion document as a stimulus to the committee and the NHS when one was needed. Its use in discussion with health authorities would give them an idea of what general practice could do in the future and how it could provide some services more cost effectively.

The chairman pointed out that the report did not represent all that had come from the exercise. The decision to publish it had been made to stimulate discussion before the government's green paper on general practice was published. Referring to the dated figures in the report, he said that these would be used only to give an indication of how some health service work could be done in general practice and how cost effective it might be.

Agreeing that the report's value was less than when it had first been produced, Dr J G Ball, who was chairman of the GMSC when the report had been commissioned, pointed out that it must be viewed in the light of events since its preparation. Nobody pretended that the report was the last word, but the fact that it carried the stamp of independent management consultants was of value and probably more convincing to those outside the profession than those within it.

The chairman added that the reason that the GMSC had commissioned the report was to ensure that it had some well briefed advisers when the government's Binder Hamlyn inquiry on family practitioner services was published. The report was a discussion document containing examples to stimulate debate.

Dr P R Baker sensed a feeling of disappointment in the committee because, he believed, members were expecting something different. All felt that there ought to be a great deal of evidence to justify what general practice had done in the past 30 years or so. *General Practice—A British Success* had gone some way towards doing that, and members had looked to the latest report to reinforce that. In order to confront the forthcoming green paper the committee needed a document saying what general practitioners had done, how they worked, what their workload was, how much money they put into the running of their practices, how much time they spent, and how much their families often suffered as a result. What was needed was a measurement of what general practitioners were doing.

Dr Wilson pointed out that the matter of general practitioners' workload was to be looked at elsewhere. The negotiators had agreed with the review body that if an assessment was possible the committee would offer to cooperate with the DHSS and jointly produce figures about workload.

Paediatric surveillance

Dr Wilson reported on the meeting with representatives of the CCCMCH over the latter's disquiet on the GMSC/RCGP booklet on paediatric surveillance (27 October 1984, p 1157). Dr Wilson said that he thought that there was agreement that eventually paediatric surveillance would move into general practice, but there was disagreement about the rate at which this would happen. The GMSC representatives had recognised that for the foreseeable future clinical medical officers would continue to do this work because general practitioners would be unable or unwilling to take on the role in all parts of the country.

The representative from the CCCMCH, Dr Fleur Fisher, said that developmental paediatrics was only a part of the work of clinical medical officers and she agreed that many general practitioners, who were suitably trained, were doing the work. But her committee could not see all paediatric surveillance passing to general practice unless there was a change in training. Her committee was worried about the patchy nature of the service that would be provided for children, particularly those at risk of minor handicap, if clinical medical officer posts were phased out.

Correction

Inner London Education Authority

In the report from the CCHMS on 5 January (p 87) we referred to a document on child guidance service and responsibilities from the Inner London Education Authority. The authority has pointed out that this was a draft document sent out for consultation.