PRACTICE OBSERVED

Practice Research

Maintaining the accuracy of a computer practice register: household index

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Abstract

In this practice, with a family practitioner committee list of 9726 patients, we use a computer register for recall, screening, morbidity data, audit, and repeat prescribing. The computing techniques used to achieve accuracy in maintaining the register are described. After one year of full use the register was validated by using the computer to select a random sample of 200 patients from patients' computer records that had not been updated recently. Two patients were untraceable, and in only 11 records were errors of information found, none of which was important. We think that it is feasible and valuable to have a household index.

Introduction

Sheldon *et al* and Fraser *et al* have measured the accuracy of age-sex registers in general practice.[1 2] In 10 highly motivated practices Sheldon found an average inflation rate in the number of patients of 4% when compared with the family practitioner committee register and of 7·2% when compared with the number of patients in the community. We set out to achieve much greater accuracy by using the computer's inexhaustible capacity to rapidly search, sort, and compare the data we entered. Some methods were merely manual tasks that can be carried out more quickly on a computer, others were a feature of many computer systems, but in addition we wrote special programs dedicated to checking the practice register. One of these led us to believe that having an index of households would be a natural development of computing in general practice with fixed lists of patients. Our system was written for the practice and runs on a TRS-80 Model III with hard disk storage.[3]

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Setting up the register

Avon Family Practitioner Committee is computerised and we could have transferred data electronically, but we wished to enter details into our computer more consistently and include extra details, such as the marital state and the dates of the last consultation, cervical cytology examinations, and visits for family planning. Our manual records are Lloyd George, with families with the same surname and address bundled together. Details were entered by a member of the ancillary staff, who was employed for 200 hours, representing an addition of 2·3% to staff costs in that year. She took batches of notes from the filing cabinets and added a marker when they were entered.

At this stage the register was a list of the manual records with the possibility that patients might have been entered twice or missed. Furthermore, not all the manual records we held were for patients who were registered with us, being either omitted from the family practitioner committee list or unreturned. Of those patients registered with the family practitioner committee, some would have left the practice area permanently or died without our knowing about it, and we describe them as untraceable. Errors of detail on address and date of birth, for example, could result from continuing errors, inaccurate transcription, or a failure of the patient to notify changes.

Maintaining the register has been the sole responsibility of the records clerk, who works 12 hours a week in a separate office entering data in to the computer and receiving, sorting, and returning manual records. Temporary cards were made for newly registered patients and filed in a new patients' file and not added to the computer register until registration was confirmed, an average time of two weeks in Avon since 85% of our patients move within the county.

year. Although we had identified untraceable patients, the biggest source of error must still be patients who have left the practice area but have not registered elsewhere, particularly moves that have occurred in the past year or two. To increase the chance of picking up these patients the computer first separated the under 5s and patients on whom we had entered data in the past three months and then selected a random sample of 200 from the remainder. A personalised mailing list was produced at the same time so that word processed letters to patients could be produced with all the details that we wished to confirm. Using our family bundles of records it was easy in many cases to find sufficient corroborative evidence on accuracy and only 21%, were written to or telephoned. Two patients were untraceable, six had incorrect dates of birth by one year at the most, and five had incorrect postcodes.

Discussion

Age-sex registers may be expected to develop an increasing number of inaccuracies in proportion to both the length of time they have been set up and the turnover of patients unless they are regularly checked. Inflation leads to inaccurate morbidity figures and apparently poor response rates to screening. For example, the percentage of patients seen in the practice in the past five years was corrected from 93·2% to 96·7% from our findings. Mistakes over registration may cause unnecessary distress or embarrassment to relatives and may make the practice appear inefficient. Improving the records is less work when superfluous notes are identified, and practice projects and audit can appear more manageable. Computers will work more efficiently in selecting patients and performing searches than people. As general practitioners undertake preventive and anticipatory care the accuracy of their patient list becomes more important. Surgery computers will continue to list patients for preventive care and screening unless they are labelled as untraceable or are removed from the practice register.

Provision for list inflation is made in calculating the target income of general practitioners, and perhaps a rough fairness operates since inflation bears some relation to list turnover, with its attendant workload. One legal requirement on general practitioners is set out in schedule 1, part I of the 1974 National Health Service regulations. Paragraph 30 states that the doctor "shall . . . not later than one month of . . . learning of . . . a death . . . forward the records relating to that person to the [family practitioner] committee." Thus when the practice has issued the death certificate or has a document referring to the death then the responsibility is clear. Paragraph 13 states that doctors shall render services if the condition of the patient so requires at some other place where the doctor has agreed to visit him and has informed the patient and the family practitioner committee accordingly. Thus if a patient is known to have moved to an address where the doctor is not prepared to visit the doctor should notify the patient and the family practitioner committee. Nevertheless, having complied with these regulations, most patients we identified apparently disappeared without a trace. That we are not absolutely correct in our assumptions is confirmed by our having had to reinstate two patients on the practice register. We have, however, a percentage figure (3·5%) approximating to the percentage inflation of NHS registered patients above the Registrar General's estimate of the population for the county (figure). A further one to two per cent of the family practitioner committee list will have moved out of the practice area but not yet reregistered, and this is balanced by an equal percentage that will not register with the practice unless the need arises. This is the smallest margin of error of a practice register that computer monitoring and checking with the last electoral roll can produce.

As all family practitioner committees become computerised and thus able to offer more facilities to general practitioners, such as age-sex registers, cervical cytology recall, and morbidity data, they will also have the means to control list inflation by the methods described.[1] More detailed guidelines may be necessary than a "gentlemen's swings and roundabouts agreement." Family practitioner committee staff, however, who work on up to 500-fold numbers of patients and are remote from the point of patient contact, will find it difficult to maintain the motivation for achieving the accuracy that is necessary for doctor initiated interventions. If we rely too much on family practitioner committees for computerised data our independent contractor status may lose some credibility. Regardless of where the computerised data is held there is room for improvement in the office procedures of most of our surgeries. Computers can help to check for errors and focus attention on possible anomalies in the simple ways that we have described.

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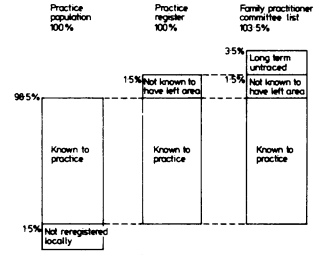

Relation between population of practice catchment area, practice register, and family practitioner committee list

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100 YEARS AGO

Our Paris correspondent writes: At a recent meeting of the Council of Hygiene of the Department of the Seine, M. Riche, in the name of a commission of medical and sanitary authorities, read a report concerning the practice of using vaseline in pastry as a substitute for butter or fat. Pastry thus prepared can be kept for some time without becoming rancid, a quality advantageous to the seller, and as equally undesirable for the buyer and consumer, who is not warned, either by smell or taste, of the falsification of the ingredients or the staleness of the pastry. Vaseline does not possess the nutritive qualities of either butter or fat, and its action on the digestive apparatus has not been determined, so that it cannot be affirmed that its introduction into articles of food may not be dangerous to health. The Council of Hygiene, therefore, has resolved that it is not desirable that the use of vaseline, petroleine, or neutraline, and all similar products, in preparing pastry or any other form of food, be permitted in France. (*British Medical Journal* 1885;i:242.)

The registration of new babies was checked off a list of maternity services that the computer produced. Deceased patients were removed immediately, but patients who were leaving the list were not removed until the notes were requested by the family practitioner committee. Eight hundred and forty five patients joined the list and 783 were removed in the year to July 1984, representing a turnover of 8%, and an increase of 0·64%.

The following features of our computer system were used both to improve and to maintain accuracy:

Alphabetical index—The main patient record is not stored alphabetically, but an alphabetical index of surname and forenames is updated at every entry and includes numbers that refer to the main data record. The practice register can be displayed in alphabetical sequence and compared with the family practitioner committee list. This comparison took roughly 20 hours' time of two staff but resulted in identifying about 300 records that were not on the family practitioner committee list. Subsequently, we registered roughly 30 patients and returned the records of those whom we had not treated for several years. This was a useful exercise that would have been difficult to perform manually with our method of filing records by family name.

Size of households in practice compared with that in 1981 census[4] *(9351 patients in 3719 households)*

No in household	No of patients	Percentage of total households in practice	Minimum percentage correct in >10% sample	Corrected percentage for practice	Percentage of total households in 1981 census
1 aged 65 +	551	14·8	95	12·5	
aged 40-64	323 } 1192	8·7 } 32·0	70	6·1 } 22·0	21·7
aged 17-39	318	8·5	40	3·4	
2	2044	27·5	94	33·5	32·2
3	1605	14·4	97	17·5	17·0
4	2472	16·6	98	17·0	18·1
5	1195	6·4		6·9	7·3
6	516	2·3		2·3	2·5
7	98	0·4		0·4	0·7
8	40	0·1		0·1	0·3
9	18	0·1		0·1	0·1
10+	171	0·2		0·2	0·1
Average household size		2·51		2·68	2·67

Household index—This indexes addresses by the first three letters of the street, the post code, the number or house name, and the first letter of the surname and date of birth of each occupant. The household index requires individual programming for a practice but once implemented the address may be used for demographic information as well as for identification and location. Thus a detailed breakdown of the practice population by locality is possible, and the whole practice may be listed by household in a sequence by street and number. This is more helpful to the general practitioner than alphabetical listings and closely resembles the electoral roll, except that it includes those aged under 18 but not members of the household who are registered with other practices. The table shows how we validated the index by comparing our analysis with the figures from the 1981 census on the size of households. Single person households are shown in three age ranges. Checking at least a 10% sample against the electoral roll showed that 85%, of the patients 65 and over who our index showed were apparently living alone were indeed, though figures were unreliable in younger single person households. Figures for households of two people and more were accurate. The corrected percentages for each household size are remarkably close to census figures. Using the household index we produced a list of every household in which there were two or more different surnames, which numbered 369 out of the total of 3719 households. This shows extended families, other family relationships, cohabiting, and that new patients have moved into the residences of former patients who may have left the district some time earlier. This list was of interest to the partners, showing domestic situations that they had not previously recognised. We also produced a list of patients over 64 living alone (with its 85% accuracy) for the geriatric health visitor to use. The under 5s were listed in address sequence for the children's health visitor, which clearly showed, for example, families with three children under 5. The household index may be used to identify in seconds all the persons living at a given address and is helpful when parents have different surnames from the children.

Checking for errors at input—The computer system can provide programmed safeguards against error at input. Thus when new patients are entered similar names or dates of birth of patients already on the register are displayed to avoid duplication. The postcode may be checked for basic postcode rules and that it lies in the practice area.

Programs to detect errors—Special programs may be run to check all the registration data by creating, sorting, and comparing temporary indexes. Thus the computer can check that the postcode is identical for a given address, that the address for a particular surname in a particular postal area is similar, and that the sex for a particular first name is the same. Duplicate entries may be sought by listing patients with identical surnames and roughly the same birthdays or identical first names and same birthdays. Not all the computer listings are errors and these methods are not 100% effective, but we found them useful in tidying up the register.

Single register for all data recording—Separate registers are not necessary in a computer system so that whenever morbidity data and cervical cytology and family planning dates are entered the practice register is accessed, as it is with the 15% of patients with a repeat prescription record. Failure to include a patient in the computer list would be recognised immediately.

Patient contact with computer output—Patients may notice incorrect personal details on their repeat prescription. Computerised recall and screening letters may be returned or amended. We have sent more than 750 recall letters for hypertension, cervical cytology, and rubella screening, and this has led to address corrections and the recognition of untraceable patients in non-responders.

Date of last data analysis—Data may be regularly entered to record important information on morbidity, cervical cytology, family planning, expected date of delivery, immunisation, blood pressure, and even the date of the last consultation in selected cases. A program was written to list all the patients for whom no event dates had been entered for five years. Checking their notes and the electoral roll showed many who must have left the practice. When the search was confined to patients with no event data for shorter periods the computer produced an impossibly long list. On the assumption (not always valid) that patients with the same surname in the same household move together, the computer was programmed to identify patients who had no current prescription record or no event data entered for the past year. If any were found then this patient and all patients with the same surname in the same household were eliminated from the check, leaving a list of 350 unfamiliar names with a high probability of having left the practice.

Validating the register

After one year of using these procedures we had excluded roughly 360 patients from the practice register for screening and statistics and made hundreds of corrections. Having checked once that all patients on the practice register are included on the family practitioner committee list, a further comparison of the two lists would not be necessary for some years. A serious omission would be to miss patients from the practice register who were registered with us, but since only a handful of patients might be concerned, checking a sample would be meaningless. Using the computer regularly is the most likely way to discover these—two have come to light in the past

Giving advice about welfare benefits in general practice

BRIAN JARMAN

Abstract

Many people do not receive the full state welfare benefits to which they are entitled. Roughly two thirds of the population consult their general practitioners at least once a year. General practitioners and community nurses are exceptionally well placed to detect those who are suffering genuine financial hardship but they are not well equipped to give advice about the complex system of state social security benefits. Imparting such advice in suitable cases, particularly where the lack of it is detrimental to health, might be regarded as a proper function of general practitioners and health centres. A method of providing such advice in a health centre with the help of a computer is described.

Introduction

In our practice we have recorded the diagnoses made at every consultation for 7000 patients over the past few years. For 1979–81 roughly 2·3% of the problems presented by patients were given a primary diagnosis (in accordance with the ninth revision of the *International Classification of Diseases*) as being connected with their social circumstances—that is, 1427 diagnoses out of a total of 62 829—and 565 (40%) were directly or indirectly related to financial problems. We know that in some cases where physical, psychological, or social symptoms are thought by the general practitioner to be due, at least in part, to financial stresses, there are state benefits that might be claimed by the patient. In most of these cases the patients do not present with direct complaints of financial problems.

We wondered how many of our patients were not receiving the benefits to which they were entitled, although these might have beneficial effects on their health. By examining the list of our "chronic visits"—the 100 or more people we visited regularly in their homes—we discovered that about a third were entitled to, but were not receiving, an attendance allowance (to enable them to pay someone to look after them) and that several were also entitled to a mobility allowance (to help them get out and about if they had substantial difficulty in walking). Unfortunately, some of these last patients had passed the age of 65, the upper age limit for claiming mobility allowance. Had they claimed in time the allowance would have been paid until the age of 75 if they remained immobile. Most who were entitled to claim now receive these allowances, a few after appealing against decisions that they were not entitled.

It is difficult to obtain reliable data on the national uptake of mobility allowance and attendance allowance, but according to Department of Health and Social Security figures 49% of people who are entitled to family income supplement do not claim it[1] and at least £760m per year of supplementary benefit goes unclaimed.[2] The rules governing individual benefit entitlements depend on age, income, marital state, and other fairly easily quantifiable things. Finding the rules written down somewhere, putting them all together, and then doing all the arithmetic is complicated as there are so many factors involved.

The obvious answer is a computer, which can be given all the rules, and then if the correct information for each case is fed in it will do all the calculations needed in a fraction of a second. This is now possible because since 1980 the conditions for payment of supplementary benefit have been formalised on a full statutory basis and no longer depend so much on the judgment of individuals in the local social security office. There are, however, times when it is difficult to decide by computer whether, for instance, a person is entitled to a heating addition, but these are relatively few.

Using the Child Poverty Action Group booklets on welfare benefits,[3 4] Tolley's *Social Security and State Benefits*,[5] and the DHSS's housing benefit guide,[6] I have written a computer program that is run daily in our health centre and has been used to give advice to some of our patients who we think have problems related to their financial difficulties. I started writing the computer program early in 1980, and it is updated and modified continually but has been working fully for more than a year.

There are roughly 30 state social security benefits. Some depend on National Insurance contributions that people have paid in the past—for example, the contributory benefits such as retirement pension and widow's benefit. Others are means tested, such as supplementary benefit and family income supplement, and others, like attendance allowance and mobility allowance, depend on disability. Doctors give evidence about sickness and disability for some of these benefits. Housing benefit, which replaced rent and rate rebates and allowances in April 1983, is administered by local authorities, unlike the other benefits, which are administered and paid by the social security branch of the DHSS.

In 1983–4 the United Kingdom spent £35 478m on social security[7]—twice as much as is spent on health, defence, or education. Therefore, it is all the more important to ensure as far as possible that social security payments are going to those who need them most rather than to those who are most efficient at making claims.

Method

The computer program is divided into several parts. In the first part there is a series of questions about details such as the age and sex of the person concerned. A form of branching logic ensures that people are asked only relevant questions—for example, men are not asked if they are pregnant. It is possible to inquire about one benefit only rather than to be considered for the whole range of benefits, and in this case the questions asked relate only to the benefit in question. Attendance allowance and mobility allowance require a few questions only, family income supplement more, and supplementary benefit still more. When housing benefit is included things become even more complicated, as it is closely connected with supplementary benefit.[6]

Having asked about the details in the first part of the program, the program goes on to test one by one whether the person is entitled to each of the possible benefits. One main problem is that for the contributory benefits it is necessary to have an accurate record of National Insurance contributions made in the past, which most people cannot remember. They may obtain this information by writing to the DHSS and then enter the details into the computer, but the program gives them the option of entering the amount that they are actually receiving of any contributory benefit (retirement, widows's, sickness/invalidity, maternity, unemployment) and assuming that this is correct. Alternatively, to calculate any of the con-

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tributory benefits when the values are not known they may put estimated figures into the computer, which may be used as a guide to give the correct amounts. The means tested benefits (supplementary benefit, housing benefit, and family income supplement) come last, as the amounts received from some of the other benefits, which come beforehand, are used as part of the income figure for the means tested benefits. When there is a choice among the strategies that may be adopted—such as whether to claim one parent addition to child benefit if that would mean not receiving supplementary benefit, or whether, when both are possible, to claim family income supplement rather than supplementary benefit—then both possibilities are considered and the consequences of each are indicated.

The third part of the program is a summary of the benefits that may be claimed, with the option of having the details of the factors on which the decisions are made printed in full. Single payments, which may be made for clothing and other items on a once off basis in cases of particular hardship, may be given: the program will, for instance, print out a list of the amounts that may be paid for 20 or so items of children's clothing if the patient is eligible and asks for the information.

The last part of the program gives brief details for quick reference about the conditions that apply to various benefits. The whole program, excluding this last part (which may be any length), takes up about 120k of Random Access Memory on a computer, depending mainly on the brevity or comprehensiveness of the questions asked. In general the questions are as precise as is necessary to get the correct answer, and an attempt has been made to make the program sufficiently comprehensive to include most of the "small print" details. An abbreviated version of the program without the part on contributory benefit is being considered for one of the hand held computers now available.

The program runs on a Hewlett Packard HP85B computer, which is portable and has an integral screen and printer, and is written in the HP85 version of the Basic computer language. It is being re-written in other versions of Basic so that it can run on other micro-computers, and these should be available in 1985 for use by others who have different computers, such as the IBM PC.

The benefits covered by the program are given in the table, and a brief outline of the program is given in the figure.

No record is kept on the computer of any details of any person whose benefit entitlement is being tested, but it is possible to restart at different points in the program while keeping the information that has already been entered and then seeing what would happen if some of the details were different.

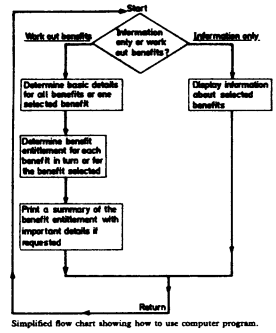
Benefits covered

Contributory benefits:
Retirement pension
Widow's benefit (widow's pension, widow's allowance, and widowed mother's allowance)
Sickness benefit
Invalidity benefit (invalidity pension and invalidity allowance)
Maternity allowance
Unemployment benefit
Child's special allowance

Non-contributory benefits:
(a) Means tested:
Supplementary benefit
Family income supplement
Free prescriptions, dentist, optician, fares to hospital, etc
Housing benefit (DHSS responsibility, administered by local authorities)
Housing benefit supplement
(b) Non-means tested:
Child benefit
One parent benefit
Attendance allowance
Mobility allowance
Invalid care allowance
Non-contributory invalidity pension
Non-contributory retirement pension
Age addition
Statutory sick pay (an employment right, not social security)
Guardian's allowance
Industrial disablement benefit, vaccine damage payment

Notes:
(1) In addition, maternity grant and death grant are lump sum payments rather than weekly payments.
(2) Four of the contributory benefits are "short term" and after a fixed period the person must transfer to some other benefit. These are unemployment benefit (52 weeks), widow's allowance (26 weeks), maternity allowance (usually 18 weeks), and sickness benefit (28 weeks less period of statutory sick pay).
(3) Local authorities are allowed small variations when applying the housing benefit regulations enabling them to be up to 10% more generous to people claiming standard housing benefit.[8] These have to be programmed individually for each local authority together with local upper limits for board and rent. Educational maintenance allowances may be paid by some local education authorities, and details have been included for London.

The program has over 100 variables set at the beginning, giving the current levels of payment for different benefits. These levels are usually changed in November or April each year, and updating them is a fairly simple task, taking a few hours only—much quicker than updating paper records. If benefit rules change then the appropriate part of the program has to be changed.



Simplified flow chart showing how to use computer program.

In addition to the fixed variables giving benefit levels there are more than 200 variables, such as age and income, for the details that may be needed about each person being tested. A small proportion only is needed for any one person, and only the variables appropriate to that individual are determined. For instance, it is not necessary to ask the ages of children for a person who is childless and does not have dependant children.

The program is run with an operator helping the person who is inquiring about their benefit entitlement. If the answers to the questions are known then the whole program takes about 10 minutes to run, but if time is needed to find the answers to certain questions then it takes correspondingly longer. It is possible to enter figures for income, rent, etc, weekly, monthly, or yearly, and errors may be corrected at entry or by stopping the program and re-entering the new value (if the wrong value has not already been used in the program). Repeated use of the program ensures that advisers become used to covering the whole range of benefits without forgetting details and thus acts as a useful training tool. They cannot fail to consider benefits of which they have no previous experience if the computer indicates that the applicant might be entitled to them.

The local DHSS social security office has allowed one of their officers to work with the program in our health centre since mid-1983, and he has been able to test the program and also give advice to people who go to his "surgery," which he holds in the health centre every morning for unbooked or booked referals from professionals working there.

Results

An analysis of the last 100 cases seen by the social security officer during the past few months showed the following breakdown of inquiries: attendance allowance, four; mobility allowance, six; statutory sick pay, one; sickness benefit, three; invalidity benefit, three; non-contributory invalidity pension, two; retirement pension, two; widow's benefit, one; family income supplement, one; invalid care allowance, two; supplementary benefit: normal and housing

requirements, 58, additional requirements, 52, single payments, 27; and housing benefit, 15.

In all of the 100 cases the answers given by the computer were correct when checked by the social security officer from the DHSS, and no details of other possible benefits had been omitted. It would be interesting to compare advice given to a few applicants in a social security office with that given by the computer to the same applicants as described above.

Referrals have been received from the general practitioners, health visitors, and district nurses in the health centre. There has been an average of two or three inquiries a day, a few from people who were not patients at the health centre who had heard of the service. Doctors have also given advice to patients in their homes regarding attendance allowance, mobility allowance, and invalid care allowance without the use of the computer since they are now more aware of the existence of these allowances.

Discussion

Whether or not it is part of the function of general practitioners, community nurses, and other primary care workers to give advice on welfare rights is perhaps open to question. A considerable proportion of the patients whom they visit regularly at home because they are too disabled to get out are entitled to attendance and mobility allowances, which they do not receive, although they would benefit from being able to pay people to look after them and from being more mobile. Paying these allowances would probably be less costly to the state in the long term if their effect is to enable these people to avoid going into hospital or living in similar institutions permanently. It is therefore appropriate that primary health care workers should give advice in such circumstances.

At the other end of the scale it is perhaps more questionable whether advice regarding entitlement to means tested benefits, such as supplementary benefit, housing benefit, and family income supplement, is best given in a setting such as a health centre, even though general practitioners may have patients with illnesses deriving from stress connected with their financial position. Government surveys have shown that a proportion of these people are entitled to welfare benefits but do not claim them.[1-3] The reasons for not claiming have been discussed elsewhere and are generally due to ignorance of the help available, the complex rules of the social security benefit, and the reluctance of many people to go to social security offices, citizens' advice bureaux, and other sources of professional advice and help.[4-10] It is not unknown for the professionals to be ignorant of parts of the complex rules governing welfare benefits or even to make mistakes in giving advice.[4-10]

Using a computer program to give advice in a health centre has advantages in overcoming some of these difficulties. Primary health care workers are in a good position to detect when people are under financial stress, they are usually trusted by the patients who consult them, and patients know from experience that the information they give is treated in confidence. In addition, roughly two thirds of the population consult a general practitioner at least once a year. The barrier between profession and public has been broken. Patients feel that they are on home ground and are willing to see someone along the corridor in the same building who will give them financial advice when introduced by their general practitioner or community nurse.

The system that we adopted of having a local social security officer using the program to advise patients had the following advantages: (*a*) it introduced the patient to someone who could actually help him or her to get a benefit if the advice indicated a probable entitlement, and (*b*) it tested the computer program thoroughly for possible errors in programming the benefit rules with a wide variety of cases, thus verifying its accuracy. The social security officer, unlike the general practitioner or community nurse, was probably more conscious of the need to ensure that only valid claims for benefit were paid. The computer was helpful here also, as the claimants could see clearly, in the presence of the officer, what they were or were not entitled to, and, for example, the definition of what counts as income was clearly stated and could be re-emphasised by the officer if necessary.

This difference in the relationship between the social security officer and the claimant and that between the general practitioner and patient is important. It is possible to have someone attached to the primary health care team to give advice to patients. If such an adviser has a good relationship with the local security office and if the computer program prints out all the details of how the advice given is arrived at and this is accepted by the social security office, then it should be possible to give advice about social security benefits in complete confidence in a primary care setting and facilitate the process of making a claim. This model is being tested with the computer program at another health centre.

I thank the DHSS for allowing Geoff Rees and Leonard Levy to help give advice to patients and thank them for their valuable contributions, Peter Rice for helping to adapt the program for use with different computers, primary care workers in our health centre for making referrals, and the City Parochial Foundation for financial support with purchasing computer equipment.

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100 YEARS AGO

Sir William Harcourt, with something of his old skill as a special pleader, is losing no opportunity of discrediting in the House of Commons the present municipal government of the metropolis. We have already been told on authority that, despite the pleadings of Mr. Firth's Reform League, the Cabinet have abandoned all hope of passing their London Government Bill this session. Probably, however, it will not even be introduced, but be handed over to the new Parliament, along with a number of other matters, such as the land laws and private bill legislation, that have already been conveniently hung up in the same way. But the Home Secretary is careful to let it be known that he is still of the same mind about the deplorable mismanagement of metropolitan affairs; and herein he is wise. For, especially in an overgrown invertebrate organisation like London, no reform has the least chance of acceptance that is not persistently dinned into people's ears as the only remedy for a state of things admittedly wasteful and scandalous, but because everybody's business is nobody's. Sir William Harcourt even went so far, in a discussion last week on the Thames Crossings Bill, as to express his view that the Metropolitan Board of Works did not command the confidence of London, though he ostentatiously washed his hands of any responsibility in the matter. Now, this is surely carrying the principle of anti-centralisation too far. Does Sir William mean that he will sit still and offer no help in getting things done right, because his municipality is not yet in working order? The moral of his recent lectures on the subject, apparently is that, until Parliament can find time to pass his Bill, Londoners must struggle on as best they can, and that he is only prepared to end, not to mend, the existing local government of the metropolis. This is hardly encouraging; and we venture to think that, even at the expense of a little consistency, the Home Secretary might lend a helping hand to London in its present administrative difficulties, instead of offering to it counsels of perfection that, from no fault of its own, it is unable to embrace. (*British Medical Journal* 1885;i:552.).

Women in General Practice

Provision for maternity leave for general practitioners

PENNY SCHOFIELD, GILL WARD

Half of the students in medical school in the United Kingdom are women. Thus issues that relate to women doctors have become of more importance and interest. The number of women who are qualified to become principals in general practice is increasing, while positions in general practice are becoming harder to obtain. During 1983 a group from the Newcastle branch of Women in Medicine decided to look at the provisions for maternity leave in general practice, thinking that the present arrangements were unsatisfactory and might be contributing to prejudice against women as partners. Women candidates are often asked about their family intentions and commitments when interviewed. To discuss these openly women need to be well informed about maternity arrangements, as do their prospective partners. Guidelines issued by the BMA in their notes "Medical Partnership and the NHS" are not helpful in this respect.

General practitioners are classed as self employed. Women principals are therefore not covered by the Employment Protection Act 1978, which granted working women certain maternity rights. Women doctors who are employed in hospitals are covered by the Whitley Council maternity leave agreement (March 1981), which embodies these rights. Briefly, a woman who has been employed for two years or more is entitled to 18 weeks off work at a decreasing rate of pay and 29 weeks of unpaid leave after the birth. (There are actually several problems with such a scheme for women doctors on training schemes and short contracts.)

The woman general practitioner must negotiate conditions with all her partners when the partnership agreement is drawn up, if indeed one exists. The doubts over maternity leave place a woman general practitioner at appointment in a poor negotiating position. She and her partners are aware that an ensuing pregnancy may increase her partners' workload and affect them financially. Conditions that are favourable for her must leave her partners disadvantaged. Alternatively, she is left with inadequate time off or a substantial loss of income, or both. The only financial provision is that laid down in the "red book"—*Statement of Fees and Allowances*—which states that the family practitioner committee will make additional payment towards the cost of a locum for up to 13 weeks for a doctor on maternity leave. This payment, however, is discretionary and except in exceptional circumstances is available only for single-handed doctors or for a partnership that is left with more than 3000 patients per doctor in the woman's absence. It does not meet the cost of a full time locum. (At present the payment is £206 a week. The cost of a locum at rates recommended by the BMA is £280 a week.) Thus although the independent contractor status confers financial advantages on general practitioners in general, it allows women general practitioners to be disadvantaged when they become pregnant. Unlike other women workers, women principals do not have clearly defined maternity rights but must negotiate from a poor position conditions that depend on the good will of their partners.

We therefore carried out a survey of local general practitioners to find out what practising doctors knew about the current regulations, what arrangements they had, and what their attitudes were. We also sought to discover, through an advertisement in the *BMJ* and an article in *Pulse*, what experiences doctors had had.

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Survey

A questionnaire was sent to all general practitioners in the Newcastle and North Tyneside Family Practitioner Committee areas. Altogether 250 doctors (201 men, 49 women) from 95 practices were sent questionnaires with an accompanying explanatory letter. The questionnaires were unlabelled, and the information remained confidential. One hundred and thirty three were returned completed, 95 from men and 38 from women. We were not surprised that proportionally more women than men replied but were disappointed that fewer than half of the men thought that the issue was important enough to complete the form. This questions their interest in working with women colleagues and is particularly worrying as alterations in policy decisions are largely determined by men because of their representations at the profession at various levels. Their interest and support on issues affecting women colleagues are essential.

Question 1

We asked if maternity leave was a major anxiety when appointing a woman as a full time or part time partner. Fifty five per cent of the men and 66% of the women who replied thought that it was when appointing a full time partner. Given the present arrangement, this is to be expected. Obviously, there are aspects of a partner's absence that cannot be replaced purely by adequate cover by a locum, but we hope that women may begin to lessen the anxiety surrounding this issue by discussing it openly at interview. Women doctors, too, are responsible and are aware of the need to provide good and continuous care to their patients, even in their absence. They accept responsibility in sharing the cost and effort in providing adequate cover. They also retain an active interest in the practice while away (as do their colleagues when on holiday, sabbatical leave, or sick leave).

When asked about a part time partner only 17% of the men and 32% of the women thought that maternity leave was an anxiety at appointment. It is easier to manage without someone who works fewer hours, of course, but we think that this reflects prevailing attitudes to part time workers.

Question 2

We wanted to know how much was known about the "red book" regulations and what proportion of practices would qualify for

reimbursement for a locum. Seventy six per cent of women and 56% of men were aware of the "red book" regulations. The remainder did not answer. Again we were not surprised that a higher proportion of women than men knew the regulations. It underlines the fact that so far men practitioners have not concerned themselves in issues that mainly affect their women colleagues.

Forty three per cent of the men and 50% of the women said that their practices would not qualify for locum reimbursement. This suggests that in nearly half of practices there would be no additional financial help for a woman doctor who took maternity leave. A decision to do so would place a considerable financial burden on the woman or on her partners or leave the partners with additional workload.

Question 3

Stating that the family practitioner committee would partially reimburse locum cover for 13 weeks (if eligible), we asked doctors whether they thought that this was enough, too much, or too little. Sixty three per cent of the women and 45% of the men replied that 13 weeks was inadequate, 29% of the women and 35% of the men thought it adequate, and one man thought it was too much. Over half of the general practitioners of both sexes who answered the questionnaire thought that 13 weeks is not sufficient time away from work to meet the demands of pregnancy and motherhood. The Whitley Council allows for 18 weeks, and this is now the accepted minimum. General practice is a demanding job physically and emotionally, and we think that it is unrealistic to expect women general practitioners to return after such a short absence of 13 weeks.

Question 4

Arrangements for maternity leave depend on the partnership agreement and thus on the support of the partners. We wanted to know whether general practitioners thought that even in the context of the independent contractor status such an important matter as maternity leave should be given special treatment and so be covered by national regulations outside the partnership agreement. We asked whether negotiations on maternity leave should be (*a*) between the partners or (*b*) covered by a national scheme as in hospital practice. Roughly half of both the men and women thought that maternity leave should be covered by national regulations. Thus an appreciable proportion would find it helpful to have outside regulations determining maternity rights for women principals in general practice.

Question 5

We asked doctors whether they thought that the women themselves, the practice as a whole, the family practitioner committee, or a combination of all three should be responsible for financing locum cover during maternity leave. Fourteen per cent of the men and 8% of the women thought that the partnership should be responsible, and 8% of the men and 13% of the women thought that the family practitioner committee should be responsible. All of the remaining doctors thought that the responsibility should be borne by a combination of all three.

Question 6

We wanted to know how many doctors had considered the question of maternity leave in their contracts. Few had, and this is relevant only to the women doctors who answered. On appointment only 11% had agreed by contract, although 34% had verbal agreements. Of course, some women would have chosen not to have children and others would have completed their family before taking up their appointment. It is worrying, though, that a large proportion of women have not negotiated maternity leave in their contracts.

Response to advertisement

We received 13 letters from women doctors in response to the advertisement in the *BMJ* and an article in *Pulse*, including one from a doctor's wife who was incensed by the attitude of her husband's newly pregnant partner, underlining that this is not just a women's issue—pregnancy affects the whole practice. Eleven women doctors told us of their experiences, and two were requests for information. It is difficult to comment as they were all very individual. Several women felt indebted to their partners for tolerating their absences and for supporting them financially. One woman's maternity leave had to be paid for in kind in partner's sabbaticals.

Conclusion

This is the first survey of its kind, and, although the numbers were small, we believe that it is of value. Our aim is to emphasise to women who are entering general practice the need to organise their contracts appropriately when they are appointed and to encourage them to discuss openly their interest in maternity leave with prospective partners. Women must be well informed. Advice from sources such as the BMA's pamphlet on partnerships is unhelpful and sexist. On applying to the BMA Personal Services for advice one woman doctor was told: "If I were a general practitioner in partnership with a woman who required time off because of pregnancy, I think I would expect her to pay the full cost of her absence." Such an attitude is unacceptable in 1984.

The present circumstances place burdens on men colleagues when appointing a woman partner. Clear guidelines and adequate financial support would do much to lessen their anxieties. The national regulations for employed women is now 18 weeks' minimum for maternity leave; the "red book", however, allows for 13 weeks only. The minimum demands that could be met immediately would be to extend this to 18 weeks and for locum payments to be made irrespective of practice size. Clearly, taking maternity leave without financial provision is meaningless. Most general practitioners in the survey thought that the financial burden should be divided among the woman, her partners, and the family practitioner committee, but for this to become reality the regulations must now be changed.

With more women entering general practice we can only hope that these issues will be debated and progress made. Women have a particular contribution to make to general practice that may be enhanced by the experience of pregnancy and motherhood. Women general practitioners need support to continue practising throughout their professional lives, free from unnecessary guilt and anxiety over provision for maternity leave.

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100 YEARS AGO

The Metropolitan Asylums Board deserves, as a body, the distinct and hearty thanks of Londoners for the efforts which it is making in the general welfare to limit the spread of infectious disease in our midst, and for the readiness which it manifests in acting upon any suggestions calculated to enhance the efficiency of its work. The neighbours of Sullivan's Wharf, Fulham, will doubtless not be overjoyed at the construction of a pier there for the embarcation of smallpox cases from the western districts of London; but the employment of the wharf cannot fail to be of great advantage in the removal of such cases, which at present, when they are taken to the hospital ships, have to embark a long way below London Bridge. It is worthy of record that the managers now despatch the ambulance-steamer on its last journey at 8 p.m., instead of 6 p.m., an alteration which will have the effect of considerably reducing the number of "mild cases" left in their own homes for the night, in consequence of the Board's officers not having hitherto been able to remove them in time to meet the steamer before its start on its final journey at 6 p.m. (*British Medical Journal* 1885;i:610.)

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