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 main tested benefits (supplementary benefit, housing benefit, and family income supplement) come last, as the amounts received from these benefits are usually known beforehand, and are used as part of the income figure for the main tested benefits. When there is a choice among the strategies that may be adopted—such as whether to claim one pension addition to child benefit, or 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 leaving 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 30 items of children's clothing if the patient is eligible and asks for the information.

The last part of the program gives brief details of 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 observation on the program is that both possibilities for a 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 HP85B 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 enter data 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:**
- Attendance allowance
 - Widow's benefit (widow's pension, widow's allowance, and widowed mother's allowance)
 - Sickness benefit
 - Unemployment benefit (invalidity pension and invalidity allowance)
 - Maternity allowance
 - Unemployment benefit
 - Child's special allowance
- Non-contributory benefits:**
- (a) Means tested:
 - Family income supplement
 - Free prescriptions (optician, optician, far to hospital, etc.)
 - Housing benefit (DHS responsibility, administered by local authorities)
 - Attendance allowance
 - (b) Non-means tested:
 - Child benefit
 - Parent's benefit
 - Maternity allowance
 - Unemployment benefit
 - Invalid care allowance
 - Non-contributory invalidity pension
 - Non-contributory retirement pension
 - Age addition
 - Statutory sick pay (on employment right, not social security)
 - Statutory disability benefit, vaccine damage payment

Notes:

- (1) In addition, maternity grant and death grant are lump sum payments rather than weekly payments.
- (2) The program is designed to be used by the social security officer during the first few months of the following breakdown of inquiries: attendance allowance, four; mobility allowance, six; statutory sick pay, six; family income supplement, six; invalid care allowance, two; 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

The program has over 100 variables set at the beginning, giving the current levels of payments 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 dependent 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 values (if the answers have 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 DHS 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 patients who go to his "surgery" (which he holds in the health centre every morning for unbooked or booked referrals from professionals working there).

Results

An analysis of the last 100 cases seen by the social security officer during the first few months showed the following breakdown of inquiries: attendance allowance, four; mobility allowance, six; statutory sick pay, six; family income supplement, six; invalid care allowance, two; 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

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. This issue that relates to women doctors has 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, and their prospective partners. Guidelines issued by the BMA in their "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 hospital 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 of 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 a disadvantage in a poor negotiating position. She and her partners are aware that an ensuing pregnancy may increase her partners' workload and affect their financial conditions that are favourable for her must leave her partners disadvantaged. Alternatively, she 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.

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 to policy decisions are largely determined by men because of their representations of 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 share 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

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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 using DHS, and no details of other possible benefits had been omitted. It was 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 but 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.^{1,2} 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.^{3,4} 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.^{5,6}

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 professional 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 possible 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 benefits 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 social 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 DHS 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 numerous occasions, despite the pleadings of Mr. Frib's Reform League, the Cabinet have abandoned all hope of passing their London Government Bill this session. Probably, therefore, it will not even be introduced, but he has been told by the new Parliament, having with a number of other matters, such as the land law and private bill legislation, that have already been conveniently hung up in the way. But the House Secretary is careful to make the least chance of acceptance that is not presently dinned into people's ears as the only remedy for a state of things admittedly wretched and scandalous, but because everybody's business is nobody's. Sir William Harcourt even went so far, in a discussion last week, as to suggest that the Bill, as to express his view that the Metropolitan Board of Works did not command the confidence of London, though he ostensibly washed his hands of any responsibility in the matter. Now, this is surely carrying the principle of 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 the 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 House Secretary might lend a helping hand to London in its present administrative difficulties, instead of offering to its counsellors of perfection that, from no fault of its own, it is unable to embrace. (*British Medical Journal* 1885:552.)

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 most of the practices there would be no locum. 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 practice 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 3

Stating that the family practitioner committee would partially reimburse locum cover for 13 weeks (if eligible), we asked doctors whether they thought that that 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 practice 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 the BMA's *Statement of Fees and Allowances* presented only to the women doctors who answered. On appointment only 11% had agreed by contract, although 34% had verbal agreements. Of course, some women 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 absence 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 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" regulations allow 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.

We thank our colleagues in Women in Medicine for their enthusiasm and ideas, and the Women's Union of Newcastle upon Tyne for their support and interest, and Jackie Brown and Maureen Lillie for secretarial help.

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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, Barking, will doubtless not be overjoyed at the construction of a pier there for the embarkation of smallpox cases from the western districts of London; but the employment of the wharf cannot fail to be of great advantage in the general scheme of things, which at present, when they are taken to the hospital ships, have to embark a long way down London River. 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 "mid-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* 1885:610.)