Responses by general practitioners in Avon to proposals for general practice in the white paper *Working for Patients*

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Abstract

***Objective*—To determine the views of Avon's general practitioners about the general practice proposals within the government's white paper *Working for Patients*.**

***Design*—Postal questionnaire survey.**

***Setting*—A county in south west England.**

***Subjects*—All general practitioner principals (n= 537) under contract with Avon Family Practitioner Committee.**

***Measurements and main results*—492 doctors (92%) responded to the survey. More than three quarters of the respondents were opposed to the government's proposals on budgets for specific surgical procedures, prescribing, and diagnostic tests; and between 63% and 93% felt negative about advantages that might accrue from the proposals. Over three quarters of general practitioners were in favour of family practitioner committees monitoring work load, prescribing, and referrals. General practitioners in large, potentially budget holding practices held similar views to doctors in smaller practices.**

***Conclusions*—Avon's general practitioners substantially reject most of the government's proposals about general practice in the white paper *Working for Patients*.**

Introduction

In January 1989 the government issued the white paper *Working for Patients*.[1] The stated reasons for the review of the NHS include the need to raise the standards of care and secure best value for money, the rising cost of providing care, the wide variation in cost of the care provided, and the desire to extend patient choice. The government believes that these will be best achieved by delegating responsibility to where health care is delivered to the patient.

The proposals for general practice centre on the government's belief that money should flow with the patient from the practice. For the first time since the start of the NHS this concept introduces the need for a general practitioner to know accurately the cost consequences of most clinical decisions. To encourage the doctor to take on this new managerial role the government proposes to allow eligible general practitioners to plough back savings into their practices.

The proposals will necessitate the development of practice budgets for outpatient services, certain specified surgical procedures, diagnostic tests, and prescribing. They will also require the development of obligatory systems for medical audit. Other proposals include increasing capitation fees paid for patients registered with the doctor while reducing basic practice allowances, easing the regulations for changing doctors, encouraging doctors to provide information about their practices, and reducing the professional representation on family practitioner committees. Despite the Prime Minister's assertions[1] that patients' needs will always be paramount and that greater satisfaction and rewards will be available for those working in the NHS, the medical profession has reacted strongly against the proposals.[2,3] These major changes, introduced with proposals for developing a competitive market for the hospital services, have been criticised by the General Medical Services Committee (GMSC), who have asked local medical committees to ascertain the views of local doctors.[4] To do this the Avon local medical committee circulated a questionnaire to all general practitioners in Avon asking for their views on the proposals in the white paper. Information about the general practitioners' current use of computers, and prescription, analysis, and cost (PACT) prescribing information was also requested to determine their present interest in monitoring their work.

Subjects and methods

Questionnaires were sent to all 537 general practitioners in contract with Avon Family Practitioner Committee. The area comprises three large towns, Bristol, Bath, and Weston super Mare, and surrounding rural areas. The questionnaire comprised a series of questions to determine doctors' views on the content and consequences of the proposals in the white paper and the possible time scale for their implementation. There were possible responses to each of yes, no, and (when applicable) don't know (see table 1). The doctors' age group, sex, health district, and the number of partners in each practice was also identified. Information about respondent's and practice's use of computers, high level (PACT) prescribing information, and where the doctor had gained information about the white paper was also requested. Questionnaires were sent out in March 1989: a reminder was sent to those general practitioners not responding within three weeks. Non-parametric analyses were performed to test hypotheses of average differences in the obtained responses among subgroups of doctors.

Results

Questionnaires were received from 492 (91·6%) doctors. Table I shows the responses to the questions about the proposals, and table II shows views on the likely effects of the white paper if implemented as proposed. Most general practitioners in Avon expressed opposition to all but two of the proposals.

Most respondents were in favour of general practitioners cooperating with the family practitioner committee in monitoring workload, prescribing, referrals, etc (78·8% in favour) and retiring at 65 (60·1% in favour). Doctors aged 45 and younger were more likely than older colleagues to agree that general

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TABLE I—*Overall responses from 492 general practitioners to questionnaire on government proposals for NHS. Results are numbers (percentages)*

Questions asked	Yes	No	Don't know
In principle, do you feel that a practice should have a fixed budget for:			
Referrals for specified operations?	32 (6·6)	441 (90·4)	15 (3·1)
Prescribing?	98 (20·1)	368 (75·4)	22 (4·5)
Diagnostic procedures?	44 (9·1)	429 (88·3)	13 (2·7)
Do you agree that capitation fees should form a greater part of general practitioners' income?	61 (12·5)	408 (83·8)	18 (3·7)
Do you agree that basic practice allowance should form a reduced part of remuneration?	25 (5·1)	435 (89·1)	28 (5·7)
Do you agree that general practitioners should be made to retire at 65?	297 (60·1)	175 (35·8)	17 (3·5)
Do you feel that general practitioners should cooperate with family practitioner committees in monitoring work load, prescribing, referrals etc?	383 (78·8)	77 (15·8)	26 (5·3)
Do you believe that general practitioners should be able to use budgetary savings to increase their personal income?	44 (9·0)	422 (86·5)	22 (4·5)
Do you accept that it is reasonable for family practitioner committees to impose financial penalties on general practitioners who persistently overspend their indicative prescribing budgets?	130 (26·6)	288 (58·9)	71 (14·5)
Do you agree that family practitioner committees should be reduced to 15 members, of which only one will be a general practitioner?	22 (4·5)	439 (89·8)	28 (5·7)
Do you believe that the regional health authority will be able to allocate appropriate budgets for large practices by April 1991?	40 (8·1)	332 (67·6)	119 (24·2)
Do you believe the family practitioner committees will be able to accurately monitor overspending in referrals by April 1991?	30 (6·1)	357 (72·9)	103 (21·0)
Have you asked for level 2 or 3 PACT prescribing information?	233 (47·8)	241 (49·4)	14 (2·9)

A small number of respondents did not answer all of the questions.

TABLE II—*Overall beliefs about consequences of white paper among 492 general practitioners. Results are numbers (percentages)*

White paper provisions will result in:	Yes	No	Don't know
A more cost effective NHS	98 (20·0)	325 (66·5)	66 (13·5)
A more efficient NHS	40 (8·2)	391 (80·0)	58 (11·9)
Shorter waiting lists	47 (9·6)	346 (70·6)	97 (19·8)
Greater equality of patient care	17 (3·5)	443 (90·6)	29 (5·9)
Increased personal income for general practitioners	34 (7·0)	313 (64·1)	141 (28·9)
Improved doctor/patient relationships	13 (2·6)	456 (92·9)	22 (4·5)
A greater proportion of cost of NHS being used within the community	49 (10·1)	306 (63·4)	128 (26·5)

A small number of respondents did not answer all of the questions.

practitioners should retire at 65 ($\chi^2=12·01$, df=2, $p<0·005$) and that general practitioners should co-operate with the family practitioner committee in medical audit ($\chi^2=21·5$, df=2, $p<0·001$). Nearly half of the doctors stated that they had asked for level 2 or 3 of the PACT prescribing information. Once again there was a significant average age related difference in the responses: 52·2% of the doctors aged 45 and under and 39·9% aged over 45 had done so ($\chi^2=7·80$, df=2, $p<0·025$). Of the respondents, 27% believed that it was reasonable for family practitioner committees to impose financial penalties on those doctors who persistently overspend their indicative prescribing budgets. This percentage rose to 33·5% in general practitioners aged 45 and over ($\chi^2=7·62$, df=2, $p<0·025$). Few believed that health authorities will be able to allocate appropriate budgets (8·2%) or monitor over spending in referrals (6·1%) by April 1991, though about a quarter of the doctors were uncertain. The replies received seemed to be based on informed opinion concerning the content of the white paper as more than three quarters of the sample said they had read the white paper itself (table III).

TABLE III—*Overall responses from 492 general practitioners about where they gained information about white paper*

Information from	No (%) of general practitioners
Original source	381 (77·4)
Media including medical newspapers	365 (72·4)
Medical journals	334 (67·9)
Talking with colleagues	330 (67·1)
Other	89 (18·1)

Crucial to the implementation of proposals is the degree of computerisation within general practice. Of the general practitioners responding, 59% said that their practice did not have a computer, although 46% of this group said that they were actively investigating the use of a computer within their practice.

The proposed qualifying point for larger practices to handle their own budgets is 11 000 patients. The average list size in Avon is about 2000 patients, so virtually all practices with six or more partners are likely to qualify for budgets. There are 18 such practices in Avon, which compares with the 23 practices said to be eligible for budgets (Avon Family Practitioner Committee administrator, personal communication). To determine whether the views of partners within large practices differed significantly from those in smaller practices we compared the answers given by doctors within both types of practices. Overall, 105 replies were from doctors working in practices of six or more partners. There were two significant differences between these two subsamples. Of those in potentially budget holding practices, 11% believed that the provisions of the white paper, if implemented in full, would result in increased personal income for the general practitioner compared with 6% in smaller practices (χ^2 7·31, df=2, $p<0·05$). The other finding indicated that 58% of doctors in larger practices had asked for level 2 or 3 PACT prescribing information compared with 44% of their colleagues in smaller practices (χ^2 7·04, df=2, $p<0·05$).

Discussion

Any regional study of general practitioners' views can be criticised on the grounds that the general practitioners within that region are not a representative sample. The general practitioners within Avon can be compared with others by examining their performance as monitored by the family practitioner committee. Avon Family Practitioner Committee has good performance indicators for vaccination and immunisation rates, cervical cytology screening, and provision of contraceptive care compared with other large non-metropolitan family practitioner committees.[5] The practices within Avon may therefore be expected to conform to the government's preferred practices rather more than those performing less well. In fact, almost 79% of the doctors were in favour of the proposals for medical audit, which implies that the Secretary of State for Health is not correct to suggest the adverse reaction to the white paper is because "the BMA... have never been in favour of any change of any kind."[6]

The white paper is described by the Prime Minister as "the most far-reaching reform of the NHS in its forty year history."[1] We have found that more than three quarters of general practitioners object to the idea of fixed budgets for specified surgical operations, prescribing, and diagnostic procedures and to increasing the proportion of a general practitioner's income that comes from capitation fees and reducing the importance of basic practice allowances. Of the general practitioners, 87% opposed the idea of using budgetary savings to increase their personal income, which may result from being able to plough back budgetary savings into a practice. It seems unlikely therefore that the general practitioners' reactions to the proposals are because they are "feeling nervously for their wallets."[7] The concerns reflected in most replies were principally that the proposals were not likely to improve doctor-patient relationships, provide greater equality of patient care or shorter waiting lists, or result in a more cost effective NHS (see table II).

The applications of information technology are steadily increasing within the NHS. About 40% of the general practitioners had at least one computer within

their practice. Most general practitioners did not believe that monitoring of referrals or allocation of appropriate budgets would be possible by April 1991. This scepticism is shared by others. The public accounts committee said, "Resource Management Initiative may not be operational for a number of years."[8] The editors of a health service computing journal said, "Can Mr Clarke seriously expect information technology to be the engine room of NHS change when its performance to date is so demonstrably patchy?"[9] and the Secretary of State for Health is quoted as saying that "We haven't a clue" when asked about management costs.[8] One widely held view is, "Why does it need so many changes to bring about a free flow of information, rational use of resources, and a better deal for patients and staff? Wouldn't it be cheaper to modify what is already there?"[10]

The government's approach seems to centre on the hope that general practitioners, as a collection of small businesses, will be encouraged to develop entrepreneurial skills and that these will overcome the conservatism and reservations about the possible reduction in the quality of the doctor-patient relationship and of patient care. Our study indicates that doctors within large practices hold a similar range of views on these issues to those in smaller practices. At present, they are not persuaded that the white paper proposals for general practice are workable, are good for patients, or will improve the cost effectiveness of the NHS. Even in larger practices, the few who believe that they are likely to improve their personal incomes are unlikely to be able to persuade their colleagues to succumb to the governments' financial incentives.

We thank the general practitioners for their prompt and willing responses to our questionnaire and members of our department for their considerable help in distributing the questionnaire, processing the data, and constructive criticism.

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