BMJ
1840-1990

LONDON, SATURDAY 31 MARCH 1990

Screening and the 1990 contract

Accurate believable information should put pressure on the politicians

One of the intentions of the 1990 contract for general practitioners was to give prevention of illness and health promotion greater emphasis. The proposed approach was that doctors should seek out potential problems in their patients before they were translated into real ones. Naturally enough, politicians and commentators were agreed about the desirability of "improving the health of the population" or "delivering care in a cost effective manner." The difficulties arose when the politicians and the medical profession attempted to reach agreement about the best way to go about achieving these objectives.

The misgivings of the profession that surfaced during the negotiations have largely been overridden by the decision of Mr Kenneth Clarke to impose the new contract on general practitioners. Time will tell whether the government should have taken a little more notice of those who actually provide the service. Perhaps it is my inherent optimism that leads me to believe that before too long politicians will abandon confrontation and support the profession when—inevitably—it seeks to modify and revise the newly imposed terms of service.

Despite the present upheavals, however, British general practice has retained two vital features. The list of registered patients is to remain—although at the margins it may be less stable because of the facility to change doctors more easily. Secondly, the general practitioner is to continue to be the doctor of first contact and the gateway to specialist care.

One of the prime features of the new contract is screening, and this week the *BMJ* begins publication of a series of articles on this topic with a review by Dr J Chisholm of the background of the contract and its content (p 853). With a stable list of patients and an accessible family doctor opportunistic and systematic screening should become complementary. Problems tend to arise when population screening is not based in—or fully integrated with—general practice. Patients may fail to respond to requests from unknown agencies, but personal invitations from the patient's own general practitioner are generally more favourably received. Inappropriate requests for screening procedures may be kept at a minimum if the person in charge of treatment is also responsible for the invitation. The communication of positive findings and, indeed, their interpretation are more likely to be undertaken sensitively by a doctor whom the patient already knows and trusts.

Paediatric surveillance should also find its proper place as an integral part of general practice. The unrealistic standards set for accreditation for the child health surveillance list, and a derisory payment for the service, may discourage some general practitioners from taking on this important extra new work. But the arguments for ensuring that the same doctor who screens the children is also responsible for treating them are self evident. Any risk of conflicting advice being given is minimised, parents are less inconvenienced, and records of treatment and development are not fragmented.

It is true that the district health authority has a statutory responsibility for ensuring that surveillance is provided and for maintaining the child health record and also that cooperation between district health authorities and general practitioners is vital to the success of surveillance. But there must be a commitment from the district health authority to ensure adequate health visitor and administrative support and from general practitioners to comply with the locally determined programme of the health authority.

In the new "purchaser-provider" trading environment envisaged by the white paper *Working for Patients* district health authorities will have to purchase health services for their resident populations. They will not wish to purchase a service that is being provided out of someone else's budget, and they will identify and eliminate areas of duplication.

Family planning services, for the most part a general practitioner activity, are an obvious candidate for examination. Paediatric surveillance, and indeed minor surgery, may be further examples of services that district health authorities may not wish to purchase.

The new contract offers payment to general practitioners who organise clinics for the management of a range of chronic diseases or health problems. Diabetes, hypertension, hyperlipoproteinaemia, asthma, and joint problems as well as antismoking, alcoholism, and stress counselling are but a few that might find favour with the authorising Family Health Services Authority. District health authorities will take a keen interest in these general practitioner clinics and will surely wish to consider the wisdom of purchasing from hospital providers expensive outpatient facilities for what are essentially general practitioner services. Inevitably there will be an increasing diversion of work into general practice.

Will general practice survive in the market economy? Modern drugs have allowed ambulant patients to be treated at home and led to the closure of hospital beds. These trends have been further fuelled by managerial drives for efficiency savings. The disincentive of long waiting lists for outpatient appointments and routine surgery have sent to the private

sector those who can afford it and reduced the expectations of those who cannot. General practitioners will continue to be advocates on behalf of their patients, but they will also be expected to shop around for more distant hospitals with shorter waiting times so that the expectations of the poor can be raised to those of the better off.

General practice is faced with an increasing role in screening not only for specific diseases but also in the contractually required examinations of the "unseen healthy"—yet it must continue to carry the burden of providing traditional medical services but in a more demanding and custom orientated market: something must happen. Will it cope with the change by increasing its efficiency and its numbers or will its standards start to fall as the workload increases? The relative priorities of screening programmes and therapeutic services are always difficult to balance but are also made so when doctors and their political managers are ignorant of, or simply ignore, each other's objectives. The resolution of ignorance is through better understanding. The key to better understanding is good quality information, reliably and simply presented.

We have now entered an era where it is not difficult to gather information and analyse it at a standard that is universally accepted and believed. Dealing with these new data will require an openness not only of clinical decision making (in which the cost implications of those decisions are a crucial factor) but also from the government. If some services are not to be provided within the NHS then the politicians must be honest enough to say so and declare their reasons, even if they are simply those of cost.

How far are we away from the goal of "information accuracy" that will allow the reasonable on both sides of the negotiating table to prevail over the intransigence of the dogmatists? At a guess—10 years.

But the foundations are being put in place. The gross inaccuracies of family practitioner committee registers will soon be challenged by those general practitioners with practice based information that is more up to date—and with the added imperative that their income will depend on successful challenges. The NHS number is to become the "unique patient identifier," and the computerisation of the NHS Central Register and all family practitioner committee records should eliminate many of the inaccuracies. Each general practitioner will be uniquely identified through his Prescription Pricing Authority number (which is stamped on the bottom of the prescription pad). Each district health authority will also have a unique number, and ultimately each contract that a district health authority agrees to place with a hospital provider will be tagged, costed, and related to an episode of health care.

It may be that the intention of the government is to put a downward pressure on indicative budgets through better "PACT" (prescribing analysis and cost) information and that its idea of general practitioner budget holders is one of cost containment, but I believe that on the other side of the information equation there will be new opportunities to show gaps in health care provision and to identify the resource deficiencies that are often responsible for those gaps.

The screening revolution that has been impelled by the government's white papers and underpinned by its commitment to better information systems may ultimately become its bête noir. The better the quality of the information the less easy it will be for politicians to get away with failing to provide adequate resources. Unsubstantiated arguments about "the wasteful inefficiency of health authorities" or "the idleness of general practitioners" will not be possible in a brave new world—where all information about the NHS is accurate, believable, timely, and uncensored.

SIMON JENKINS

General Practitioner,
Minden Medical Centre,
Bury BL9 0QG

Venous ulcers

General practitioners should organise the care of these

Long after we have found a way of preventing deep vein thrombosis, probably the most common cause of ulceration of the legs, venous ulcers will still be giving rise to much disability, especially in the elderly. This is not because the actual ulceration is untreatable but because even when it is healed the underlying condition—a failure of the venous drainage with consequent serious pathological changes in the skin and underlying tissues—remains.[1] As this defect in venous drainage cannot be reversed continuing episodes of ulceration are inevitable.

Because the clinical picture starts to emerge long before any actual ulceration appears general practitioners are best placed to manage the care of patients with impaired venous drainage. They should recognise the condition in the earliest stages, when oedema, lipodermatosclerosis, and staining indicate serious deficiencies in the venous system.[2] At this stage the treatment needed is mobilisation—that is, the reinforcement of the calf muscle pump by active ankle movement—combined with adequate elastic support; at the very least this regimen should slow the development of damaging skin changes.

When the stage of ulceration is reached the primary treatment is some form of compression bandaging. Because it is the failure of the venous drainage that has caused the changes leading to skin breakdown this failure has to be dealt with. It is not sufficient to apply dressings, which provide only an environment that does not damage the ulcer surface, without an associated compression bandage to control the venous failure.

To advise that the patient should rest in bed with the legs raised may be tempting for the doctor—but rest has to be prolonged to have any real effect and this is rarely possible outside hospital.[3] Experience shows that ulcers in more mobile patients heal more quickly. Once the ulcers have healed physical activity remains just as important, supplemented by suitable elastic stockings worn indefinitely during the day.[4,5] Attention should also be paid to psychological factors. Some patients use their condition to manipulate relatives and neighbours—and even nursing staff—in the classic attention seeking manner, but others all too easily sink into an apathetic, hopeless state. Nevertheless, most venous ulcers can and should be treated within the community. The techniques of care are not difficult, and most district nurses are now trained in their use.