General practices and the new contract. II—Future directions

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In my previous articles I described how a budget holding practice and five contrasting practices (box) were coping with the introduction of the new general practitioner contract.^{1,2} During 1990 and the early part of 1991 the partners' thoughts about the future were still hampered by a continuing distaste for the way in which new regulations had been introduced and illustrated by a widely held view that "general practitioners have been collectively insulted by the imposition of a contract which left little room for manoeuvre." At the beginning of 1991 it was still hard to discover to what extent most of the partners could consider "a better tomorrow" for general practice. However, it was not all doom and gloom: one of the younger partners expressed the view: "When the white paper came out in 1989 I thought it would push general practice in the right direction, with peer review of prescribing and referrals being a good thing." The general practitioners and their staff understood the need for review of the health service, but as providers of medical care they thought that "too many things have been turned around too quickly without an opportunity to plan properly."

The six practices all had unique characteristics in terms of environment, size of practice, partners' personalities, level of support staff, and driving forces behind the aims of the partnerships and practice teams. Despite these obvious differences several common themes emerged in the practices' strategies for coping and their future plans relating to workload, rewards, personal care versus population care, and professional management and audit.

WORKLOAD

An increase in workload was mentioned by all the partners as a major concern during the past year. "It is more of a treadmill, and to hit the jackpot we will have to do even more work." General practice is a task oriented culture, and with increasing activities there was little doubt that available time was even shorter. The comment "we are all much more stressed than before" is a reminder that the demands of general practice were considerable even before introduction of the new contract.

In the larger practices previous arrangements for patient care had been based on longstanding methods of working. Many of the doctors had been blown off course, with additional time and energy having to be found to cope with increased administration. Developing new systems of patient care to maintain income required alterations to previous routines, which had resulted in an extremely stressful period for all concerned. In Gorbals Health Centre the turmoil created by a reduction in the number of partners allied to the need to reregister 7500 patients in a deprived area could be described only as an administrative nightmare. Working from two large centres, the Green practice in Hythe was trying to pull together a mass of information about 13 000 patients while carrying on

The six practices

Killin, Perthshire (two partners)
Ker practice, Gorbals Health Centre, Glasgow (six partners)
Highfield practice, Southampton (single partner)
Green practice, Hythe Medical Centre, Hampshire (seven partners)
Calverton practice, Nottinghamshire (five partners)
Thornaby, Teesside (six partners)

with the normal routine of day to day surgeries and home visits.

These problems of workload and use of time were more noticeable in larger practices, where practice organisation was more complex. "I knew it would be difficult," was the comment of one senior partner, "but I hope that reason will prevail with a slowing down of the speed of change which is all around." The singlehanded practitioner in Southampton was not in favour of many of the changes within the contract, but his day to day work went on much as before. For one of the partners in Killin: "The quantification of surgery hours and patients seen is only a partial measurement—there is more to general practice than merely collecting statistics."

Obtaining accurate statistics about doctor-patient contacts was impossible in all the practices because most of their time and energy had been spent on reorganising methods of working and developing new services. Practice computers were used primarily as age-sex registers, for repeat prescribing, and for recording information about individual patients. Pooling information on doctor-patient consultations, home visiting, and use of hospital services was only beginning so that estimates of current workload and predictions for the future were not yet clear.

One striking problem in quantifying workload was the lack of agreement between practices and health authorities about list sizes. While the denominator of patient care remains unclear making reasonably accurate estimates of workload will be difficult. Introducing health promotion clinics and shared care with nurses poses a need to devise a "utilisation rate" which reflects the overall level of patient services being provided.

REWARDS

Although fears and uncertainty about levels of payment to maintain personal income and invest in practice development were ever present, money was not considered to be the main reward. Rewards came from a sense of clinical freedom, and in the Calverton practice "the decision about budget holding was not just about money but giving us control over our own destiny." In the Ker practice in Glasgow the new contract had led to occasions of feeling out of control,

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BMJ 1991;302:1247-9

and, for one partner, the situation had reached the stage that "after 23 years in practice I now feel very insecure." With the increase in filling in forms partners were concerned that "there are so many things going through our minds that we are not listening to patients."

Where practices had created a range of clinics for patient care this had contributed to increased practice income. The income gained was welcomed but the methods of achieving financial rewards were still being seriously questioned. Targets for immunisation and cervical cytology were seen as punitive, although at least one practice had seen them as a means of "pulling our socks up." The provision of deprivation payments for half of the patient population registered with the Ker practice in Gorbals Health Centre was a major step forward in recognising the unique characteristics of the practice, but this type of reward was offset by the complexities of claiming payments.

Budget holding as a means of controlling resources and maximising income generated mixed feelings. Of the larger practices qualifying for budget holding, only Calverton had decided "to take the plunge with the first wave." Some resentment existed within the remaining practices about the potential financial advantages of budget holding for them, but the risks seemed to be too high. One of the Hythe partners reflected his colleagues' doubts by stating: "We should be an ideal practice for budget holding, but we are not yet ready to trust the proposals—once dedicated to budget holding can we pull out?"

Compared with the views of the partners, those of support staff provided distinct contrasts about professional rewards. Practice nurses were thriving in new activities and extended responsibilities, which were bringing greater job satisfaction. In well person clinics and clinics for patients with chronic conditions they now had greater control of segments of primary care which had previously been the domain of doctors. "I now have an identity and can take decisions about continuing care" was how one of the practice nurses summed it up.

Where practice managers were well established they were taking charge of information systems and personnel management: "We are gaining new skills and setting up support groups which are leading to further education and qualifications." The professionalisation of "ancillary staff" was all around: "We have a lot to offer and can improve the organisation of general practice." This need to consider the practice as a whole brought into focus one of the continuing dilemmas of general practice—that is, the balance between personal care and population care.

PERSONAL CARE VERSUS POPULATION CARE

The apparent regimentation of a contract which "would be putting work and patients into boxes" was seen by the partners as an erosion of personal care.

"I will continue to enjoy clinical problem solving in my day to day care of patients"—Singlehanded practitioner, Highfield, Southampton

With personal care, job satisfaction was derived from clinical problem solving and "there is little evidence that well person checks and routine examinations of new patients will lead to improved outcomes for patients." In both large and small practices this switch in emphasis was seen as a threat to one to one personal care with "the fear that the move towards clinics will mean less time to listen to the patients." Despite these doubts the partners in larger practices were beginning to accept the need to focus attention on specific groups of patients, the main difficulty was deciding on priorities when conflicting views existed within a partnership; those in smaller or isolated practices were seriously concerned about lack of acknowledgment for being continuously available and accessible.

The balance between personal care and population care was at the heart of many of the problems relating to the future direction of the six practices. Although general practice has claimed to provide care for defined populations, an epidemiological approach was not overwhelmingly endorsed. General practitioners cherish their independence, and many have entered practice to escape the shackles of the more rigid boundaries of the hospital service. Most partners in the six practices genuinely feared that "general practice could end up mimicking the more impersonal aspects of hospital care." The aim of the Calverton practice, which had opted for budget holding, was to regain its sense of direction by identifying aspects of its practice which could be improved by controlling finance for items such as referrals to hospital and laboratory investigations. By this means "population care will have to become a more central part of our planning for the future." The expected benefits of budget holding included the prospect of investing income to develop services related to local needs, but uncertainty still existed about the future balance of clinical activities in the practice.

The strength of general practice lies in the privileged loneliness of the consulting room. In daily practice a general practitioner is going from the population to the family, to the individual, and focusing on the primacy of the person. The partners accepted that the new contract has forced general practice to think more about the population based approach, "but juggling with priorities was proving to be very demanding." Large practices will, unavoidably, have a range of professional staff and groups of patients with specific clinical problems which may benefit from more structured arrangements for continuity of care. The means whereby changes in practice organisation might be achieved were leading to a reappraisal of well established working arrangements. In the larger practices the ability to adopt principles of good management in deciding future priorities was going to have an important influence on their future direction.

PROFESSIONAL MANAGEMENT AND AUDIT

Management is often seen as a "top down exercise," driven by line diagrams and chains of command. Regrettably, it is an image that it is true for many large organisations, and "decision making by health service managers still seems remote from those charged with responsibility for carrying out tasks at the front line." The six practices observed were tussling with the principles of good management, where shared values about providing patient care can generate the energy that permeates a practice and gives coherence to diverse activities. In the words of a newly appointed practice manager: "I have to help the doctors understand that professional management is about expanding the creative capacity of the practice and not about number crunching." Partners and support staff were getting together to overcome common problems, and during my visit to Gorbals Health Centre an extended

Gorbals Health Centre, Glasgow, where professional management decisions seem to the partners far removed from daily practice

lunchtime meeting at the Ker practice, which was attended by all the staff, was testimony to this desire for teamwork. The decision to opt for budget holding in Calverton had led to a definition of the core purpose for which the practice exists and the main aims for its future success.

A key issue in managing the larger practices was the need to give continual attention to building the team. This is no easy task when past arrangements for patient care have been largely driven by doctors, with support staff seldom brought into early discussions about finance and practice organisation. In the words of one practice manager: "There has never been a greater need for mastering team learning in general practice than there is today." The main problems were the time and effort required to meet and discuss priorities when the overall staff complement might include up to 40 people. Ensuring a healthy supportive environment for all health care providers was going to be crucial before thinking of ideas for increasing services and conducting audit.

Audit is one of the "buzz words" of the 1990s, and there was a desire within all six practices to develop performance review from within. For one practice "current requirements for practice reports and information gathering for the FHSA are largely data collection exercises and little to do with quality of care." The rather subdued reaction to audit was probably owing to lack of clear objectives of gathering information, but this reaction was offset by the desire to create practice reports, which would highlight positive attributes and would incorporate a range of input from support staff. By this means a sense of common purpose was emerging and "was vital in raising morale."

One of the partners in Calverton summed up the view, saying that "ownership of a process of review is crucial to successful assessment of performance," but it was still too early for most of the practices to have worked out their own priorities in medical audit. However, the first steps were being taken. Ideas about defining prescribing policies and measuring the impact of new services were but two relevant examples of topics which were being developed for audit in three of the practices. Getting together and getting agreement are the starting points before navigating a common

pathway, and in this respect the six practices were all adjusting to the need for "management from within."

Conclusions

A day in the life of a practice is only a snapshot, and a focus within the practice was often hard to find. Currently, the six practices are caught between adding to existing services to maintain income at the level expected and coping with an administrative upheaval which had destabilised the larger practices. One of the problems for the partners had been that they had no index of how well they were doing and whether their strenuous efforts to adjust were being recognised. Their devotion to personal care conflicted with the financial and contractual pressures to adapt to the new contract. The investment of time and economic resources to achieve goals about which there was profound scepticism had produced widespread disappointment with the changes. In contrast, practice managers and practice nurses had new and attractive goals.

Despite financial incentives the partners were doubtful about the emphasis on "well person medicine." Here again there were contrasting reactions from support staff, who were showing more enthusiasm for this approach. The growing professionalism of allied primary care staff will demand a stronger sense of partnership within the primary care team when deciding practice policies. Merely delegating tasks will not be enough, and in large practices the discipline of team learning, like any discipline, will require practice.

The practices were attempting to adapt to two of the beliefs about modern technology in general practice: firstly, that computerised information systems save on paperwork, when in fact they create paperwork and, secondly, that computer generated data makes decision making easier, when in fact most clinical decisions in primary care may be taken without access to large data systems. Computers cannot be avoided, and when large quantities of information have to be processed they have obvious advantages. Prescribing analysis and cost (PACT) data is a good example of this. However, the price of collecting statistics without adequate previous thought being given to gathering essential and non-essential data may be high.

Recently Roberts described the current state of general practice as "feeling fine and getting better."³ From my observations this statement would have gained little support among the partners in the six practices I visited. They and their staff are still at the stage of adapting to radical reforms in the NHS and learning how to restructure models of practice for the 1990s. Maintaining energy to cope with the demands of general practice will be the most important requirement in their efforts to optimise the delivery of primary medical care and to achieve appropriate rewards for the daily tasks of clinical practice.

Reporting on the experiences in the six practices would not have been possible without the cooperation of their general practitioners and staff, and I thank everyone who set aside time to express their views and give information about their activities.

1 Bain J. Budget holding: a step into the unknown. *BMJ* 1991;302:771-3.

2 Bain J. Five practices and the new general practitioner contract. I. Reactions and impact. *BMJ* 1991;302:1183-6.

3 Roberts J. General practice: feeling fine, getting better. *BMJ* 1991;302:97-100.