General practices and the new contract. I—Reactions and impact

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The white paper *Working for Patients* stated two objectives: to give patients, wherever they live in the United Kingdom, better health care and greater choice of the services available and greater satisfaction and rewards for those working in the NHS who successfully respond to local needs and preferences.[1] It heralded the introduction of a new contract for general practitioners encompassed in the statement of fees and allowances payable to general medical practitioners from 1 April 1990. Central to the contract was a shift in the methods of payment for services, with the intention of raising average remuneration accounted for by capitation fees from 46% to at least 60%. Within the white paper was the theme of health promotion, targeted incentive schemes for childhood immunisation and cervical cytology being two specific examples. Payment would be received for regular health surveillance for children aged under 5 years and patients aged over 75, with financial rewards for health checks for newly registered patients, at risk groups, and patients with chronic conditions. Practices would provide an annual report, prescribing costs would be scrutinised, and larger practices would be free to apply for their own NHS budgets for a defined range of hospital services. Medical audit was to be introduced as a means of providing information about services and of improving the effectiveness of primary care.

The new general practitioner contract for general medical services within the NHS was introduced on 1 April 1990. Between December 1990 and January 1991 I visited six practices throughout the United Kingdom, spending a day meeting the general practitioners and support staff, to discuss the opportunities presented and problems faced within the reorganisation of general medical services. Various practices had been approached, but identifying a truly random sample would have been impossible; the six practices were chosen to represent contrasting settings and type of practice. All were prepared to provide information about practice organisation and clinical care.

A previous article described the experiences of the Calverton practice in Nottinghamshire, which had decided to opt for budget holding.[2] The remaining five practices were in Killin, Perthshire; Gorbals Health Centre, Glasgow; Highfield, Southampton; Hythe, Hampshire; and Thornaby, Teesside, Cleveland.

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TABLE I—*Staffing and organisation in five practices visited between December 1990 and January 1991*

	Killin, Perthshire	Ker practice, Gorbals, Glasgow	Highfield practice, Southampton	Green practice Hythe, Hampshire	Thornaby, Teesside
List size	1370	11 855	2230	13 249	13 372
Partners	2	6	1	7	6
Age range (years)	35, 34	53-31	59	57-32	55-31
Premises	Attached to doctor's house	Health centre and branch surgery	Attached to doctor's house	Two medical centres	Health centre and small branch surgery
Total employed staff (full and part time)	4	13	1	31	13
Practice manager		1		1	1
Receptionists/clerical	3	11	1	21	10
Practice nurse		1		9	2
Other	1				
Attached staff:					
Health visitors	3 Triple duty nurses	4	1	3	2
District nurses		4	1½ (shared)	2	3
Midwives		1	—	From local hospital	1
Other		1	1	1	2
Use of A4 folders	Yes	Yes	No	Yes	Yes
Computer assisted records:					
In operation	No	Yes	No	Yes	Yes
Planned	Yes		No		
Training practice	No	Yes	No	Yes	No

Living with the new contract

Table I gives details of staffing and organisation in the five practices and table II the information available about medical care. Although four practices had computer assisted records, accurate details of workload, consultation rates, and use of hospital services were not yet uniformly available. The methods of collecting information varied among practices, and present estimates were insufficiently reliable to allow exact comparisons between practices.

KILLIN, PERTHSHIRE

The village of Killin, in the midst of spectacular highland scenery, is the focal point of a two man dispensing practice with an established list size of around 1370 patients; the presence of temporary residents during the summer holiday season provides a notional list of just over 3000 patients.

The partners in this practice could see few opportunities for them within the new contract. Looking after a widely scattered highland community requires methods of working which bear little relation to the more regimented approach of the new regulations. Considerable time is spent travelling to visit patients, and the ratio of surgery consultations to home visits is 2:1. The actual consultation rate is difficult to calculate when a substantial proportion of patients are temporary residents. Mere statistics about workload cannot indicate the nature of a general practitioner's work in the highlands, when a house call for earache in a child may entail a round trip of 48 km (30 miles). Immunisation targets are met by having good personal contact with parents and health visitors, and it was too early to judge the extent to which higher targets for cervical cytology would be achieved.

The partners accepted that structured care was worth while, but this was not seen as synonymous with running clinics. Financial survival and investment for improved premises may result in some moves towards "clinics," but "the only reason we would run a clinic would be to make money, not to improve the service we offer or to improve outcome for patients." Collecting information about the practice was leading to considerable increases in personal time spent on administrative tasks. Practice income was expected to remain at the current level, but increased expenses on computer assisted records, telephone calls, correspondence, and photocopying were seen as an unfair financial burden. The imposed regulations and administrative tasks were considered punitive, and both partners were con-

cerned about the lack of recognition for just "being there when patients need care." For both partners the measurement of surgery hours and workload did not take into account the responsibility of 24 hour cover 365 days a year.

Throughout my visit the theme of personal and continuing care was ever present. On the weekend before my visit a snowstorm had hit the area, and one partner had spent three hours on the management of a shepherd's wife with acute asthma. "This type of care cannot be measured on a computer," he said, and peer review would only be welcome "provided it is by someone with credibility and who works in a similar environment."

Reaction to contract and impact on practice

- Few incentives which relate to area of the practice
- Health promotion clinics are not a viable option in a widely scattered community
- Fear that personal care is not acknowledged within the new methods of payment
- To date increased expenditure on administration has not been matched by any apparent increase in income.

KER PRACTICE, GORBALS HEALTH CENTRE

To the south of the River Clyde in Glasgow is an area where old tenement blocks were demolished in the 1960s and replaced by multistorey flats. All around are signs of urban blight and decay with modern highways side by side with cobbled streets and lanes. Gorbals Health Centre was opened in 1975 and now has seven practices serving a population of about 30 000 patients. The Ker practice operates from the health centre and from converted premises at the Croftfoot surgery almost 5 km (three miles) away. About two thirds of patients reside in four wards in the neighbourhood of the health centre, but the catchment area of the practice extends into another 10 wards in Glasgow. The estimated list size is 11 855, served by six partners and a trainee assistant.

The announcement of changes in NHS organisation heralded a major upheaval in the partnership, which had previously encompassed 10 doctors. Four partners retired for various reasons, but they were largely unwilling to continue in the practice in "the new radically reformed NHS." The six remaining partners had been faced with the task of reregistering 7500 patients, many of whom lived in deprived areas in the south side of the city. The partners were muted in their responses about available opportunities within the new contract. More senior members found little satisfaction within the new methods of working. "We were busy before, but workload and administration have increased and it is extremely stressful."

There were mixed views about health promotion clinics and regular checks for people "whose concerns are about housing and unemployment and don't reply to formal requests to attend for routine checks." Of the practice's patients, 3903 qualified under the deprivation payment scheme, and this was acknowledged as "an essential reward for our type of practice." Achieving a target of around 60% uptake for cervical cytology had been a major achievement, but it was doubtful if the expected target of 80% could be achieved. The commitment of the health visitors had always been a feature of the practice, and this was reflected in the higher targets for immunisation achieved.

Collecting data on the computer and introducing new aspects to old routines were seen by the practice manager and her staff as important elements of patient care. The practice nurse commented that she could "now see more clearly what my role in the practice is." Regular visits to elderly patients and plans for regular follow up of patients with hypertension and asthma were seen by her as methods of ensuring optimum care for patients with chronic conditions.

The practice was still adapting to a barrage of changes, which had led to times of low morale. It was still difficult for most of the partners to get a true picture of how the new contract could enhance the care of patients. To offset this, there was an air of enthusiasm among the support staff, who were grasping opportunities to strengthen their professional roles.

Reaction to contract and impact on practice

- With four partners departing in 1989-90 the six remaining partners were faced with increased workload
- Administrative upheaval related to reregistering 7500 patients
- Area of high deprivation; little response from patients requested to attend for regular health checks
- Developing teamwork in midst of high workload.

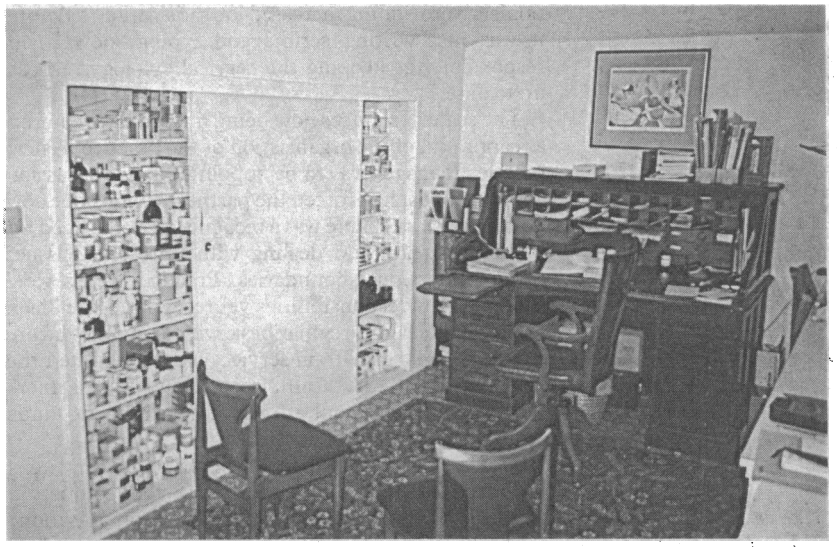
HIGHFIELD, SOUTHAMPTON

There has been a singlehanded practice at 2 Highfield Crescent, Southampton, since 1924, and the current doctor has been the sole practitioner since 1965. The practice premises are incorporated within his house and comprise a small reception and waiting area and one consulting room with an adjoining examination room. The practice area is predominantly suburban with a small pocket of inner city housing. The list size in January 1990 was 2230, with 15% of patients being aged 75 years and over. There is one full time receptionist-secretary but no other employed staff. The records are based on "Lloyd George envelopes," there is no computer, and there are no plans to install one in the immediate future. The practitioner has been a trainer, is a former course organiser in the local vocational training scheme, and continues to take part in undergraduate medical education. For him the new contract of 1990 made no significant differences to the way he operated. Surgery hours remained as before, but his one receptionist was now working overtime at 50 hours per week compared with 38 hours per week previously. This was largely due to the increase in paperwork related to form filling and correspondence with the family health services authority.

He continued to hold regular antenatal, postnatal,

TABLE II—*Medical services in five practices visited between December 1990 and January 1991*

	Killin, Perthshire	Ker practice, Gorbals, Glasgow	Highfield practice, Southampton	Green practice Hythe, Hampshire	Thornaby, Teesside
List size	1370 (+3000 temporary residents)	11 855	2230	13 249	13 372
No (%) of children aged <5 years	82 (6)	759 (6·4)	60 (2·7)	941 (7·1)	1217 (9·1)
No (%) of patients aged >75 years	109 (8)	628 (5·3)	330 (14·8)	305 (2·3)	508 (3·8)
Clinics:					
Immunisation	Within surgery consultations	Yes	Yes	Yes	Yes
Child welfare or child surveillance	Within surgery consultations	Yes	Yes	Yes	Yes
Antenatal and postnatal care	Within surgery consultations	Yes	Yes	Within surgery consultations	Yes
Family planning	Within surgery consultations	Yes	Opportunistic	Opportunistic	Opportunistic
Well woman	No	Opportunistic	No	Opportunistic	Yes
Well person	No	Yes	No	Opportunistic	Yes
Asthma	Opportunistic	Opportunistic	Opportunistic	Opportunistic	Yes
Cardiovascular	Opportunistic	Opportunistic	Opportunistic	Opportunistic	Yes
Diabetic	Opportunistic	Opportunistic	Opportunistic	Opportunistic	Yes
Minor surgery	Opportunistic	Opportunistic	Opportunistic	Opportunistic	Yes
Other	None	None	None	None	Yes
Target levels:					
Immunisation (children)	>90%	>90%	>90%	>90%	>90%
Cervical cytology	>50%	>50%	>80%	>80%	>80%



The surgery, Killin, Perthshire

and immunisation clinics, but for family planning, minor surgery, and continuing care of chronic illness his approach was opportunistic. He had not introduced any well person clinics because, "they are 95% phoney and 5% justified." "The clinics bandwagon may be a good thing for large practices," but he saw no reason to interfere with a routine that he had created based on the needs of his practice population. With a fairly stable group of patients and a large proportion of elderly people he had a deep knowledge and understanding of the medical conditions "within his patch."

He had never employed a practice nurse and had no plans to do so as he had good contact with health visitors and district nurses. He carried out the immunisations and the examinations for cervical cytology and had faced no specific problems in reaching the higher targets. His prescribing costs were above the local average, but with a large proportion of elderly patients he could not identify any specific areas where he could make substantial reductions in costs.

He had always regularly attended local postgraduate meetings but now saw many new faces. "I doubt if this lunchtime stamp collecting exercise is about education." "Assembly line medicine" and "assembly line education" were certainly not for him. He had vivid memories of the Charter for General Practice in the mid-1960s and believed that its opportunities were underexploited even at the end of the 1980s. At the age of 59 his job satisfaction remained high as he spent his working day concentrating on clinical problem solving among patients whom he had come to know extremely well.

Reaction to contract and impact on practice

- Health promotion clinics are unlikely to improve overall health of patients
- The new contract does not allow for proper balance between personal care and population based care
- Doubts about dividing the postgraduate education allowance into three subject areas which inevitably overlap
- Indicative drug budgets will have to allow for determinants of individual general practitioner's prescribing.

GREEN PRACTICE, HYTHE, HAMPSHIRE

The town of Hythe (population 20 000) is at the head of Southampton Water opposite the ocean terminals and docks and in the shadow of the Esso oil refinery and Fawley power station, the main employers in the area. Hythe Medical Centre, sited in the grounds of Hythe General Practitioner Memorial Hospital, was opened in 1965 and is now owned by Southampton District Health Authority. There are now four practices (Red, Green, Blue, and Black) and a singlehanded doctor practising from the centre, which serves 42 000 patients. The Green practice has a combined list of 13 249 and operates from two centres: Hythe Medical Centre (7184 patients) and Blackfield Medical Centre (6065 patients), which is 6 km (3½ miles) south of Hythe. There are seven partners and, at the time of my visit, two trainees.

"Working harder, more paperwork, higher costs, and no apparent increase in income" summed up the overall reactions of the partners after eight months of the new regulations. One partner said, "The last year has been awful and I'm completely exhausted." This feeling was echoed by all the partners, one of whom had seriously considered an alternative career. At a recent trainers' conference "two out of the eight GPs in my group had looked for work outside medicine." Younger partners were less stressed and had ideas for developing services, but the two trainees had both been alarmed by their introduction to general practice with "an overwhelming impression that every practice meeting was about administration and money—nothing about medicine at all."

There was little support within the group for the principle of health promotion clinics other than for patients with established disease. Although regular health checks were viewed as of unproved value, this method of care was seen as unavoidable because of the new methods of payment.

The practice nurses and health visitors were extremely busy on the day of my visit and were unable to give me more than a few minutes of their time, but their comments and those of the receptionist and clerical staff confirmed the impression of harassed doctors and support staff. "The doctors do try to delegate work, but we cannot fill out all the forms—frankly, I don't know how they can keep it up." Immunisations and cervical cytology targets had been reached and review of prescribing analysis and cost (PACT) data had led to shared policies on care of asthmatic patients and use of non-steroidal anti-inflammatory drugs.

Despite the willingness of the staff to be involved in medical audit the destabilising influence of the contract had left little protected time for medically related activities outside the practice and effective contributions to medical education. The main wish of the group was to retain a dedication to patient care, and plans were in hand for appointing a business manager to lighten the partners' administrative load. Within the practice no one was willing to accept the Minister of Health's statement in 1989 that "good practices had nothing to fear from the new contract."

Reaction to contract and impact on practice

- Increased workload leading to stress among general practitioners and support staff
- Management of large practice working from two sites
- Erosion of protected time for undergraduate and postgraduate education
- Desire to develop internal audit as opposed to external audit.

THORNABY, TEESSIDE, CLEVELAND

Thornaby is a predominantly working class area of Teesside, where traditional industries faced major problems in the 1980s. It has been an area of high unemployment, but the industrial landscape shows signs of new industry moving into the area. The Thornaby Health Centre, sited on the outskirts of a large shopping mall, is over 20 years old and houses two practices and community health services including dentistry, chiropody, and family planning. One prac-

Thornaby Health Centre, Teesside, Cleveland

tice is based in the health centre with a small branch surgery in Ingleby Barwick, a green field development of exclusively private housing. There is a combined list of 14 053 patients and six partners, who have been together since 1988. The five whom I met were all in their 30s. In their view the new contract had diverted the practice from maximising the advantages of the old contract. There was considerable dissatisfaction among them and their support staff about the need for routine examination of new patients and routine health checks. "Patients don't like it either and find that registering with a doctor is about filling in lots of forms."

Despite these expressions of disquiet the practice income had increased during the past year, largely due to the previous existence of a range of clinics which now qualified for payment. The stimulus of targets had led to an increase in uptake for immunisation and cervical cytology, with the higher targets now being reached. A well organised computer system was in operation, and plans were in hand for developing more health promotion clinics. The secretaries and receptionists were finding increased job satisfaction: "Before it was just writing scripts and typing, now I am responsible for keeping the cervical cytology records up to date."

The scale of services now being offered had required a reappraisal of the organisation of the practice. A new practice manager was to be appointed, and discussion about this post had forced the partners to consider how best to proceed. There was a recognition of the need for building a team and dealing with unresolved issues about professional boundaries. Practice nurses were enjoying new responsibilities yet recognised the "lack of time to meet on a regular basis with doctors, who are stressed." The growth in services had highlighted the inadequacies of the health centre, and the partners were "concerned about attracting development funds for new premises."

This group practice is in transition but taking steps to tease out how best to achieve the competing demands of patient care and practice organisation. Current ideas about medical audit were submerged by an administrative workload which was only beginning to ease. The next steps were clearly about determining priorities, as opposed to merely adding more services to a practice which was already fully stretched.

Reaction to contract and impact on practice

- Still recovering from new regulations which interrupted former developments in the practice
- In transition and having difficulty working out priorities
- Moving towards more professional management
- With limited space in the health centre, uncertainty about funding applications for practice development.

Next steps

The first year of the new contract had been a time of considerable change, and the larger practices had faced major upheavals in both organisation and staffing. A subsequent article will focus on the main themes which emerged and the issues facing the practices as they take the next steps in attempting to decide future priorities.

1 Secretaries of State for Health, Wales, Northern Ireland, and Scotland. *Working for patients*. London: HMSO, 1990. (Cm 555.)
2 Bain J. Budget holding: a step into the unknown. *BMJ* 1991;**302**:771-3.

Doctors' perceptions of pressure from patients for referral

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Abstract

***Objective*—To assess the effect of pressure from patients on patterns of general practitioners' outpatient referrals.**

***Design*—Survey of general practitioners' referrals to hospital outpatient departments during one week.**

***Setting*—One health district.**

***Subjects*—All (160) general practitioners in the health district.**

***Main outcome measures*—Specialty of the referral, the reason for it, and its status (NHS or private) and the general practitioner's assessment of the degree of pressure exerted by the patient for the referral (much, little, or none).**

***Results*—122 (76%) general practitioners completed the survey. Younger general practitioners (aged ≤45) and those qualifying in the United Kingdom and Republic of Ireland reported greater pressure from patients to refer ($p<0.03$, $p<0.001$ respectively). Pressure was also greater for patients referred privately ($p<0.001$), for those referred for reassurance ($p<0.05$), and for those referred to clinics in psychiatry, rheumatology, dermatology, and orthopaedics. General practitioners with a higher referral rate (with total consultations in the week as the denominator) were more likely to report pressure ($p<0.01$).**

***Conclusions*—The pressure from patients to refer reported by general practitioners is related both to general practitioners' characteristics and to the nature of the referral. Pressure to refer seems to explain some of the variation in referral rates among general practitioners.**

Introduction

The reasons for the considerable variation in individual general practitioners' referral rates to hospital