

Letters

All letters are subject to editing and may be shortened. Letters should be sent to the BJGP office by e-mail in the first instance, addressed to journal@rcgp.org.uk (please include your postal address). Alternatively, they may be sent by post as an MS Word or plain text version on CD or DVD. We regret that we cannot notify authors regarding publication. Letters not published in the Journal may be posted online on our Discussion Forum. For instructions please visit: <http://www.rcgp.org.uk/bjgp-discuss>

Editor's choice

The real cost of primary care

The crisis in accident and emergency departments leads me to share the results of an analysis from East Devon. Two years ago we worked with hospital colleagues to identify the cause of the large increase in emergency admissions in our area. East Devon has a population structure equivalent to that projected for England and Wales in 2042; we found that people aged over 80 years formed the bulk of the increase in emergency admissions and, to a lesser extent, attendances at the emergency department of our main acute hospital. We worked in partnership with the acute hospital to address this problem.

It seemed inconceivable to us that consultations in primary care by this group wouldn't also have risen dramatically. We analysed data from our practice computer system, comparing consultation statistics between 2004 and 2012. We found that in 2004 our GPs and nurses saw 63 377 patients in the surgery, made 2531 home visits, and had 4609 telephone consultations. In 2012 these figures were 78 597 (24% increase), 3241 (28% increase), and 18 810 (408% increase) respectively. Our practice population had grown by 10% over this time period. All components of our work had increased substantially but telephone consultations had shown an extraordinary rise.

We were not able to analyse these figures by age group, but data from the NHS Information Centre (provided from the QRisk[®] studies of Professor Julia Hippisley-Cox *et al*) from 1995–1996 onwards show that, whereas the average consultation rate per year for a registered patient rose from 3.9 to 5.5, there were much higher rises in the over 85s, for whom consultation rates approximately doubled, from 7 to 14 consultations per year.

Nationally, including the 2004 contract change, real terms primary care trust (PCT) spending on primary care rose by 22% (just under 3% a year) between 2003–2004 and 2011–2012. Almost all of

this increase occurred between 2003 and 2005. In comparison, PCT spending on secondary care jumped 40.1% over the same period, increasing from £49.1 billion to £68.8 billion. This is equivalent to an average increase of over 5% a year. Between 2010–2011 and 2011–2012 there has been a real terms reduction in spending on primary care of 1.2%.¹

It is a great privilege to provide primary care for older people and, as a profession, we need to campaign for resources that reflect their needs. This means investing in primary care as well as secondary, community, and social care. The legacy of the 2004 GP contract, with its sudden 14% increase in GP income, is a failure to consider workload, or workforce planning 9 years later. At present it seems that the NHS knows the cost of primary care, but not its value.

Phil Taylor,

MA, MRCGP. E-mail: philtaylor@nhs.net

REFERENCE

1. Charlesworth A, Jones NM. *A review of NHS expenditure and labour productivity. The anatomy of health spending 2011/12: a review of NHS expenditure and labour productivity*. London: Nuffield Trust, 2013.

DOI: 10.3399/bjgp13X669086

Are there enough GPs in England to detect hypertension and maintain access?

We read with interest the paper by Baker *et al* exploring the interrelationship between size of hypertension register, GP provision, and access (defined as the ability to get an appointment within 48 hours), assessed in 8052 practices.¹ It suggests a conundrum in primary care: the 'better' a practice's recognition and presumably management of hypertension, the worse the access, given finite staffing resources. The same inverse relationship may apply in other chronic diseases such as diabetes mellitus, where the recognition of risk factors or disease in often asymptomatic individuals also leads to

additional workload. As acknowledged by the authors, no information was available on how different members of the primary healthcare team are used, but it appears that, 'an extra GP per 1000 patients would be associated with a 6% increase in detected hypertension'.

The study used data from 2008–09, preceding publication of the NICE 2011 guidelines on diagnosis of hypertension. Where implemented, these guidelines may impact on the size of hypertension registers due to the use of out-of-office monitoring to reduce the white-coat effect, therefore a reduction in inaccurate labelling and an associated reduction in future workload.^{2,3} Furthermore, alternate methods may have better answered the research question: use of structural equation modelling would have allowed the authors to model their whole conceptual framework simultaneously, allowing fuller account to be taken of the internal interactions.

Nonetheless, the study does provide data supporting the interesting hypothesis that there is insufficient capacity in primary care to provide both good access, as well as detection and on-going care for long-term conditions. Additional resources seem unlikely under current financial constraints but novel interventions such as self-management⁴ and more creative use of the primary healthcare team, as well as better diagnostic methods may mitigate these effects.

Christine A'Court,

Department of Primary Care Health Sciences, University of Oxford, Radcliffe Observatory Quarter, Woodstock Road, Oxford, OX2 6GG.

E-mail: christine.acourt@btinternet.com

Helen Atherton, Andrew Dalton, Susannah Fleming, Jennifer Hirst, David Nunan, Mary Selwood and Richard J McManus,

Department of Primary Care Health Sciences, University of Oxford, Radcliffe Observatory Quarter, Woodstock Road, Oxford.

REFERENCES

1. Bankart MJ, Anwar MS, Walker N, *et al*. Are there enough GPs in England to detect hypertension and maintain access? A cross-sectional study. *Br J Gen Pract* 2013; DOI: 10.3399/bjgp13X667204.
2. Krause T, Lovibond K, Caulfield M, *et al*.