The first three months of free contraception in a market-town group practice

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SUMMARY. Contraceptive services became free to patients of general practitioners in the British National Health Service on 1 July 1975. We report the numbers of patients advised in a practice of 6,612 patients during the first three-month period and found that in a sample of 211 women, just over half had received medical advice. The financial implications are discussed.

Introduction

There is understandably as yet minimal information on the results of the recent new policy of a free contraceptive service (*Update* 1975). A survey in this practice after three months of a free service was undertaken.

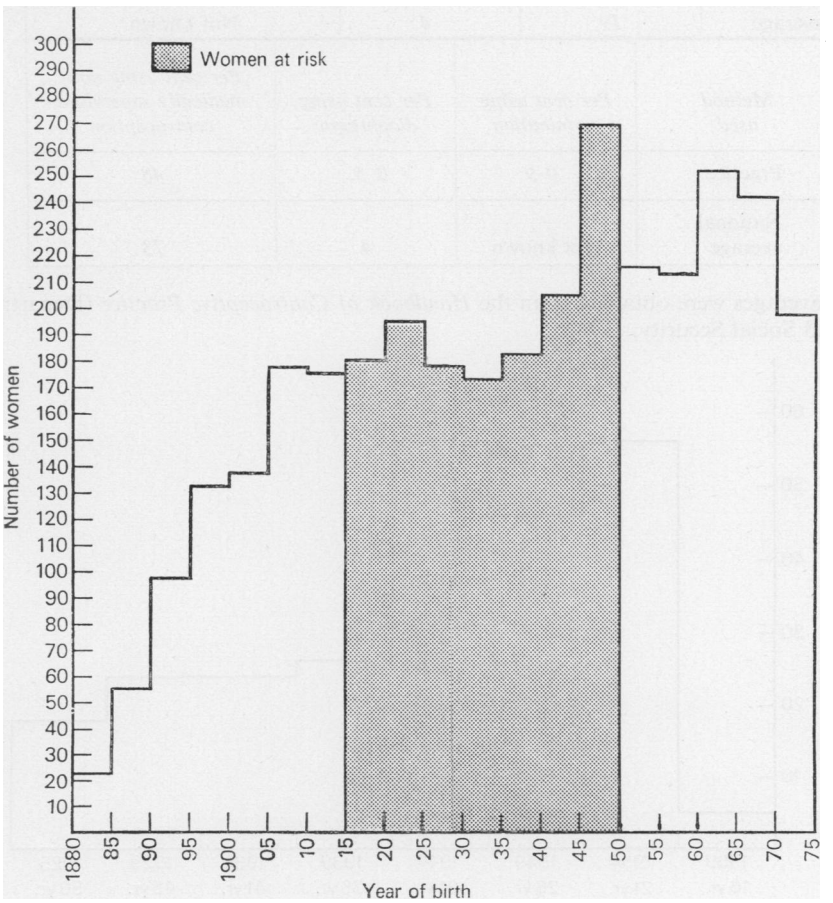

Figure 1
Age profile of female patients.

The practice

The practice consists of four partners and one general-practitioner trainee with a total list of 6,612 patients, of which 3,290 are women with an age profile shown in figure 1. From this number 1,442 women aged between 16 and 50 years were considered at risk to pregnancy. To sample this population, one year in every quinquennium was studied using the age-sex register and 211 women were studied. The practice has encouraged patients to attend for a full contraceptive service for several years and only a small proportion of patients attended Family Planning Association or local authority clinics; these were identified from the relevant correspondence from these clinics.

It was found that the most popular method of contraception was the Pill, followed by sterilisation (both male and female), and intra-uterine devices. A small number used diaphragms or had had terminations of pregnancy which had sometimes been combined with sterilisation. The percentages were as follows:

Method used	*Per cent using Pill*	*Per cent using I.U.D.*	*Per cent using sterilisation*	
			tubal lig.	*vasectomy*
Practice	*34*	*8*	*12*	*1*
National average	*19*	*4*	Not known	

Method used	*Per cent using termination*	*Per cent using diaphragms*	*Per cent using non-medically supervised contraception*
Practice	*0·9*	*0·5*	*48*
National average	Not known	*4*	*73*

National averages were obtained from the *Handbook of Contraceptive Practice* (Department of Health and Social Security, 1974).

Figure 2
Percentage of women using a reliable contraceptive.

If the Pill, intra-uterine devices, sterilisation, and diaphragms are considered reliable forms of contraception, then the percentage of women in each year using a reliable method is given in figure 2. This shows an expected low frequency in 16-year olds and 50-year olds with the greatest use being in women of 21 to 31 years. From this sample the percentage of women at risk in the 16–50 age group who were using a reliable form of contraception was 52 per cent leaving 48 per cent not receiving medically supervised contraception.

Our figures are well above the national average (Department of Health and Social Security, 1974) where only 27 per cent of patients have been predicted to have been receiving reliable medically supervised contraception, perhaps reflecting our practice's traditional interest in contraception. Despite this, 48 per cent of the at-risk patients were not receiving contraceptive advice. This could be regarded as undesirable from two points of view:

(1) It is possible that a sub-optimal contraceptive technique is being used by almost half of the at-risk patients. Further studies would be needed to confirm this.

(2) The potential revenue to the practice from the item-of-service fee for contraception is not being adequately realised.

Cost effectiveness

The new fees payable to general practitioners in the British National Health Service introduced with effect from 1 July 1975 are:

Contraceptive advice and examination	£3·50 a year.
Fitting of an intra-uterine device	£10 for the year of insertion. £3·50 each subsequent year the coil remains in place.

(National Health Service General Medical and Pharmaceutical Services amended register, 1975).

The national average consultation rate for general medical services per patient per year is three (Fry, 1975). With a capitation fee of £2·15 for patients under 65 this is equivalent to remuneration of 72p per consultation. In those women in this survey using medically-supervised contraception the average number of consultations per year was found to be 1·8. On the lower rate of fee this is equivalent to £1·94 per consultation and on the higher rate (when an intra-uterine device is fitted) £5·55 per consultation. It appears to be more profitable for a general practitioner to give contraceptive advice than routine care for women under 65. A female patient in the at-risk age group could bring in an income of at least £5·65 per year to the practice compared with £2·15 per year for males.

This survey has identified the fact that even in a practice orientated to giving contraceptive care almost half of those at risk were not receiving a service, so that obviously more potential for income from this item-of-service payment exists. Whether such patients should be approached and offered such a service obviously has ethical overtones, but we have discussed this with others and found it reasonable to use markers in the notes of female patients in the 15–50 age group, so that the at-risk group can be identified when seen regarding other matters and if appropriate a discreet question posed about whether they would like contraceptive advice.

Workload

After three months of free contraceptive service an audit showed 354 patients had been seen:

Intra-uterine devices—20 fitted	£200
Other consultations—334	£1,169
Total income in 1 July to 30 September 1975	£1,369

We think it is unlikely that this level of remuneration will be sustained after the first quarter, as many patients previously receiving a contraceptive service privately were brought back for supervision shortly after the new fees were introduced, but this must be balanced against the exposed at-risk patients who may now be approached and offered a service.

Discussion

Several points of interest have arisen. Firstly, with regard to financial incentive, will there develop a breed of general practitioner who develops an interest in contraceptive care and makes it a large proportion of his or her workload, thereby obtaining twice the income of colleagues doing routine family care? There is, after all, unlikely to be a commitment in out-of-hours work.

Secondly, local authority clinics (formerly clinics of the Family Planning Association) have fixed hours and we have found that this acts as a deterrent to some women with family commitments. Patients prefer a contraceptive service to be available at all our surgery sessions.

The specialised contraceptive clinic within general practice has become almost traditionally established as the administrative ideal, but we know of no evidence on which such claims can be based which outweighs the convenience to our patients of an open service at all surgeries. When questioned, many have valued the confidentiality of not being a visible attender at a known contraceptive session.

We believe that general practitioners who are able to investigate and prescribe drugs other than the Pill, and refer directly to a consultant when appropriate, are in a better position to offer a comprehensive contraceptive service than clinics without these facilities (Frankland and Smith, 1972).

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PENTAZOCINE (FORTRAL) SUPPOSITORIES IN THE TREATMENT OF ACUTE BACK PAIN

A single-blind trial is described, comparing pentazocine (Fortral) suppositories with indomethacin (Indocid) suppositories in the treatment of back pain.

One hundred patients entered the trial, 86 completed; 40 on pentazocine, 46 on indomethacin. Their ages ranged from 18 to 70, their weights from 110 to 200 lb. Those with malignant disease, ankylosing spondylitis, hyperuricaemia, and urinary tract infections were excluded.

At day four there was improvement in both groups equally; at day eight, 76 per cent of patients on pentazocine and 61 per cent of those on indomethacin showed improvement. Those with severe pain seemed to obtain more marked relief with pentazocine. Fingertip-ground distance was reduced in both groups over eight days, the effect being non-significantly greater in the pentazocine group. In straight leg raising there was improvement in both groups for both legs, with a higher percentage in the pentazocine group. This difference was accentuated in those with severe pain.

The incidence of side-effects was greater in the pentazocine group than in the indomethacin, this incidence being less at eight days than at four, and since pentazocine seemed more effective in these patients suffering severe pain initially it would suggest that it may be particularly useful in severe pain.

REFERENCE

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