LETTERS TO THE EDITOR

THE COST OF CARE

Sir,

Dr C. W. Richards is to be congratulated on his paper (November *Journal*). Unfortunately, neither his figure of £25,000, nor the £43,000 quoted by Dr Owen for the total annual expenditure initiated by each general practitioner, should be considered without reference to the social costs incurred or saved by their actions.

Hospital costs are easily reduced by closing wards, reducing staff, or prolonging waiting lists. I calculated the cost of a manual worker waiting two years for a hernia repair at a local district general hospital as being in excess of £6,000—this included the cost of his replacement by his employer. By referring him to our local general practitioner hospital, he returned to work after eight weeks at a cost of about £500.

Social service departments can save money by delaying admission to old people's homes (cost £40 per week) from hospital beds (cost £100 to £200 per week).

The DHSS wastes money with inflexible bureaucracy. My favourite example concerned an elderly patient who was advised to apply for an attendance allowance for herself, even though she was able to look after her husband, who was already receiving an allowance. I was informed that, as an application had been made, I must complete the form and claim my fee!

If general practitioners were circulated with the cost of investigations, certain unnecessary procedures might be reduced. An investigation performed by a family doctor with open access to pathological and radiological services, can save time, worry, money, and unnecessary referral to hospital.

Many drugs are either not used, misused or not clearly indicated. About ten per cent of hospital admissions are iatrogenic. Occasionally, the expensive drug will prevent a hospital admission or absence from work. The cheap foreign imitation of standard proprietary drugs may disintegrate on the shelf, have variable absorption rates, or be poorly standardized.

The patient instigates most expenditure. Though charges for consultation and drugs might deter the genuine sick, there is a strong case for increasing prescription charges. When 'simple remedies' cost more than the prescription charge, consultations appear to increase. Health education might reduce costs, but on the other hand it may increase the patient's awareness and expectations of good health.

Apart from the professional satisfaction, there is no incentive for a doctor to investigate and treat his patients in properly equipped modern premises. Perhaps an item of service fee would end the penalization of doctors who attempt to practise modern family medicine.

The actual cost of a general practitioner is not relevant if it can be proved that his actions are cost effective. The cost of each part of the welfare state should not be considered in isolation. Unfortunately, the accountants in the various Government agencies only consider expenditure incurred within the narrow confines of their own departments. They should remember that sometimes, to save money, some money has to be spent.

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Sir,

I read with interest the article by Dr Richards on the cost of a general practitioner in the NHS. While it contains much food for thought I would suggest that his costing is not yet complete. For example, one would expect that a general practitioner will help at least some of his patients. He may not save their lives but could conceivably reduce their period of incapacity. One would also expect that a general practitioner would, in a percentage of cases, so affect the progress of an illness to forestall admission to hospital. This must result in some saving to the community, and the sums which are saved in this way together with any increase in the patients economic productivity should be subtracted from the estimated figure of £43,000.

It should be remembered that the general practitioner, as an independent contractor, must make his own capital outlay in financing the supply of laboratory, diagnostic and office equipment which he requires to do his work. This should be included in the cost of a general practitioner's service and in so far as it is provided by the practitioner himself out of his earned income it represents a direct subsidy to the state.

One should also take into account the work performed by the members of the practitioner's family in providing back-up services for the running of his practice for 24 hours a day. This work is not normally financed by the exchequer but should be included in any costing exercise. One accepts, of course, that some of this is included in the basic practice allowance which was included in Dr Richards's original calculation, but the basic practice allowance has never been broken down into these various fractions, and one suspects that in many ways it does not represent the real cost of providing care.

One should also remember such items as the cost of petrol. Again, this will be included in the calculation for the basic practice allowance. However, since about 50 per cent of the cost of petrol is taxation, that particular fraction of the money oscillates between the exchequer and the profession and, in a sense, is money which is never spent.

Dr Richards includes the cost of sickness benefit with the cost of medical care. I would submit that this is an error. This is part of the social security service and it is not the doctor who authorizes the payment. In essence, the doctor's certificate functions as a check on the patient's good faith and nothing more.

With these additions and subtractions it would seem that the total annual cost of an average general practitioner in the British NHS is likely to be less rather than more than the £43,000 that Dr Richards suggests.

A total figure is in itself misleading since such a figure is bound to be large. If one takes £43,000 as the baseline and if one assumes that the average list size is 2,000 patients, each receiving on average four items of service a year, and if one assumes further that on average there are three items of service to each episode, the total cost of treating an episode of illness would be slightly more than £16. By comparison the annual cost of insuring a washing machine for repairs is £17, so that it appears that it is

cheaper for the state to treat an average illness than it is to service a washing machine. In view of this, one would disagree with Dr Richards's stated conclusion that "Services provided by doctors are expensive to the National Health Service."

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PRESENTATION OF CLINICAL DATA

Sir,

As the complexity of medicine increases it is becoming increasingly important that individual clinicians are capable of weighing the evidence critically for themselves rather than swallowing holus-bolus the opinions of others. To develop this capability in medical undergraduates is an uphill task, often discouraged by much of the contemporary curriculum. It is sad, therefore, to find the *Journal* occasionally doing the same for its readers.

Two recent examples will perhaps suffice. The first concerns the use of abstracts. In the October *Journal* under the heading "The Treatment of Vaginal Candidosis" appears the sentence "Of the three preparations, miconazole was found to be the most effective."

Now, it is true that you provide the relevant reference, enabling those who will to read the original paper and consider the evidence on which this statement is based. But, in the knowledge that most of us do not do so, this is precisely the method of presentation relied on by the commercial 'glossies'. Moreover, the journal in question does not happen to be available in at least one, well-stocked university library.

Should we not agree, therefore, that bald conclusions should be included in abstracts only if there is also some brief comment on the methodology used and/or the validity of the argument?

The second example is Fry's article on "The Natural History of Angina in General Practice". Here clinical data are presented, but presented in such a way as to defy independent conclusions.

For example: "The incidence during the 20-year period . . . is shown in Table 2" (page 644). This table appears to show, amongst other things, that there were 76 males aged 40 to 49 and 104 females aged 70 or over presenting as new patients with angina per year per thousand at risk. Do these figures refer to incidence or to prevalence, and are they being expressed per thousand at risk, or per thousand age-related at risk?

Secondly, throughout the paper, the author does not indicate whether he is dealing with incidence (and prevalence) or with *reported* incidence (and prevalence); nor is his method of follow-up defined. Thus, it is not possible to know whether the heading "Angina Goes" (Table 3) means that these patients had been recently reviewed and found asymptomatic, or whether they simply did not contact the doctor (although still registered with him).

Thirdly, "many associated clinical features were anaemia, a bleeding peptic ulcer . . . " (page 644). Now these clinical conditions are either important to the outcome or not important. If they are *not* important why mention them (any more, say, than mention corns or osteoarthrosis, which doubtless in some instances must also have been associated conditions)? If they *are* important then plainly Table 4 becomes meaningless. Further, in spite of Table 4, the advice given in the final two paragraphs of the paper pays no attention to age or sex.

If there are indeed valid lessons which the reader can learn from a published paper all well and good, but if he has no means of assessing the validity of what he reads it were better not to add to the mountain of paper under which he is already buried.

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THE ARTS AS AIDS TO LEARNING

Sir,

Your Editorial and theme in the August *Journal* bearing on cultural factors in medicine have been commented on by Professor I. M. Richardson (November *Journal*) in encouraging tones. However his last paragraph suggests, unhappily I believe, "that the arts should be given an educational place in the preparation of most medical students."

Many doctors have written about, and practised 'whole-person' medicine; fewer have realized, until recently, our need to be 'whole persons' ourselves, and the contribution to this aim which an interest in and study of the arts in their widest sense can make. There are two aspects implied in this statement which have, as it were, disadvantageous side-effects; first, that one can *make* a doctor a whole person by giving the arts an educational place. Surely the best that a medical school or university can do is to avoid positive discouragement, for example by a curriculum not unduly overloaded and by the example of the teachers themselves as educated and sensitive people.

Secondly, there are implications for our work as general practitioners with the emphasis now on team work. I do not wish to develop this argument here, but would merely point out some conflict between the aims of the doctor with his patient (each to develop as a whole person) and the nature of team work as currently discussed, which shows some danger of detracting from the responsibilities and fulfilments of each individual member of the team.

I hope that, in spite of this caveat, you will continue to provide in the *Journal* opportunity for your readers to be as aware of their artistic needs as of their scientific nourishment.

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MEDICAL COMPUTING

Sir,

I think a note of caution should be raised on this topic since medical computing has been an actively pursued subject for many years in many countries and some of the systems which have been introduced have been expensively abandoned. There is obviously a great application for dedicated computers for the analysis of numerical data, for example the EMI scanner, but the normal mode of entry to the data bank is via a keyboard and most general practitioners are particularly loath to use a typewriter.

The computer has the ability to retrieve and collate a great deal of information at high speed so that the age-