A comparison of general practice in Britain and Ireland

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SUMMARY. The work patterns of general practitioners in the British NHS and in the General Medical Services Scheme in the Republic of Ireland are compared. Doctors in the Republic have higher consultation and domiciliary visiting rates. These differences are not explainable in terms of the different age/sex structures of the populations under care.

Introduction

GENERAL practitioners in the Republic of Ireland are paid on the basis of a fee per item of service. Their undergraduate training is similar to that of their British colleagues and studies have shown that the morbidity presented to and perceived by doctors in both countries is also similar (Gowen, 1972).

In the Republic approximately one third of the population is covered by the General Medical Services (GMS) Scheme colloquially known as "The Choice of Doctor Scheme". This provides for comprehensive health services free of direct charge for those whose income is below a defined level, allowance having been made for dependants and the cost of housing.

The general practitioners are paid by means of a scale of fees which provides extra payment for domiciliary visits and out-of-hours work (Table 1). The remaining two-thirds of the population are personally responsible for practitioners' fees which are variable but tend to be substantially higher than those reclaimable from the State.

The recently published Reports of the General Medical Services (Payments) Board (1976) describe the first two years' operation of the scheme for the years ending 31 December 1974 and 1975. The Scheme replaced the 'dispensary service' by which a designated doctor in each district was paid a salary for an undertaking to provide general-practitioner services for all eligible persons. Former district medical officers ('dispensary doctors') were given the option of a salary or of being paid a fee per item of service with a guaranteed minimum annual payment. Other doctors joining the scheme were paid wholly by fee.

Table 1. Scale of fees payable to practitioners participating in the GMS Scheme (from 1/9/1975).

	a *Normal hours*	b *Outside normal hours other than c*	c *Midnight to 08.00 hrs*
	£	£	£
Surgery consultations	1.35	1.93	3.84
Domiciliary consultations			
urban	2.02	2.61	5.17
up to 3 miles	2.02	2.61	5.17
3-5 miles	2.61	3.40	6.64
5-7 miles	3.55	4.43	8.40
7-10 miles	4.43	5.89	9.36
over 10 miles	5.54	6.92	10.30

Consultation rates

In the GMS Scheme consultation rates, defined as doctor-patient contacts per person per year, were high at 5·51 in 1974 and 5·48 in 1975. A comparable figure for the NHS derived from the Second National Morbidity Survey, based upon 53 practices, is 3·01 (2·56 for males and 3·43 for females) (OPCS, RCGP and DHSS, 1974).

The Scheme is characterized by caring for the lower income group, and the age/sex structure is different from that of the population as a whole. By courtesy of the GMS Board an analysis of the population was made available. This is incomplete covering only 82·3

per cent of the total. Table 2 compares the age/sex structure of this population with that for all Ireland derived from data from the Irish census. These are compared with the British population included in the Second National Morbidity Survey.

In order to estimate how much of the difference in consultation rates is due to differences in the age/sex structure of the two populations, a 'standardized consultation ratio' was calculated using the age/sex specific consultation rates of the Second National Morbidity Survey (Table 3). This standard consultation ratio was 178; in other words, the age/sex adjusted consulting rates are 1·78 times higher for the Irish population covered by the Scheme than that for the British population involved in the Second National Morbidity Survey. In contrast, the non-adjusted rates are 1·82 times higher (5·48:3·01). Thus it appears that only about two per cent of the difference in consulting rates is attributable to differences in the age/sex structure of the populations.

This finding might be explained in four ways:

1. That correcting for the effects of age and sex does not take account of socio-economic deprivation.
2. That the sociocultural demands for doctors' services are greater in Ireland.
3. That differences in procedures for issuing repeat prescriptions artificially inflate consultation rates in the Irish GMS Scheme.
4. That the way doctors are paid affects workload.

These are not mutually exclusive.

The effects of socio-economic deprivation

Studies in the NHS have shown that high consultation rates are a feature of practice in socio-economically deprived areas (Cartwright, 1967; Williams, 1970). There are no equivalent data in the Republic showing a similar association.

The effects of sociocultural demands

Morbidity surveys suggest that sociocultural attitudes to the role of general practitioners are similar in the two societies. The number of general practitioners per head of the population is also similar. If there were marked sociocultural differences this would probably not be so.

The reports of the GMS (Payments) Board show that consultation rates are lower in rural as compared with urban areas. The highest consultation rate is in the Eastern Health Board which includes Dublin and its environs. The consultation rate is 6·73 for the Eastern Health Board where 91 per cent of the patients live within three miles and only 0·4 per cent live more than ten miles from their doctor. By contrast the rate for the Western Health Board, a rural area, is 4·71 but only 36 per cent of the patients live within three miles whilst eight per cent live over ten miles from their doctor (Table 4). Such marked differences between urban and rural areas are not evident in the Second National Morbidity Survey.

The differences between urban and rural rates in Ireland may be due to the effects of distance alone but could also be explained by a lower demand for care by the rural community.

Repeat prescriptions

Doctors in the GMS Scheme have been discouraged from prescribing more than one month's supply of drugs at a time so that repeat prescriptions, often issued in the NHS without a consultation, are seldom issued without a consultation, justifying a fee.

The effects of method of payment

If payment by fee is an incentive towards increasing work it would be reasonable to predict that doctors with small lists would have high consultation rates.

Table 5 shows that doctors with small lists had unusually large numbers of high and low consultation

Table 2. Percentage distribution of the population of the Republic of Ireland (1971 census), GMS population (1976) and the Second National Morbidity Survey Population (1970) by age and sex.

	Age group	*<5*	*5-15*	*16-44*	*45-64*	*>64*	*All ages (Number)*
		Percentage					
Republic of Ireland	Male	*11*	*23*	*36*	*20*	*10*	(1,495,760)
	Female	*10.4*	*22.2*	*35*	*20.4*	*12*	(1,482,488)
Population of Irish GMS Scheme (82.3 per cent sample)	Male	*9*	*22*	*29*	*17*	*23*	(451,631)
	Female	*8*	*18*	*28*	*19*	*27*	(515,248)
		<5	*5-14*	*15-44*	*45-64*	*>64*	
Population in Second National Morbidity Survey	Male	*7.9*	*17.7*	*41*	*23.6*	*9.8*	(140,346)
	Female	*7*	*15*	*40*	*23*	*15*	(151,901)

Table 3. Consultation rates in the Second National Morbidity Survey by age and sex, per patient per year.

		Surgery (office) consultations		*Domiciliary consultations*		*All consultations*	
		Male	Female	Male	Female	Male	Female
Age group	<5	3.14	2.87	0.65	0.60	3.79	3.47
	5-14	1.64	1.68	0.28	0.25	1.92	1.93
	15-44	1.87	3.48	0.13	0.33	2.00	3.81
	45-64	2.63	2.82	0.38	0.42	3.01	3.24
	>64	2.33	2.18	1.63	1.90	3.96	4.08
All ages		2.16	2.84	0.40	0.59	2.56	3.43
Total rate		2.51		0.50		3.01	
Total number consultations		733,832		145,722		879,554	
Total rate in GMS Scheme (1975)		4.33		1.15		5.48	
Total number consultations		4,534,045		1,207,348		5,741,393	

Table 4. Consultation rates and percentages of patients covered by the GMS Scheme living within three miles or over ten miles from their doctor for each health board for year ended 31 December 1974.

Health board	*Consultation rate per patient per year*	*Percentage within 3 miles*	*Percentage over 10 miles*
Eastern	6.73	*91.0*	*0.4*
Southern	5.51	*53.8*	*7.1*
North-Eastern	5.42	*48.0*	*1.3*
Midland	5.22	*51.0*	*1.5*
South-Eastern	5.18	*56.3*	*1.4*
North-Western	5.08	*38.3*	*3.0*
Mid-Western	5.06	*58.4*	*2.0*
Western	4.71	*35.6*	*8.0*

rates. Low rates might be associated with busy 'private' practices in predominantly middle-class areas but there are no data to support or refute this. Consultation rates of doctors with large lists regress towards the mean.

Home visits

Since the proportion of home visits depends on the age of the population, home visiting rates in the GMS were age and sex standardized by the indirect method. A 'standardized domiciliary consultation ratio' of 185 was calculated using the age/sex specific domiciliary consultation rates of the Second National Morbidity Survey as standard (Table 3). In other words the Irish GMS domiciliary consultation rates are 1·85 times higher than the Second National Morbidity Survey rates. In contrast, the non-adjusted home visiting rate was 2·30 times higher (1·15:0·50). Thus 20 per cent of the difference in home visiting rates between the two

Table 5. Number of doctors paid by fee in consultation rate categories. (All health boards for year ended 31 December 1974).

List sizes	*Consultation rate per patient per year*				
	Under 3.9	4-9.9	10-15.9	16 and over	*Number of doctors*
Less than 500 patients	61	184	21	6	272
500-1,499	76	442	12	—	530
1,500-3,499	46	143	—	—	189
2,500 and over	7	16	—	—	23
Total					1,014

countries may be attributed to age/sex differences in the populations.

In the Republic, fees for domiciliary visits are appreciably higher than those for surgery consultations so that doctors in the Republic are protected from the financial penalties of domiciliary visiting which exist in the NHS. Other factors may play a part, for example, difficulty of access to the surgery by patients or the relative lack of auxiliary help in the Republic. The fact that a high rate of domiciliary visiting remains a feature of practice in the Eastern Health Board Region, where most patients live near their doctors, suggests that difficulty of access may not be a major factor.

Discussion

Patterns of practice in the NHS and the GMS Scheme show marked differences. Regional or local differences within each study group were much less than the differences between the two systems of care.

The effects of socio-economic deprivation are difficult to measure but probably account for some of the difference. It is unlikely that different patterns of morbidity or different sociocultural perceptions of the doctor's role provide an adequate explanation. It may be that the way doctors are paid contributes to different work patterns, although Gowen (1976) showed that in his urban/rural practice in County Cork the proportion of follow-up consultations, i.e. those that are doctor initiated, was similar to that of practices in the British NHS.

Tudor Hart (1976) has suggested that the Second National Morbidity Survey may be biased towards practices with low workloads, as those with high workloads do not have the capacity to record morbidity. In this event the differences that we have drawn attention to may be more apparent than real.

Howie (1977) has pointed out that 274 million items were prescribed in England and Wales in 1974, about six items per person per year. The figures for Wales alone are higher, over seven items per person per year, and those for the Irish GMS Scheme, at about ten items, are highest of all. The number of items per prescription is not accurately known but is probably between 1 and 1·5 in England and Wales (it is just over two in the GMS). If this is so, the number of prescriptions still exceeds the number of consultations recorded in the Second National Morbidity Survey. As every consultation is not accompanied by the issue of a prescription, this provides further evidence that the issue of prescriptions without consultation is widespread in the NHS.

Consultation rates in the GMS Scheme are likely to be inflated when compared with the Second National Morbidity Survey because of declared policy (instructing doctors not to issue prescriptions for more than one month's supply of drugs at a time), and the payment of a fee for a consultation but not for a prescription.

In brief, little of the difference between work patterns is explainable in terms of the age-sex structure of the populations, and it would be facile to assume that different methods of payment are a major factor, although they may play a part.

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Acknowledgements

We are grateful to the Chairman and Dr P. Porteus of the GMS (Payments) Board for their co-operation.

Patients' reactions to general practitioner care for visual handicap

Patients receiving treatment for an eye condition were asked about the way that their general practitioner had helped them. Their views were reported in paragraph III (DHSS, 1976). The same rating scale was used to evaluate the help given by the hospital. Where treatment had been received at more than one hospital, views were sought about the one attended most recently. Eighty-four per cent of the sample who had attended hospital (277) were satisfied with the help received for their eye condition (Table 26). Slightly more of the women respondents (87 per cent) expressed positive attitudes than the men (82 per cent), but the number of women who changed their hospital because they were dissatisfied was also higher. Perhaps the men were less able, willing or motivated to change even when dissatisfied with their current treatment. The agency which first advised hospital care for the eyes, analyzed by the age of respondents, showed that the advice to take treatment in hospital originated most commonly with general practitioners (63 per cent) and that general practitioner referrals exceeded all other sources combined (37 per cent).

Reference

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