

Contraceptive workload in general practice in the Trent Region

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SUMMARY. A prospective study was made of the contraceptive workload of general practitioners in the Trent Region between November 1973 and January 1976. This was carried out in three stages allowing comparison between a period of time when patients paid for all contraception, when only contraceptive advice from the general practitioner was paid for, and when contraceptive services and supplies were free from all sources in the NHS. The study shows that the introduction of free contraception services under the NHS Reorganization Act 1973 led to little change for many general practitioners. The number of patients seen each week for contraception did rise slightly, but the characteristics of these patients did not change over the two years.

Introduction

THE NHS Reorganization Act 1973 placed upon the Secretary of State a duty to provide, free of charge to the patient, a service for advice on contraception, the medical examination and treatment of persons seeking such advice, and the supply of contraceptive substances and appliances (*British Medical Journal*, 1974). At that time contraceptive services were provided at a charge by general practitioners, family planning clinics of various kinds, and hospitals.

The introduction by government regulation of this service to meet a social rather than a medical need might have been expected to cause serious changes in the general practitioner's workload, affecting his accessibility to patients needing general medical attention.

No information was available in 1973 about general practitioners' contraceptive workload. Although the data for *Morbidity Statistics from General Practice* were collected during 1970/71, the information was not collated and published until 1974 (OPCS, RCGP, DHSS, 1974). Cartwright and Waite studied general practitioners and contraception in 1970/71 but were not concerned with logistics. A prospective study was therefore planned to measure what alterations of workload for contraception in general practice occurred after the introduction of the new service.

In 1973 it was expected that the new regulations would affect all family planning clinics, hospital departments, and general practitioners simultaneously. Moreover, it was surmised that, as the service would be free at every point of supply, other things being equal, patients would tend to obtain supplies from the nearest and most convenient source, usually from their general practitioner. In fact the general practitioners and the Department of Health and Social Security were unable to agree on payment for the new service until 1 July 1975, 15 months after free contraception services were started in clinics and hospitals on 1 April 1974. This delay enabled data to be collected from general practitioners at three points in time when:

1. Patients were charged a fee everywhere (before April 1974).
2. Patients were charged a fee in general practice but not elsewhere (April 1974 to July 1975).
3. Patients had a free service everywhere (after July 1975).

Method

All general practitioners working within the area covered by the Trent Regional Area Health Authority were invited to take part in the study. One hundred and seventeen agreed to collect the required data:

Table 1. Workload of participating practices at each stage of the study.

| | Stage 1 | Stage 2 | Stage 3 |
|---|---------|---------|---------|
| Practices | 99 | 67 | 57 |
| Practice weeks of recording | 386 | 268 | 227 |
| Contraceptive consultations | 2,786 | 1,872 | 2,006 |
| All consultations | 73,024 | 53,176 | 40,869 |
| Average number of patients seen per week for: | | | |
| all purposes | 189 | 198 | 180 |
| contraception | 7.22 | 6.99 | 8.84 |
| Contraceptive workload rate* | 3.82 | 3.52 | 4.91 |

*Number of consultations for contraceptive purposes per 100 total consultations.

1. The number of and details about consultations concerned wholly with contraception.
2. The patient's previous source of contraceptive advice.
3. The total number of all other consultations, including home visits.

Figures were collected by each participating doctor for four consecutive weeks on three separate occasions. The first was made in November/December 1973, four months before the expected introduction of 'free contraception' in April 1974. The second count was made in February/March 1975 when the service had been free at family planning clinics and hospitals for ten months but when patients were still paying for advice and supplies prescribed by their general practitioners. The third count was in two parts, half the practitioners collecting data in November/December 1975 and the other half in January 1976. This was done to overcome a possible bias which was likely to occur if a count were taken six months after 1 July 1975, there being a widespread tendency to review the contraceptive methods used by certain categories of patients at six-monthly intervals.

The key index for the purpose of this paper is the contraceptive workload rate, defined as the number of consultations involving contraception per 100 consultations for all purposes. Such a rate is necessary to interpret the data collected because the amount of contraceptive work undertaken must be related to the population served. Clearly the most appropriate denominator would have been the total list sizes of people aged, say, between 16 and 45, but this information was not routinely available in all participating practices. Total consultations are more easily counted and are not usually affected by changes in practice management or

Table 2. Workload of 57 'selected' practices at each stage of the study.

| | Stage 1 | Stage 2 | Stage 3 |
|---|---------|---------|---------|
| Practices | 57 | 57 | 57 |
| Practice weeks of recording | 222 | 228 | 227 |
| Contraceptive consultations | 1,558 | 1,641 | 2,006 |
| All consultations | 40,635 | 44,403 | 40,869 |
| Average number of patients seen per week for: | | | |
| all purposes | 183 | 195 | 180 |
| contraception | 7.02 | 7.20 | 8.84 |
| Contraceptive workload rate | 3.83 | 3.70 | 4.91 |

by the absence of an individual doctor at one point in the study. Additionally, this figure will not be affected by changes in practice management that have occurred during the two-year period that might have reduced consulting time, or by absence of a particular doctor at one point in the study.

The problem of bias was examined but found not to be significant in terms of total workload, although there was a discernible increase in follow-up Pill takers as a proportion of the total.

Results

The results from the practices involved in this study were that 99 out of an original 117 completed data collection at the first stage (85 per cent); 67 practices completed stage two (68 per cent of those involved in stage one), and 57 practices completed the final stage (58 per cent of those in stage one). The extended time that proved necessary to complete this study must in part be an explanation of this fall-off of participating practices. In a very small minority of cases it was not possible to collect four weeks of information and this was allowed for in subsequent analyses.

The basic data for the three stages of the study are presented in Table 1. It is possible to argue that the 57 practices completing the study are not the same, in terms of contraceptive services, as the 99 originally involved. To avoid this difficulty those 57 practices (referred to as 'selected' practices) were reanalysed, and the findings are presented in Table 2. These 57 were representative of the original 99 in all but one respect; the proportion of people seen by the doctor was higher (87 per cent) than in the original 99 (81 per cent). Consequently the conclusions of this study are based on the information in Table 2.

The contraceptive workload rate rises (statistically significantly) between stage one and stage three,

Table 3. Characteristics of contraceptive consultations in 'selected' practices at each stage of the study.

| | Stage 1 | Stage 2 | Stage 3 |
|---|---------|---------|---------|
| Percentage of such consultations involving: | | | |
| Female patients | 96.3 | 98.0 | 98.6 |
| Married patients | 75.2 | 72.2 | 74.0 |
| Patients under 30 years | 69.2 | 62.9 | 64.3 |
| Nulliparous patients | 35.3 | 38.3 | 36.4 |
| New patients | 21.6 | 21.0 | 19.3 |
| Prescribing Pill | 81.6 | 83.8 | 84.0 |
| IUCD as contraceptive device | 3.0 | 3.4 | 5.6 |
| Vasectomy as contraceptive method | 2.1 | 1.6 | 1.0 |
| Seen face-to-face by doctor | 86.9 | 87.9 | 85.6 |
| Total contraceptive consultations | 1,558 | 1,641 | 2,006 |

showing an increase of just over 25 per cent. Stage two needs a little further comment—the contraceptive workload rate falls, but this must be attributed to the large increase in total consultations brought about by the seasonal pattern of morbidity. This seasonal swing is avoided by comparison of stages one and three, and it is noticeable how stable total consultations have remained.

The characteristics of patients consulting in the 'selected' practices are given in Table 3. There has been a significant drop in the proportion of male partners seeking contraceptive help, matched by a fall in vasectomies. While marital status and parity did not change, those people under 30 years as a proportion of the total has fallen, although still accounting for almost two thirds of the consultations. The apparent increased frequency of Pill prescribing is not significant, but the use of intrauterine devices shows a significant rise in the third stage of the study. The proportion of patients seen face to face by the doctor did not change during the study period.

New patients were defined as those patients seeking contraceptive services for the first time from their general practitioner. This figure remains remarkably stable during the two years of the study. If this group is examined in greater detail, the "previous supplier" is equally stable, with almost three fifths having had no previous contraceptive services (Table 4).

Table 4. Previous suppliers of 'new patients' in 'selected' practices at each stage.

| | Stage 1 | Stage 2 | Stage 3 |
|--------------------------------------|---------|---------|---------|
| Number of new patients | 336 | 345 | 387 |
| Percentage with no previous supplier | 59 | 57 | 59 |
| Percentage previously supplied by: | | | |
| Family planning association | 10 | 8 | 12 |
| Local authority | 2 | 1 | 2 |
| Elsewhere | 29 | 34 | 27 |

Discussion

The introduction of free contraceptive services has led to an increase in this work for general practitioners working in the Trent survey area. When this service, with considerable publicity, was made free to patients attending clinics and hospitals, one might have expected a wave of patients to attend these clinics rather than pay for their supplies if they attended their general practitioners. "Women in Newark and district have gone mad since the introduction of free contraceptive supplies from family planning clinics on 1 April. The clinics have no free appointments until the first week in June and are now asking County Hall to allow them another session a week to try to even out this crush" (*Newark Advertiser*, 1974).

The survey figures for stage two, ten months later, do show a fall in the average contraceptive workload rate, largely due to the seasonal rise in other consultations. The total number of family planning consultations rises slightly even at this time. This could hardly be called a mass migration and was reversed when general practitioners, with minimal publicity, entered the free service on 1 July 1975.

It seems probable that most patients do not choose their contraceptive adviser mainly on the grounds of cost as there was little change in the pattern of new patients coming to general practice. Over half such new patients had no previous contraceptive advice or supplies but chose their general practitioner even when other sources would have provided a free service. Similarly, many patients prefer either the anonymity of the clinic or the known family doctor but are unwilling to change from one to the other purely for reasons of cost.

This study does not suggest that the provision of free contraceptive services by general practitioners endangers their ability to meet normal medical demands. Contraception represents less than five per cent of the total workload, and the ability to increase total

consultations by almost ten per cent to meet seasonal morbidity has been shown during this study. The increase that the new service has imposed represents on average two family planning consultations per practice per week in addition to a previous level of seven such consultations per week. While this is statistically significant, it must be of minor importance to the individual practitioner.

There have been suggestions that "it would be a responsible and constructive step forward in medical practice to widen the range of those empowered to dispense oral contraceptives" (Smith *et al.*, 1974). Over 80 per cent of contraceptive consultations concern the routine prescribing of the Pill. An editorial in the *Lancet* (1974) agreed that "Dr Smith is right; it is time for a change in the rules". If such a change were implemented, the high proportion of patients in this study seen face to face by the doctor (86.9 falling to 85.6) could, with the help of a specially trained nurse, be considerably reduced. This would allow the doctor more time to deal with complicated cases referred to him, seeing patients starting contraception, or those who wish to be seen by him during their continued use.

The NHS Reorganization Act of 1973 was a great opportunity to co-ordinate contraceptive, sterilization, abortion, and maternity services with each district health team planning a comprehensive service for the area it serves. More than two years have now elapsed since the service was introduced piecemeal. This survey shows that during this time the role of the general practitioner has hardly changed.

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Acknowledgements

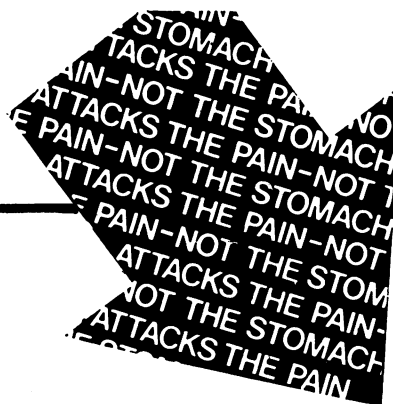
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Reference

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