Trends in the utilization of the National Health Service

IN our editorial of October 1980 we examined some trends in health service utilization between 1971 and 1976. In broad terms we showed that the increase in the population of elderly people, of half a million, between those dates had not been reflected in any greater use of hospital resources by general practitioners: indeed, outpatient referrals had dropped by 11 per cent per general practitioner, and 6 per cent per 1,000 population. Longer waiting lists and shorter inpatient stays suggested still other needs met by general practitioners. Although there was no evidence, from the *General household survey,* of rises in general practitioner utilization (remaining at 3.5 contacts per person per year) there was some evidence of increased content of general practitioner work, in that laboratory tests ordered by general practitioners had increased by 46 per cent, and that the number of items prescribed had also increased.[1] Somewhat wryly we pointed out that, in this period in which general practitioners had absorbed the extra load of an elderly population, their numbers had been increased by only 6 per cent, while the number of consultants had been increased by 22 per cent (so that in 1976 each consultant had 22 per cent fewer outpatients and 17 per cent fewer inpatients than in 1971). Meanwhile the cost of general medical services had dropped from 7.5 to 5.2 per cent of all health service costs, and pharmaceutical costs from 8.8 to 7.2 per cent. 'Quarts', we said, 'cannot indefinitely be poured into pint pots. If the general medical services are denied their fair share of resources, goodwill could go.' The publication of *Health and personal social services statistics for England 1982* allows us to examine further the trends from 1977 to 1980.[2]

Referrals, list sizes and laboratory tests

The small growth in the population has been more than offset by the number of new general practitioners, so that the average list size has dropped from 2,331 to 2,247, and the average doctor now looks after 320 persons aged over 65 years, of whom 122 are aged over 75 years, compared with 323 and 118 in 1977. The *General household survey,* however, does show an increase in utilization rates, so that whereas in 1978 the average general practitioner dealt with 9,300 patient contacts, in 1980 the figure had risen to 9,617. Waiting lists are fortunately not any longer, but the continued shortening of hospital stays meant that in 1980 the general practitioner was responsible for 710 days of patient care that would have been in-hospital care in 1977. Outpatient referrals have increased, from 160 per 1,000 population in 1977 to 171 in 1980, and inpatient episodes from 115 per 1,000 population to 122. (Each general practitioner actually makes fewer outpatient referrals (360 in 1977, 353 in 1980) and from a smaller proportion of his consultations (1 in 26 in 1977 to 1 in 27 in 1980) but does so from a smaller list. Inpatient rates per doctor have remained the same.) This increase in hospital utilization probably represents a delayed effect of the 1971–76 demographic changes, rather than 'load shedding', because those indicators of the content of consultation (laboratory tests and x-rays ordered by general practitioners, and items prescribed for each patient on the practice list) have continued to grow. Laboratory tests are up by 25 per cent, x-rays by 16 per cent, and items prescribed by 2 per cent. Meanwhile there are 9 per cent more consultants, who see 36 fewer new outpatients (4.7 per cent reduction), 17 fewer inpatient episodes (3.3 per cent reduction) and are responsible for 73 fewer follow-up outpatients (3.4 per cent reduction) per year.

Costs and manpower

As for costs, these reflect both increased manpower and the increase in care given: pharmaceutical costs increased from 7.8 per cent in 1976/77 to 9.1 per cent in 1978/79, but had dropped back to 8.2 per cent in 1980/81; general medical services, 5.1 per cent in 1976/77, dropped to 4.9 per cent in 1978/79, but had climbed back to 5.2 per cent in 1980/81. So, for all the avowed intent to 'put more money into medicine in the community', the National Health Service has actually seen a reduction, from 16.5 per cent of costs for general medical and pharmaceutical services in 1970/71 to 13.4 per cent in 1980/81.

Resources have, of course, been put into community nursing: in the five years from 1971–76 health visitors

increased by 20 per cent and district nurses by 35 per cent, and in the three years from 1976–79 by 14 per cent and 11 per cent respectively. But this only amounts to an increase, from 1971–80, from 0.3 health visitors per general practitioner to 0.4, and 0.5 district nurses to 0.6, and at one health visitor to 5,774 people and one district nurse to 3,777 people in 1979 their caseloads remain far too high.

The quarts appear to be coming out of the pint pots: general practitioners are responsible for more and more of the total care provided by the National Health Service, without any real increase in the share of the National Health Service resources with which to do it. The addition of new principals is a niggardly contribution, when they are largely remunerated on capitation from a stable population. 'Transferring resources to the community' means new spending on health centres, community nursing staff, computerizing FPC records, and new initiatives.

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Is training in psychiatry relevant for general practice?

THE psychiatrist's appreciation of the training needs of general practice is coloured by an erroneous perception of the type of emotionally disturbed patient in general practice, by a misguided approach to general practice training, and by a lack of appreciation of the nature of general practice itself.

Goldberg, in the excellent monograph *Mental illness in the community. The pathway to psychiatric care,* clearly defines the dimensions of the 'referral filter' through which patients pass from community to general practitioner, to psychiatrist.[1] The patients who are not primarily referred to the psychiatrist suffer from minor mood disorders with anxiety and depression. The psychiatrist sees essentially the 'psychiatric' patients with affective disorders, the psychoses, organic brain disorders, and the severe personality disorders. Many psychiatrists thus believe that severe disturbance is common in general practice, and general practitioners are accordingly often exhorted to recognize and treat depression more effectively. The general practitioner needs assistance for the ambulatory patients whom he does not refer, who are likely to comprise more than 90 per cent of the emotionally disturbed population. Only 10 per cent of cases present openly with a psychological problem, so that efficient interviewing detection skills are of paramount importance. Johnston and Goldberg have shown that early detection and treatment of the overt emotional problem results in relief of symptoms and psychological pain, without 'medicalizing' the illness and with probable cost benefits.[2]

Wakefield and Lesser have shown that such patients prefer and need to be treated by general practitioners in their 'home setting', that most of them do not need referral, and few need pharmacotherapy.[3] They want brief and effective help in problem resolution. Thus the training locus for general practitioners should be with their own patients, in their own settings, and not in tertiary care psychiatric settings where the emphasis is on diagnosis and treatment of the major disorders. In these tertiary care centres, it is not easy for general practitioner trainees to be readily accepted by multidisciplinary groups. General practitioners require such training only where some specialized need must be met.

General practice differs from psychiatry not only in the nature of patient population, but in the nature of the practice itself. General practice is a primary contact speciality, offering continuity of care, multiple and continuing points of entry into individual and family systems, with particular time constraints requiring a different interviewing approach, and with a varied practice that involves significant change in the mental set of the practitioner. Their patients do not want long-term therapy and, like the general practitioners themselves, are not impressed by a psychodynamic model, but would rather have a pragmatic, problem-orientated approach. General practitioners need effective and efficient interviewing approaches to detect the covert problems, to discuss them with their patients, and to assist in resolving them; it may well be that they have to be the most efficient interviewers in clinical medicine.

The psychiatrist who works with general practitioners must understand the referral pathways, the way patients present, the need for detection and brief problem-orientated treatment, and the nature of general practice. Psychiatrists must not be wedded to one theoretical model but must be able to use all the major theoretical models for the understanding and treatment of patients. If psychiatry is to be relevant to general practice, then it is the psychiatrist who must go to the general practice setting and teach the general practitioner trainees along with their patients, using approaches that are geared to general practice.