The general practitioner as manager

The general practitioner who is likely to advance in the management structure is likely to have sound health, be emotionally stable and come from a secure practice base. With experience the skills of clear thinking, quick sifting and communicating clearly will have been developed. None the less the general practitioner manager will not be able to function fully unless there is an appreciation by general practitioner colleagues of the problems faced by their representative. Coming from an environment of the independent contractor there is a feeling when in NHS management of being less involved because of the closer working relationship of those working in the hospital and the district authority.

Some general practitioner colleagues resent the time which is spent in the managerial process. Their motivation is often different and they lack an appreciation of the importance of the general practitioner contribution. It may be thought that health authority management takes too keen an interest in hospital matters to the detriment of primary care. The general practitioner member has to see that there is a proper balance between primary and secondary care and to be knowledgeable in hospital matters as it is on their adequacy that general practice depends.

Doctors who become involved in management need continued support not only from their partners who invariably have to share the burden of extra patient care in the practice but also from all their colleagues in their locality. An appreciation is necessary of the effort put in on their and their patients' behalf, as some of the decisions having to be made will be unpopular despite being tested in the LMC and in other committees.

Role of the district management team

As a member of a district management team (DMT) the general practitioner is responsible with the other members for managing and coordinating most of the operational services of the NHS in a district.

The team reviews the needs of the community for health care and the provision of services within the district. It identifies opportunities for improvement to services or changes in priorities; the aim is to provide the best possible care with the resources available. In response to new national and regional policy guidance or in response to local innovation the team discusses proposals for new or modified district policies which are then submitted to the health authority. Annually the DMT presents to the health authority proposals recommending objectives and priorities for the development of services, allocation of resources within the district budget, allocation of additional resources and methods of finding them to finance future projects and programmes of action including performance targets.

Presenting the general practice view

To perform these functions successfully the general practitioner has to establish good relationships with the consultant and officer members of the team, establish credibility with them and recognize and respect the collective responsibility of the DMT. The general practitioner is expected to be responsible for the representative input of general practice interests based on his awareness of the views of general practitioner colleagues. It is essential for the general practitioner member to know of the service, financial and academic implications of national general practice policies. Having this knowledge the general practitioner must be prepared and able to comment on all matters from the general practice point of view and be innovative in bringing to the notice of the team matters which originate in general practice. Where there is no consensus within the DMT a decision may have to be deferred until advice has been taken from general practitioner colleagues. Thereafter the general practitioner must be able to evaluate the problem from his colleagues' point of view and advance suitable argument or pose relevant questions to help the chairman and members reach a decision.

Health authorities appreciate the value of the general practice contribution to management teams. Problems are looked at in a different way from the hospital view. In many areas, despite difficulties, the general practitioner member has been able to draw satisfaction from the influence of his major contribution to DMT discussions and decisions. Examples are where the suggested closure of a general practitioner hospital has been prevented, a proposed restriction of open access to radiology was stopped by the general practitioner member's input to a review procedure, physiotherapy in the community was begun largely because of the general practitioner member's contribution to discussion, and there are others.

There are difficulties in management, and for the general practitioner in management these cannot be underestimated. There is, however, a challenge in planning for the future. The general practitioner is able to influence the way the NHS is to be developed and managed and to have satisfaction in the interest in efficiency and quality control. The general practitioner's contribution is an important one.

FROM CHAPEL HILL

Financing primary care in the United States

JOHN J. FREY

Professor John Frey from the Department of Family Medicine at the University of North Carolina sends a further newsletter. He considers the re-organization of the financing of primary care in the United States.

CAPITATION, a word not heard above a whisper in *doctors' lounges in this country for 50 years, is back. It has actually been back for a long time in selected areas such as Southern California, but most of the country just attributed this to the different way Southern California does everything. Kaiser-Permanente Health Plan has been successful for decades, providing complete medical care at reasonable costs. It is the largest and best known HMO in the country. The Kaiser Plan was begun by a large steel company seeking to provide both comprehensive and high quality care for

workmen and their families.

An HMO is a Health Maintenance Organization through which patients purchase ambulatory and hospital coverage for themselves and their families through monthly payments to the Plan, rather than similar payments to an insurance company. In turn, the Plan hires salaried, full-time doctors who care only for patients of the Plan. Private practice by physicians is either discouraged or not allowed. The Kaiser Plan operates its own ambulatory centers, hospitals and laboratories. Its patients must consult Kaiser doctors and its doctors must use Kaiser consultants and hospitals. It is not traditional fee-for-service medicine, and, for this reason, has drawn the ire of organized medicine for decades. 'Freedom of choice' is a phrase central to the political position of the AMA.

A more recent but equally expanding financial organizational concept is the IPA, or Independent Practice Association (also called an open panel HMO). Patients and families purchase care through a plan which is usually organized through a large insurance company or corporation. The plan then contracts with primary care physicians and consultants who agree to care for patients from the plan. The average family doctor will have a mix of IPA patients and traditional patients, the only differences being that the IPA patients are not billed and that they must see IPA consultants when a referral is necessary. A family doctor receives a monthly capitation fee for each patient on his or her list and agrees to accept this in lieu of an office charge. Patients in turn agree to choose a family doctor from a list of participating physicians and to receive clearance from him or her before being seen by a consultant. IPAs strive to control the cost of care by paying family doctors to care for patients whether patients use the practice heavily or not, and by limiting patients' direct access to expensive consultant care.

Reasonable cost

In his atricle in the Winter 1977 issue of *Daedulus* entitled, 'Doing Better and Feeling Worse: Health in the United States,' the economist Eli Ginzberg argued that decisions concerning the distribution of health resources in the US would continue to reflect the right of all individuals to all levels and complexity of medical science as long as the cost to the country remained 'reasonable'. That reasonable level in 1977 was 8 per cent of the GNP. Ginzberg predicted that when the limits of tolerance were reached, profoundly different methods of financing would be brought to bear on the system of medical care with accompanying ethical choices. Now that the health care industry accounts for almost 11 per cent of the GNP, passing the 300 thousand million dollar mark spent yearly for health care, the country seems ready to get serious about making the needed changes to control the system. A scholarly, contentious history of American medicine even made the *New York Times* best seller list in 1983.[1]

However, in typical American fashion, we have set out madly in all directions simultaneously recognizing the need for reform (for others) while maintaining the status quo (for me). While the American Medical Association has lobbied for years against government intervention in medical care (in the mid 1960s, one of Ronald Reagan's first national political statements opposed the creation of Medicare for the elderly when he raised the spectre of 'socialized medicine' and told the public to trust their doctors) and has spent millions to elect members of congress who pledged to *decrease government regulation*, the real assault on the traditional practice of medicine in the US is coming from a most unlikely source—big business. It is as if the AMA has been outflanked in its battle for free market medicine by members of its own army—since business and medicine have for years been grouped on the conservative end of the political spectrum by each other and by most of the rest of the country. However, in the past few years, large corporation expenditures for employee health benefits have ballooned. In a vigorous economy, such an increase might not bite so deeply into corporate profits, but in time of depression and reassessment of corporate strategy, medical care inflation of 15 per cent per year presents a serious problem in most corporate budgets. I recently heard a health consultant to large US companies give an example of a firm employing 120,000 people which had an *increase* in health related benefits last year of 45 million dollars. Figures like that usually provoke action in the corporate world. The action has taken the form of promotion of capitation plans like HMOs and IPAs for employees.

Family practitioner's place

One important factor in all this reorganization is the redefinition of the entry point into the system. It is here where family practice may be made or broken. Most HMOs and IPAs realize that well trained generalists use less technological (read high cost) medicine and are central to the success of an efficient delivery system. Pediatrician or internist 'specialoids', in John Fry's term, are neither trained to do primary care nor really enjoy it. Many HMOs are hiring family doctors as the major providers of primary care, with a smattering of internists and pediatricians to provide other opinions when needed. Similarly, IPAs seek out family doctors who will contract with them to accept patients, since family doctors can decrease the referral rate to expensive consultants, thus making the whole plan less inflationary.

All this activity is not without its impact on medical education. More often lately one hears residents being asked, 'why *did* you order this test?' when in years past it would have been 'why *didn't* you order this test?' Deans of medical schools are beginning to use terms such as 'cost-consciousness' and 'cost-effectiveness' in their conversations. One questions whether the staff of medical schools who were trained in what might be called the golden age of American medicine—not necessarily because the ideas and research were golden, but because there was sufficient gold to support them—will be able to control their technological activities, teaching an approach to patients without 64 channel blood analyses in hand.

Cost-effective medicine

I remember two attending cardiologists I had as an intern. One was a 65 year old, trained when the ECG was a new technology. He would refuse to look at the ECG on a patient until after the history had been outlined; physical examination, complete with blue pencil for percussing the borders of the heart, had been reviewed and differential diagnosis had been criticized. The other attending was a young cardiologist who had made his reputation on Bundle of His catheterization. He demanded cardiograms first and used his stethoscope as a permanent type of decorative brooch appended to this lapel pocket. If students and residents are to learn 'cost-effective' medicine, I have my concerns that they will do so from the generation of teachers for whom it was never an issue.

There is an old Chinese curse which frequently comes to mind these days: 'May you live in interesting times'. These are indeed interesting times.

Reference

1. Starr P. The Social Transformation of American Medicine. New York: Basic Books, 1983.