

Referral to consultants — the National Health Service versus private practice

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SUMMARY. In a three-month audit of referrals to consultants by 18 general practitioners, a wide variation in individual doctor's referral rates was observed. The rate for private referral varied between doctors to a remarkable degree. Referrals made privately were twice as likely as NHS referrals to have been initiated by the patient. Private referrals were perceived by the doctors to have been no less worthwhile than NHS referrals. The holding of private health insurance by patients was a factor in a third of private referrals.

Introduction

THERE are considerable differences in the rate at which general practitioners make referrals to consultants. It is obvious that there is not a 'correct' rate, a rate applicable to all doctors in all circumstances, but, even so, the difference in referral rates between doctors can be striking.^{1,2} Referral to specialists serves many functions, some appropriate and some less so.³ It is a subject worthy of audit, not least because of its economic implications. We should aim to make the most effective use of resources.

Patients are less passive than formerly and the trend is towards greater involvement in decisions about their own health. This study attempts to identify referrals initiated by patients and to compare them with referrals initiated by doctors.

Membership of private health insurance schemes has grown rapidly in the last few years. This may affect the referral process. The patient who is prepared to pay for a consultation with a specialist may be less willing to allow the general practitioner to be the sole and unquestioned arbiter of whether such a referral is arranged. This study attempts to document this effect.

Method

Discussion at the Northampton Vocational Training Scheme trainers group led to the setting up of this study. The participants comprised 10 trainers or prospective trainers, two trainees and six partners in training practices. Participating doctors were asked to keep a record of the total number of personal contacts made with

patients during ordinary working hours for a three-month period (February, March and April 1982). Only the referrals to hospital outpatient clinics and the requests for domiciliary visits were reported. Acute cases admitted to hospital were excluded. The doctor filled in a card whenever a referral was made (Figure 1).

In completing this card, only one of the following reasons for referral could be given: for diagnosis, for management advice, for some form of action or for a check-up. Participants agreed that it was sometimes difficult to choose between these categories. The doctor was asked to reach a firm conclusion in identifying the instigator of referral. This was an entirely subjective judgement, but in practice was rarely difficult to make. If a referral was deemed to have been influenced by the patient's ability to consult privately, it was often for more than one of the reasons given, and participants were then free to express this on the card.

At the end of the recording period the cards were collected and the results analysed for each doctor. This information was sent to each participant and a meeting was

GP's name	
PATIENT DETAILS	REFERRAL
Name (or code)	Specialty
Sex	*Outpatient/Domiciliary visit *Private/NHS
Date of birth	
Reason for referral	Diagnosis/Management advice/Action Check-up
Instigator	Doctor/Patient/Relative/Other
Was this referral influenced by the patient's ability to consult privately? *Yes/No	
If yes, was it made (please tick appropriate answer(s))	
(a) only because it was a private referral?	<input type="checkbox"/>
(b) because NHS delay was unacceptable?	<input type="checkbox"/>
(c) because the patient had private insurance?	<input type="checkbox"/>
(d) because the patient had already made an appointment to see a consultant?	<input type="checkbox"/>
Please make any comments on reverse of card	
* please delete as appropriate	

Figure 1. The recording card.

arranged to discuss the results. From this meeting a further analysis of results was proposed. Each doctor was asked to look back at his own referrals to two specialties and to decide whether, with hindsight, each referral was worthwhile or not. The specialties that were chosen for this analysis were medicine, and rheumatology and rehabilitation. Each doctor had made at least one such referral yet there was a wide scatter in referral rates between doctors. Each participant was asked to consider the following questions before deciding whether to class a referral as worthwhile or not:

1. Was a diagnosis made that had not been made by the referring doctor?
2. Was a suggested diagnosis confirmed?
3. Was different treatment advised?
4. Was action taken? Was this appropriate or inappropriate?
5. Was subsequent management altered in any way? Was this for good or ill?
6. Did this referral lead to any change in your relationship with the patient? Was it for good or ill?

A further meeting was attended by nine participants; four other doctors sent in their assessments for inclusion in the analysis. Much debate centred around the meaning of the word 'worthwhile'. For whom was a referral worthwhile, the patient, the doctor or the NHS? In this analysis it was the doctors who decided. We wondered if a different picture would have emerged if the patients had been asked to make the assessment.

Results

The average number of patients seen by each doctor over the three-month study period was 1,547 (range 1,177–2,172 patients). The total number of referrals was 898. The specialties to which NHS referrals were made are shown in Table 1. The rank order for private referrals was

Table 1. Number of referrals to each specialty.

	Number of referrals
Surgery	230
Ear, nose and throat	101
Gynaecology	88
Medicine	79
Obstetrics	63
Orthopaedics	59
Rheumatology and rehabilitation	57
Ophthalmology	55
Dermatology	54
Psychiatry	38
Geriatrics	19
Paediatrics	16
Other	39
Total	898

almost identical. Only 11 out of 898 referrals were for a check-up (1.2 per cent).

Referral rates for individual doctors are shown in Table 2. As in most referral studies, the rates are expressed as referrals per 1,000 patient contacts. However, the referral rates are also expressed as consultations per referral which has the advantage of being a number that may be more comprehensible. The mean number of consultations per referral was 31.0 (range 15.9–56.1 consultations). Expressed as referrals per 1,000 patient contacts this gives a mean of 31.4 (range 17.8–62.9 referrals). Table 2 also shows private referrals as a percentage of total referrals for each doctor.

Table 3 shows the factors influencing private referral. The instigator of referral, as perceived by the doctor, is shown in Table 4 for both NHS and private referrals.

Apart from the doctor, the patient and relatives, referrals were instigated by a variety of professionals, for

Table 2. Referral rates for individual doctors.

Doctor	Total number patients seen	Consultations per referral	Referrals per 1,000 patient contacts	Private referrals as a percentage of all referrals
A	1,177	45.3	22.1	3.9
B	1,271	55.3	18.1	4.3
C	1,473	27.8	40.0	7.6
D	1,699	19.1	52.4	7.9
E	1,359	23.8	41.9	12.3
F	1,466	36.6	19.1	14.3
G	1,503	35.8	27.9	16.7
H	1,312	37.5	26.7	17.1
I	1,218	42.0	23.8	17.2
J	2,172	47.2	21.2	17.4
K	1,224	15.9	62.9	18.2
L	1,683	56.1	17.8	23.3
M	1,913	40.7	24.6	23.4
N	1,593	24.1	41.4	25.8
O	1,874	29.3	34.2	28.0
P	1,547	30.9	32.3	36.0
Q	1,498	31.2	32.0	45.8
R	1,865	36.6	27.3	52.9
Mean	1,547	35.3	31.4	20.7

Table 3. Reasons given for arranging a private referral (total 180).

	Number of referrals
Private referrals made:	
(a) only because it was a private referral	26
(b) because NHS delay was unacceptable	62
(c) because the patient had private insurance	64
(d) because the patient had already made an appointment to see a consultant	4
Total	156

Table 4. Instigator of referral in total of 864 referrals. (Percentages in parentheses.)

	NHS referrals	Private referrals
Doctor	473 (69.2)	108 (60)
Patient	140 (20.5)	72 (40)
Relative	35 (5.1)	nil
Other	36 (5.2)	nil
Total	684	180

Note: No information was available for 34 referrals.

Table 5. Thirteen doctors' assessment of whether their own referrals to specialties of medicine and rheumatology and rehabilitation were worthwhile or not. (Percentages in parentheses.)

	Type of referral		Initiator	
	Private	NHS	Doctor	Patient
Worthwhile	13 (76.5)	57 (73.1)	57 (76)	13 (65)
Not worthwhile	4 (23.5)	21 (26.9)	18 (24)	7 (35)

example opticians, health visitors and community nurses.

After the main study was completed, 13 doctors agreed to look at their own referrals to the specialties of rheumatology and rehabilitation and medicine. Ninety-five such referrals were considered. Each doctor assessed whether his own referrals had been worthwhile (Table 5). It is apparent that doctors were neither more nor less satisfied with the worth of private referrals compared with NHS referrals.

Discussion

The overall referral rates observed in this study were comparable to those in earlier studies,^{1,2} although the designs were not identical. In this study only referrals to consultants for outpatient or domiciliary assessments were considered. Acute admissions were excluded as were referrals to non-consultant hospital agencies, for example to dietitians. The wide variation between referral rates of individual doctors appears to have no simple explanation.^{3,4} The practices represented in this study were mostly situated in the town of Northampton but two of the practices were entirely rural: no difference between them was apparent. Referral rates were not related to the total number of patients seen. The two trainees, however, saw fewer patients than average and had a lower than average referral rate.

The low rate of referrals for check-ups cannot necessarily be taken to be the level of demand for such a service. Some patients may have been satisfied by their general practitioner's response. Others may have

referred themselves to a private health screening clinic in the town.

Two methods of representing the rate of referral are used: consultations per referral and referrals per 1,000 patient contacts. Either method is satisfactory. Some older studies used the concept of the number of patients for which the doctor was responsible. This approach seems redundant in today's general practice when practices increasingly contain trainees and part-time partners whose contribution to dealing with the practice's workload may be difficult to quantify.

No single factor satisfactorily explains the extreme variation in rates of private referral. A potent factor must be the degree of affluence of the practice population. This study has no direct evidence on this point. Nonetheless, all the participants were surprised by the degree of variation. There was a tendency for the older doctor to have a higher rate of private referral. Two or more partners from three practices participated in this study. They were doctors B, E, F and Q, doctors G, L, M and P, and doctors N and R (Table 3). In each case increasing seniority in the practice was associated with a higher proportion of private referrals.

Although the holding of private health insurance was the commonest reason given for making a referral privately rather than on the NHS, it was a factor in only 35.6 per cent of private referrals. A study in 1974⁵ in Leicester found that only 6 per cent of patients referred privately had health insurance; 46 per cent of the patients referred privately said that they chose private referral in order to avoid the wait for an outpatient appointment with the NHS.

The low incidence of referrals made because the patient had already approached a consultant (0.5 per cent of all referrals) was reassuring in that it suggests that our patients did not see their ability to pay for private consultation as a reason for attempting to bypass the general practitioner.

Patients referred privately were twice as likely to be the instigator of the referral (Table 5). However the doctor was only slightly less likely to instigate a private referral (60 per cent) than an NHS referral (69.2 per cent). This apparent contradiction arises because 10 per cent of NHS referrals were instigated by a third party.

The worth of his own referrals as assessed by the individual doctor is of necessity a subjective and imprecise judgement. However, the benefits or disadvantages of referral may be so subtle as to prevent any better assessment by a third party. Brown,⁶ assessing his own referrals to all specialties, judged with hindsight that 36 per cent were not worthwhile. Extracting the figures for the same two specialties as are examined in this present study, Brown's finding was that 75.6 per cent were not worthwhile, including all nine of his referrals to specialists in rheumatology.

The doctors' assessment of whether referrals were worthwhile or not showed that participating doctors were

neither more nor less satisfied with the worth of private referrals compared with NHS referrals. Doctors assessed patient-initiated referrals as only slightly less worthwhile than those initiated by the doctor.

The general impression from this study is that access to private consultations has little adverse effect on the referral process of general practitioners. Patient-initiated referrals were common. Doctors recognized that such referrals could be worthwhile.

References

1. Anonymous. Practice Activity Analysis 5. Referrals to specialists *J R Coll Gen Pract* 1978; **28**: 251-252.
2. Morrell DC, Gage HG, Robinson NA. Referral to hospital. *J R Coll Gen Pract* 1971; **21**: 77-85.
3. Cummins RO, Jarman B, White PM. Do general practitioners have different referral thresholds? *Br Med J* 1981; **282**: 1037-1039.
4. Bourne S. Second opinion — a study of medical referrals in a seminar for general practitioners at the Tavistock Clinic, London. *J R Coll Gen Pract* 1976; **26**: 487-495.
5. Fraser RC, Patterson HR, Peacock E. Referrals to hospitals in an East Midlands city — a medical audit. *J R Coll Gen Pract* 1974; **24**: 304-319.
6. Brown JM. Why not audit hospital referrals? *J R Coll Gen Pract* 1979; **29**: 793.

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Food poisoning from *Clostridium perfringens*

Recent outbreaks of food poisoning demonstrate the value of serotyping and enterotoxin detection in investigation of outbreaks of food poisoning suspected to be due to *Clostridium perfringens*. Studies in the Food Hygiene Laboratory have shown that enterotoxin can be detected in over 80 per cent of the faecal specimens associated with *Clostridium perfringens* food poisoning if the specimens are collected within the first two days of illness. The majority of such outbreaks are usually serologically confirmed i.e. a common serotype is isolated from the faeces of most of the patients examined. When outbreaks are not serologically confirmed, detection of enterotoxin can be an important and significant finding.

Source: Public Health Laboratory Service. Importance of serotyping and detection of enterotoxin in *Clostridium perfringens* food poisoning. *Communicable Disease Report* 84/18, 1984.



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