

# Family practitioner committee records — a neglected resource.

## 2. Drawing the profile of an area

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*SUMMARY. Capitation and item of service fees paid by a family practitioner committee can be analysed to produce a profile of the area which covers list sizes, age structure and mobility of the population and the extent of various practice activities. Such an analysis was made for Kensington, Chelsea and Westminster, an area for which it was particularly appropriate to consider these variables in terms of partnership size and doctor's age. Practices with one or two principals had lower rates of claiming for items of service than the larger partnerships, and within these smaller groupings it was the practices with elderly doctors that had the lowest rates. The findings indicate a problem associated with elderly doctors but wider conclusions are not necessarily justified. Profiles produced in the way described should be available for local planning but must be interpreted with caution.*

### Introduction

THE first paper in this series described how data on claims for capitation and item of service fees accepted by a family practitioner committee (FPC) could be used to provide an information service for general practitioners.

This paper shows how these data can be used to draw a profile of general practice in an area. Kensington, Chelsea and Westminster is a densely populated part of the West End of London in which wealthy neighbourhoods lie side by side with areas of social deprivation. A fifth of all the residents and more than two-fifths of the pensioners live alone. The population is highly mobile and falling rapidly in numbers. The many problems of providing primary care in such a setting were described in detail in the Acheson Report.<sup>2</sup>

The Report laid considerable emphasis on the high proportions of single-handed and elderly doctors who serve the area, and for this particular profile it was appropriate to analyse the claims by partnership size and doctor's age; different variables may be more relevant in other areas.

General practice is, of course, much more than a matter of registering patients and claiming for items of service and it is important to see this study in proper perspective: it shows the truth but not the whole truth; it is a profile, not a portrait.

### Method

The methods used have been described in an earlier paper.<sup>3</sup> Briefly, net figures on which each practice's capitation and item of service fees were based were extracted from the records of the Kensington, Chelsea and Westminster FPC. Data from 154 practices with 227 principals were analysed. Practice list sizes

for patients living in the Kensington, Chelsea and Westminster FPC area were calculated by taking the means of their four quarterly figures for the year April 1984 to March 1985. Unless otherwise stated the list sizes in the results relate only to the population within the area registered with the doctors in the study and not to patients living outside the area. The 'total' list size of the doctors was also calculated; this covered both patients living within the Kensington, Chelsea and Westminster area and those living outside it. The population of the area was derived by adding together the mean values for all the practice lists in the area.

The size of the partnership and age of principals were noted as were the age of patients (in three age groups), list data (registrations, removals and temporary residents) and claims for items of service payment (night visits, immunizations, contraceptive advice, cervical smears, maternity services).

The final analysis looked at the employment of ancillary staff for whom 70% reimbursement of salary can be claimed: the regulations permit every principal who receives a full basic practice allowance to claim for two workers (whole-time equivalent at 38 hours per week) in defined categories. Principals with fewer than 1000 patients may claim for up to one worker (whole-time equivalent). The calculations are based on total list sizes and relate to claims for the quarter ending 30 June 1985. All periods of half-an-hour or more have been rounded up.

### Problems

Certain claims give rise to particular complications: not all cervical smears are deemed to be items of service; the rates for contraceptive advice and coil insertions are based on the numbers of quarterly payments made rather than on the numbers of patients involved; and for the 'female' items of service rates are calculated per 1000 patients aged under 65 years because different kinds of practices have markedly different percentages of elderly patients. Contraceptive advice and coil insertion rates are based on numbers of quarterly payments rather than on numbers of patients. Finally, the sub-headings of immunization and maternity service claims are so numerous that for simplicity the rates quoted are in terms of £ paid per 1000 patients rather than the numbers of claims per 1000 patients.

There were changes in partnership size in a small number of practices during the year. Since the increases almost balanced the decreases they have been ignored and practices have generally been classified by the number of partners at the beginning of the year. There were, however, two partnerships of five doctors initially both of which had only four by the end of the year: these have been placed with the partnerships of four so that this category is more correctly seen as 'four and over'. The few practices which disappeared altogether during the year have been omitted from our calculations.

### Results

In the year analysed, the population in the Kensington, Chelsea and Westminster FPC area was 372 038. There were also about 38 000 residents of the area registered with practitioners outside the area and about 45 000 patients living in other areas who were registered with doctors in the area. Table 1 gives the numbers

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of practices and principals, with the mean list sizes per principal analysed by size of partnership. It can be seen that the principals of the three-partner practices had the biggest (notional) lists and the single-handed doctors the smallest. Table 2 shows that the area is still characterized by a high proportion of single-handed and elderly doctors with small lists.

**Table 1.** Number of practices and number of principals in the Kensington, Chelsea and Westminster (KCW) area and mean list sizes per principal by size of partnership.

	Partnership size				
	Single-handed	Two-doctor	Three-doctor	Four-doctor	All
Number of practices	104	34	9	7	154
Number of principals	104	68	27	28	227
Mean list size (patients in KCW area)	1496	1546	2223	1833	1639
Mean list size (total)	1691	1807	2327	1995	1829
Percentage of total list outside KCW area	11.5	14.4	4.5	8.1	10.9

Looking at the data for patients, Table 3 demonstrates a generally similar age distribution across partnerships of differing size: the single-handed doctors have a slightly higher percentage of elderly patients than the average for the area, though the proportion is even higher for the partnerships of four; the three-doctor partnerships have the lowest percentage of elderly patients.

High mobility in the area is revealed by the figures for patient registrations and removals and temporary residents per 1000 registered patients (Table 3). As a group, only the four-partner

**Table 2.** Percentage distribution of principals by partnership size, mean notional list size per principal and age. Figures for England and Wales at October 1983 from DHSS.

	Kensington, Chelsea and Westminster area		England and Wales
	All principals	Single-handed principals	All principals
<i>Partnership size</i>			
Single-handed	45.8	—	12
Two-doctor	30.0	—	17
Three-doctor	11.9	—	22
Four-doctor	12.3	—	48
<i>Mean list size (small practices)</i>			
<1000	19.4 (15.4) <sup>a</sup>	32.7 (27.9)	2
1000–1499	21.1 (11.9)	19.2 (10.6)	8
<i>Age of principal</i>			
<45 yrs	24.3	11.5	50
45–64 yrs	51.6	50.9	46
≥65 yrs	24.3	37.5	5

<sup>a</sup>Figures in parentheses are based on total list size.

practices have more registrations than removals, while list sizes for the single-handed and three-partner practices are decreasing most rapidly. Just why the two-doctor partnerships should have an especially high claim rate for three-month temporary residents is not clear.

The rates for various item of service claims are also displayed in Table 3. Emergency treatments have been omitted because one

**Table 3.** Percentage distribution of age of patients and distribution of list data and claims for items of service per 1000 registered patients by partnership size.

	Partnership size				Range for all practices	Mean for KCW <sup>b</sup> area	Mean for England and Wales <sup>c</sup>
	Single-handed	Two-doctor	Three-doctor	Four-doctor			
<i>Age of patients (%)</i>							
<65 yrs	84.7	86.5	87.1	83.1		85.4	85.0
65–74 yrs	8.2	7.2	7.0	8.8		7.8	8.7
≥75 yrs	7.0	6.3	6.0	8.1		6.8	6.4
<i>List data (no. per 1000 patients)</i>							
Registrations	132.6	142.4	133.6	162.7	0–1404.8		
Removals	160.4	154.8	159.5	145.7	0–510.7		
Temporary residents (2 wks)	12.0	13.1	14.6	13.2	0–67.2		
Temporary residents (3 mths)	56.7	71.1	40.7	47.6	0–409.8		
<i>Items of service claims (no. or £ per 1000 patients)</i>							
Night visits	3.8	5.4	5.0	7.1	0–17.1		
Immunizations (£)	71.6	60.5	167.2	169.3	0–989.4		
Contraceptive advice <sup>a</sup>	188.4	194.7	282.9	245.0	0–1246.8		
Coil insertions <sup>a</sup>	4.5	3.6	25.5	8.5	0–207.8		
Cervical smears <sup>a</sup>	2.8	2.5	6.8	4.8	0–37.2		
Maternity services (£) <sup>a</sup>	148.6	209.7	499.7	476.2	0–1626.0		

<sup>a</sup>Rates per 1000 patients aged under 65 years.

<sup>b</sup>KCW = Kensington, Chelsea and Westminster.

<sup>c</sup>At October 1983 (DHSS).

single-handed practice had extremely high figures that made comparisons meaningless. A strong pattern emerges from these figures: single-handed and two-partner practices, with whom 41.9% and 28.2% of the population living in the area are registered respectively, have much lower claim rates than do the larger partnerships.

It can be seen from Table 4 that single-handed and two-partner practices differ from the larger groups in another way too — they contain almost all the older doctors. Table 5 shows that within the single-handed practices, where most of the elderly doctors are to be found, the older the doctor the smaller the list size.

The evidence that it is doctor's age rather than size of partnership which is directly related to low claim rates appears in the next table. Table 6 gives all the data of the single-handed doctors in three age groups, and the differences between the youngest and oldest doctors are great. The trends (shown in Table 3) for single-handed practices to have above average percentages of elderly patients, falling list sizes and low claim rates can now be seen to be due to this group's elderly doctors. The young single-handed doctors display exactly the opposite characteristics and their data much more closely resemble those of the three- and four-doctor partnerships. Table 6 also shows data for the 34 two-doctor practices and demonstrates that doctor's age was having an effect on them too. In 20 of these practices both principals were below the age of 65 years, while in the remaining 14 at least one was 65 years or over. The mean list size of the 20 practices for patients living in the area was 3257, while that of the 14 practices where at least one principal was over 65 years of age was 2854; the former were looking after 17.5% of the population in the area and the latter 10.7%. Table 6 shows that having one older partner is associated with older patients, a more rapidly falling list size and lower item of service claim rates, though the findings are not as dramatic as those shown in Table 3.

When the print-outs for the quarterly information service were prepared it was striking how many practices had made no claims at all for various items of service. Table 7 shows the

**Table 4.** Distribution of age of principals by partnership size.

Age of principal (years)	Partnership size			
	Single-handed	Two-doctor	Three-doctor	Four-doctor
25-34	2	8	4	5
35-44	10	8	10	8
45-54	17	16	5	8
55-64	36	21	7	7
65-74	21	12	1	0
≥75	18	3	0	0

**Table 5.** Distribution of age of single-handed principals by mean list size of patients living in Kensington, Chelsea and Westminster (figures in parentheses are for total list size).

Age of principal (years)	Mean list size			
	<1000	1000-1999	2000-2999	≥3000
25-34	1 (0)	1 (2)	0 (0)	0 (0)
35-44	1 (1)	4 (4)	4 (3)	1 (2)
45-54	1 (1)	8 (5)	6 (4)	2 (2)
55-64	10 (9)	13 (11)	11 (11)	2 (5)
65-74	7 (6)	10 (8)	3 (6)	1 (1)
≥75	14 (12)	3 (4)	0 (1)	1 (1)

percentages of the population in the area registered with such practices and a breakdown of the practices by partnership size; 106 doctors — almost half the general practitioners in the area and all either single-handed or in two-partner practices — made no claims for maternity services.

**Table 6.** Percentage distribution of age of patients and distribution of list data and claims for items of service in single-handed and two-doctor practices by age of principal.

	Age of principals in single-handed practices			Age of principals in two-doctor practices	
	<45 yrs (n=12)	45-64 yrs (n=53)	≥65 yrs (n=39)	Both < 65 yrs (n=20)	One or more ≥65 yrs (n=14)
<i>Age of patients (%)</i>					
<65 yrs	90.0	84.8	81.7	87.4	85.3
65-74 yrs	5.4	8.2	10.0	6.7	8.0
≥75 yrs	4.6	7.1	8.3	6.0	6.7
<i>List data (per 1000 registered patients)</i>					
Registrations	201.7	136.5	85.4	156.0	120.2
Removals	190.4	148.4	171.2	143.4	173.3
Temporary residents (2 wks)	18.1	10.0	13.3	13.2	12.8
Temporary residents (3 mths)	87.9	59.7	32.6	78.0	59.9
<i>Items of service claims (no. or £ per 1000 patients)</i>					
Night visits	7.1	3.4	3.0	6.4	3.8
Immunizations (£)	195.6	64.4	19.2	71.1	43.3
Contraceptive advice <sup>a</sup>	358.6	185.4	92.8	190.4	201.9
Cervical smears <sup>a</sup>	10.6	2.0	0.2	3.4	1.0
Coil insertions <sup>a</sup>	19.6	2.4	0.0	4.7	1.8
Maternity services (£) <sup>a</sup>	443.6	115.4	47.0	249.7	143.0

<sup>a</sup>Rates per 1000 patients aged under 65 years. n = number of practices.

The figures for reimbursement of salaries show an overall figure for the area of 53.6% of allowable hours claimed and this is the same as the national average of 1.1 ancillary staff employed per principal, but variations with partnership size can be seen (Table 8). The larger practices are taking much greater advantage of the regulations — the claims of the four doctor practices are more than three times higher than those of the small single-handed ones (Table 8). There were no claims from 19 of the small single-handed practices and nine of the larger ones, or from one of the two-doctor partnerships.

**Table 7.** Practices making no claims in the year for certain of the items of service: percentage of the population living in Kensington, Chelsea and Westminster (KCW) registered with the practices and size of the partnerships.

Items of service not claimed for	Percentage of KCW popl <sup>n</sup> registered	Number of practices			
		Single-handed (n = 104)	Two-doctor (n = 34)	Three-doctor (n = 9)	Four-doctor (n = 7)
Immunizations	47.9	59	11	0	1
Coil insertions	35.9 <sup>a</sup>	84	19	1	1
Cervical smears	35.5 <sup>a</sup>	75	14	0	0
Maternity services	29.7 <sup>a</sup>	70	18	0	0

<sup>a</sup>Percentage of population aged under 65 years. <sup>n</sup> = total number of practices.

**Table 8.** Percentage of allowable hours claimed for permitted ancillary staff under regulations for reimbursement of salaries by partnership size (April–June 1985).

Partnership size	Percentage of allowable hours claimed			
	Secretary/receptionist	Secretary/receptionist/nursing	Nursing	Total
Single-handed	35.7	9.5	4.6	49.7
List size <1000	18.6	1.7	3.4	23.8
List size ≥1000 <sup>a</sup>	38.9	10.9	4.8	54.4
Two-doctor <sup>b</sup>	37.1	5.0	3.1	45.2
Three-doctor	51.1	8.5	1.9	61.5
Four-doctor <sup>c</sup>	66.4	3.2	7.9	77.5
All	42.3	7.1	4.2	53.6

<sup>a</sup>One practice allowed only 38 hours. <sup>b</sup>Three practices allowed only 2 x 38 hours. <sup>c</sup>One practice allowed only 7 x 38 hours.

## Discussion

There were some problems with the analysis of the data which should be taken into account. List inflation in the area is stated by the Medical Practices Committee to be 132%, and this implies that the denominator used in calculating the rates is seriously inaccurate. No correction was made for the error because it is not known if list inflation varies with size of partnership or doctor's age.

The analyses take account only of claims submitted by practices and accepted by the FPC. The accuracy of the profile is inevitably affected both by failure to claim and by faulty claims. Because of the variation in the dates when items of service are

counted, claims paid during the year do not exactly reflect the work done by a practice in that year. Since district services offer immunization, cervical smears and coil insertion the figures for these items of service claims, low as they are, may be credible; it is, however, surprising that almost half the general practitioners in the area made no claim for maternity services. They must have referred some women to hospital antenatal clinics in the course of a year and been eligible to claim for doing so; the inference is that they are failing to claim. There is no way of estimating the extent to which this casts doubt on the value of the profile as a whole, but the print-outs that were sent to these practices may alert them to the loss of income and the situation may begin to change.

The analyses relate only to unrestricted principals. It is worth noting that an above average number of assistants are employed in the area — for instance in the first quarter 15 assistants were recorded at the FPC, of whom 12 were with single-handed practitioners. Twelve single-handed practitioners had arrangements of various sorts with other doctors so that in some respects they were working in larger groupings.

Our aim in undertaking this study was to demonstrate that information recorded routinely by an FPC can be used to throw light on the strengths and weaknesses of general practice in its area. It would be naive, however, not to recognize that these findings have a bearing on such wider issues as professional accountability and the imposition of a retiring age for principals. Objective evidence of any kind about standards of care is hard to come by, and since any item of service which attracts a fee must be accepted as a component of good practice, the apparent deficiencies of the elderly doctors in providing these services could count against them. This is a problem which should not be ignored. That said, we would not like more weight to be put on our results than they should bear. It is not known if elderly general practitioners in other areas behave like those in the Kensington, Chelsea and Westminster area; in one instance at least — maternity services — the apparent deficiency in providing services may be due to a failure to claim. Furthermore, there are many ways in which a general practitioner can be of value to his patients that do not correspond with an entry in the files of the FPC, and those that count for most are the most difficult to count.

Finally, it is always dangerous to assume that there can be quick administrative solutions to problems whose historical, social and economic roots are of great complexity; for example, introducing compulsory retirement at a specific age is very much a treatment of symptoms and should not be expected to produce a cure. Policies which would allow more young doctors to practice in the area, with special provisions to overcome the practical difficulties of doing so, would seem to be a much more suitable response.

We believe that the analysis of data held by a family practitioner committee has a valuable part to play in planning the local development of primary care, but it will always be sensible when trying to make use of the findings to have an eye to their limitations.

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