

Family practitioner committee records — a neglected resource.

3. Three inner city areas compared

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SUMMARY. Data from the family practitioner committees of three inner city areas — Kensington, Chelsea and Westminster; Lambeth, Lewisham and Southwark; and Manchester — were compared. The information about general practitioners over one year included number of principals, distribution by partnership size and numbers working from health centre premises. Data about practices covered the five years 1979–83, with figures for mean list size, registrations and removals, temporary residents and claims for various items of service. Comparisons between the three areas showed great differences for which no convincing explanation could be found. The possibility that people living in these areas have different primary care health services suggests that comparisons should be made nationally; this requires family practitioner committees to be fully computerized and to collect their data in the same way.

Introduction

THIS third paper shows how data on claims for capitation and item of service fees held by family practitioner committees (FPCs) can be used to compare the characteristics of general practice in different areas, thereby drawing attention to issues which may need explanation or action. The objectives of the exercise are in a way analogous to those of the feedback service provided for individual practices which was described in the first paper in this series.¹

The three FPC areas chosen were: Kensington, Chelsea and Westminster; Lambeth, Lewisham and Southwark; and Manchester. All are inner city areas with serious social problems and much is known about the characteristics of general practice in them. Kensington, Chelsea and Westminster lies in the north-west and north-east Thames regions, while Lambeth, Lewisham and Southwark is in south-east Thames; they are two of the four core inner London areas described in detail in the Acheson Report on primary care in inner London.² Manchester features in studies from the research unit of the Department of General Practice;^{3–6} their data show how misleading it is to assume that the problems of inner London resemble those of the inner Manchester health districts, or, by extension, those of the inner areas of other provincial cities. Their data were obtained from general practitioners rather than from the FPC.

Method

In late 1984 the authors wrote to the administrators of the three FPCs requesting information and, although involved with the

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forthcoming reorganization of the FPCs, all agreed to help. Fewer categories of data were requested than for the more detailed study of Kensington, Chelsea and Westminster,⁷ but they were thought to be sufficient to demonstrate the feasibility and potential of making comparisons. The inclusion of figures over five years makes it possible to see the trends that have been taking place with time.

The data collected were: registered population at 1 July (in three age groups), list data (registrations, removals and temporary residents) and claims for items of service (emergency treatments, night visits, cervical smears, contraceptive advice, and coil insertions per 1000 registered patients and maternity services and immunizations in money paid per 1000 registered patients rather than number of claims accepted). All data covered the five years 1979 to 1983 inclusive. Data were also recorded about the total number of 'responsible' principals, the distribution by partnership size and the number working from health centre premises; this information related to 1 July 1983 only.

Results

The distribution of principals by partnership size and the percentages working from health centres are shown in Table 1. The important feature was the much higher proportion of general practitioners working in health centres and in partnerships of four or more in the Manchester area than in Kensington, Chelsea and Westminster.

Table 1. Percentage distribution of principals by partnership size and health centre practice for the three FPC areas, at 1 July 1983. Percentages for England and Wales at 1 October 1983 (DHSS, 1984).

	KCW (n=236)	LLS (n=401)	MAN (n=261)	England and Wales
Single-handed	46.2	21.4	22.2	12
Two-partners	27.1	24.9	10.7	17
Three-partners	14.0	23.9	29.9	22
Four or more partners	12.7	29.7	37.2	48
Working from health centres	5.9	18.2	23.8	27.6

n = number of principals. KCW = Kensington, Chelsea and Westminster; LLS = Lambeth, Lewisham and Southwark; MAN = Manchester.

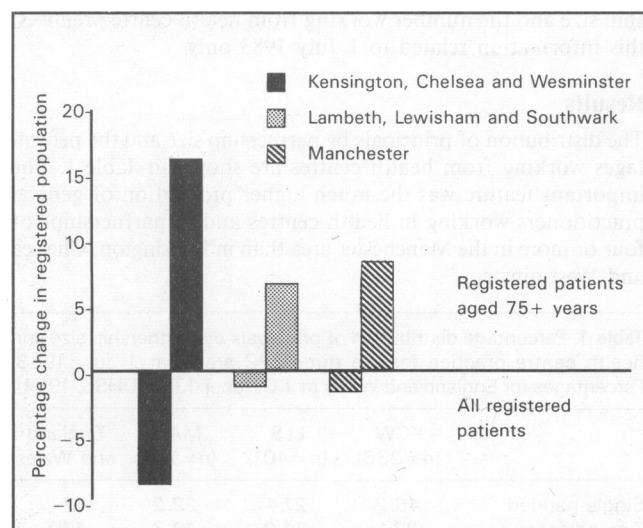
The age structures of the three populations did not differ greatly (Table 2) but in Kensington, Chelsea and Westminster there was an unusually rapid growth in the number of patients aged 75 years and over, while its total population was falling more steeply than that of the other two areas (Figure 1).

Table 3 covers the components of mobility — patients registering and moving and temporary residents. Not surprisingly, Kensington, Chelsea and Westminster had the most restless population and Manchester the least overall but it is worth noting that Lambeth, Lewisham and Southwark had a higher percentage of registered list changes than even Kensington, Chelsea and Westminster.

Table 2. Percentage distribution of three age groups in the registered populations of the three FPC areas for the five years 1979–83 (at July 1) and percentage change in each age group over the period.

FPC area	Age of registered patients (years)	1979	1980	1981	1982	1983	Percentage change 1979–83
KCW	<65	86.8	86.7	86.4	85.8	85.3	-9.6
	65–74	7.9	7.8	7.9	7.9	8.0	-6.9
	75+	5.3	5.5	5.8	6.2	6.7	+15.9
	Total	100.0	100.0	100.0	100.0	100.0	-8.1
		(n=471 978)	(n=472 555)	(n=466 638)	(n=450 096)	(n=433 962)	
LLS	<65	85.5	85.1	85.1	85.3	85.6	-1.3
	65–74	8.8	8.9	8.8	8.5	8.2	-7.9
	75+	5.7	6.0	6.0	6.2	6.2	+6.6
	Total	100.0	100.0	100.0	100.0	100.0	-1.4
		(n=849 745)	(n=836 400)	(n=835 126)	(n=838 919)	(n=837 838)	
MAN	<65	84.5	84.4	84.4	84.4	84.7	-1.7
	65–74	9.7	9.6	9.5	9.2	8.9	-10.1
	75+	5.8	6.0	6.1	6.4	6.4	+8.1
	Total	100.0	100.0	100.0	100.0	100.0	-1.9
		(n=500 912)	(n=497 832)	(n=495 565)	(n=494 784)	(n=491 302)	

n = total number of registered patients. KCW = Kensington, Chelsea and Westminster; LLS = Lambeth, Lewisham and Southwark; MAN = Manchester.

**Figure 1.** Percentage changes in the total registered population and in registered patients aged 75 years and over for the three areas between 1 July 1979 and 1 July 1983.

The rates for the remaining item of service claims appear in Table 4. Emergency treatments were nearly 45 times more common in Lambeth, Lewisham and Southwark than in Manchester, but it was in Kensington, Chelsea and Westminster that the rate increased most rapidly. Lambeth, Lewisham and Southwark doubled its already great lead over Kensington, Chelsea and Westminster in night visiting rates between 1979 and 1983, with Manchester intermediate and showing little change. Maternity services and immunizations expressed as £ per 1000 patients went up between 1979 and 1983 almost equally in the three areas, in line with review body awards: Manchester had the highest rise for the maternity services but the lowest for immunizations.

For cervical smear testing Lambeth, Lewisham and Southwark started at a higher rate per 1000 patients than the other FPC areas in 1979 (8.3 per 1000 patient) and this rate increased faster, so that by 1983 the cervical smear rate had risen more than three-fold to the remarkably high figure of 26.3 per 1000 registered

Table 3. Registrations, removals and two-week and three-month temporary residents, as percentages of the resident populations of the three FPC areas for the five years 1979–83.

List data	FPC area	1979	1980	1981	1982	1983
Registrations	KCW	12.3	12.1	11.9	12.5	13.4
	LLS	16.7	18.6	17.3	16.4	17.3
	MAN	16.0	13.4	14.3	15.2	12.6
Removals	KCW	12.6	12.2	13.4	17.0	17.0
	LLS	16.9	18.8	17.6	16.2	17.2
	MAN	16.9	14.3	14.3	15.8	12.9
Temporary residents (2 wks)	KCW	1.3	1.2	1.4	1.2	1.3
	LLS	1.1	1.1	1.1	1.0	1.0
	MAN	0.8	0.8	0.6	0.9	0.9
Temporary residents (3 mths)	KCW	6.3	5.8	5.2	5.2	5.6
	LLS	2.0	2.1	2.1	2.1	2.1
	MAN	1.3	1.1	1.2	1.3	1.2

KCW = Kensington, Chelsea and Westminster; LLS = Lambeth, Lewisham and Southwark; MAN = Manchester.

patients. To put this into context, if every woman aged between 35 and 64 years had a cervical smear in general practice every five years, this would produce an annual rate of about 35 per 1000 patients.

For both contraceptive advice and coil insertion claim rates, here based on quarterly payments rather than on numbers of women, Manchester had lower figures than either of the London areas.

Discussion

The overall picture was one of considerable variation between the three inner city areas, and the size of the variations was often surprising. It revealed not only how different general practice is in London and Manchester, but also the extent of the diff-

Table 4. Rates per 1000 registered patients of claims for items of service in the three FPC areas for the five years 1979-83.

Items of service claims (no. or £ per 1000 patients)	FPC area	1979	1980	1981	1982	1983
		Emergency treatments	KCW	0.9	0.9	1.8
	LLS	2.5	5.4	8.6	7.9	8.9
	MAN	0.1	0.1	0.1	0.2	0.2
Night visits	KCW	3.1	3.2	3.6	4.3	4.3
	LLS	49.1	58.1	88.1	105.2	130.6
	MAN	19.8	19.1	20.4	19.8	23.8
Immunizations (£)	KCW	31.6	35.7	49.2	69.2	87.1
	LLS	49.3	61.2	78.3	97.8	141.4
	MAN	24.4	31.8	41.5	56.2	68.0
Cervical smears	KCW	0.9	1.0	1.5	2.0	2.6
	LLS	8.3	11.7	19.4	22.6	26.3
	MAN	1.6	3.0	3.5	3.7	3.7
Contraceptive advice ^a	KCW	148.3	146.6	148.5	158.3	177.1
	LLS	115.1	126.0	133.2	141.2	159.4
	MAN	117.0	127.0	131.5	140.4	133.4
Coil insertions ^a	KCW	9.2	9.3	7.8	7.4	7.3
	LLS	8.5	8.8	8.2	7.0	8.5
	MAN	3.6	3.6	3.2	3.2	3.7
Maternity services (£)	KCW	72.6	94.3	118.4	144.6	179.0
	LLS	156.8	207.3	290.2	340.8	399.6
	MAN	270.8	390.4	477.3	541.7	600.6

^a Based on numbers of quarterly payments rather than annual claims. KCW = Kensington, Chelsea and Westminster; LLS = Lambeth, Lewisham and Southwark; MAN = Manchester.

erences which exist within inner London. Factors which might account for the differences need to be considered.

First, list inflation is known to differ in the three areas. The Medical Practices Committee bases its most recent (1979) calculations of true list size on 103.9% of the population being registered in Manchester, 109.3% in Lambeth, Lewisham and Southwark and 132.0% in Kensington, Chelsea and Westminster, while the national figure is 105.4% (Medical Practices Committee, personal communication, 1985). If the denominator used in calculating rates in Kensington, Chelsea and Westminster was too high, the rates for the items of service must all be too low and correcting them would tend to increase the variation between the three areas rather than reduce it.

Secondly, variation between doctors in the efficiency of claiming fees is unlikely to be an important factor. It is difficult to believe for example that practices in Kensington, Chelsea and Westminster were assiduous in sending in their forms for temporary residents and contraceptive advice but careless with those for night visits and cervical smears. The numbers of practices in the three areas should in any case be large enough to even out the differences.

Thirdly, there is often an association between larger partnerships or health centres and a higher routine provision of services, particularly preventive services; this tendency was apparent in data from Kensington, Chelsea and Westminster in an earlier paper.⁷ If it were generally true, however, there would be a consistent polarization between Kensington, Chelsea and Westminster and Manchester, with a higher provision of services in Manchester where more doctors work in large partnerships or health centres. In fact only claims for maternity services were

higher in Manchester, and this may be accounted for in part by Manchester's higher birth rate and lower abortion rate. There is also a strong indication that some doctors in Kensington, Chelsea and Westminster were failing to claim fees for which they were eligible.⁷

Fourthly, differences in administrative procedure and in the use of hospital and community services may explain part of the variation but some of the findings, such as differences in night visiting rates, remain difficult to account for. Night visiting rates have been studied by several other workers, and individual practice rates from 1.2 to 46.1 claims per 1000 patients were quoted by Sheldon and Harris,⁸ who calculated the rate for the Nottinghamshire FPC area as a whole as 15.5 per 1000 patients. Hobday's figure for Kent FPC was 10.95 per 1000.⁹ The contrast, therefore, between a rate of 130.6 per 1000 in Lambeth, Lewisham and Southwark and one of 4.3 per 1000 in Kensington, Chelsea and Westminster (where that of the highest practice was 17.1) is extraordinary. The reasons for the high night visiting rate in Lambeth, Lewisham and Southwark are worth exploring, although it falls within the annual 'allowance' which all three FPCs grant of 144 visits per 1000 patients in the use of a deputizing service.

The simplest explanation of the variation between the FPC areas cannot be discounted: that the residents of the three areas have different health services. This is a matter of considerable importance, and it lends weight to the idea that comparisons of FPC data should be made on a national scale. The new responsibilities of FPCs, as described by Ellis,¹⁰ do involve the collection of information for scrutiny by the DHSS but it is not clear if items of service will be included.

If national comparisons are to be made, all FPCs will have to collect their figures in the same way and publish them. In practical terms this will be easier to achieve when the FPCs are fully computerized and we would urge that they be provided with the necessary resources without further delay.

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