

Quality in general practice: a focus on inner cities

IT is in inner cities that the effects on health of social conditions are most acute and the financial problems faced by hospitals most severe. Inner cities are where general practice has in the past been criticized most and where there is the greatest need for high quality practice but the greatest difficulty in monitoring it and ensuring that it is achieved. The College's policy statement *Quality in general practice*¹ did not concentrate on the problems of primary care in inner cities but it will be in these areas that improvements in quality of care will have the most effect.

Improving quality in general practice can be looked at in terms of lowered levels of morbidity and mortality, better services and more efficient usage of National Health Service resources.

Levels of morbidity and mortality

If any sector of the NHS is going to have an influence on morbidity and mortality, general practice is in a good position to do so because general practitioners see their patients on average three or four times per year, often early in their illnesses and a practice has a registered population which is ideal for good preventive medicine.

It would be possible to design audits which examine activities that are known to improve health such as measles and rubella vaccination, cervical screening and anti-smoking counselling. An increasing number of practices are obtaining computer systems which can help in the organization of preventive medicine programmes so that much of the routine work can be delegated allowing general practitioners to concentrate on consultations with patients. It is now possible to relate mortality and some morbidity data to electoral wards by means of post-codes. Electoral wards are of a similar size to individual practices and the information from wards can be used to test the effectiveness of action taken to reduce morbidity and mortality at a practice level. Social conditions and, in some regions, hospital usage data are also available for wards and their relationship to health status and primary care can be studied. This work would be enhanced if computerized general practice morbidity records were collated on a ward basis using patients' post-codes.

Changes made by individual practices would be unlikely to have an effect which could be measured nationally unless there were some national method of coordinating general practitioners' actions, possibly by means of a computerized recording system. This is unlikely to happen in the near future, although the technology is available and the structure of general practitioner services ideally suited to an initiative of this type. If an important aim of general practice is to reduce mortality and morbidity rates then reducing the level of tobacco smoking would be the most effective preventive measure to tackle.

Improving general practitioner services

Even though it may be difficult to show that medical services have a significant effect in modifying morbidity or mortality on a national scale, people still value good health and health services more than other aspects of their lives.² General practice in the UK has a high reputation but there have been several reports which have drawn attention to poor standards in some areas especially in inner cities.^{3,4} The Royal Commission on the NHS stated that 'improving the quality of care in the inner city areas is the most urgent problem which NHS services in the community must tackle'.⁵ Previous editorials in the *Journal*^{6,7} have concurred with this view and it was a major theme in the

College's evidence to the Royal Commission.⁸ Despite a number of attempts at change, these problems remain. Educational improvements may be most effective in the long term but may bypass general practitioners with little motivation to change. There are however a number of areas of action which could bring about immediate improvements, such as the introduction of an agreed retirement age for all NHS general practitioners,⁹ the payment of a registration fee for fully registering new NHS patients, the introduction of primary care teams in good premises in underprivileged areas and monitoring of general practitioner services.

It would be invidious to introduce effective monitoring of services without at the same time attempting to make changes to help general practitioners working in difficult areas under the least favourable conditions. Allowance should be made for these difficulties when considering the recommendations concerning monitoring of services and introducing a good practice allowance in the Government's green paper on primary care.⁹ On the other hand, as Maxwell has stated, 'in the harsh world in which we live the Treasury is simply not going to be impressed by anecdotal evidence about health care quality based on self assessment. There has to be objective evidence'.¹⁰ It could be said that this is doubly applicable to a service provided by independent contractors. If general practice is to be given the greater share of NHS resources which Metcalfe¹¹ has argued so clearly it deserves, then it must also show that it can monitor its performance with objective data routinely collected on a national basis.

There are already considerable amounts of accurate information used for patient registrations and payment of general practitioners and pharmacists, much of which is being computerized. The most practical way of using this for quality control would be to have a national general practice registration system which would provide a computerized data base covering virtually the whole population. From the large range of items recording general practitioner activities it would be possible to select a number of key factors which would reflect the quality of service provided. A possible selection might include:

- Qualifications and postgraduate training of general practitioners.
- Prescriptions for central nervous system stimulants recorded by the Prescription Pricing Authority (drugs for which there is virtually no indication — used as a measure of prescribing standards).
- Removals of patients remaining within the practice area under the 'N', 'C' or 'B' codes indicating that patients have removed themselves from their general practitioner's list without changing their address or have been removed from the list by their general practitioner.
- Information regarding standards of premises and primary care team services offered, systematically collected by Department of Health and Social Security regional medical officers (or their equivalents).
- Hospital inpatient, outpatient and accident and emergency department usage by patients (once the Körner recommendations¹² are implemented).

These data could be kept and analysed centrally noting extreme deviations from the mean. The results could be sent confidentially to family practitioner committees, which are beginning to develop a range of performance indicators and they could review the results in the light of other information which they hold.

Usage of NHS resources

In the UK, the general practitioner filters patients before they are referred or admitted to hospital (except for emergencies and cases of drug addiction and sexually transmitted disease) and it has been suggested that this results in a lower usage of hospital services than in other Western countries and a lower proportion of the gross national product being spent on health services. Certainly about 95% of consultations with doctors in this country¹³ are with NHS general practitioners and this accounts for about 7% of the total expenditure of the NHS.^{14,15} However, there are wide variations in general practitioners' referral and admission rates to hospital even after allowing for differences in age, sex and social class structures in their practices.¹⁶ General practitioners are responsible for initiating all pharmaceutical services costs (12% of NHS costs) and about 85% of hospital costs (themselves 61% of NHS costs).¹⁵ It would appear therefore that general practitioners could have a significant influence on the consumption of more than 70% of NHS costs.

These factors are important when considering the current reduction in resources allocated to some inner city district health authorities and the move to transfer care from hospitals to the community. If general practice has a considerable influence on the usage of hospital resources¹⁷ and is particularly under stress in inner cities, there could be increasing problems for primary and secondary care services in inner cities if the difficulties for general practitioners working in these areas are not overcome. There is therefore a need for an overall national quality control of general practice, to determine whether the increased stress imposed by social conditions, hospital closures and transfer of services to general practice without the resources to go with them is imposing too great a strain on primary care, possibly leading to expensive and inappropriate use of hospital services, particularly in inner cities.

BRIAN JARMAN

*Professor of Primary Health Care,
St Mary's Hospital Medical School, London*

References

1. Royal College of General Practitioners. *Quality in general practice. Policy statement 2*. London: RCGP, 1985.
2. Abrams M. Subjective social indicators. *Social Trends* 1973; **4**: 35-40.
3. Collings JS. General practice in England today: reconnaissance. *Lancet* 1950; **1**: 555-585.
4. London Health Planning Consortium, Primary Health Care Study Group. *Primary health care in inner London* (Acheson report). London: DHSS, 1981.
5. Royal Commission on the National Health Service. *Report of the Royal Commission on the National Health Service*. London: HMSO, 1979: chapter 7.
6. Anonymous. Primary care in big cities. *J R Coll Gen Pract* 1972; **22**: 653-654.
7. Anonymous. General practice in big cities. *J R Coll Gen Pract* 1976; **26**: 710-711.
8. Royal College of General Practitioners. *Evidence to the Royal Commission on the National Health Service. Policy statement 1*. London: RCGP, 1985.
9. Secretaries of State for Social Services, Wales, Northern Ireland and Scotland. *Primary health care: an agenda for discussion (Cmnd 9771)*. London: HMSO, 1986.
10. Maxwell RJ. Quality assessment in health. In: *NHS management perspectives for doctors*. London: King's Fund, 1985.
11. Metcalfe D. Trends in the utilization of the National Health Service. *J R Coll Gen Pract* 1983; **33**: 615-618.
12. Department of Health and Social Security. *Steering group on health services information: community health services*. London: HMSO, 1983.
13. Office of Population Censuses and Surveys. *General Household Survey 1982*. London: HMSO, 1984: Table 8C.
14. Office of Health Economics. *Compendium of health statistics*. 5th edition. London: OHE, 1984.
15. Department of Health and Social Security, Welsh Office. *Health services costing returns for year ending March 1982*. London: DHSS, 1983.
16. Cummins RO, Jarman B, White PM. Do general practitioners have different 'referral thresholds'? *Br Med J* 1983; **282**: 1037-1039.
17. Day P, Klein R. Controlling the gatekeepers: the accountability of general practitioners. *J R Coll Gen Pract* 1986; **36**: 129-130.

Alcohol — finding solutions

WHY are screening tests for alcohol problems not widely used in general practice when it is known that general practitioners are aware of only a small proportion of the problem drinkers among their patients? This question was posed in the *Journal* in 1983 in the editorial 'Alcohol — looking for problems'.¹ The suggested explanation was that general practitioners were sceptical about the effectiveness of treatment for problem drinkers and doubtful that early detection was in any way beneficial. Recent surveys have confirmed that general practitioners are gloomy about the prognosis for problem drinkers, and only a minority are motivated to work with such patients. Even general practitioners with a special interest in the management of alcohol misuse have stated that it is unrealistic to aim to treat the bulk of problem drinkers in primary care. Is such pessimism still justified?

The development of an effective screening instrument presupposes that a 'case' can be defined adequately. While most clinicians would agree on the features of severe alcohol addiction, there is less agreement about the definition of early harmful drinking. Some people drink significantly more alcohol than their peers and a small proportion of these heavy drinkers will become addicted to alcohol. However, people who are not

habitual heavy drinkers can suffer harm from their drinking and this is particularly true of the social morbidity that may accompany acute intoxication, for example, drunk driving and violent behaviour. Often such individuals are called problem drinkers. A common definition of a problem drinker is someone who experiences social, psychiatric or physical problems because of his or her repeated drinking of alcohol. But there is no general agreement about this definition or what evidence is necessary to indicate that a problem is caused directly by drinking too much. Epidemiologists are dissatisfied with the concept of the problem drinker but many clinicians have argued that this approach is quite sufficient to define individuals who need help. In general practice, problem drinkers are much more common than alcoholics.

Most screening techniques have been developed and validated among alcoholics in hospital. Clinical findings — for example, spider naevi, tremor, traumatic scars — and short questionnaires about drinking habits have been found to be more powerful screening tools than laboratory tests. Such techniques, however, may not be as useful in general practice. Few of the common signs and symptoms of alcoholism are common in general practice.² However, the most promising of the screening question-