Workload in a general practice 1950–85

JOHN FRY, MD, FRCS, FRCGP
General Practitioner, Beckenham, Kent

JOHN B. DILLANE, FRCS
General Practitioner, Beckenham, Kent

SUMMARY. Annual patient consultation rates have been recorded continuously for 36 years in a stable National Health Service practice in a south-east London suburb. Four phases in consultation rates were noted: rising rates from 1950 to 1956; peak rates from 1957 to 1963; falling rates from 1964 to 1970 and low stable rates from 1971 to 1985. Thus workload fell by almost 50%, from a peak of 3.81 to a low of 1.93 consultations per patient per year. The reduction of 91% in home visits was much greater than the 43% reduction in surgery (office) consultations.

Certain questions are raised by the study: why are the consultation rates of this practice so low (one half the national rates); why have consultation rates in the practice fallen; and how many general practitioners are needed by the NHS? More studies are needed which compare practices, their processes and outcomes, and which analyse cost benefits in the health service.

Introduction

SINCE the introduction of the National Health Service in 1948 the issue of the optimum number of patients per general practitioner has been constantly debated. The Royal Commission on the National Health Service[1] stated that 'Before a maximum or a minimum list size is adopted, considerable research on this important question should be undertaken'.

In the most comprehensive review on the subject Butler[2] noted the lack of information for manpower planning in general practice, not only about numbers of patients but also about how many doctors are needed.

General practice offers special and feasible opportunities for continuous recording of consultations for a known population. We report on 36 years (1950 to 1985) of recording of doctor–patient consultations in a single practice.

Method

Practice

The practice is situated in a south-east London suburb. The population belongs mostly to social classes 2, 3 and 4 and is relatively stable with a 5–7% annual removal rate.

Doctors

From 1950 to 1960 there was one principal and one part-time assistant, from 1961 to 1970 there were two principals, and from 1971 to 1986 there were two principals and one part-time assistant. There was no private practice and the practitioners were not involved in any outside work in hospitals or in training.

Staff

From 1950 to 1954 there were no secretarial or receptionist staff, from 1955 to 1965 there was one whole-time equivalent member of staff and from 1966 to 1985 there were two whole-time equivalents. From 1965 onwards a health visitor, district nurse and midwife were attached to the practice.

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Services

An appointment system was introduced in 1962. The practice policy is that patients requesting appointments should be offered one the same day with one of the doctors. There is no limit to the number of appointments available. Antenatal and childrens' clinics have been running from 1960; there are no other special clinics.

Recording methods

The methods of recording were simple and cheap. All face-to-face consultations and home visits were entered on a day sheet and then logged each week and for each year. An age–sex register provided the population at risk (denominator). Thus, the annual consultation rates per person were calculated.

Results

Size of practice

The size of the practice grew gradually from 1950 to 1968 and then stabilized (Figure 1).

Consultation rates

The annual consultation rates per person (Figure 1) can be divided into four periods:

1950–56, rising rates (up to 3.5);
1957–63, peak rates (3.5 to 3.8);
1964–70, falling rates (3.3 to 2.3);
1971–85, stable rates (below 2.3).

Home visiting rates

Annual home visiting rates declined by 91% from a maximum of 0.70 per person in 1959 to a minimum of 0.06 per person in 1981. This drop was twice as great as the decline in annual surgery (office) rates of 43% from a maximum of 3.21 per person in 1961 to a minimum of 1.82 per person in 1972.

Discussion

Butler[2] stressed that each general practice was unique in its staffing, organization, patients and philosophy. Therefore the experiences of this practice may be unique but because of the long period of recording, almost since the beginning of the National Health Service, the trends should be noted and considered.

Contrary to general belief our workload, as measured by annual consultation rates, has declined from a peak between 1957 and 1963, to a remarkably stable rate since 1971. Our present annual consultation rate of around 2 compared with 4.3 in the 1983 general household survey[3] and 3.7, 2.8 and 3.4 in the three national morbidity surveys in 1955/6, 1971/2 and 1981/2 respectively.[4] Butler[2] observed an inverse relationship between list size per doctor and consultation rates. This practice has a 'high' list size per doctor which may partly explain why the consultation rates per person are low.

There are two questions which are raised by the data but cannot be answered satisfactorily. First, why do our patients have low consultation rates? We have not been able to discover any discrete factors. We believe that the decline and then the stability of the consultation rates in our practice have emerged from general policies as determined by the doctors themselves.

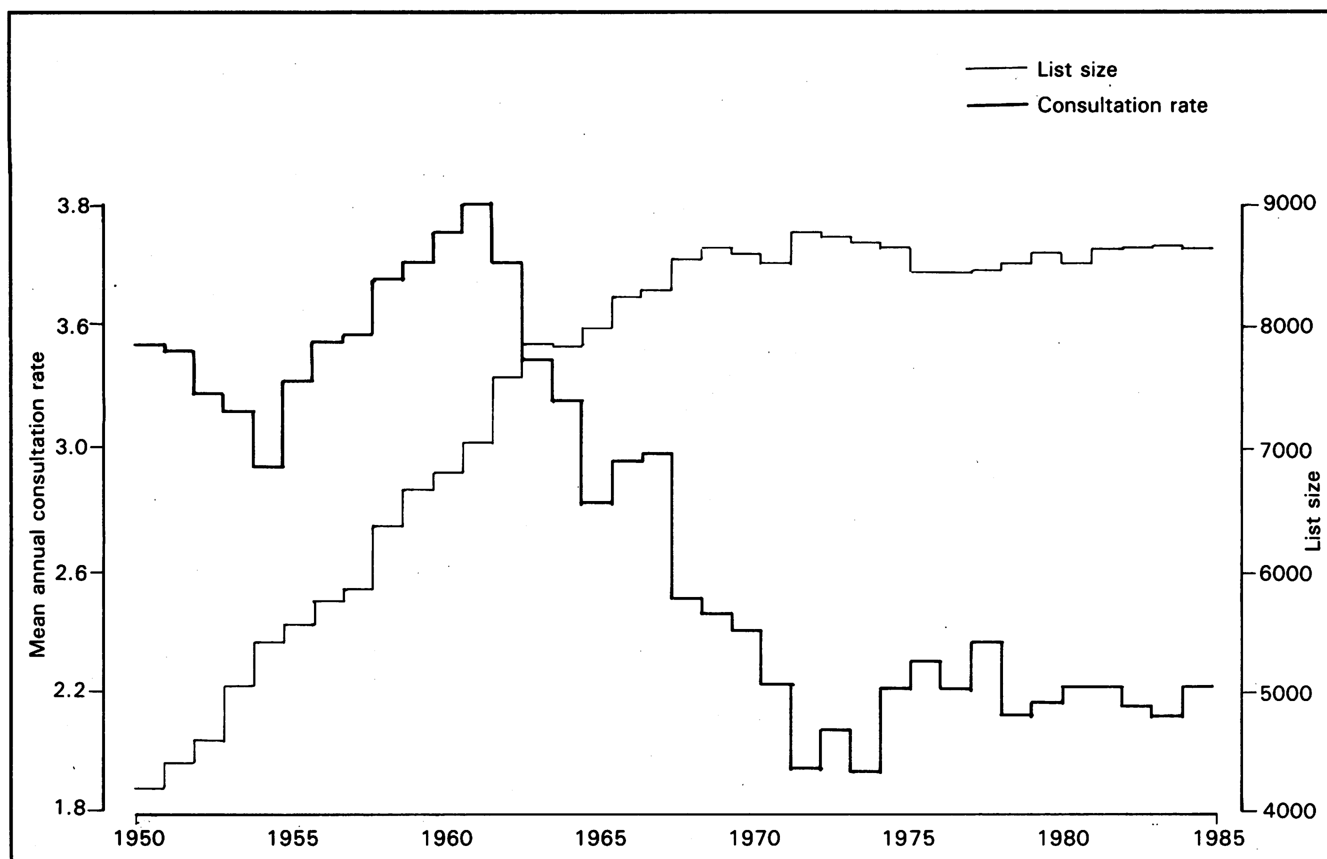

Figure 1. *Practice list size and annual consultation rate per patient 1950-85.*

Secondly, what are the implications of our findings of low stable consultation rates for the last 15 years for manpower policies for general practice? We are not alone in this finding. The general household survey found no real changes in consultation rate from 1972 to 1983[3] and the Royal College of General Practitioners[5] quoted falling consultation rates in practices between 1961 and 1974. It has to be asked whether list sizes should be encouraged to decline or whether the numbers of general practitioners can be reduced.

We have measured 'quantity' of work and have not attempted to assess our 'quality', but we believe that our processes and outcomes compare well with other practices and that our costs per patient are lower than average.

Our study demonstrates that long-term recording of consultation rates has been possible with simple pen and paper methods. We consider that there is a need to carry out national prospective studies on workload in general practice. Consultation rates offer just one part of a potential quantitative audit of general practice. In addition, composite practice profiles can, and should, be provided regularly by family practitioner committees on items of services carried out for preventive and other reasons; on prescribing rates and costs; on numbers of ancillary staff employed: and on costs of premises by rates and rent reimbursements.[6] Such comparative data would assist practices to consider their own policies and enable national planning to be made on accessible and meaningful information.

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Address for correspondence

Dr J. Fry, 138 Croydon Road, Beckenham, Kent BR3 4DG.

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