The Nuffield courses were hailed as a milestone in the development of postgraduate medical education.[5] If their aim was to organize the organizers and nurture the embryonic vocational training schemes, it is the purpose of the MSD Foundation to nurture the College's quality initiative and raise the standards of general medical care. Time will reveal the effect of the courses on the present generation of young enthusiasts and on the future of general practice.

D.C. MACINNES
General Practitioner, Motherwell

References

1. Parry KM, MacFarlane RG. An extended course in general practice. *J R Coll Gen Pract* 1983; **33:** 431-433.
2. Freeling P, Barry S. *In-service training.* NFER-Nelson Publishing, 1982.
3. Royal College of General Practitioners. *Quality in general practice. Policy statement 2.* London: RCGP, 1985.
4. Secretaries of State for Social Services, Wales, Northern Ireland and Scotland. *Primary health care: an agenda for discussion.* (Cmnd 9771). London: HMSO, 1986.
5. Anonymous. The Nuffield Experiment. *J R Coll Gen Pract* 1975; **25:** 547-548.

Money and the nature of practice

THE way in which doctors are paid accounts in large part for the differences in general practice between countries in the rich world. The two systems which I know best are those which operate in the United Kingdom and in the Republic of Ireland. General practitioners in the Republic are paid a fee for each item of service; for almost 40% of the population the fee is paid by the state, the remainder of the population pay at the time, usually in cash. Because practice denominators are available only for the poorer 40% of the population, good data on consultation rates are restricted to this section of the population which over-represents the young, the old and the poor. Nonetheless the data demonstrate annual consultation rates twice as high as most figures from the UK, an average of over six per person per annum compared with three or even less in the UK. Domiciliary visits attract a larger fee and domiciliary visit to surgery consultation ratios are much higher than in the UK. Lastly, as might be predicted, doctors with small lists tend to have very high consultation rates.[1]

The Irish College of General Practitioners has recently made public a discussion document entitled *The future organisation of general practice in Ireland.*[2] For many years Irish general practitioners have looked enviously across the Irish Sea. Those things which they particularly envy are the security of UK general practitioners, their pensions and the 70% subsidy of staff salaries. General practice in Ireland is still predominately single-handed and poorly supported by secretaries, receptionists and nurses. Provision for his own illness, early death or retirement has to be secured (and often is not) out of the doctor's earnings. It is not surprising that the document wistfully compares Irish and UK practice and aspires to achieve what in the UK is commonplace. (Somebody remarked that the document is more about catching up than leaping over.) It addresses many other issues including teaching and training, continuing education and relationships with other health professionals, hospitals and specialists in community medicine. It touches on manpower planning.

The document also considers how practitioners in Ireland should best be paid. The suggestions refer only to the state funded sector, as no major change is envisaged for the remainder of the system. Not surprisingly it plumps for a scheme which would combine capitation and fee-for-item-of-service payments. Such a system still provides inducements for activity which discourage idleness and delegation but diminish the temptation to create unnecessary work.

I believe that governments on both sides of the Irish Sea and our two Colleges recognize, and have recognized for a long time, the importance of methods of payment in relation to standards of care. The tendency is for the two systems to come closer together. The Charter of 1966 and subsequent developments have concentrated on inducements on top of basic capitation.

It would, however, be nice if we eschewed euphemisms and talked more openly about self-interest. Money can be used constructively to improve the quality and alter the nature of practice for better.

This notion is implicit in both the College document *Quality in general practice* and the Government's green paper on primary health care.[3,4] Both speak of incentives, which is a kinder word than bribes, but neither has much to say about the distorting effects on practice of such payments. 'Special' payments induce activity but such activity can only be provided by diminishing the time and energy devoted to other things. For example, a practice which has demonstrably high levels of immunization, blood pressure recordings or cervical smears may have achieved these at the expense of listening to people or visiting them in their homes. Incentives, like Boadicea's chariot in reverse, cut both ways.

J.S. MCCORMICK
Professor of Community Health,
University of Dublin

References

1. Allwright SPA, McCormick JS. A comparison of general practice in Britain and Ireland *J R Coll Gen Pract* 1977; **27:** 271-274.
2. Irish College of General Practitioners. *The future organisation of general practice in Ireland.* Dublin: ICGP, 1986.
3. Royal College of General Practitioners. *Quality in general practice. Policy statement 2.* London: RCGP 1985.
4. Secretaries of State for Social Services, Wales, Northern Ireland and Scotland. *Primary health care: an agenda for discussion (Cmnd 9771).* London: HMSO, 1986.

Postnatal care — who cares?

BEFORE the birth of her baby a mother has probably been seen on about 9 to 12 occasions by her doctor and/or midwife to ensure that her pregnancy is progressing satisfactorily, and, as the carrier of the baby, she feels that she is the recipient of the attention. After a straightforward delivery, however, attention switches quite abruptly to the baby. Once she has been discharged by the midwife, the mother is offered just one routine check-up for herself at six weeks.

This six-week postnatal examination seems to be of a variable standard. Some mothers receive a full examination with a smear test, family planning advice and the opportunity to talk about any of their perceived problems affecting their health. In other