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Is there a case for smaller lists?

THE government's green paper on primary care[1] came as disappointing reading for some, with its assertion that there is 'little evidence of a direct link between list size and the quality of care' and its suggestion that general practitioners' remuneration should be linked more closely to capitation fees, which would encourage large lists.

In 1980, Butler[2] reviewed the literature on ideal list sizes. His most definite conclusion was that doctors with large lists were more likely to be dissatisfied with the care they provided. He also found evidence that practices with small lists had higher annual consultation rates than practices with large lists. This effect could have been explained by easier access to doctors with small lists and he found no clear evidence that quality of care would improve if list sizes were reduced. However, Butler's conclusions were limited by the scarcity of evidence available to him.

Since 1980, a number of areas have become clearer as a result of published research. First, two studies have confirmed that annual consultation rates appear higher in practices with small lists.[3,4] These studies also suggest that actual time spent with patients[3] or booked time[4] is greater in practices with small lists. Although these associations were not strong and there was wide variation between practices with similar list sizes, practices with small lists were much more likely to see or to book surgery patients for 10 minutes or more. It does therefore appear that doctors with small lists see their patients more frequently and spend longer with them at each consultation.

Secondly, a study where booked time was used as an experimental variable has helped to clarify some of the benefits likely to accrue from longer consultations.[5,6] In this study, the aim was to compare the care of patients allocated at random to surgeries booked at 5.0, 7.5 and 10.0 minute invervals by analysing tape recordings of the consultations. In contrast to a previous study which compared the behaviour of doctors in two practices with contrasting booking arrangements,[7] patients attending surgeries booked at five minute intervals were no less likely to be examined, no more likely to receive prescriptions, no more likely to be referred to hospital, and no more likely to be asked to return for a further appointment. The main benefits found in surgeries booked at 10 minute intervals were that the doctors identified more problems, carried out more preventive procedures, and spent more time listening to patients and explaining their management. There was also an improvement in patient satisfaction in surgeries booked at 10 minute intervals.

The question which government must answer is 'Are these benefits worth paying for?' If surgeries were to be booked at 10 minute intervals, average list sizes would probably have to fall to 1750, or less in areas of high demand or need.[8] Alternatively, a substantial part of the workload could be taken over by other members of the primary health care team as in the model described by Marsh.[9]

Whether it is worth paying for more doctors in order to allow a reduction in list size depends on what is expected of general practitioners. Patients, rightly, have increasing expectations of their general practitioners. As well as receiving competent medical care, they expect to have an opportunity to express their views and to receive an explanation of their treatment. Responding to the government's green paper,[1] the House of Commons Select Committee on Social Services commented that 'Shortage of time in consultation is ... the major criticism of general practitioners expressed by patient organisations'.[10]

In addition to spending more time in consultation with their patients, there are

demands for general practitioners to extend their services in many other ways. These include care of patients discharged earlier from hospital, greater responsibility for the management of chronic disease and a greater emphasis on preventive services, including detection of hypertension, prevention of coronary heart disease, prevention of incapacity in the elderly and prevention of mental illness.[1]

It seems unlikely that the general practitioner's role can be extended into these areas without further time becoming available or without substantially increased support from other members of the primary health care team. To quote the Select Committee again: 'It is clear to us that shortage of consultation time is the greatest single obstacle to improvement and extension of primary care services by general practitioners ... the case for further reduction in general practitioner list size seems unanswerable'.[10]

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Use of hospital based investigations

THE size and complexity of the National Health Service is best appreciated by the fact that it is the country's largest employer with a budget in excess of £14 billion and over 50 million potential clients. For administrative purposes the NHS is divided into regions and districts; and functionally into primary, community based services and secondary, hospital based services. It is important to maintain good lines of communication between those working in hospital and in the community and to have effective deployment of both manpower and technical facilities.

At the inception of the NHS in 1948, X-ray and clinical pathology investigations were largely restricted to hospital practice. This lead to excessive outpatient referrals and a decline in both the standard of general practice and the morale of general practitioners. Happily over the last 40 years sense has prevailed and widespread access to these facilities has been made available to doctors working in the community.

The principle of direct access involving discussion between general practitioners and hospital colleagues about the most appropriate use of expensive and intrusive tests is preferable to open access which implies access as a right.

A recent study of the availability of hospital based investigations to general practitioners in the West Midlands has confirmed the willingness of doctors and their staff in both hospital departments and general practice to work together to provide a high standard of services for patients in the community (Thorpe GW. Unpublished report). The study notes that there is a wide range of clinical pathology investigations available through open access with rapid reporting of results. Although there is little published work on the subject, it has been shown that general practitioners do make appropriate use of clinical pathology facilities.

The trend in the USA for doctors to carry out their own biochemistry and haematology testing on office equipment is not likely to be repeated in this country because the NHS already provides excellent services and the commercial incentive is lacking. One exception is blood glucose monitoring in diabetics, where the patient is encouraged to make use of on-the-spot blood glucose monitoring.

The West Midlands study showed that the arrangements for general practice access to X-ray and ultrasound investigations were variable. As expected, chest and skeletal X-rays are readily available and in many district cholecystograms and barium meals are also available, although waiting lists vary from one to six months. Other contrast investigations and ultrasound scanning, both general and obstetric, are available in under half of the districts surveyed. These investigations are very labour intensive and therefore costly but there is evidence that general practitioners request the tests appropriately.[2,3]

Access for general practitioners to endoscopy, other than via outpatient referrals, is at present limited both in the West Midlands and nationally. Recent evidence suggests that not only are gastroscopy, sigmoidoscopy and colonoscopy complementary to barium studies, but in many instances preferable as a primary procedure.[4] Accurate diagnosis in gastrointestinal disease is essential for management and the case for an open access endoscopy service has been well argued by Jones.[5]

Accurate early diagnosis and appropriate management frequently depend on scientific tests to confirm or extend clinical findings and there is an excellent case to be made for a wide range of hospital based investigations being available to patients from general practice. There are clinical restraints, such as the false security given by a barium enema carried out as an isolated test for bowel disease, but the major constraints at present are lack of finance and trained manpower.

It is essential to audit the use made of investigations to establish whether they are being used appropriately and to justify the expense involved. At present the cost of investigations requested by general practitioners has to be met by district health authorities as the family practitioner committees have no finances to support this. The West Midlands study showed that 19% of requests for clinical pathology and 9% for X-rays in the region were from general practitioners, but the cost of these