Out of the fire and into the frying pan: thoughts in anticipation of a new contract

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SUMMARY. In anticipation of the government's review of the National Health Service an inner city doctor considers some of the issues raised by a contract which will challenge the general practitioner to manage a budget for both primary and secondary care and will require standards of care to be audited. There will be difficult clinical, management and ethical problems ahead, but these are capable of being solved. Such a contract holds out the prospect of enhanced health care for patients and a more fulfilled professional life for general practitioners.

Introduction

IN a report on the Queen's speech in the *Times* (23 November 1988) mention is made of a new contract to be introduced for general practitioners in which a budget would be held for both primary and secondary care. The College is concerned with professional standards and with the academic development of general practice, not with the terms and conditions of service of general practitioners. But the nature of the doctor's contract, no less than medical education and research, is an important determinant of quality.[1-3] The College can therefore have a legitimate interest in this new contract, and must now critically examine the clinical, organizational and ethical issues raised.

What follows is simply speculation fed by the carefully orchestrated hints and leaks from less than secret government sources. All general practitioners already operate a budget for the management of their practices but what appears to be proposed is a budget for almost all primary health care services, and a contract which will motivate the deployment of resources so as to achieve the maximum benefit for individual patients and for the practice population as a whole. What is revolutionary is the proposal to give general practitioners the responsibility for a substantial part of the hospital budget.

In the past year or two there has been much discussion about improving the cost effectiveness of hospital services. In particular there has been a great deal of enthusiasm for the creation of an internal market in the National Health Service. Now it would appear that the government intends to give the general practitioner responsibility for buying hospital care for his patients in a competitive market. By operating a budget for referrals, the general practitioner will be motivated to be more discriminating than at present about the optimum use of hospital services. By giving the doctor the freedom of an enlarged internal market, hospital services will be forced to compete with one another so as to become more quality conscious, and more cost conscious.

Type of budget

Clearly the proposed budget would be based on capitation, and take into account an actuarial estimate of the average cost of health care per capita. Immediately problems present themselves. The average cost per capita in the NHS conceals wide variations between the young and the old, between different morbidities, between social classes and between different parts of the country. Actuarial advice will be necessary to determine the minimum size of population for which a budget can be safely estimated and there is a danger that small practices may be excluded from the new contract. There would then be an impetus to create larger units in the name not of good management, or of good clinical practice, but of safe accounting.

It is easy to envisage the inclusion of prescribing costs and the costs of laboratory and imaging investigations in the budget for primary care but what of the cost of the community nursing services? The Cumberlege report[4] suggested a primary health care service based on neighbourhood nursing. A new budget holding contract for general practitioners may place community nursing services, like hospital services, in the position of competing suppliers. The implications for the relationship between general practice and community nursing are intriguing.

The creation of a budget for secondary care will be even more complex. Hospitals would be encouraged to quote competitively for first referrals and might be expected to compete in terms of rapidity of response, the guarantee of a consultant opinion at the first consultation, and cost. It would be relatively straightforward to create a budget for planned surgery. What fails to fit neatly into this model is the place of emergency hospital care and the long term institutional care of the mentally ill, the mentally handicapped and the infirm elderly. These would surely have to be excluded.

Type of control

It seems unlikely that the government will present the profession with an alternative and radical contract as a *fait accompli.* An experimental approach would be prudent and sensible, but perhaps too cautious and slow for a government bent on quick and radical change. It is therefore likely that health boards (elsewhere family practitioner committees) would offer such contracts as alternatives to the present one, and that progressively advantages would be built into the new contract and disadvantages into the old one.

A new contract might stipulate certain criteria relating to premises, equipment, staff ratios and records as a prerequisite to the granting of the contract. Perhaps something similar to the current national requirements for training practices would be appropriate. Minimum standards of care (and record keeping) could be created for a number of chronic diseases like diabetes and asthma; for the monitoring of pregnancy, early childhood and old age; and for a review of prescribing of a number of major drug groups. A practice annual report containing much of this evidence might be required by the new contract. In addition to data about preventive measures, the practice would be asked to give evidence of the review of critical events, including sudden deaths, the management of terminal illness at home and emergency admission to hospital. The creation of such an audit would provide new opportunities for academic thinking and professional negotiation with government.

The profession should monitor all these criteria by peer review. The cost of creating such a system, and the injunction to take part, would form an integral part of the contract and the budget. The role of the College in this peer review and its ability to

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develop reliable and valid monitoring may become the major challenge for the 1990s. The College's past experience with 'what sort of doctor?'[5] and the present work on fellowship by assessment will provide powerful working tools.

Public accountability, however, would seem to demand that this professional peer review should itself be subject to some sort of external audit. Full participation by practising general practitioners would be necessary if such external monitoring is to be both sensitive and well judged.

Management

Practices might accomplish the management of such a large budget in a variety of ways. First, one of the partners might change his or her major responsibility from the clinical care of patients to the management of the practice and its budget. Secondly, larger practices may well be able to recruit managers with the necessary experience and ability. Thirdly, the practice may wish to hire management services from other organizations; small practices may find that they have no other choice.

Private organizations are already in place which could provide the necessary data for decision making. Further, they might be able to provide a management service for general practice, advising on the optimum use of resources. There is a particular danger here. The proposal to set up managed health care organizations[6] envisages a form of contract in which individuals will register not with a particular doctor in practice, but with the care organization. In such a system each general practice would become the client of the management organization and the contractual bond between general practitioner and patient would be broken. Until now this bond has formed the basis of the doctor–patient relationship in NHS general practice.

Incentives and disincentives

Practices which fail to meet agreed criteria, or which fall short of negotiated targets, would stand to lose the contract. Although there would be checks and balances in such a system, and although provision would have to be made for due warning and renegotiation, the disincentive of losing the contract would be a powerful motivation to produce good practice at low cost. In its most crude form the contract would involve the general practitioner keeping as legitimate profit a portion of the difference between the sum allocated and the sum spent. Immediately a powerful moral objection presents itself. Is a doctor to be financially rewarded for postponing a 'low priority' hip replacement or hernia repair? It is one thing to consider costs in clinical decision making but quite another to boost income by denying treatment to a patient.

In a free market the provider has to temper the wish to cut costs with the need to compete. Currently in British general practice there is little competition because the Medical Practices Committee attempts to ensure an equitable and limited supply of doctors to all parts of the country. Competition for patients was not uncommon in the early days of the health service and it is remembered with distaste by older general practitioners. Yet without a discriminating consumer who has a choice in terms of both quality and cost, the free market cannot work.

I am assuming that the general practitioner as budget holder will operate entirely within the NHS. The basis of NHS funding, like that of any other pre-paid insurance scheme, is risk-sharing. Traditionally, doctors have had the right to refuse to accept patients, and they have not been required to give a reason for such exclusions. Even under the present system, there is a built-in disincentive to accept responsibility for patients likely to generate a high workload. Such patients will be even more costly to the practice under a budget holding system. There is the danger that unscrupulous doctors might be motivated to recruit high profit/low cost populations. The older, the disabled and perhaps the poorer members of our society might thus find themselves disenfranchised.

There would therefore need to be strict rules about risk-sharing and the right to refuse patients might have to be severely curtailed. Such curtailment would meet the economic needs of the system, and the ethical criterion of justice. However, it could threaten the quality of the doctor–patient relationship.

Quality of care depends both on choice of doctor and practice, and on professional judgement. The rewards and incentives for doctors in the new contract may therefore need to be calculated to balance quality, cost and consumer appeal. On the basis of these three elements, it might be possible to calculate a scale of bonuses which would be paid to the practice. Such a scale, sensitive to professionally judged quality and consumer appeal, could meet some of the moral objections to raw practice for profit.

The doctor–patient relationship

No system of health care is free from rationing. In the open market resources are limited by the individual's ability and willingness to pay for them. In a state welfare system they are limited by the priority which society puts on the health care budget, and the priority which is accorded to particular services. Traditionally, the general practitioner has acted as the advocate of his individual patient. In the real world, however, no doctor can champion the cause of his patient without regard for the needs of others, and for the general good of society. When the general practitioner has to manage the budget, the principle of distributive justice will become much more dominant in decision making and as a consequence the doctor–patient relationship may change radically.

As budget holder, the general practitioner may determine waiting times, and may find it necessary to refuse some treatments to some patients. It can be argued that such budgetary responsibility ought to lie outwith the doctor–patient relationship in general practice, which is essentially a relationship based on trust and advocacy. But such unalloyed trust and advocacy is less than honest. At present the general practitioner can hide behind some nameless bureaucracy which takes the blame for delaying and denying services. In effect there is no nameless bureaucracy, only a professional and political consensus about priorities.

The doctor–patient relationship in this new context may therefore change radically, but may be strengthened by a new honesty and a new realism. There is another hidden strength in moving responsibility directly to the individual's general practitioner. It may be that general practitioners' advocacy for the individual patient will be weakened but if they are in possession of good data about the needs of patients in their practice, and about shortfalls in the resources required to meet them, they become a far stronger advocate for the needs of their community. Further, if the general practitioner can re-deploy money saved from the budget in providing new and appropriate services for the practice, most of my reservations about the morality of profiting from good management disappear.

Conclusion

I practice in a two doctor inner city teaching practice. I expect to continue in practice for at least another 30 years. It seems inconceivable that at a time of accelerating technical and social change, I shall spend the rest of my life constrained by a contract which has its origins in the national health insurance act of 1911. It would be foolhardy to underestimate the clinical, moral, educational, organizational and financial problems which lie ahead. If the new contract is to succeed in enhancing the

quality of medical care and in achieving a better use of limited resources and a more fulfilling career for doctors the College will have to play a full part. The corporate strength of its membership will be needed to encourage, to question and to help build the educational and research infrastructure which the new contract will demand. Despite my anxieties and reservations, I have a sense of real opportunity. I want therefore to be not a victim, but an agent of the changes which lie ahead.

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