implementation of practice budgets is to proceed beyond the demonstration stage. The emergence of prices which are good proxies for health service resource costs will take time. During the transition period, the process of establishing prices should heighten general practitioners' awareness of the resource implications associated with their own practice style and that of others.[4]

Biased selection or biased subsidy?

The second set of prices are those assigned to patients via capitation payments. In the UK the process of setting risk based capitation payments is at an early stage. Its growth and development is likely to follow that of other countries where capitation payments reflect historical (average) patterns of health service utilization in different strata of the population. Age, sex and geographical area of residence are obvious factors that can be used to determine capitation payments. However, these factors on their own are poor predictors of variation in the use and cost of medical care.

A heavy dependency on capitation payments may encourage a biased selection (and retention) of patients.[5] This bias in favour of 'healthy' or less costly patients is a common criticism of capitation when compared with other payment systems such as fee-for-service. Overcoming this bias is a difficult task in a system which uses pre-determined capitation payments which are independent of actual service use. Biased selection will remain a possibility until a capitation system emerges which is based on an informed understanding of the distribution of health risks and the utilization of health services. Similarly, budget holders inheriting a set of patients with favourable health risks would effectively receive a subsidy from practices with less healthy populations.

Critical acceptance or blind faith?

Although the idealized features of a theoretical market may be irresistible, prospective budget holders like all novices in the marketplace have good reason to tread carefully. In health care, as in other markets, poor information leads to poor decisions. Information is costly but so too are the unintended consequences resulting from ignorance. The introduction of practice budgets should await the evaluation of well designed pilot projects. Despite pleas for experimentation from those responsible for popularizing the notion of primary care budgets in the UK[6-8] much work remains to be done. When the current atmosphere of confrontation is replaced by one of collaboration both the government and the medical profession should seize the opportunity to subject the budget scheme to the same critical appraisal that would naturally take place in a true market setting. Neglecting this requirement could unwittingly induce more costs than gains.

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Classification of psychosocial disturbance in general practice

PSYCHOLOGICAL disorder is one of the commonest reasons for consultation in general practice[1-5] yet at present we lack an effective system of classification of psychological disorder which is understood by all those who encounter patients in primary and secondary care as well as by mental health specialists themselves.

It is inherent to human society that we categorize to make sense of our environment. For classification to be of value, clear objectives need to be defined. First, a classification system should be a tool in the creation of a sensible differential diagnosis, which is the first step towards taking effective clinical action, avoiding non-specific and inappropriate care. A 'multiaxial' system, which takes account of psychological, physical, social and personality factors[6] may sensitize practitioners to diagnostic possibilities they had not previously considered. Secondly, classification should allow us to predict the natural history of a disorder, but this will only be the case after careful epidemiological study of each syndrome or diagnosis. Lack of agreement between researchers and clinicians on the diagnostic criteria of psychosocial disorders has so far impeded this work. Thirdly, classification is needed to achieve clear communication between doctors, patients and their families, not only for clinical purposes but also for education. Thus it is imperative that diagnostic labels are unambiguous. Lack of confidence in present systems of classification may explain why general practitioners remain reluctant to apply diagnostic labels in this field of care. However, labels can have a positive effect, giving patients an understanding that their symptoms are part of a recognized disorder.[7] Patients may function more effectively when they and others understand the psychological component of their problems. Obviously, labels can have negative effects by becoming self-fulfilling, by failing to encompass the complexity of individual human behaviour or by their inappropriate medicalization of social concerns. Thus diagnostic labels should not be considered indelible but should be subjected to regular review. Fourthly, classification not only directs research but must also be the object of carefully designed research in order to refine its own reliability and validity.

Present state of the art

Psychiatric diagnosis remains at the descriptive or syndromal

stage of classification. Because the aetiology of psychiatric disorders is frequently considered in social or psychological terms, there is a prima facie case for adopting a multiaxial system of classification.[6] Multiaxial systems have been adopted only in the last 25 years and stemmed from a final acknowledgement that aetiological and associated factors were important in the understanding and management of psychological problems.[8] In general practice in particular, outcome of neurotic illness may be predicted not only by the severity of the psychiatric disorder but also by the quality of the social environment and the presence of physical illness.[9] One of the principal classification systems to have utilized multiaxial concepts is the *Diagnostic and statistical manual of mental disorders (DSM-3)*[10] of the American Psychiatric Association and its revised version *DSM-3R*.[11] The five axes include psychological, physical and personality assessments together with psychosocial stressors and an evaluation of best previous functioning. The *International classification of diseases (ICD-9)*[12] may also adopt a multiaxial approach in its tenth revision.

Primary care physicians, however, recognize and treat a great deal of mental distress that they do not describe in the vocabulary of psychiatry. Whether the difficulty lies in the vocabulary or in the doctors remains unclear.[13] Furthermore, this problem is not restricted to psychiatry. Howie has shown that treatment of a physical disorder in general practice does not necessarily flow from a particular diagnosis.[14] Is it any accident that diagnostic systems have not found universal acceptance in general practice? The special features of general practice where illness often presents at an early stage and many disorders are transient, hinders the use of classification systems developed in the hospital setting.[14,15]

General practitioners classify in several ways. The first, but probably least common, is the use of traditional diagnosis.[13,14,16] However, the problems which constitute the majority of mental problems in primary care — psychosomatic conditions, organic disorder with associated emotional distress and psychosocial problems — are poorly served by traditional diagnostic systems. In fact, *ICD-9*[12] consigns many psychosocial categories to chapter 16, 'Signs, symptoms and ill-defined conditions', as well as to the little-known V code in the appendix. Secondly, many general practitioners, particularly when consulted by patients with psychosocial difficulties, classify on the basis of loose aggregates of symptoms. Although there is nothing inherently wrong with this system for any individual doctor, it casts to the wind any notion of reliability and with it all the benefits of effective communication, education and research. Thirdly, a problem oriented approach has been adopted by some doctors to rationalize management decisions.[16,17] Although this has advantages in that the physical, psychological and social aspects of problems are considered, this method also remains idiosyncratic to each doctor. Lastly, but by no means least commonly, doctors may proceed directly from symptoms to treatment and then in a tautological manner apply a diagnostic label on the basis of that treatment.[14]

Where does the problem lie? We would argue for a system of classification of psychological problems in primary medical care which is sensible and useful in practice. General practitioners seem to agree. There has in fact been an adaptation of the *ICD* scheme for specific use in primary care, the *International classification of health problems in primary care (ICHPPC)*[18] now to be known as the *International classification of primary care (ICPC)*.[19] For the first time, in a single classification, *ICPC* considers three important elements of health care, namely reason for encounter, diagnoses or problems and process of care. Jenkins and colleagues[15] have shown that while neither *ICD-9*[12] nor *ICHPPC*[18] could be applied consistently by general practitioners rating videotaped consultations, agreement on individual observations of patients' psychological, physical, personality and social features in this research setting was moderately good. In fact, the doctors in this study incorporated several of these domains into their diagnostic formulations. General practitioners are often not clear how much weight they should place on stress factors, individual symptoms or personality variables.[20] Their instinct to classify the 'whole' patient was frustrated by the lack of more than one axis in either *ICHPPC* or *ICD-9*. In fact, *ICD-9* has often been criticized by hospital doctors as a 'hotch potch of classifications by cause, pathology, course and clinical pattern'.[21]

With the increasing use of information technology in general practice, it is not surprising that an attempt is underway to offer general practitioners a computerized method of recording information about their consultations. The Read clinical classification[22] offers a system that records information in a form that aids the treatment of individual patients and facilitates the statistical analysis of aggregated data and information retrieval. It is a hierarchical statistical classification which incorporates *ICD-9* diagnoses as well as providing a new classification for history and examination findings. It comprises a branching code which allows for precision in the diagnosis of physical disorders and, while the Read classification is likely to be chosen by the Department of Health as the standard classification in primary care, it is unlikely to be capable of encompassing the multiaxial classification which is required in psychosocial disorders.

Recommendations

Lack of an acceptable and useful system of classification militates against the recognition of much psychological morbidity, leaving it 'hidden' from the doctor. Recognizing this hidden morbidity has a positive influence on intervention and subsequent prognosis.[23] In addition, a multiaxial approach to classification may lead to more than one treatment option being considered.

Trainee general practitioners experience psychiatry mainly in the hospital setting and may later find that the labels they applied there are inappropriate in primary care. These trainees should receive at least some psychiatric teaching in general practice under the tutelage of the increasing numbers of psychiatrists who work from a primary care base.[24,25] There is a similar need for doctors training in psychiatry to spend time in general practice.

Collaboration between the Royal Colleges of Psychiatrists and General Practitioners is needed not only for such innovations in training but as importantly to develop a classification system which can be used by all. A joint approach should be used to ascertain current practice and views and then facilitate the inception of a new system of classification. Only a group derived from both professional bodies would have the necessary resources and influence to develop such a system, supervise the research and coordinate funding. There are potentially substantial benefits for clinical research in having a valid and reliable diagnostic framework.

Sartorius has noted the drive towards a separate system of classification in primary care in many countries.[26] We would prefer to see a single classification for use by all. This would not exclude the use of briefer versions in certain settings,[27] or the expansion of some categories where needed.

In 1990 *ICD-10* will be upon us. Despite acknowledging that it will be used in general medical settings, no field trials were undertaken to assess its suitability for use in primary care. It is time for the voice of primary care to be heard.

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The Scientific Foundation Board's definition of research is catholic and includes educational research, observational as well as experimental studies, and accepts the methodologies of social science as valid. It is not in a position to fund educational activities.

If the study involves any intervention or raises issues of confidentiality it is wise to obtain advance approval from an appropriate research ethics committee otherwise a decision to award a grant may be conditional upon such approval.

Studies which do not, in the opinion of the Board, offer a reasonable chance of answering the question posed will be rejected. It may sometimes be useful to seek expert advice on protocol design before submitting an application.

Care should be taken to ensure that costs are accurately forecast and that matters such as inflation and salary increases are included.

The annual sum of money available is not large by absolute standards and grant applications for sums in excess of £15000 for any one year are unlikely to be considered.

Application forms are obtainable from the Secretary of the Board at: The Clinical and Research Division, 14 Princes Gate, London SW7 1PU. *The closing date for receipt of completed applications is 30 September 1989;* any forms received after that date will, unfortunately, be ineligible for consideration.

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