General practitioners' contract: the good, the bad, and the slippery slope

IT is now two years since the new contract for general practitioners[1] was introduced and it seems an appropriate time to reflect on the changes that have occurred over that period. The changes represent a fundamental shift in the relationship between an elected government and an independent profession, which are not a matter of party politics. The aims of the contract were to increase consumer choice, bring health promotion and disease prevention within general medical services, strengthen management and budgetary control, and make remuneration more dependent on performance. The methods used were a mixture of competition, financial control, positive discrimination, financial inducements and legal and prescriptive requirements. Some of these measures are good, in that they seem sensible and should improve the quality of general practice. Other measures are bad, in that they are based on no good evidence, and at best merely increase administration with no obvious benefit to patients or doctors. But there are also parts of the new contract which if not ugly in themselves, represent a slippery slope, the bottom of which can be very ugly indeed.

The good points about the new contract include bringing health promotion and disease prevention within the terms of service of general practitioners, and increasing the involvement of patients. We may dispute some of the methods used but such aims are consistent with encouraging prevention as envisaged by the profession[2] and by the white paper on promoting better health.[3] It is also sensible for family health services authorities to be responsible to regions, as are districts, rather than directly to the Department of Health. In the long term this must make cooperation between primary care, community services and secondary care easier. The style of general practice is increasingly one of patient participation which should include more information and greater ease in changing doctors. Although there has been a significant increase in workload since the new contract, this has not been due to more administrative work done by doctors, nor has the time spent with each patient decreased.[4]

The bad points about the new contract involve some of the methods used such as positive discrimination and financial inducements. An example of positive discrimination is the deprivation allowance which is based on the Jarman index derived from subjective responses by general practitioners about their workload.[5] The allowance depends on indices based on the 10 year census, but ignores the fact that there is a high turnover in inner city areas where addresses are notoriously inaccurate.[6] There is little evidence that the index reflects workload,[7] nor that more doctors will improve the health of patients in inner cities or reduce deprivation. A second example of positive discrimination is differential night visit fees. The case for these fees is not supported by research sponsored by the Department of Health, which failed to show either patient dissatisfaction with deputizing services or that such services result in a higher proportion of unnecessary referrals to hospital.[8]

Financial inducements, like positive discrimination, increase administration so that aims are clouded by disputes about levels of payment. The growth of health promotion clinics has resulted in disproportionate payments going to a minority of practices and yet there is little evidence that periodic health examinations improve morbidity or mortality.[9] It is questionable whether the cost of administering inducements for general practitioners to act as policemen for herd immunity in children is justified, when this responsibility could be handed back to parents as a requirement for child benefit or school entry. It is also questionable whether screening for cervical cancer should be made the subject of targets in view of the financial and psychological costs involved.[10,11] These inducements have greatly increased paper work in general practice,[12] and the management costs of the National Health Service,[13] with some family health services authorities doubling their staff since the introduction of the new contract. The shift from executive committees with clerks, via family practitioner committees with administrators, to family health services authorities with managers, has also highlighted the conflict between a self-governing profession and management answerable to central government.

Bad reforms may lead to frustration and unnecessary administration, but these are usually reversible. However, embedded in the new contract are other changes which are the start of a slippery slope. For the first time, the new terms of service[14] lay down in a legally binding document precise details of what doctors must do for three groups of patients, the newly registered, those not seen within three years, and those aged 75 years or over. These prescriptive requirements represent a fundamental shift from what is reasonable for a government to require of an independent profession, to what is inappropriate for a government to demand in matters of professional judgement. Although the examples themselves are not draconian, there should be no illusions about what lies at the bottom of such a slippery slope, namely the political direction of doctors as has happened in totalitarian regimes.

These prescriptive requirements also highlight the extent to which the findings of research have been ignored.[15] One general practitioner, on the basis of his own research, has refused to carry out three yearly checks,[16] for which others have been unable to find evidence of benefit.[17] Indeed the results of research commissioned by the Department of Health call into question the benefit of three yearly checks.[18] Prescriptive screening of elderly people has also been questioned as an inappropriate form of surveillance.[19]

Overall there needs to be a clearer definition of the boundaries between management and the profession. Professional autonomy is not a licence for freedom, but a recognition of the importance of self-regulation as a counterbalance to centralized political control. The shift from an administered service to a managed system within an internal market highlights these issues, and evidence from the United States of America suggests that when financial management becomes paramount then costs increase and professional morale slumps.[20,21] A recent report from managers of family health services authorities, entitled *FHSAs — today's and tomorrow's priorities,* concluded that 'the full range of wholly appropriate aspirations that general managers and others have for FHSAs cannot all be met at the desired pace' (Foster A, regional manager, Yorkshire Health, 1991). It is important for managers to spell out what these aspirations are in relation to a self-governing profession. There is also a need to reduce needless administration. Item of service payments were introduced to encourage general practitioners to undertake preventive measures which were not part of general medical services. With the new contract this is no longer so, and it should be possible to simplify the present complex system of financial inducements. One way would be for specialists in public health medicine to negotiate local targets which would then be owned by the profession, instead of being imposed.

Two principles should guide policy makers in dealing with professions — consent before coercion and self-regulation before legislation. For managers, the requirements are to clarify the boundaries of their roles, and where possible to simplify unnecessary administration. Doctors need to stop being evasive about the rights and duties of a self-regulating profession, while appreciating that for medicine there will always be both a political and professional agenda. Whatever one thinks of the new contract and NHS reforms, it took political courage to shake up such a large and complex organization. The situation requires a corresponding professional courage to state clearly where the boundaries with management lie, if the NHS is not to slip further down the slippery slope of political expedience.

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Usefulness of telephone consultations in general practice

THE use of the telephone consultation in primary care has not been extensively studied in the United Kingdom. The telephone has been used by patients for a number of decades to make an appointment, to ask for therapeutic advice, to enquire about test results or to request a home visit. The telephone has also been occasionally used by the doctor as a diagnostic tool and the earliest reported account of this was the diagnosis of croup by telephone at the end of the last century.[1]

Much has been written about the use of the telephone for out of hours calls but until fairly recently there has been little investigation into the nature of this form of contact with the doctor during surgery hours. Research is now being carried out in this area in the UK and two studies of patient access to general practitioners by telephone are published in this issue of the *Journal*.[2,3] The UK lags behind other developed countries in the use of the telephone for consultation. In North America over 20 calls per doctor per day have been documented,[4] in Scandinavian countries telephone advice is commonplace,[5] but a survey carried out in Glasgow reported a mean of only 2.4 telephone consultations per surgery session.[6]

Anyone who has tried to contact a general practitioner by telephone during surgery hours will have discovered how difficult it can be to overcome the barrier presented by the receptionist. In one study it was found that only about 30% of patients had ever tried to contact their doctor by telephone;[7] of these eight out of 10 successfully managed to speak to their doctor. There is evidence that a telephone consultation with the doctor would be greatly appreciated by patients. In one survey patients rated direct telephone access to their doctor more highly than better receptionists, longer surgery hours, longer consultations, a quicker response to calls for emergency visits and improvements in surgery premises.[8]

How do general practitioners perceive increased accessibility to patients? Some doctors may feel threatened by the prospect of unrestricted telephone access by patients and be concerned that they will receive many calls which are inappropriate or trivial. However, there is no evidence that encouraging patients to use the telephone for consultations actually leads to a large number of 'unnecessary' telephone calls.[3] It has been found that the proportion of consultations considered by doctors to be trivial, inappropriate or unnecessary does not diminish when doctors are less available.[9] If this is true of face to face consultations, it is also likely to be true of telephone consultations.

It also seems possible that pressures on the appointment system may be effectively controlled by the judicious use of the telephone to allay undue anxiety among patients and to deal