Assessing the outcome of making it easier for patients to change general practitioner: practice characteristics associated with patient movements

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SUMMARY

Background. *The government white paper,* Promoting better health, *suggested that primary health care services should be made more responsive to patient needs and that competition, brought about by the freer movement of patients between practices, could act as a mechanism for improving the quality of the services provided. Policy changes reflecting these aims were introduced with the 1990 contract for general practitioners.*

Aim. *A study was carried out to estimate the volume of patient movement between practices not attributable to a patient's change of address or to a major change in the practice they had left, and to investigate which practice characteristics patients moved towards and which they moved away from when changing general practitioner.*

Method. *Data on 2617 patient movements during June 1991 were collected from five family health services authorities. These patient movements were analysed in relation to data on practice characteristics obtained from family health services authority records.*

Results. *The estimated volume of movement of patients between practices was small (1.6% of the registered population per year). The majority of movements were between group practices; a quarter of the movements recorded were to single-handed general practitioners. However, the ratio of the number of movements from group practices to single-handed general practitioners compared with those from single-handed general practitioners to group practices was 1.37 (95% confidence interval 1.19 to 1.57). In choosing single-handed general practitioners these patients were willing to forgo access to a woman general practitioner, extended services and greater hours of general practitioner availability. Among the subset of movements between group practices, patients were more likely to gain access to a practice nurse, longer surgery hours and a woman general practitioner as a consequence of their move.*

Conclusion. *The scale of patient movement observed did not indicate any substantial mechanism by which the new policy of encouraging consumerist behaviour on the part of primary care users could effect desired changes in primary care practice. Among the patient movements observed, the evidence suggests that when choosing a practice potential patients were not deterred by the fact that a practice was single-handed. The public's perception of the factors contributing to a high quality of service may conflict with the official characterization of good practice and high quality services in primary health care.*

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Introduction

THE government white paper, *Promoting better health,* suggested that primary health care services should be made more responsive to patient needs and that competition, brought about by the freer movements of patients between practices, could act as a mechanism for improving the quality of the services provided.[1] In practical terms, the ease with which patients could choose and change their doctor was facilitated by two changes introduced with the 1990 contract for general practitioners. First, practices and family health services authorities were to encourage informed choice by providing information to potential patients about local practices and their services, and secondly the requirement that patients approach their existing doctor if they wish to change to another doctor was abandoned.

A study was undertaken to assess the impact of this policy by looking at the exercise of patient preferences through the evidence of patient movement between practices where there was no change of address recorded and where the practice left had not undergone any major changes that could have precipitated the movements observed.

Method

Family health services authority sample

Data on transfers (patient movements) between practices were requested from routine sources from a sample of six family health services authorities in England for a period of one month, June 1991, just over one year into the operation of the 1990 contract for general practitioners. The family health services authorities were chosen from a sample frame of 12 created for a different study. The sample frame was structured according to geographical location and level of health promotion clinic activity. The six family health services authorities selected for this study of patient movements were chosen to include a range of different populations: three metropolitan, two non-metropolitan and one London inner city location. Information on a three-month period from May to July 1991 inclusive was collected for one of the sampled family health services authorities where preliminary enquiries suggested that the number of patient movements would be small. The average of the three months' movements was used for comparative purposes in the tables relating to the total volume of patient movement.

Practice characteristics

Information was sought from each family health services authority on the following practice characteristics: number of practice partners, list size, age of general practitioners, whether or not there was a woman general practitioner partner, advertised surgery hours, whether the practice operated an appointment system only, practice nurse availability, training practice status, and the provision of services (minor surgery, health promotion clinics, obstetrics and contraception services and child health surveillance). Health promotion clinic information was based on family

health services authority data on all clinics held between 1 October and 31 December 1990.

Patient sample

Data were collected on all registered patients who transferred between practices in the family health services authority, where no change of residential address was recorded at the time of transfer, and contained the following information on each newly registered patient: age, sex, current address, previous address, new general practitioner and previous general practitioner. Patient movements were only included where the registered patient had the choice of remaining with the current practice, as well as the opportunity of changing to another practice.

Block transfers of patients were excluded, as were cases where the family health services authority allocated patients to a particular practice. Patients movements coinciding with a major change in practice structure which occurred in the three months before or after the sample period, such as the division or merging of a practice or the retirement of a single-handed general practitioner, were also excluded.

The final data set consisted of all movements that fulfilled the study criteria with information on the characteristics of the practices that were left and those that were joined, as well as the age and sex of the patients changing general practitioner. Movements of households, rather than individual patients, were also identified by aggregating all movements where patients shared an identical postcode and all had joined the same and moved from the same general practitioner.

Analysis

Analysis investigated whether the data provided any evidence of a net movement of patients away from practices with certain characteristics (for example, single-handed general practitioners) towards practices with other characteristics (for example, group practices). To do this calculations were made of the maximum likelihood estimate of the ratio of the odds of joining, for example, a single-handed general practitioner rather than a group practice to the odds of leaving a single-handed general practitioner rather than a group practice. Odds ratios with 95% confidence intervals were calculated; a confidence interval that embraces a value of 1.00 is not considered to be statistically significant. The odds ratio estimates were independent of the prevalence of the characteristic observed.

Analyses were undertaken of patient movements between practices and by age and sex subgroups. Analyses by household were also undertaken in order to explore the possibility of bias being introduced through the effect of multiple movements which may have been the result of a decision on the part of a single member of a household.

Historical data were sought from family health services authorities on total movements fulfilling the same criteria relating to a one-month sample period one year before the introduction of the general practitioner contract changes. The data were examined in order to determine whether there had been a discernible increase in the number of patients who appeared to have changed practice, without changing their address, in the post-contract period studied.

Differences in proportions of men and women changing practices were tested using chi square tests, and the statistical significance of the odds ratios assessed by computing 95% confidence intervals.

Results

Family health services authority sample

All six family health services authorities that were approached agreed to participate in the study. One (non-metropolitan) family health services authority was ultimately unable to generate data according to the study specifications on patient movements. The timetable of the study did not allow for a substitution of this family health services authority with another and the final data set therefore comprised movements relating to five authorities only. In aggregate, the data may better represent urban as opposed to rural populations. However, non-urban populations are represented by one non-metropolitan family health services authority.

Practice characteristics

Background data were collected for a total of 374 practices comprising 116 single-handed general practitioners and 258 group practices. The mean number of partners in the group practices was 3.4 (standard deviation (SD) 1.4). The age of all general practitioner partners was known for 70% of the practices. In these practices, the mean age of the single-handed general practitioners was 50 years (SD 11 years) compared with 44 years (SD five years) for general practitioners in the group practices. There were differences between family health services authorities in the data on practice characteristics which were available, particularly with respect to the services provided at the practice. One family health services authority was only able to provide information derived from capitation lists. Data on obstetrics and contraception services were not analysed as these services were provided by almost all practices.

Patient movements were recorded for 359 practices, representing 90% or more of all active practices (that is, practices that did not have lists that were in abeyance or cancelled at the time of the study) in each of the five family health services authorities. In total, 366 patient movements away from practices and seven movements to practices were excluded according to the study criteria. This affected a total of 12 practices.

One single-handed woman general practitioner actively recruited patients through targeted local advertising in the sample period; during June 1991, 94 patients were recorded as having joined this practice from 11 different practices. In this case, patients had chosen to move to this practice and to leave their existing practice and, in this sense, the movements represented a true expression of patient preferences. On the other hand, patients were stimulated into considering changing their doctor by the recruiting practice and thus the expression of this preference was manipulated. On balance, these patient movements have been retained in the main analyses, but some results are reported that exclude this practice.

Patient movement in 1989 and 1991

Historical data on patient movements in June 1989 proved difficult to generate from existing family health services authority computer systems. Data on total patient movements not accompanied by a change of address were obtained for two of the five family health services authorities. In one, a metropolitan family health services authority, the number of recorded movements between practices fulfilling the study criteria rose from 151 in June 1989 to 385 in June 1991. In the other, a non-metropolitan authority, a similar increase was found for a three-month period, from 327 in 1989 to 719 in 1991. Reliable data were not available on practice characteristics for the pre-contract period.

Volume of movement, and age and sex of patients moving practice

A total of 2617 patient movements between general practices were identified that fulfilled the study criteria, and 1816 move-

ments of households were recorded. In the five family health services authorities, the annual number of movements per 100 registered population between practices for the sample period varied by a factor of three, from 0.6% in a small non-metropolitan authority to 1.9% in a large metropolitan authority. Overall, in the five sampled authorities, assuming that there was no seasonal effect on the rate of movement, it was estimated that 1.6% (95% confidence interval (CI) 1.5% to 1.7%) of the registered population might have changed doctor in this way in a one-year period.

All age groups were found to be represented among the 2617 patients moving practices, but more females than males moved between practices (58.3% versus 41.7% of 2164, $\chi^2 = 71.4$, 1 degree of freedom, $P<0.001$); Table 1. This trend was observed in all age groups except among those aged under 16 years where the percentages were similar.

Characteristics of practices that patients joined and left

In order to determine the overall pattern of movement between practices, the characteristics of practices that were joined by patients were examined and compared with the distribution of practice characteristics in the sample as a whole. It was found that twice as many patients joined single-handed general practitioners than would have been expected by chance (Table 2). This trend for joining single-handed general practitioners was observed in all family health services authorities with the exception of the inner London authority, where there was already an exceptionally high level of registrations with single-handed general practitioners.

To explore the pattern of these movements further, an analysis was undertaken taking into account the characteristics of the practice that was left as well as the one that was joined. All patient movements in which patients moved from a practice without a specific characteristic to a practice with that characteristic were compared with their matched opposite, that is, those where the patient moved from a practice with the specific characteristic to one without. An example of a resulting two by two table is shown in Table 3.

Single-handed general practitioners

The outcome of the analysis, and resulting odds ratios, for the single-handed general practitioner characteristic for all patient movements and for a number of subpopulations are shown in Table 4. Characteristics of practices that were left or joined were not known for 265 patient movements; these were excluded from this and subsequent analyses. The direction and the sizes of the ratios of movement from group practices to single-handed general practitioners was similar for households and for individuals, suggesting that movements by households involving large numbers of patients were not biasing the results (Table 4).

Across the five family health services authorities, the direction of patient movement was the same (from group practices to single-handed general practitioners) with the exception of the large metropolitan authority, where movement was nearly equal in both directions (odds ratio (OR) 1.02). The single-handed general practitioner characteristic appeared to exert a particularly strong significant effect on patient movements in two family health services authorities: one of the two small metropolitan authorities (OR 2.67) and the small non-metropolitan authority (OR 1.54). In these two authorities an above average level of new patient registrations were identified among a few single-handed general practitioners. These patient movements were from a number of different practices, the majority of which were group practices. The effect of the single-handed general practitioner characteristic remained in all age and sex subpopulations examined, but was stronger among adult men than adult women, and was strongest in the 55+ years age group compared with younger age groups (Table 4).

Table 1. Age and sex of patients moving practices.

	% of patients in age group moving practice who were	
Age (years)	Male	Female
⩽16 (*n* = 609)	*48.4*	*51.6*
17–24 (*n* = 314)	*33.4*	*66.6*
25–34 (*n* = 539)	*38.4*	*61.6*
35–44 (*n* = 318)	*45.3*	*54.7*
45–54 (*n* = 246)	*45.5*	*54.5*
55–64 (*n* = 216)	*41.7*	*58.3*
65-74 (*n* = 195)	*38.5*	*61.5*
75+ (*n* = 177)	*35.6*	*64.4*
Total (*n* = 2614)[a]	*41.7*	*58.3*

n = number of patients in age group moving practice. [a]Age or sex data not known for three patients.

Table 2. Proportion of patient movements to practices and proportion of all patients on all practice lists, by practice characteristics.

Practice characteristic	No. (%) of patient movements to practice with characteristic[a]	% of patients on all practice lists where characteristic recorded[a]
Single-handed GP	649 (*25.7*)[b]	*12.5*
Mean list size ⩽1500	457 (*18.2*)	*11.7*
Woman GP partner	1665 (*66.5*)[b]	*68.9*
Surgery >20 hours per week	1031 (*65.2*)	*72.8*
Appointment system only operated	922 (*54.5*)	*53.5*
Practice nurse employed	1392 (*82.3*)	*83.5*
GP training practice	377 (*22.2*)	*30.9*
Minor surgery provided	1223 (*72.1*)	*78.3*
Health promotion clinics held	2176 (*85.8*)	*88.5*
Child health surveillance undertaken	1206 (*71.7*)	*73.3*

[a]Denominators vary according to the number of practices for which information was known. [b]If movements to the single-handed woman GP who advertised new practice premises during the study period are excluded, 22.8% of patient movements were to single-handed GPs and 65.2% were to practices with a woman GP partner.

Table 3. Example of a two by two table of patient movements between single-handed and group practices.[a]

	No. of patients leaving practice		
Joining practice	Single-handed	Group	Total
Single-handed	130	481	611
Group	352	1389	1741
Total	482	1870	2352

[a]Characteristics of practices that were left or joined were not known for 265 patient movements; these were excluded from the analysis.

Table 4. Odds ratios of patient movements from group practices to single-handed general practitioners to patient movements from single-handed general practitioners to group practices.

Subpopulations	No. of patient movements between practices: From group to single-handed	From single-handed to group	Odds ratio (95% CI)[a,b]
All patient movements	481[c]	352	1.37 (1.19 to 1.57)
Movement of households	324	241	1.34 (1.13 to 1.59)
FHSA			
Small metropolitan	115	43	2.67 (1.87 to 3.89)
Small non-metropolitan	103	67	1.54 (1.12 to 2.12)
Small metropolitan	25	21	1.19 (0.64 to 2.24)
Inner London	97	83	1.17 (0.86 to 1.59)
Large metropolitan	141	138	1.02 (0.80 to 1.30)
Women patients aged 17+ years	209	159	1.31 (1.06 to 1.62)
Men patients aged 17+ years	150	108	1.39 (1.08 to 1.79)
All patients aged (years)[d]			
0–16	122	87	1.40 (1.06 to 1.86)
17–54	248	192	1.29 (1.07 to 1.57)
55+	110	72	1.53 (1.13 to 2.07)

FHSA = family health services authority. CI = confidence interval. [a]This represents the maximum likelihood estimate of the ratio of the odds of moving to a single-handed GP to the odds of moving to a group practice. [b]The direction of patient movements in all subpopulations was from group practices to single-handed GPs except in the large metropolitan family health services authority where movement was nearly equal in both directions. [c]If movements to the single-handed woman GP who advertised new practice premises during the study period are excluded 426 patient movements were from group practices to single-handed GPs. [d]Age not known for one patient.

Practices with a woman general practitioner partner

The outcome of a similar analysis, and resulting odds ratios, for the woman general practitioner partner characteristic for all patient movements and for a number of subpopulations are shown in Table 5. Patient movements between practices did not increase the proportion of patients registered with a practice in which there was a woman general practitioner partner (Table 2), and the association of patient movement with a woman partner in the practice was less marked than with the single-handed general practitioner characteristic (OR 1.13 versus OR 1.37; Tables 4 and 5). However, being a single-handed general practitioner was likely to exert the opposite effect because of the relative rarity of single-handed women general practitioners. This was apparent in the contrast between the effect of a woman partner in all patient movements where a group practice was joined (OR 2.71) and those where a single-handed general practitioner was joined (OR 0.21). Women aged over 16 years were more likely to move from a practice without a woman general practitioner to one with a woman general practitioner than vice versa (OR 1.21). This was not the case for men where movement was nearly equal in both directions (OR 0.99).

Patient movement between group practices

In order to remove the effect of patient movements to single-handed general practitioners, the 1389 movements to and from group practices were analysed separately. The characteristics exerting the strongest positive effects in this subpopulation of patients moving practices were the availability of an appointment system only, a practice nurse, more than 20 hours of surgery per week, and a woman general practitioner partner (Table 6). Among this group, patients were more likely to leave a training practice and join one which was not a training practice (OR 0.77)

Table 5. Odds ratios of patient movements from practices without a woman general practitioner partner to practices with a woman partner to patient movements from practices with a woman partner to those without.

Subpopulations	No. of patient movements between practices: Without woman GP to woman GP present	With woman GP to woman GP absent	Odds ratio (95% CI)
All patient movements	521[a]	460	1.13 (1.0 to 1.29)
Movement of households	356	318	1.12 (0.96 to 1.31)
Women patients aged 17+ years	234	193	1.21 (1.00 to 1.47)
Men patients aged 17+ years	152	153	0.99 (0.79 to 1.25)
All movements to a group practice	460	170	2.71 (2.26 to 3.25)
All movements to a single-handed GP	61[a]	290	0.21 (0.16 to 0.28)

CI = confidence interval. [a]If movements to the single-handed woman GP who advertised new practice premises during the study period are excluded, 486 patient movements were from a practice without a woman GP partner to a practice with a woman partner, and 26 movements were from a practice without a woman partner to a single-handed woman GP.

Patient movement to single-handed general practitioners

A similar analysis was undertaken for the subpopulation of 611 patients joining a single-handed general practitioner, representing almost a quarter of all patient movements (23.3% of 2617). Women aged over 16 years accounted for 44.8% of all 611 patient movements. The practice characteristics which this group were acquiring or losing as a result of the move are shown in Table 7. As might be expected, this group of patients moving to a single-handed general practitioner appeared to be gaining little in the way of practice services. Despite smaller mean list sizes in the practices joined, access to the general practitioner in terms of surgery opening hours was almost invariably reduced as a result of the move.

Discussion

A central theme in the 1986 government green paper, *Primary health care — an agenda for discussion*[2] and the ensuing white paper, *Promoting better health,*[1] was that primary health care services should be made more responsive to the needs of potential patients and that this should go hand in hand with improving the quality of services currently provided.

Among the main changes proposed in *Promoting better health* were: the statutory provision of practice leaflets and family health services authority directories giving information about general practitioner and practice characteristics, and recommendations for the provision of a wider range of services including minor surgery, health promotion clinics and more nursing ser-

Table 6. Odds ratios of patient movements between group practices, by practice characteristics.

Practice characteristic (factor)	No. of patient movements between practices: Without factor to with factor	With factor to without factor	Odds ratio (95% CI)
Appointment system only operated	31	14	2.21 (1.14 to 4.50)
Practice nurse employed	115	69	1.67 (1.23 to 2.28)
Surgery >20 hours per week	112	69	1.62 (1.19 to 2.22)
Woman GP partner	239	169	1.41 (1.11 to 1.66)
Health promotion clinics held	115	99	1.16 (0.88 to 1.54)
Minor surgery provided	74	67	1.10 (0.78 to 1.56)
Mean list size ≤1500	168	179	0.94 (0.76 to 1.17)
GP training practice	183	239	0.77 (0.63 to 0.93)

CI = confidence interval.

Table 7. Odds ratios of patient movements to single-handed general practitioners, by practice characteristics.

Practice characteristic (factor)	No. of patient movements between practices: Without factor to with factor	With factor to without factor	Odds ratio (95% CI)
Appointment system only operated	12	28	0.43 (0.20 to 0.87)
Practice nurse employed	66	97	0.68 (0.49 to 0.94)
Surgery >20 hours per week	16	267	0.06 (0.03 to 0.10)
Woman GP partner	61[a]	290	0.21 (0.16 to 0.28)
Health promotion clinics held	76	116	0.66 (0.48 to 0.88)
Minor surgery provided	29	169	0.17 (0.11 to 0.26)
List size ≤1500	107	78	1.37 (1.02 to 1.96)
GP training practice	10	69	0.14 (0.07 to 0.28)

CI = confidence interval. [a]If movements to the single-handed woman GP who advertised new practice premises during the study period are excluded, 26 patient movements were to a single-handed woman GP from a practice without a woman partner.

vices. It also gave a commitment to encouraging more women doctors to enter and remain in general practice, in recognition of the fact that some women patients are reluctant to seek medical advice from men general practitioners.[1] Regulations brought in with the 1990 contract for general practitioners made it easier for patients to change doctors.

One avenue for exploring the implications of these policy changes would have been to conduct a satisfaction survey among those patients who chose to change their general practitioner.[3] It was felt, however, that a more direct approach to assessing the impact of the policy could be taken by looking at patient movement between practices, thus identifying the practical effects of making it easier for patients to change general practitioners.

In the five family health services authorities sampled, the scale of patient movement not precipitated by a change of residential address or a major change in the structure of a practice was small (estimated to be 1.6% of the total registered population in one year, overall). The range across individual authorities (0.6% to 1.9%) is likely to reflect the degree of choice available to a rural population with widely dispersed practices compared with that available in a densely populated urban area.

It is not clear precisely how much of the patient movement observed can be attributed to policy changes. The historical data suggest that patient movements increased considerably in the period after the 1990 contract. However, data were obtainable from only two family health services authorities and these data could mask an underlying secular trend. It is also possible that the level of patient movement has increased since 1991 as a result of more widespread knowledge among patients of the policy changes.

All ages and both sexes were represented in the sample of patients moving practices. However, adult women in all age groups were more likely than men to change their general practitioner. This may reflect that fact that women are more frequent users of primary care services[4] which in turn may give rise to greater scope for dissatisfaction and/or a critical assessment of the services provided. The relatively small number of elderly people changing general practitioner in this way is in keeping with findings showing high levels of satisfaction and loyalty among elderly patients.[5-7]

The majority of patient movements were found to be between group practices. However, approximately a quarter of all movements were to single-handed general practitioners and this was considerably in excess of the overall distribution of patients registered with single-handed general practitioners (13%). Given the scale of the movements, this will not result in a noticeable change in the proportion of people registered with single-handed general practitioners. It does suggest, however, that a shift to single-handed general practitioners was an important feature of the type of patient movements studied, and this was reinforced by the results which showed that significantly more patients moved from a group practice to a single-handed general practitioner than the reverse. This suggests that patients may have been showing a preference for single-handed general practitioners or for practices with some other characteristic frequently associated with single-handed general practitioners.

Consideration needs to be given to the possibility that this trend was caused by factors other than patient choice. The potential to move to a single-handed general practitioner varied between family health services authorities. Given the different sample sizes in each authority, it is possible that the overall results were biased in favour of such moves. In two authorities, an above average level of new patient registrations were identified among a few single-handed general practitioners. Although the effect on the overall picture of patient movements associated with these few general practitioners was considerable, they did not fulfil the study criteria for exclusion; it is considered that they were not exceptional but merely the tail of the distribution of patient movements between patients. The tendency to move from a group practice to a single-handed general practitioner was apparent in all family health services authorities with the exception of the authority that contributed the largest number of moves to single-handed general practitioners, where little effect was observed, suggesting that the possible bias effect of one large authority with many movements was not the underlying cause of the overall effect.

It may have been the case that new practices were more likely

to have been single-handed general practitioners who were seeking to extend their list size over time. As the recorded patient movements represented patients' decisions to leave a practice where they were currently registered and where they could have remained, the 'pull' exercised by any practice wishing to expand its list size will have been limited in its impact and unlikely to account for the majority of the patient movement observed. It is possible, however, that there was a differential likelihood of new practices accepting someone wishing to move practice (some more established group practices may close their lists to new patient registrations). The extent to which the choice of joining a single-handed general practitioner was a second choice, exercised by someone whose main motivation for moving was dissatisfaction with their current practice, cannot be derived from the study data. This factor is, however, unlikely to account for the size of the observed trend towards single-handed general practitioners and, as choice is always exercised under conditions of constraint, the single-handed general practitioner characteristic remains a measurable net outcome of the movements studied.

Were the patients going to single-handed general practitioners moving to practices or doctors who best suited their needs? Studies of patient satisfaction with general practitioner services tend to show high levels of satisfaction at a general level, with criticism aimed at particular aspects of services. Access to a woman general practitioner has been suggested to be an important consideration, but the most important determinant of satisfaction is consistently reported as the perceived quality of the doctor–patient relationship in the consultation[5-8] with considerable patient loyalty being expressed for general practitioners where the level of patient satisfaction was high. Patients joining a single-handed general practitioner have the advantage of knowing whom they will see in a consultation and there is a greater opportunity for continuity of care than may be found in a group practice. Patients leaving training practices in favour of non-training practices may also be increasing their opportunity for continuity of care.[5] No data were available on how long the general practitioners in the practices studied had been in post. It is possible that at least some of the movement to single-handed general practitioners was because patients perceived that this was a 'new doctor' offering a different kind of service. The mean age of the single-handed general practitioners (50 years) does not suggest, however, that this was a particularly young group of doctors.

Are patients really acting as consumers? Little is known about the accessibility of practice leaflets to potential consumers making enquiries with a view to changing their general practitioner, but in one of the family health services authorities studied a practice directory was still unavailable early in 1993. Personal recommendations from other patients, though non-statutory, are usually available to people already resident in an area and its seems likely that they will continue to form an important part of the process of choosing a doctor. Other studies and commentaries of consumer behaviour in health care have suggested that patient attitudes and behaviour are not generally in keeping with a consumerist orientation.[8-10] In the present study, one practice actively recruited patients through a local advertising campaign. The success of this approach suggests that potential patients may be willing to act more as consumers in the conventional sense if given encouragement.

The effect of competition on practices is hard to determine in the short term, but the volume of patient movement estimated here does not indicate that much pressure will be brought to bear on practices losing patients. Single-handed general practitioners gaining patients do not generally conform to the characterization of the good practice (greater access and wider services) being encouraged in government policy.[1,2] These features are unlikely to change as most single-handed doctors are more constrained in the breadth of services they can offer compared with their colleagues in group practices. There is some evidence, however, that access to a woman general practitioners and a practice nurse are endorsed as positive attributes by those moving between group practices. This study did not look at the fundholding status of practices, but this is a feature which may now be an important factor affecting patient choice of practice. If fundholding is perceived as a positive feature, this could reduce the volume of patient movement to single-handed general practitioners, who cannot compete under standard fundholding arrangements.

In conclusion, the scale of patient movement between practices found in 1991 was small and did not, at that stage, indicate any substantial response to new policy encouraging consumerist behaviour on the part of primary care users. However, among the patient movements observed, there was no evidence to suggest that single-handed general practitioners are unattractive to patients wishing to change their doctor. The findings seem to support the belief that the public's perception of the factors contributing to a high quality service and high levels of patient satisfaction may conflict with the official characterization of good practice and high quality services in primary health care.[11]

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