against over-ambitious plans without adequate additional resources. In the current climate of resource constraints, the best way forward is for community hospitals to establish their place as part of a range of quality patient services. We must now provide the systematic evidence and commitment to make that happen.

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# Shifting the work

THIRTY years ago the mad were confined in hospital while women in labour were confined at home. Today the situation is reversed and it is the mad that are looked after in the community while childbirth has become a hospital specialty. Equally startling shifts in the balance of work between primary and secondary care have occurred elsewhere: a significant portion of secondary care nursing has been transferred into the community as the length of stay after elective surgery has halved and the throughput doubled, and as large numbers of National Health Service respite beds have been shut. Changes in clinical treatments mean that, today, patients suffering acute myocardial infarction or miscarriage are almost always sent to hospital, while antenatal patients and those with peptic ulcer disease are largely looked after in primary care. Some work has

disappeared altogether (measles rarely troubles children or GPs these days) and some traditional patterns of work within general practice are changing rapidly as, for example, GP cooperatives find that a large number of requests for a visit at night can be dealt with over the phone.

If we look at the historical flows of work between secondary and primary care, several points emerge. First, enormous shifts in the patterns of work are not new. Secondly, these changes have not always been based on much evidence. Thirdly, changes have rarely been driven by general practice; usually they have emanated from a hospital specialty, therapeutic advances, or a managerial agenda. Fourthly, good medicine demands that the pattern of work in both secondary and primary care needs to be able to respond flexibly: in 1926 insulin was new and dangerous and no GP had experience of using it, but keeping it in a hospital ghetto or declaring it a non-core service would have been disastrous for patients and primary care alike. Finally, few of these shifts have been linked to incentives; instead, most have simply occurred, more or less passively, to general practice.

If the shifts in services between primary and secondary care over the past three decades are often underestimated, so too are the increased resources that have gone into primary care. The cost of general medical services (GMS) has grown fourfold since 1949, and in the period 1985–96 the number of staff employed by practices rose from 27 300 in 1985 to 59 500 in 1995, which included a quadrupling of practice nurses.[1] Numbers of attached staff have also rapidly increased: the first community psychiatric nurse (CPN) was appointed in 1954, and there are now 6500 CPNs in England and Wales, up from 4000 in 1990.[2] Finally, £45 million has gone into improving out-of-hours care.

Practice teams have coped admirably with these transitions, but attitudes have changed. Gone is the old passivity that accompanied previous shifts; instead, GPs, consultants, and managers are stressed and fractious. The world is more complex — and much busier. The increase in workload is well documented in hospitals, where a whole range of routinely collected statistics supports the claim that hospitals are doing much more than they used to. But what about general practice? To what extent have all the shifts in services resulted in more work for practices? On p. 1085 of this issue, Scott and Vale report a systematic review to determine whether the shifting of services from secondary to primary care settings has resulted in an increase in GP workload. Their paper shows that few adequate studies have been done, and that many of those that have are primarily evaluations from a hospital perspective; comparatively little effort has gone into assessments of the effects on practices. Such work as there is does not demonstrate large effects on GP workload. However, the overriding message is the paucity of adequate studies and methods.[3]

Our understanding of general practice activity patterns is at a comparable stage to hospital activity analysis twenty years ago. The decennial National Morbidity Survey[4] does sterling work as do some new initiatives,[5] but general practice remains a black box: large resources go in and massive numbers of consultations come out, but the connection between the two, and between GP workload and other changes in the system, remains opaque. As one health authority manager said to me in relation to a proposed cut in hospital services, 'When we have to decide about shifting services from secondary to primary care, the cost to practices in terms of consultation rates aren't known or included. For us they're a freebie. They don't cause us any pain!'

Two points are important for the future. First, a rapidly changing world demands that the pattern of work between primary and secondary care should be flexible. This in turn means that practices need to feel they are being treated fairly. Clearly, resources are important but fairness also seems to encompass a sense both of how appropriate the new work is, and of how clinically challenging it is: GPs have taken over most of the care of peptic ulceration because new drugs have turned a surgical problem into a therapeutic pleasure to deal with. Similarly, many patients prefer day-case surgery, and their endorsement has helped practices to accept this change. Both shifts have been relatively unproblematic because the new service is manifestly better for patients. Anticoagulation, by contrast, is perceived as a case of hospitals 'dumping' unwanted work, which significantly increases clinical responsibility and workload. The technical improvement (better care for people in atrial fibrillation), which is driving up the amount of warfarin-related work in both hospital and general practice, brings little positive feedback from patients. In short, since non-GMS contracts may risk ossifying a service, they should only be considered when large, unequivocal increases in workload are accompanied by widespread resentment.

Secondly, if general practice wishes to argue its corner it needs comprehensive figures about workload and costs. Our understanding of the health economics of primary care is particularly rudimentary;[7,8] for example, there is no consensus about such basic data as how many hours a week are worked by an average full-time GP, so the standard text for calculating costs[9] simply assumes a 40-hour week. The new White Paper demands much of general practice, yet our ability to innovate is limited by lack of such knowledge: a primary care group pondering whether to provide comprehensive practice-based care for maturity-onset diabetics needs to predict the number of extra appointments the required for this shift, plus, ideally, the associated costs.

The danger of generating a better understanding of the health economics of primary care is that we might end up knowing the price of everything and the value of nothing. Nevertheless, the current position (not being able to state accurately the quantity or cost of most of the services we deliver) limits planning, reduces the value others place on our work, and weakens the profession as a whole. Being perceived as a 'freebie' is a recipe for resentment.

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