

Letters

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Editor's choice

The real cost of primary care

The crisis in accident and emergency departments leads me to share the results of an analysis from East Devon. Two years ago we worked with hospital colleagues to identify the cause of the large increase in emergency admissions in our area. East Devon has a population structure equivalent to that projected for England and Wales in 2042; we found that people aged over 80 years formed the bulk of the increase in emergency admissions and, to a lesser extent, attendances at the emergency department of our main acute hospital. We worked in partnership with the acute hospital to address this problem.

It seemed inconceivable to us that consultations in primary care by this group wouldn't also have risen dramatically. We analysed data from our practice computer system, comparing consultation statistics between 2004 and 2012. We found that in 2004 our GPs and nurses saw 63 377 patients in the surgery, made 2531 home visits, and had 4609 telephone consultations. In 2012 these figures were 78 597 (24% increase), 3241 (28% increase), and 18 810 (408% increase) respectively. Our practice population had grown by 10% over this time period. All components of our work had increased substantially but telephone consultations had shown an extraordinary rise.

We were not able to analyse these figures by age group, but data from the NHS Information Centre (provided from the QRisk[®] studies of Professor Julia Hippisley-Cox *et al*) from 1995–1996 onwards show that, whereas the average consultation rate per year for a registered patient rose from 3.9 to 5.5, there were much higher rises in the over 85s, for whom consultation rates approximately doubled, from 7 to 14 consultations per year.

Nationally, including the 2004 contract change, real terms primary care trust (PCT) spending on primary care rose by 22% (just under 3% a year) between 2003–2004 and 2011–2012. Almost all of

this increase occurred between 2003 and 2005. In comparison, PCT spending on secondary care jumped 40.1% over the same period, increasing from £49.1 billion to £68.8 billion. This is equivalent to an average increase of over 5% a year. Between 2010–2011 and 2011–2012 there has been a real terms reduction in spending on primary care of 1.2%.¹

It is a great privilege to provide primary care for older people and, as a profession, we need to campaign for resources that reflect their needs. This means investing in primary care as well as secondary, community, and social care. The legacy of the 2004 GP contract, with its sudden 14% increase in GP income, is a failure to consider workload, or workforce planning 9 years later. At present it seems that the NHS knows the cost of primary care, but not its value.

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Are there enough GPs in England to detect hypertension and maintain access?

We read with interest the paper by Baker *et al* exploring the interrelationship between size of hypertension register, GP provision, and access (defined as the ability to get an appointment within 48 hours), assessed in 8052 practices.¹ It suggests a conundrum in primary care: the 'better' a practice's recognition and presumably management of hypertension, the worse the access, given finite staffing resources. The same inverse relationship may apply in other chronic diseases such as diabetes mellitus, where the recognition of risk factors or disease in often asymptomatic individuals also leads to

additional workload. As acknowledged by the authors, no information was available on how different members of the primary healthcare team are used, but it appears that, 'an extra GP per 1000 patients would be associated with a 6% increase in detected hypertension'.

The study used data from 2008–09, preceding publication of the NICE 2011 guidelines on diagnosis of hypertension. Where implemented, these guidelines may impact on the size of hypertension registers due to the use of out-of-office monitoring to reduce the white-coat effect, therefore a reduction in inaccurate labelling and an associated reduction in future workload.^{2,3} Furthermore, alternate methods may have better answered the research question: use of structural equation modelling would have allowed the authors to model their whole conceptual framework simultaneously, allowing fuller account to be taken of the internal interactions.

Nonetheless, the study does provide data supporting the interesting hypothesis that there is insufficient capacity in primary care to provide both good access, as well as detection and on-going care for long-term conditions. Additional resources seem unlikely under current financial constraints but novel interventions such as self-management⁴ and more creative use of the primary healthcare team, as well as better diagnostic methods may mitigate these effects.

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Authors' response

We agree with A'Court and colleagues that the consequence of diagnosing greater numbers of people with other chronic conditions in addition to hypertension may be associated with increasing difficulties in providing access.¹ The argument is that as more patients with chronic disease require regular management, the demand for appointments with GPs and practice nurses increases. This is important since some other chronic conditions are under recorded, including for example chronic obstructive pulmonary disease, chronic kidney disease, and obesity. The implications are that tackling chronic disease in this country is going to be challenging unless the capacity of primary care is increased. We also agree, however, that changing methods of diagnosis may help to reduce the numbers of people with false positive diagnoses, as may be the case in hypertension.

The suggestion that structured equation modelling offers an alternative analytic approach is interesting. However, although structured equation modelling would be possible, the fact that the associations are at the population level would mean that inferences about causality could only be supported at the population level. Perhaps this is an approach that could be used in future studies that include additional data.

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Perinatal obsessive–compulsive disorder

I found this article by Challacombe and Roe interesting and timely.¹ The idea of harming your baby can be terrifying for a new mother and the distress is aggravated by the fact that such thoughts 'should not be felt' by a caring mother. Clearly the difference between obsessive–compulsive disorder (OCD) and other more serious forms of mental illness is that with OCD there is no desire to carry out the thoughts.

I have been in practice for over 30 years in Derby and feel OCD in general is underdiagnosed. When I see a patient with anxiety, problem drinking, or depression, I ask if they have problems with excessive checking or contamination fears. Although I have not kept any figures, a significant number have OCD; some for years and there is often well-meant collusion with friends or relatives. Questions about OCD could be incorporated into anxiety/depression health questionnaires.

OCD is often a chronic illness. Even after appropriate referral and therapy, I find relapse is common. I now negotiate treatment goals with the aim of 'minimising its effects on everyday living'. Patients seem relieved about this, as they get frustrated and disappointed that their problem was not 'cured' by therapy. They are often thorough and conscientious and can make excellent parents and valued workers.

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Registrar feedback on 'Formative assessments in medical education'

I write in support of the article 'Formative assessments in medical education' by Dr Lakasing.¹

I love my job as a GP registrar and look forward to qualification in a few months. Despite the contract wranglings, bad press, and the ever-increasing workload, I feel optimistic and enthused about the future.

I support most aspects of the ePortfolio process from the AKT and CSA exams to the Case-based Discussion and Consultation Observation Tool assessments. I think the patient satisfaction questionnaires and multisource feedback assessments are crucial aspects of good training, as these collate the views of the many people we are working respectively for and with.

I completely agree with Dr Lakasing about the negative impact of the requirement for writing huge volumes of reflective entries. I believe that potentially excellent GPs with the ability and energy to be involved in innovation and improvement within primary care are shackled by the need to endlessly document reflections in accordance with the curriculum. I also think that the quantity of trainee reflection must be hugely wearing for GP trainers and must put off good people from doing the job. Given the pending rise in need for GP trainers, as a profession we will need all the good people we can get.

Another problem with the 'log entries' is the variability of volume required across deaneries. In the London deanery, registrars do two entries per month. In Oxford, Kent, Surrey, and Sussex deaneries the recommended minimum is two per week. This creates inequity of training and I would suggest that the London deanery has nearer the right balance.

The recent Francis report identified the adverse consequences of box ticking on clinical care. I would suggest that excessive box ticking has the same negative impact on training. Coerced excessive written introspection erodes professionalism and motivation. It has the potential to encourage gaming and creative writing among trainees trying to keep up in a numbers game with their peers.

Compared to my friends in other specialities such as medicine, paediatrics, and psychiatry, I feel we GP registrars have a superior training programme and I am