TALKING POINT

Work load in general practice

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"Unfortunately the evidence available to us on work load is limited and inconclusive. Such indicators as waiting lists and length of hours worked do not fully reflect changing clinical complexity brought about through the continuing development and application of new techniques which enable more patients to be treated and are more demanding in resources. We referred in our 1972 report to the need for detailed studies aimed at obtaining systematic information on work load in the different branches of the medical and dental professions: we regret that it has not yet proved practicable for these studies to be made. We recognised then that it would take time to collect useful results, and we are more than ever convinced from developments over the last two years that such studies are needed and ought to be made. We hope that steps will be taken to make them and to make the results available to us."¹

This paragraph in the Review Body's Seventh Report summarises the difficulties of evaluating general practice work load. Even so, the Review Body is convinced that studies should be made. Appendix C of the Seventh Report showed, however, that the "indicators," which have formed the basis of the calculations have, so far, been of limited value.

The current interest in work load by the profession has been prompted by diminishing rewards in the face of growing demands. Doctors' attitudes have been influenced by the increased support nationally for work-sensitive

pay systems, productivity deals, and allied bargaining manoeuvres. In these terms recognition of rising work load seems to have much to offer. This concept has support not only in general practice but also in the salary-based hospital service, where working hours and work content can be defined more readily. In the general dental services a fee-for-service system exists and work has been defined and quantified for many years. Like GPs, dentists are independent contractors. In its 1972 report the Review Body said "The work load of dentists is, in a sense, easier to measure than the work load of doctors, since dentists are paid for each item of service."²

To test the validity of work-load measurement as a true basis for assessing the overall levels of remuneration we must first look at all general practitioners' activities and commitments. The desirability of a fee-for-service system of payments is a separate but related issue.

Present background

General practitioners are now well aware of the Government's deliberate policy to transfer a considerable burden of care from the secondary care services to the community at a time when there are progressive constraints throughout the Service. The DHSS's consultative document, *Priorities for Health*

and *Personal Social Services in England*,³ shows how the shift will work. The "priority" given to primary care "can be achieved only by restraining growth in other services." In practice, the proposed augmentation of supporting staff to meet increased demands does not always have the effect intended. When the extra staff do appear the GP has increased responsibility for them and their activities. In their absence he has to deal with the increased burden in the face of diminishing medical and social supporting services.

Wherever restraint is exercised in the NHS the general practitioner's work load will increase. He is the patient's first point of contact and he has to satisfy or modify their needs and demands because of his continuing accountability under an open-ended contract. He has the difficult task of matching the growing opportunities of medical capability with resources that are relatively shrinking. As a result, his task of guide, philosopher, and friend has been overtaken by that of arbiter, ombudsman, and advocate. In addition to his clinical work load the general practitioner has to run a growing independent "business" organisation. This includes the supervision and deployment of supporting staff, the management concerned with the financing and provision of surgery premises, general administration, clerical, and accounting services. He also has an important part to play in NHS administration. If work load is to be measured in specific terms then these essential activities will have to be recognised as part of a GP's overall commitment. A study of only part of the work load would be worse than useless.

A further factor is the continuing commitment. We have to consider the relative values of a given number of services performed routinely within regular hours—industrial-type work—with an equal number of professional obligations, including on-call responsibilities, unevenly distributed because of variable demand inside and outside social hours.

Assessment of work load

This can be done in two ways, either indirectly by the study of indicators which provide a basis for inference or by the direct measurement of recognised and carefully defined units. The latter is common in industry and relevant to procedures where the whole of an individual's output can be measured.

DENTISTS

The remuneration of NHS general dental practitioners is based on output, measured in defined terms, of services whose value relates to expected hourly "output." When new techniques or equipment are introduced which increase productivity there is a consequential reduction in unit payment. Both the units of

NHS planning guidelines for 1978-9

Annual planning guidelines (HC(78)12) issued on 20 March to NHS and local authorities confirm the priorities set out in 1976 and 1977: community support, primary care, prevention, services for children, the elderly and disabled, the mentally ill, and mentally handicapped. The Secretary of State for Social Services commented that though there was still a long way to go there were some indications of movement towards the priorities for the NHS set out in the 1976 consultative document and *The Way Forward*, published last year. More was being spent on health visiting, district nursing, and some of the preventive services. According to Mr Ennals, staffing and other standards were being improved in the psychiatric hospitals and patient numbers were continuing to fall.

He continued: "We must press on with the priorities we have identified—improving the care of children, the elderly, the mentally ill, the mentally and physically handicapped and the general shift of emphasis to developing care in the community rather than in hospital or residential homes. I do not believe that . . . the ordinary hospital services will be damaged by these priorities. We are well aware of the need to protect these services and to find for

them, too, year by year additional funds. We are handling more and more acute hospital cases each year. . . . If more resources become available in the future, we will be able to speed up the pace of change, and increase the speed of development of our ordinary hospital services."

Turning to the local authorities, Mr Ennals declared that the national policies of community support were generally approved by them. While they had made progress in the services for the mentally ill and handicapped, they had not been able to expand all their services for the elderly as rapidly as the elderly population itself had been increasing. That was the result of the country's economic pressures. "I shall," he went on, "be discussing with the local authorities what can and should be done about it. Because some local authorities are finding particular difficulties in making progress I am pressing on with the programme of joint financing, the budget for which will rise to £40 million in 1980-1. The teething troubles . . . of the programme now seem to be largely over. Out of £24 million available for 1977-8, authorities have planned to spend about £19 million and the bulk of it is intended for the priority programmes."

work and the claims are monitored to ensure working standards and to identify those dentists whose work "profiles" show unexpected variations. Despite the relative simplicity of measuring dental work load, neither the profession nor the Review Body has been satisfied with the procedure. The Review Body is still trying to distinguish between productivity changes arising from technical advances, patient demand, and personal effort.

GENERAL PRACTITIONERS

In general medical practice changes in workload patterns are recognised by reference to various statistical indicators. But indicators do not measure absolute changes; they only provide a basis for inference. The Review Body's Seventh Report mentioned the following indicators.

Average list size

The report calls this "the main indicator." It has fallen from 2413 patients in 1970 to 2307 in 1975; however, the increase in the needs of the growing elderly population is recognised.

Consultation rates

One source has been national surveys such as the general household surveys. These provide consultation rates and morbidity incidence, showing age and geographical distribution. For example, they show clearly the progressive increase in forms of mental illness and allied disorders, but do not quantify unemployment and social deprivation, both of which increase the complexity of providing medical care. The Review Body has concluded from these that there has been "a small overall reduction in the number of consultations per year per doctor of about 5% over the past five years."

Commercial surveys—for example, those by Intercontinental Medical Statistics Ltd (IMS Ltd)—have been another source and have led the Review Body to conclude that there has been "a small decline of about 2% in consultation rates." This survey continuously monitors the patient contacts of a changing sample covering a total of 2000 general-practitioner weeks per year, and this was described in the Seventh Report as "evidence of a limited nature."

Volume changes in general-practitioner activities

The table shows the changes in some GP activities between 1970 and 1975.

Percentage change in GP activities between 1970 and 1975

Activity	% change 1970-5
Prescribing volume: scripts per GMP	+6.2
Maternity services: births per GMP	-26.3
Injury and sickness: new claims per GMP	-16
Notification of infectious diseases per GMP	-52.2
Cervical cytology: total GMP examinations	+94.3

Other indicators indirectly reflect general-practitioner activities.

Hospital waiting lists—A delay in admission implies an extra burden of care and support within the community. The number of patients on waiting lists increased by 26.3% between 1972 and 1977.

Use of open access facilities—This has increased and extended the degree of care provided by GPs. The use of pathology services increased by 27.6%

GMSC accepts Clothier recommendations

Last week we reported the GMSC's debate on pensions for GPs' ancillary staff (25 March, p 799). When the committee considered the report of the Rural Practices Subcommittee it accepted the recommendations of the Clothier Committee (the National Joint Committee of the Medical and Pharmaceutical Professions on the dispensing of NHS prescriptions in rural areas) as a basis for discussions with the pharmacists (10 December 1977, p 1501). The two professions will then make a joint approach to the DHSS for the recommendations to be implemented. The report, the GMSC states, represents a compromise which could mean a diminution in patients' freedom of choice and the doctor's freedom to dispense for a patient. For these reasons the committee has decided not to take any steps for implementation until the report has been endorsed by the LMC Conference. The committee also agreed to extend the voluntary standstill on dispensing arrangements until 10 October 1978.

In a circular to LMC secretaries after the meeting the GMSC secretary reported the correspondence he had been having with the DHSS about the proposed reconstitution of the Prescription Pricing Authority on the lines proposed by the Tricker Report (12 March

1977, p 670). The new constitution includes three GPs, and the DHSS had proposed that one of these should be appointed on the nomination of the RCGP as an organisation "being representative of medical practitioners providing general medical services." The GMSC pointed out that the committee was the only body which had ever been recognised as the representative body of doctors engaged in NHS general practice. The DHSS has accepted this view and the three representatives of general practice will be appointed only on the nomination of the GMSC. The RCGP will be nominating one GP to look after "academic and research interests."

The 1977 LMC Conference resolved: "That the GMSC should draw up contingency plans for a viable alternative to the Health Service, to reinforce its demands for improved general practitioner remuneration." Dr John Noble and Dr Keith Davidson have been examining the work which the BMA has done in the past on alternatives to the NHS and the committee has decided that the scheme proposed by the Rugby Division in 1965 and updated in 1970 would be the most effective. This is being brought up to date and will be distributed to local medical committees before the 1978 conference.

in 1972-5; radiology services went up by 11.8%, 1973-5.

Domiciliary consultations—An increase in consultations indicate more demanding cases needing care and support. There was a 35.9% increase between 1971-2 and 1975-6.

Work-load studies

There have been many articles exploring work load in relation to morbidity patterns, demand levels, consultation rates, delegation programmes, treatment policies, and management arrangements.⁴⁻⁸ Despite a growing interest in standards none has identified an acceptable basis for assessing the contribution to health care, and its quality, which the doctor makes as an individual.

Since the early 'sixties the General Medical Services Committee of the BMA has made several assessments of the practicability and value of centrally directed surveys.⁹ In 1975 it looked at material invited from individual practices in seeking support for the general contention that work load was increasing.¹⁰

INDIVIDUAL STUDIES

There was a good response to the GMSC's request for information which showed a willingness to help in collecting data. Many practices were able to supply figures of surgery consultations, home visits, and list sizes. Most practices had retrospective information covering quite a long period. Furthermore, many doctors could supply comprehensive statistics about local hospital waiting times for inpatients and outpatients. Even so, the data supplied did not often cover the "full commitment" of general practice activities and thus did not reflect the full increase in work load.

In statistical terms the sample was relatively

small and self-selected, with the principal drawback being the absence of a common methodology. It highlighted the wide range of variations in practice patterns and the frequency of changes to which practices are subject. Any development of these sources to achieve comparability of size with the IMS survey would be difficult and would yield only similar quantitative data of less certain validity. The encouraging response, however, did raise the possibility of forming a network to monitor the changes in practice expenses—another problem area.

GMSC STUDIES

On several occasions since the Fraser Working Party in 1964¹¹ the GMSC has made detailed studies to assess the feasibility, requirements, and value of centrally directed comprehensive "in depth" surveys of GP work load. These have prompted the following conclusions:

(a) In view of the constantly changing patterns of public expectations, morbidity, and health care, any surveys would have to be on a continuing or repeated annual basis.

(b) There is no established baseline at present and it would be several years before the results could be fully applied.

(c) To be statistically valid the samples would have to be at least of the order of 2000 doctor weeks a year.

(d) Adequate recording in the detailed form necessary would require the presence of an acceptable observer for each participating doctor.

(e) The presence of such an observer would affect the results, as would potential self-selection or rejection. There may also be difficulties in achieving proper stratification of the sample.

(f) Even in the early 'sixties some estimates of the annual costs of such studies were as much as £250 000.

(g) Such a survey would be justifiable only if it

could produce information not already available from present sources—for example, National Household Survey, IMS Ltd, etc.

The survey would have to be a qualitative valuation of the content of the present indicative units (consultations, visits, etc) reflecting the personal aspect of care and medicine's increasing complexity—that is, the true nature of the doctor's work. This could not be fairly represented in quantitative terms which ignore the stream of clinical and management decisions that the doctor makes in the course of his continuing responsibility. This daily responsibility is made more difficult because of the need to match clinical priorities with limited resources. At the same time the GP is trying to meet a potentially unlimited demand. This highlights the need to distinguish between "cure" and "care."

Cure can be measured in terms of process audit and may be said to be the major element of secondary care services, where procedures

are identifiable—for example, hernia repairs, number of babies born, coronaries treated; in units of time—duration of hospital stay or procedure, outpatient department attendances, units of investigation performed. General practice includes not only a variable, on-demand, element of cure, and business and medical management, together with overall professional accountability, but also the increasingly important element of care.

Care is as hard to define as cure. It is especially important to the patient and, paradoxically, increasing technology in medicine has enhanced its value. Care represents the personal support, understanding, communication, and assurance of quality and interest of the doctor on the patient's behalf. It is the difference between treating cases and providing a service to individuals, between dealing with population units and looking after families on an established and personal basis. Care is implicit

in quality, insensitive to audit, and is directly threatened by any watertight commitment to work load as a measurement of the value and standards of general practice.

Conclusions

Given the protean nature of general practice —its clinical and non-clinical demands, the varying patterns of social equilibrium, morbidity, and the changing patterns of health care—I doubt whether the adoption of unitary work-load measurements as a basis for establishing overall remuneration levels would be an advance. What values have to be placed on personal care, concern, interest, and mental as opposed to physical effort, and on the doctor as a therapeutic agent? How can you measure responsibility and continuity, let alone the genuine professional approach? Do the increasing demands on family doctors for these qualities represent his increased work load? Furthermore, does it reflect their shortage in a progressively standardised outside world? Is there a case for dismissing the "art" of general practice in favour of systematic valuation, with its debatable consequences?

The adoption of overall unitary work-load assessment would favour the adoption of a general fee-for-service basis for individual remuneration. Experience elsewhere has shown three possible outcomes. Firstly, productivity increases tend to be assimilated into the baseline for the following year. Secondly, expenditure ceilings are preset at national, provincial, or regional levels, resulting in depressed payments when output exceeds the projection. Thirdly, where charges to the patient are varied there is a critical effect on demand with sudden and dramatic effects on income levels. What is more important, however, is the overall effect of work-load measurements on the future of general practice in the NHS. Would it inhibit or promote favourable development? Furthermore, would such an innovation have the confidence of general practitioners. GPs themselves must debate and decide on the prospects.

Finally, work-load assessment is valid only if it is complete. Not only must we count all the fences around the course: we must also measure the height and composition of each one, noting the changes round after round, as well as the going in between.

First annual report of Health Services Board

During the first year of operation of the Health Services Act 1356 pay-bed authorisations were withdrawn from NHS hospitals out of a total of 4444. This is stated in the Health Services Board's first annual report (HMSO, price 45p), published on 22 March by the DHSS. One-thousand of the withdrawn authorisations were removed directly by the Secretary of State under the terms of the Act and 356 as proposed by the board. Facilities for private outpatient consultations were also withdrawn from over 100 hospitals after proposals made by the board. The five-man board, which is chaired by Lord Wigoder and has Dr Derek Stevenson and Dr Cyril Scurr as medical members, also prepared a report on the feasibility of introducing common waiting lists for NHS and private patients. Many comments and suggestions on the report's recommendations have since been received from interested bodies by the Health Departments, and the DHSS is considering ways of implementing the report.

The board's two main tasks are to determine the rate of withdrawal of pay-beds and other private practice facilities from NHS hospitals and to control and monitor new private hospitals over a certain size and changes in existing ones. The board describes difficulties they faced during 1977 such as a delay in their appointment and a lack of sufficiently detailed information about private practice in and outside the Health Service. The Health Departments have already begun to collect from health authorities the more detailed information on private patients' use of the NHS requested by the board.

The annual report also outlines plans for future withdrawals. The pace at which withdrawals are proposed will, it says, largely depend on factors outside the board's control, with the major factors being the demand for private medicine, the expansion of the private sector, and especially the availability of better information on the use of private medical facilities. The board has already consulted health authorities on provisional proposals to withdraw a further 339 pay-bed authorisations by the end of 1978: these authorisations are, according to the board, largely unused or underused.

Spare capacity in private sector?

Among other comments the board says it will consider whether there is scope for revoking outpatient authorisations on the basis that demand could be redirected to private sector facilities with spare capacity. It proposes to adopt this approach initially in Inner London and two health regions to establish its practicability. The board hopes in March 1979 to make its first pay-bed revocation proposals based on the availability of suitable alternative replacement accommodation in the private sector. It also observes that failure to take reasonable steps to develop alternative facilities may be grounds for the board to propose the withdrawal of authorisations provided it has issued warnings to this effect. Two applications were granted for authorisation of developments to existing private hospitals in 1977. But under the separate notification arrangements for other hospital developments which do not require authorisation the board was told of 26 projects in 1977 which could provide up to an additional 605 beds in private hospitals. The report points out, however, that some of the projects are speculative.

Fees increased for part-time medical services

The BMA reports that "under the new Counter-Inflation (Price Code) Order which came into operation on 1 August 1977 it is not necessary for the Association to seek prior approval for increases in fees. Increases in fees are now permitted up to a level that will not lead to profit margins, in a given historical reference period, being exceeded. It is therefore appropriate for the Association's Recommended (Category D) Fees to be increased by 25% on 1 April 1978. Negotiations are in progress for this increase to be applied also to other fees such as life assurance reports and adoption agency forms."

Full details of the new Category D fees can be obtained from the Secretary, BMA House, Tavistock Square, London WC1H 9JP, or from BMA regional offices.

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