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The Royal College of General Practitioners

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Chairman of Council
Professor Denis Pereira Gray, OBE, MA, FRCGP

31 March 1988

RL

The Right Honourable Margaret Thatcher MP
Prime Minister
10 Downing Street
London SW1A 2AA

Dear Prime Minister,

Thank you again for inviting me to join you on Sunday 27 March for your review of the National Health Service. It was a great pleasure amd privilege to work with you and I very much appreciated the chance of coming to Chequers.

I did not feel I answered clearly several points about general practice about which you were asking, and I was grateful to you for making it clear that you would welcome letters afterwards.

INTRODUCTION

Professor Sir John Butterfield in his introduction spoke about the mass of medical problems in the community. These are handled mainly by general practitioners who deal with 90 per cent of medical problems and refer about 10 per cent to hospital. In my own practice we refer 4 to 5 per cent; half of the conditions we do send to hospital are for routine surgery.

As you know, 97 per cent of the population are registered with general practitioners and we think this is the most widely used public service. Since there are 225 million consultations each year between patients and family doctors, the average is as many as four consultations per patient per year. Of all the professions, we have the greatest face to face contact with the British population.

At present general practitioners are already looking after over 90 per cent of all patients with asthma, high blood pressure, chest infections, middle ear infections, arthritis, and with depression.

The great majority of patients with diabetes and thyroid disease and many other similar diseases are already being seen in general practice and cared for at home. We also see all the many problems of society such as drinking and British general practice leads the world in integrating the prevention of disease with treatment.

We are now ready to do more. We hope to save unnecessary referrals to hospital and to do much more of the follow-up of disease, which is often done more expensively in hospitals.

One of the reasons the National Health Service is so much more cost effective than many other Western countries is the considerable efficiency of general practice in containing this huge load of illness and saving it from being handled at greater cost in hospitals.

This "gate-keeper" function is likely to become increasingly important in the future. I hope therefore that cost-effectiveness will be a major topic for consideration in your review of the National Health Service.

CORRECTIONS

During the seminar some errors of fact were stated which need to corrected for your records.

1. Proportion of Government spending on the NHS

First, it was suggested that the proportion of the National Health Service budget spent on general practice was about half National Health Service spending. In fact, the actual proportion of the Health Service spent on family practitioner services is about 22 per cent and within this the proportion actually spent on general medical services represents about 7 per cent of the National Health Service.

Even after allowing for all the increase in resources and the improved development of general practice in the last few years the figures published by the Secretaries of State (1986) show that the entire cost of general practitioners' incomes, professional expenses including staff, drugs, telephones, medical equipment, postage and car allowances, and all professional expenses combined comes to £23 per patient per year.

This is the most cost-effective general practitioner service in the western world.

2. Career earnings

The second error was the statement that general practitioners were now as well paid as specialists. This is factually wrong.

The Review Body on Doctors' and Dentists' Remuneration can give you an authoritative statement for the relative career earnings and pensions received.

3. Education and research

May I also correct any misconception I may have given you about the need for education and research in family doctoring. As you

said, the initial period of training as a general practitioner in the National Health Service is now about nine years. My concern was in relation to the years after qualification and the need to help keep general practitioners up to date.

There is also a tremendous need for more research in general practice to find out the way diseases arise, what the various risk factors are and what the best way is of tackling them. We also need to research how best to do medical audit and the most efficient way to work.

We do now have some very exciting evidence that general practitioners can identify risk factors for the main killing diseases. One general practitioner, Dr Maurice Stone, has been able to reduce statistically significantly the number of patients with coronary thrombosis in his practice. If we can discover the best way of doing this in everyday general practices then we have a good basis for teaching the skills required and attacking the illness that causes the most adult deaths in Britain.

NUMBER OF PATIENTS PER DOCTOR

You asked about the average number of patients per general practitioner.

The average number of Health Service patients per general practitioner in England and Wales is now 2,011 and has fallen from 2,275 in 1977.

ACHIEVEMENTS

You asked what gains had been achieved in return for this important investment. In summary they are:

1 Early discharge from hospital

You have spoken in the House about the considerable reduction in the number of days now spent in hospital - a measure of improved efficiency of the hospital service.

Obviously if patients are discharged home after an average of say 9 days instead of 12 days as previously, then the complications and problems arising between days 9 and 12 are now handled by general practitioners instead of hospital doctors.

2. Day care surgery

Day care surgery is another advance achieved by hospital doctors and is being used increasingly.

By definition, patients are at home the night after day care surgery, so again any complications or anxieties that arise in either the patient or his family leads to a call to the general practitioner.

3. The mentally ill and the mentally handicapped

During the last few years an unprecedented number of mentally handicapped and mentally ill patients have been discharged from long stay hospitals. Tens of thousands of these patients are now on the lists of general practitioners and their considerable needs for medical advice are being met outside hospital.

In Exeter we have closed two mental hospitals and my own general practice now includes a group of quite disturbed patients, including several schizophrenics, most of whom have been in mental hospitals for many years.

4. Demographic change

There has been a substantial increase in the number of the elderly in the population, especially the elderly elderly. Their care falls mainly to general practice.

Of the elderly:

93 per cent are at home in the care of general practitioners
4 per cent are in residential homes and private nursing homes also in the care of general practitoners
3 per cent remaining are in geriatric beds in hospitals under the care of geriatricians.

In addition:

40 per cent of all the over 75s live at home alone
33 per cent of all the over 75s have seen a general practitioner within 4 weeks

(General Household Survey, 1985)

You asked about home visiting and what problems old people have.

The figures for my own patients over the age of 75 are:

5 per cent have cancer
5 per cent have had a coronary thrombosis
5 per cent have had a stroke
5 per cent have dementia
5 per cent have diseases like thyroid failure and vitamin B12 deficiency which general practitioners can well diagnose and treat without referral to hospitals
10 per cent have cataracts
12 per cent have had arthritis bad enough to have had a joint already replaced
Another 12 per cent have arthritis in a form which requires treatment
12 per cent are depressed, a tenth of whom have suicidal thoughts or who at least feel that life is not worth living
30 per cent are deaf.

The average number of different medical problems per patient among the over 75s is six and the range is between one to ten.

5. Preventive medicine and health promotion

There has been a dramatic increase in the amount of personal preventive medicine and health promotion provided by general practitioners and their teams.

I enclose a photocopy showing the provision of cervical cytology for women in two adjacent health districts including my own as just one illustration of how one of your Government's present priorities is being implemented.

(Postgraduate Medical School, University of Exeter)

The figure shows the striking improvement in the performance of general practitioners. In 1979 they took less than half the cervical smears. However, they have increased the proportion in every year since, and for every cervical smear now taken outside general practice (in a hospital, family planning clinic, woman's welfare clinic or cytology clinic) general practitioners in this population of just under half a million now take four.

MEDICAL AUDIT

You spoke about the importance of medical audit and asked for solutions.

The experience of the Royal College of General Practitioners over about 12 years is that there are three main requirements:

1. Education

Education is needed in order to achieve a change in professional attitudes and to acquire the necessary skills. A local educational person is needed such as a local general practitioner tutor.

2. Information

A reorganization of records and data is needed in most practices. This usually means a microcomputer if it is to be done systematically. We greatly welcome the speech last year by the Secretary of State in which he said he planned to put a microcomputer on every general practitioner's desk.

3. Incentives

Worthwhile medical audit takes time. If it is to be encouraged incentives are required and certainly the removal of the many existing perverse incentives.

I enclose a short paper for you on medical audit in general practice.

VISIT TO MY PRACTICE

If when you are next passing through Exeter, perhaps on your way to Cornwall, I would be delighted if you could find about an hour to see a demonstration of medical audit in my general practice which I have been very keen to develop.

EVIDENCE TO YOUR REVIEW OF THE NHS

I would be very grateful if I could give evidence to you for your Review, either as an individual or on behalf of the Royal College of General Practitioners, as you prefer.

I would be very pleased to answer any enquiries or give you any further information you would like.

With best wishes

Yours sincerely

Denis Pereira Gray

Denis Pereira Gray

ENCLOSURES

1. Figure showing source of cervical smears
2. Paper on medical audit in general practice

REFERENCES

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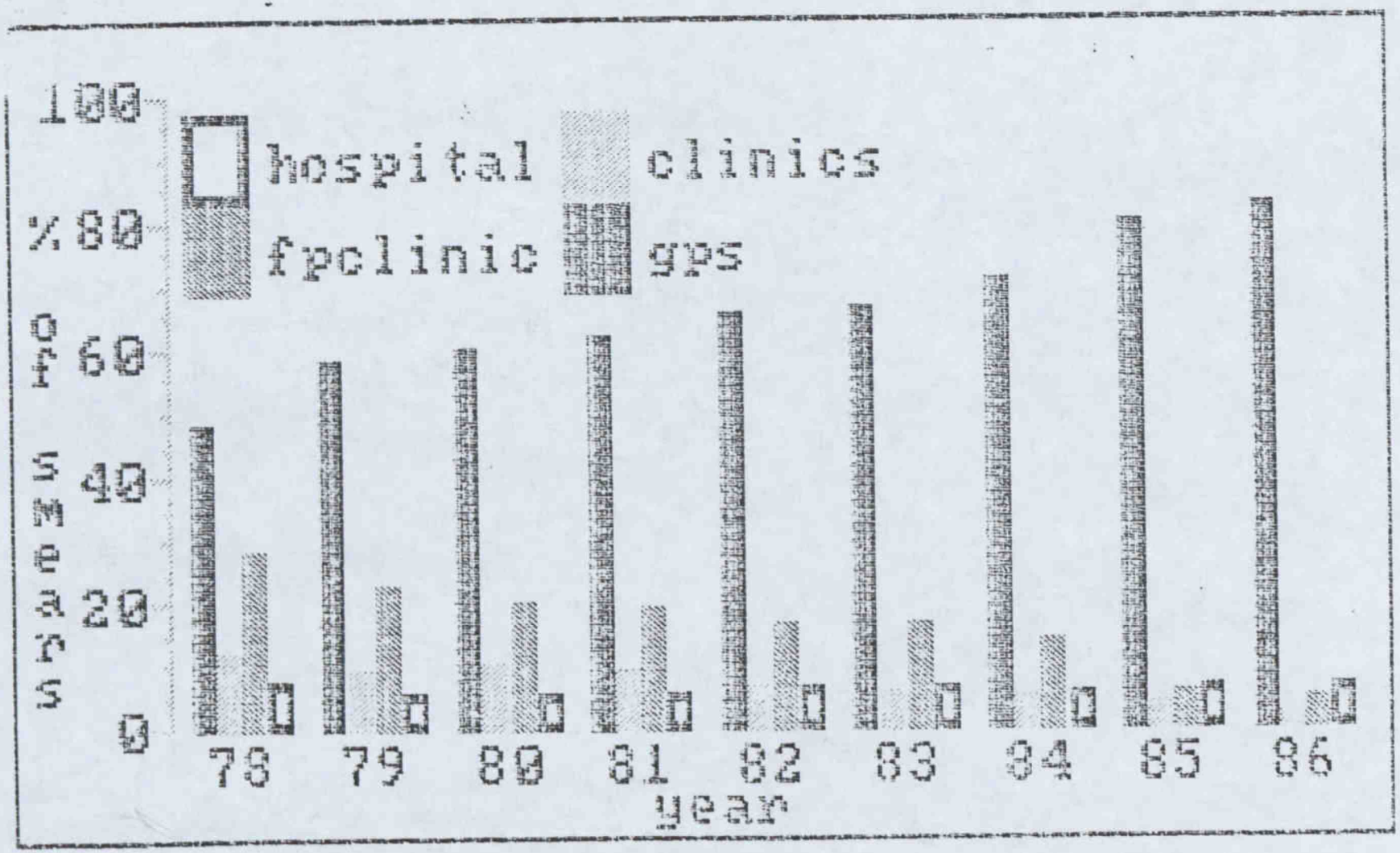
Office of Population Censuses and Surveys (1985) General Household Survey 1983. London: HMSO.

Royal College of General Practitioners (1987) The Front Line of the Health Service. Report from General Practice 25. London: RCGP.

Secretaries of State for Social Services, Wales, Northern Ireland and Scotland (1986) Primary Health Care - An Agenda for Discussion. London: HMSO.

SOURCES OF CERVICAL SMEARS IN THE EXETER AND NORTH DEVON HEALTH DISTRICTS

Population involved = 431,635



Source: Postgraduate Medical School, University of Exeter
(Anthony and Kelly from Pathology Laboratory and Analysis from Department of General Practice)

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CONFIDENTIAL

MEMORANDUM

TO: THE PRIME MINISTER

FROM: DENIS PEREIRA GRAY

DATE: 4 APRIL 1988

SUBJECT: PRIVATE MEETING AT CHEQUERS ON 27 MARCH 1988

MEDICAL AUDIT

The College

The Royal Charter of the College of General Practitioners requires it to:

> "encourage, foster and maintain the highest possible standards in general medical practice"

The College is a voluntary body with about 15,000 members. It is a registered charity and it exists to promote better quality of care for patients in general practice.

Medical audit

Medical audit (which the College now calls performance review) is one of the highest priorities of the Royal College of General Practitioners. This was the first Royal College to concentrate heavily on medical audit and has several years experience of helping doctors to undertake it.

The College believes that medical audit is important for quality control and that doctors should organise it as soon as possible.

If Government now wishes to promote widespread medical audit in general practice it will be necessary to:

1. Support those forces in the medical profession which are actively encouraging medical audit.

2. Remove or at least substantially reduce perverse incentives.

1. ENCOURAGING EDUCATIONAL SUPPORT

I University departments of general practice (undergraduate)

General practitioners have not been taught how to do medical audit as undergraduates. Although general practice is the largest branch of the medical profession and there are about twice as many general practitioners as all consultants in all specialties combined, university departments of general practice are the least resourced and suffer serious discrimination through SIFT.

The College wants university departments of general practice resourced equally compared with departments of medicine and surgery.

2. Postgraduate departments/institutes

There are about a dozen important postgraduate institutes like that of Child Health in the University of London which raise standards in the specialties. An equivalent is urgently needed for general practice but apart from small departments at Exeter and Keele which have no security of funding, nothing yet exists.

3. Regional general practice education committees

The regional general practice education committees are a key force. They have done much to introduce medical audit especially in training practices (about a quarter of all general practices).

Their budget for all general practitoner education in all subjects from AIDS to audit is about £50 per general practitioner per year. This is equivalent to the average cost of one general practitioner's prescriptions for one morning.

Compared with private industry this is a surprising sum. What industry would have a training budget so small for a key group of professionals who, as the White Paper "Promoting Better Health" states, handle 90 per cent of the health problems brought to the National Health Service and determine most admissions to hospital?

4. Regional advisers in general practice

The staffing of those who have responsibility for organizing general practitioner education in all Health Service regions (the regional advisers in general practice) is low. The average level is about one-and-a-half whole-time equivalent general practitioners for two thousand working general practitioners.

Audit is probably best taught to established doctors using real examples from their own practice.

5. Local general practitioner tutors

The College believes that the best way to organise local education for general practitoners in each health district is through a local general practitioner tutor. Only a few exist.

2. PERVERSE INCENTIVES

There are three:

1. Perverse incentive for training practices

As I said at your meeting, the College in its Statement The Front Line of the Health Service recognised that the best achievements in medical audit were taking place in training practices. Research shows clearly that medical audit now occurs more often in these university-selected practices (Baker, 1985).

The DHSS has for several years given public evidence to the Review Body on Doctors' and Dentists' Remuneration that the rewards for trainers should not even be adjusted for inflation.

Consequently, these have in real terms been reduced steadily so that general practitioners who submit to trainer inspection (a practice visit and a ten page written report every three years in my region) and who do undertake audit regularly, are rewarded considerably less well than those who do other work.

2. Perverse incentives in the current general practitioner contract

The current general practitioner contract provides no incentive to medical audit.

The most effective way of doing medical audit in general practice is by using a microcomputer in the practice itself. This provides rapid access to the necessary information and the ability to handle many factors at once.

The practices which have bought microcomputers and are doing medical audit are each penalized by several thousand pounds.

3. Perverse career structure in the universities

Medical audit is quite complicated in general practice. It needs careful organization or it can be a waste of time and money. It involves clear definitions, unambiguous targets, good, simple measuring systems, reliable records, reasonably quick recall of information and accurate analysis.

The general practitioners who have done most to develop medical audit and work out how it can be done in practice are mainly university professors/lecturers or regional advisers. They have, with the Royal College of General Practitioners, emerged as the leaders of thought and action.

The leaders of the largest branch of the medical profession are paid about half of what is routine for the leaders in every other branch. The College believes that career development should be the same in all the main branches of the profession.

CONCLUSION

General practice is now ready to take on substantially more work and responsibility. The potential is great.

Medical audit is the key. The Royal College of General practitioners is introducing it rapidly and believes it is the responsibility of general practitioners to look critically with their peers at their own work and try to see how to do it better. Medical audit is the best method known for improving quality of care and containing costs.

As I said at your meeting, we ask for no special favours for general practice. It should compete on equal terms and be treated exactly the same as the other branches of the medical profession.

We do ask for removal of all the various forms of discrimination against general practice and believe that this would encourage medical audit greatly.