Guest Editorial

Traumatic Evolution: Recent Changes In British General Practice

Everywhere changes are taking place in family practice. The current and anticipated worldwide stresses are brought on partly because of health care problems in general, but they are also related to the nature of family practice.

Escalating costs of health care have resulted from new medical technologies and opportunities for preventing and managing disease, including more, better, and more expensive drugs and steady increases in numbers of physicians. Providers, often national governments and private insurers, while attempting to control costs, are at the same time trying to improve quality, standards, services, and outcomes of care.

Inevitably, family practice is affected. Recent experiences with imposed changes in family practice in the British Health Service should provide lessons for colleagues elsewhere.

A brief history is pertinent. The British National Health Service (NHS) was introduced 5 July 1948. This health service was not a radically new system but had evolved over 100 years.[1] The NHS has become an essential part of the British way of life, popular with the people, and accepted by the medical profession. Run by the government and paid for largely (85 percent) out of general taxes, the NHS is inexpensive compared with other national health systems (NHS costs 6 percent of the gross national product, whereas health care in the United States costs 11 percent, and in Western Europe the costs are 8 to 9 percent). Nevertheless, the Conservative government has been trying to reduce expenditures through policies that emphasize increased efficiency, more competitive marketing of health care, and increased value for money, together with considerable attention to consumer (patient) demands.

In the last 2 years, this emphasis has led to radical changes for hospital and family practice.[2,3] With a strong-minded politician (at this time, Kenneth Clarke) in charge of the British Health Service, changes have been imposed in spite of conflicts with such medical political bodies as the British Medical Association, the Royal College of Surgeons, the Royal College of Physicians, and other specialties. The New Contract for family practice was imposed 1 April 1990.

In theory and on paper, the New Contract reads as a sensible attempt to improve primary health care. In reality, it is too theoretical and not based on any reliably documented evidence of cost benefits or other improvements in the health and welfare of British people.

The New Contract for family practice is consumer oriented. As such, it aims to provide better value for public money, to make available better information for patients, to increase emphasis on health promotion and disease prevention, to promote competition for patients among physicians based on providing a better and wider range of services, and to create more controls by government agencies through audit and other measures.

Because British general practitioners are private and independent physicians in contract with the British Health Service to provide primary care, the changes have been enforced through alterations in remuneration. Financial incentives provide the quickest means of effecting change in medical practice. Although capitation fees for all patients registered with a general practitioner provide for the physician's basic remuneration, accounting for some 60 percent of income (the average number of patients per general practitioner now is 2000), there are a variety of other payments for services and reimbursements for premises and employed staff.

The New Contract has given increased power to local executive Family Health Services Authorities, who are expected to carry out audits of each general practice, receive annual reports from each practice, exercise controls on overprescribing (if possible), and reduce excessive use of hospitals (if possible). General practices are expected to produce approved leaflets for public distribution giving information on services provided, schedules of consultation, emergency coverage, and names of physicians and staff. General practitioners are now allowed to advertise to the public.

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General practices are encouraged to compete for patients. Larger practices, caring for more than 9000 patients, are being invited to become budget-holders to buy services from hospitals, pay for drugs, and keep any profits generated by more efficient care. Practices in poor areas of the country will receive a supplementary deprivation allowance to attract physicians to work in such places.

Disease prevention guidelines request that general practitioners offer Papanicolaou smears to all women aged 20 to 65 years; however, these physicians will receive payments only if they perform this test on 50 percent of all women in this age range in their practice. They will receive higher payments for reaching more than 60 percent. Similarly, child immunization payments will be made only when at least 80 percent of preschool children in the practice have been immunized, with higher rates awarded for achieving a target of 90 percent or more.

Physicians receive reimbursement for health checkups for child surveillance, for new patients registering with the practice, for patients who have not been seen for 3 years, and for all patients aged 75 years and more (7 percent of the population). In addition, extra payments are made for organizing and running health promotion clinics in the practice (groups must include at least 10 patients, and instruction must last for at least 1 hour per session) for diabetes, hypertension, asthma, well-woman and well-man care, and any other subject that is approved by the local Family Health Service Authority. There are also extra payments for carrying out specified minor surgery sessions, and a $4000 postgraduate education allowance is available to each general practitioner to "buy" his or her approved education each year.

There were bitter conflicts between the Department of Health and the British Medical Association before the introduction of the New Contract, with threats of sanctions and resignations by physicians. In the end, physicians accepted the changes and are working with them. Faults occurred on both sides, with public confrontation resulting when private discussion was essential. There were no pilot trials beforehand, and little help was available for the major changes for general practice.

What has happened since 1 April 1990? It has been a time of considerable paperwork and increased administrative demands on the practice teams, including physicians, managers, secretaries, and nurses. Computerization has increased with all its attendant problems and difficulties. Morale fell and anger was fueled.

British general practice is remarkably resilient, however, and after a 6-month shakedown period, the new system is being worked out; more hours per week are involved, but there is more income, and profits are increased for efficient practices. Nevertheless, it has become clear that many of the theoretical ideas imposed by the Department of Health are ineffectual and wasteful, and detailed audit evaluations are necessary.

What lessons are to be learned? The chief one is that close collaboration and discussion by political and professional leaders are needed when a new health care system is introduced. It is essential that the profession and public are carefully prepared and reassured about the intended changes. A suitable scientific approach is necessary, involving preliminary trials of the proposed changes to iron out problems, and results should be published and used to persuade the profession. There must be built-in evaluation processes to check on benefits or defects and regular reports on outcomes.

Looking back, personally, over my 44 years of practice in a southeast London suburb, I am amazed at the radical changes that have taken place in the organizational delivery of care. I am also amused at the relatively few changes in what comprises good patient care. It seems that patients and physicians can absorb imposed bureaucratic changes providing that physicians remain interested and concerned about their patients' welfare and that care is supportive, continuous, and above all, filled with clinical common sense, giving due respect to what is old and proved while avoiding too much zeal for what is new and uncertain.

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