

## CONTROVERSY

## Effect of the new GP contract on child health clinics

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Under their old contract general practitioners (GPs) were obliged to carry out the duties normally expected of a GP.<sup>1</sup> A GP did what a GP did. The strength of this loose definition was that it allowed the profession room to develop and innovate unconstrained by contractual fetters. The weakness of such a traditional professional stance, which has steadily been exposed over the last two decades, was that most GPs did develop their service quite dramatically but some failed to do so. This led to inconsistency of service provision with the hardest working practices not necessarily receiving the most resources.<sup>2</sup>

Nowhere was this more true than in the provision of preventive child health care. For child health surveillance was not considered the normally expected duty of a GP. Despite this many practices were working closely with their attached health visitors to provide the service. A recent survey in Newcastle showed that 40 of the 51 practices were routinely offering preschool child health surveillance and 47 were undertaking preschool immunisation.<sup>3</sup>

It is important to understand how general practice is funded, for this had been and is likely to remain a contentious issue between GPs and community health staff. GPs are independent contractors. The last major overhaul of the GP contract came as a result of the charter for the family doctor service in 1966.<sup>4</sup> Since then there has been a three part payment system of basic practice allowances, capitation fees, and item for service payments supplemented by group practice allowances and incentives for doctors to work in under doctored 'designated' areas. Partial reimbursement of the salary costs of clerical and nursing staff was also instituted, and funds were made available, by grants and loans, for the building and upgrading of premises. The 1966 contract heralded major developments in the service, which have subsequently been reinforced by the expansion of vocational training. This became mandatory in 1982, so that most new entrants to practice have now completed a paediatric hospital appointment.

Under the 1966 contract child health surveillance by GPs was not funded, but immunisations were paid for on an item for service basis. The increasing provision of child health surveillance by GPs occurred because they believed it was the right thing to do for their patients.

Under the terms of the new GP contract,<sup>5</sup> which came into force in April 1990, GPs may seek approval to be placed on the Family Health

Services Authority (FHSA) child health surveillance list. If approval is granted by the FHSA (formerly the Family Practitioner Committee) the GP may recruit children under 5 years of age for child health surveillance—the parents have to sign a form—and the GP is then remunerated with a small annual fee. Children will thus be registered with a practice for 'general medical services' and 'child health surveillance'.

There are precedents for this list system. Women can sign up with a practice for family planning and/or maternity care separately from general medical services. The GPs must obtain the approval of the FHSA to provide these services, and the FHSA maintains family planning and obstetric lists. Approval to join these lists is not automatic, and the GPs must meet criteria of training, qualification, and experience set by the FHSA. This mechanism allows the FHSA to exert some measure of control over quality of care. The FHSA's are presently establishing their criteria for admission to the child health surveillance list. Many have consulted local paediatricians about the criteria.

The item for service payments for preschool immunisations have been replaced by a system of target payments. Practices are now remunerated according to the level of immunisation uptake in the practice population.

It is a paradox that the government should have decided that preschool child health surveillance and immunisation should remain as optional components of primary health care based in general practice. Regular geriatric surveillance conversely is now a contractual obligation, though its value is questionable.<sup>6</sup> Equally it remains to be seen whether the new target payments lead to a rise in overall immunisation uptake rates. There is a danger that practices who fail to achieve the top target of 90% may reduce their investment of time and resources in immunisation, and accept the lower target of 70%. Theoretically this is more likely to happen in areas of greatest need where high levels of immunisation uptake are difficult to achieve, and where practices will be compensated financially by the new deprivation allowance.

The government's intention is clear. They have recognised that preschool child health surveillance can most satisfactorily be carried out when the doctor has continuing responsibility for the child and is thus fully aware of his or her medical and family background.<sup>7</sup> Quite properly the government wishes preschool child health surveillance and immunisation to take

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place within general practice. Sadly their approach is half hearted and both activities remain as optional extras. Fortunately most practices were already engaged in both, and more are beginning to get involved. Furthermore, there is comfort in the experience of community based antenatal and postnatal care, which used to be provided in clinics and which is now virtually exclusively provided within general practice.

Why is the government's intention quite proper? Why should preschool child health surveillance and immunisation take place within general practice? Why are clinics inappropriate?

As long ago as 1976 the Court report concluded that the tripartite structure of child health services between general practice, hospitals, and community clinics was undesirable.<sup>8</sup> The Court committee's first recommendation stated that 'the organisational structure of the child health service should be changed to provide an integrated 2-tier system based on comprehensive primary care linked with supporting consultant and hospital care'. With the Alma Ata Declaration two years later the World Health Organisation (WHO) acknowledged that the only way to achieve their global goal of 'health for all by the year 2000' was through the development in each country of a system of primary health care, providing comprehensive curative and preventive care accessible at the point of first contact with the national health system.<sup>9</sup>

Britain was fortunate among nations in having a primary health care service based on general practice already in existence. The development of multidisciplinary primary health care teams (PHCTs) had been expressed government policy since 1974.<sup>10</sup> It is no surprise that Jarman and Cumberlege concluded that primary health care in this country is best provided by a PHCT of GPs, community nurses, and others working together from good premises serving the population registered with the practice.<sup>11</sup>

It is simply historical accident and the antithesis of comprehensive primary health care that preventive child care should have been provided and administered as a separate vertical system.

Much of the debate about child health surveillance has been concerned with its content and quality, rather than where and by whom it should be carried out. A survey in 1983 revealed that each of 192 health districts in England ran its own wholly different child health surveillance programme.<sup>12</sup> The choice seemed to depend more on the whim of the individuals responsible than on any apparent rationale such as research. Yet high quality surveillance programmes can only be developed if research becomes an obligation. By 1985 the WHO had admitted that preschool screening had not been adequately evaluated.<sup>13</sup>

The Hall report has made a useful contribution to the debate about content and usefulness,<sup>14</sup> though even its conclusions have been disputed by some.<sup>15</sup> Any discussion about quality is meaningless without adequate measures of process and outcome. It is the responsibility of the health professionals concerned to define a basic screening programme with an

appropriate reporting system for both interventions and outcomes to allow evaluation. This is beginning to be achieved in some parts of the country,<sup>16</sup> but we are a long way from being able to demonstrate that examination of babies at 6 weeks of age leads to a reduction in the later presentation of congenital dislocated hips or undescended testes.

In short, anxieties about the quality of surveillance provided by PHCTs<sup>17</sup> need to be addressed by the establishment of a properly evaluated reporting system and appropriate training for GPs and health visitors and not by continuing a similarly unproved parallel service.

Preschool child health surveillance and immunisation as an integral part of comprehensive primary health care provided by PHCTs based on general practice has much to recommend it. The GPs have continuing clinical responsibility for the child and its family in sickness and in health. The families are in regular contact with the team, and most mothers receive antenatal care and family planning advice from the team. The GPs and health visitors regularly attend to other matters during well baby clinics, for example social problems, intercurrent family illness, family planning, and postnatal care. This is convenient for families. Further the GPs are best placed to catch children opportunistically—typically the most needy—when they fail to attend structured clinics. Better communication within the PHCT can overcome the problems of inconsistent and conflicting advice so many mothers receive.<sup>18</sup>

It has been suggested that the traditional medical officer of health responsibility for the health of the population should be undertaken by GPs,<sup>19</sup> each practice being responsible for individual and group health surveillance in its own registered population. The potential of the defined GP list is now beginning to be realised as practices rapidly computerise and increasingly accept responsibility for anticipatory care.

Eventually practices will report annually on the health status of the practice population,<sup>5</sup> and GPs may stand as powerful medical advocates of behalf of their patients. The PHCTs using their accumulated and up to date computerised information could make a significant impact on the planning and delivery of services. In short, a vision of the future has emerged in which PHCTs will have the critical roles of identifying need and providing essential health services for their defined population. This vision must include the children.

In contrast what can community clinics offer? The buildings are mostly poorly designed, unattractive, and underused. They are staffed almost exclusively by part time clinical medical officers (CMOs) who have neither clinical responsibility nor adequate career structure. The appointment of consultant community paediatricians, while easing the pangs of guilt felt by their hospital colleagues, has done little to improve the lot of the CMOs. In many parts of the country the clinics are staffed by GPs working on a sessional basis or by junior medical staff.

The clinics do offer certain positive benefits. The doctors have a special interest (and most

have had special training) in preventive child care. They dispense vitamins and cheap baby milk. Most provide a sociable clinic atmosphere. All of these features are steadily being reproduced within general practice. In particular there is no reason why milk and vitamins have to be provided exclusively from clinics. Furthermore the claim that clinics are geographically more accessible is unsupported by the evidence. GP premises are more numerous and more widely distributed in the community.

The question now is not whether general practice can or should provide primary preventive care for children, but how quickly it can be done.<sup>20</sup> If some GPs are unable or unwilling to provide the service, CMOs could be invited to carry out these tasks with access to the practice records and premises. Such a move would foster integration, and might provide better career opportunities for CMOs.<sup>21</sup>

This will allow consultant community paediatricians to concentrate on supporting PHCTs with advice, training, and suitable reporting systems, while accepting responsibility for school health services and the community based services for children with special needs. The clinics, which are at best an expensive anachronism dispensing milk, vitamins, and condoms, and at worst a source of conflicting advice and wasteful duplication, could then be sold—probably to GPs who would upgrade them attractively as they have done so successfully with their own premises! It may be sensible to retain a few clinics to provide secondary paediatric care for those children who are better assessed and treated in a community setting, for example cases of child abuse.

For too long the clinics have been maintained on the grounds that GPs are not ready. It is time we placed our resources and faith in comprehensive primary health care based on general practice. This is essential for the future of our children.

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## Child health clinics

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In the last two years one of the major arguments in the National Health Service has been for a reduction in the duplication of services. District health authorities which are euphemistically 'a little short on cash' look towards reducing their services and transferring the cost to another agency, often with the lame excuse that this agency can 'do it better'.

Who makes those decisions about the quality of the service and on what criteria? What may be perceived as 'duplication' by managers and doctors may similarly be viewed as 'choice' by patients or community health councils. There is usually a tendency in such circumstances for professionals to assume that they know what is best for users, often without asking. It is important, therefore, to scotch the myth held by some general practitioners (GPs) that the Court report

recommendations said that they are the mainstay of child health surveillance.<sup>1</sup> In my view there are three key participants in ensuring good child health surveillance, these being the parent(s), health visitors, and doctors.<sup>2</sup>

I cited the issue of choice as one of the key elements of the argument in favour of child health clinics. Why do users of child health services prefer clinics run by the district health authority? On a visit to a local clinic I asked a mother why she brought her child to this clinic rather than taking her baby to her local GP run child health clinic. The answer was simple and direct 'You go to the doctor when you're sick, my bairn's not sick'. Clinics in Newcastle are linked to the notion of health. If GPs are to succeed in providing clinics capable of matching those provided by the district health authority

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