2.7 Determinants of general practitioner workload

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The workload of general practitioners plays an important role in discussions about list size and remuneration, at least in health care systems with fixed patient lists and capitation payments, such as The Netherlands and the United Kingdom. Against the background of the fairness of differences in income level between general practitioners the question is posed as to what extent differences in list size as such reflect differences in workload and to what extent differences in patient characteristics influence workload. Both list size and practice composition relate to the influence of demand characteristics on workload. Apart from demand characteristics the literature suggests that general practitioners also in part regulate their own workload through practice organisation and workstyle. In our presentation we will try to assess the relative influence of demand related and supply related influences on workload.

The study is part of a large project, called the National Study of Morbidity and Interventions in General Practice. Central to this project is a three month recording of all doctor-patient contacts of 163 general practitioners in The Netherlands (N= 386.000). Data recorded include patient identification code, characteristics of the consultation (e.g. first or repeat consultation, length of consultation, time of the day), reason for encounter, diagnosis, and intervention (diagnostic services, treatment, prescriptions, referral). For all practices (N= 103) an age/sex register has been set up to be able to relate the doctor-patient contacts to the practice population (N= 335.000). The participating general practitioners have filled out a mailed questionnaire with, among other things, questions to indicate the means at their disposal for managing their own workload. Moreover they have kept a detailed diary covering 24 hours a day for one week.

Indicators of workload are the number of patient contacts, the consultation rate, the average duration of the consultation and hours worked, differentiated by field of activity.

The frequency of contact with the GP is (in a random sample of all patients) 1.06 contacts in the three months recording period. Contact frequency is higher among women than among men. The age pattern shows relatively high figures for young children (aged 0-4 years), low frequencies for children from 5-14 years of age and after that a gradual increase with age.

On the average during one week the GPs spent 28,5 hours in patient contacts in the office hours (8.00 till 17.00 h.) and another 5,5 hours outside office hours.

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2.8 Care for children, cooperation between general practitioners and pediatricians

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Recent publications have generated much discussion on the future of health care services. Unfortunately, the character of the provisions at present has not yet been clearly documented, so it will be difficult to prove the changes recommended to be beneficiary for the people involved.

Considering this we conducted a study to classify the pediatric problems presented to GPs and specialists and to establish the doctor's management of these problems. This study is part of a research project, financed by the Ministry of Education and Sciences, designed to investigate the possibilities of improving cooperation between primary and secondary health care services and to enhance the quality of care regarding sick children.

In 1988 general practitioners and pediatricians completed questionnaires for every child - from a community with a population of 27,700 amongst which 5700 children under the age of 15 - that consulted them during a period of respectively four and six months. The reasons for encounter and diagnoses were classified according to the ICPC-classification. The questionnaires were designed according to those of the National Study performed by the NIVEL in order to estimate the reliability of the results in future. We added questions considering referral, pediatric follow-up and task delimitation.

During the registration period 2082 children consulted their GP. Only 185 children were referred to a specialist of which 35 children to a pediatrician. 136 Children visited the pediatric outpatient clinic including 92 children that were already under pediatric surveillance, 6 were referred by another specialist and 7 came on their parents' initiative.

The GPs overall certainty about the diagnosis was 78%. This percentage was considerably lower at the time of referral, especially regarding pediatric referrals. Nevertheless, no significant difference between the diagnoses of the GPs and the pediatricians could be found.

Although a substantial number of referrals considered long term problems, the decision to refer was frequently made after one consultation. Besides that, 35% of the pediatric referrals were referred back within 3 months time.

Communication problems at the time of the referrals were scarce, but during the pediatric surveillance there was hardly any communication between GP and pediatrician.

According to our analysis we can draw the following conclusions: General practitioners undertake the care of almost all sick children themselves, but the lack of exchange of information during pediatric surveillance may have implications for the children involved. A strategy to make the care complementary may well improve the quality of the care provided.

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2.9 Standardized patients as a method to assess performance of general practitioners

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In recent years the assessment of the quality of care by general practitioners has become a major issue. One of the best, but still seldom used, methods to assess the actual care given by doctors is to make use of standardized (or simulated) patients. Using the definition of performance (what a physician does in his day-to-day practice) this project has as its main object to assess the