Impact of the introduction of fee for service payments on types of minor surgical procedures undertaken by general practitioners: observational study

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Abstract
The 1990 general practitioners (GPs) contract introduced item of service payment for minor surgery, payable for six categories of procedure. Early review showed no substitution of cheaper procedures for more expensive treatments. Detailed payment data from six Health Authorities for the period 1993–2000 show an 11 per cent increase in claims, largely accounted for by the rise in cautery, incorporating cryotherapy. Cryotherapy is no more effective at treating warts than cheap commercially available products, but is quite profitable for GPs. This is yet another example of item of service payment distorting treatment priorities. The new GP contract, and the initiative to develop GPs with special interests in dermatology and minor surgery, will allow primary care trusts to develop minor surgery undertaken by appropriately skilled and experienced GPs, and which reflects the needs of the population.

Introduction
The 1990 contract for general practitioners (GPs) in England and Wales specified an item of service payment for minor surgical procedures, which replaced an element of per capita funding and contributed to target income. GPs could claim for up to 60 procedures annually, drawn from a prescribed list, and received £20 (1990 prices) per procedure. It was hoped that this would encourage them to provide minor surgery services in primary care and therefore reduce referrals to secondary care. Following contractual change, early review showed an increase in GP minor surgery claims, which was due to extra treatments being undertaken, rather than a transfer of procedures from secondary to primary care. No substitution of simpler and cheaper procedures for more time-consuming and expensive treatments was noted at that time. This paper examines the situation 10 years on.

Methods and results
We wrote to all Health Authorities in England and Wales asking for data on payments made to GPs, broken down by category of procedure claimed for. Seventeen were able to provide us with data. All 17 could provide data for 3 years, 14 of them for 5 years, seven for 6 years, six for 8 years, three for 9 years and only one for 10 years. In order to be able to examine trends over a sufficient time period without the possible confounding effects of changing geographical area of analysis over time we conducted the analysis presented here using data from the six Health Authorities who could provide 8 years of data. However, we also conducted an analysis using all of the available data: the results of the two analyses differ little.

Rates were calculated for each year for each type of procedure claimed for, using mid-year population estimates for the combined Health Authority populations. The population covered rose from 3,758,320 in 1993 to 3,875,668 in 2000, or ~8 per cent of the population of England. Ninety-five per cent
confidence intervals for rates were calculated using the method described by Estève et al. 1

Figure 1 shows the trends in six claims categories. For the sake of clarity 95 per cent confidence intervals around these trends have been omitted from the figure, but are given in the table of raw data and rates. Total claims in the six authorities rose from 109 876 in 1993 to 122 114 in 1999 (an 11 per cent increase) falling back to 116 455 in 2000. This increase was explained largely because of the rise in cautery (incorporating cryotherapy) from 28 per cent of claims to 38 per cent of claims, accompanied by a decrease in excisions from 23 per cent to 19 per cent. Injections rose initially then fell back, but still form a substantial proportion of claims. Claims for aspirations, incisions and ‘other’ procedures maintain low baseline levels.

Discussion

Only a minority of Health Authorities were able to provide data for this study. The large majority responded to our request for data, but mainly to say that they did not keep their data in an accessible form, or did not keep the data at all. However, those that did keep data were geographically diverse and covered a large population, and our results probably reflect the situation across England and Wales.

These data could be interpreted in several ways. First, there could be differences in coding and recoding practices over the period studied. Given that there are only six procedural codes, however, and that it is the responsibility of general practices to claim for procedures by category, this seems unlikely. Nevertheless, it cannot be ruled out.

Secondly, it could be that the increase in cryotherapy treatment may reflect an increase in the confidence of GPs in treating lesions other than warts (e.g. skin tags) with cryotherapy, with a consequent decrease in excisions. Although the former may be true, we do not believe the latter to be the case. Based upon data available to us from an as yet unpublished randomized controlled trial comparing minor surgery in hospital and general practice settings it seems to be the case that the size and

![](https://example.com figure1.png)

**Table 1** Numbers of minor surgery procedures claimed for by GPs, by payment category, and overall population in six health authorities, 1993–2000, claim rates per 1000 population, and 95 per cent confidence intervals

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<tr>
<td>Aspirations</td>
<td>1.14 (1.11–1.18)</td>
<td>1.00 (0.97–1.03)</td>
<td>0.98 (0.95–1.01)</td>
<td>0.98 (0.95–1.01)</td>
<td>0.98 (0.95–1.01)</td>
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<tr>
<td>Rate</td>
<td>4300</td>
<td>4382</td>
<td>4032</td>
<td>3800</td>
<td>3730</td>
<td>3586</td>
<td>3401</td>
<td>3147</td>
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<td>Rate</td>
<td>30 658</td>
<td>34 865</td>
<td>37 772</td>
<td>42 097</td>
<td>42 684</td>
<td>43 283</td>
<td>40 038</td>
<td>39 447</td>
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<tr>
<td>Rate</td>
<td>25 538</td>
<td>25 862</td>
<td>26 032</td>
<td>26 510</td>
<td>25 851</td>
<td>24 405</td>
<td>23 352</td>
<td>21 929</td>
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<tr>
<td>Rate</td>
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<td>34 812</td>
<td>34 436</td>
<td>34 933</td>
<td>34 864</td>
<td>33 443</td>
<td>32 841</td>
<td>32 450</td>
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<tr>
<td>Rate</td>
<td>4183</td>
<td>4017</td>
<td>3760</td>
<td>4093</td>
<td>3954</td>
<td>3851</td>
<td>3567</td>
<td>3478</td>
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<tr>
<td>Rate</td>
<td>11 563</td>
<td>11 667</td>
<td>13 619</td>
<td>14 785</td>
<td>15 066</td>
<td>12 739</td>
<td>11 442</td>
<td>11 113</td>
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<td>Population</td>
<td>3 758 320</td>
<td>3 766 925</td>
<td>3 783 604</td>
<td>3 806 095</td>
<td>3 815 628</td>
<td>3 831 134</td>
<td>3 852 003</td>
<td>3 875 668</td>
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**Fig. 1** Minor surgery claim rates/1000 population, 1993–2000, by procedure category.
complexity of lesions treated by excision has fallen since work in the early 1990s, and it seems unlikely that large and complex lesions are being treated using cryotherapy. If more non-wart lesions are being treated with cryotherapy, then, it is likely that they are small and non-complex.

Thirdly, the rise in cautery in primary care could reflect a transfer of workload out of the secondary care sector. No research has been published on this front since the early 1990s, and our attempts to get data from hospital dermatology departments on numbers and types of procedures undertaken were unsuccessful. The best we could obtain was of numbers of clinic attenders, which could tell us little. However, it is worth considering the decrease seen in excisions in primary care over the period studied. If the overall increase in minor surgery activity in primary care does reflect a transfer of workload from the secondary care sector, would we not expect to see this reflected across all types of procedure? Even if hospital departments were concentrating their attention on potential skin malignancies, there is a wealth of non-malignant lesions to be treated in primary care. Overall, it seems unlikely that there has been a major transfer of workload.

Fourthly, it could be that there has been a general increase in demand for cryotherapy, fuelled by increased availability of facilities in primary care. This may well be the case, but alone would not explain the decrease seen in numbers of excisions. Only when we take into account the fixed number of procedures available to each GP does it become clear that there has been a substitution within primary care of lesions requiring excision with lesions able to be treated by cautery.

Whichever the explanation, it has resulted in the total budget available to fund minor surgery in general practice being spent on cheaper and easier procedures, the use of which is not justified by the evidence available, being claimed for at the expense of more expensive and difficult ones. Given previous examples, including that provided by fee for service dentistry, this should come as no surprise to policy makers. The motivation of practitioners to do this is quite clear. A 1992 study showed that the cost of treating viral warts using cryotherapy in general practice was £3.00, compared with £33.53 for excising a lesion such as a sebaceous cyst (1989–1990 prices). Compared with the £20 received for each procedure, therefore, cryotherapy is profitable and excision loses money. Cryotherapy also carries with it less risk of complications and cosmetic disfigurement which might result in a claim against a GP in an increasingly litigious age. It is sad, then, that there is so little evidence for its effectiveness. Last, but perhaps most important, the 1990 contract was based upon the premise that doctors in practice were not using skills in minor surgery that they had acquired in medical school. Changes in the content of medical school curricula, coupled with increased public expectations of certain procedures only being carried out by ‘qualified’ doctors, mean that in most UK medical schools minor surgery skills are no longer the province of the medical student. Minor surgery may be perceived by many GPs as an area for which they are ill prepared, therefore.

The last few years have seen a multitude of changes to the context of primary care in England, starting with the abolition of Health Authorities and the establishment of Primary Care Trusts, and ending with the new GP contract, instituted from April 2004. The new GP contract dispenses with the old item of service list. It includes, under additional services ‘the minor surgery procedures of curettage, cautery, cryocaautery of warts and verrucae, and other skin lesions’. GPs will be allowed to opt out of providing these services, at a cost in terms of reduced payment to the practice of £654 per GP in 2004/2005 (0.6 per cent of projected practice income). There will be, for practices that are willing, able and successful in negotiation, the option for contracting with the local Primary Care Trust to provide a minor surgery service, via the enhanced services scheme. Enhanced services are: ‘essential or additional services delivered to a higher specified standard, for example, extended minor surgery’. Primary Care Trusts will be free and able to commission whatever enhanced services they consider appropriate to meet local health needs…’ within centrally decided budgetary limits.

In addition to the new contract there has been the development of the General Practitioners with Special Interests initiative. The NHS has sought to recruit more than 1000 GPs to become providers of specialist services to their Primary Care Trusts, amongst them dermatology and minor surgery. General Practitioners with Special Interests will need to demonstrate that they have appropriate skills, and will have to maintain those skills in cooperation with the local secondary care services. It is currently envisaged that they will be offering services in addition to the minor surgery offered by most practices under the ‘additional services’ section of the new contract.

The new GP contract will remove the most distorting elements of the item of service section of the old contract. The financial inducement of having to provide minor surgery in order to maintain practice income, and the equality of payments for procedures requiring different levels of skill and entailing quite different levels of cost, have contributed to the trends in activity described above. This may now change, as there will be no item of service payment system for these procedures.

The opportunity for Primary Care Trusts to determine the amount of minor surgery undertaken, and who undertakes it, will now genuinely allow the development of minor surgery by appropriately skilled and experienced GPs in suitable practices. The range and volume of procedures undertaken will not only have to reflect the needs of the local population, but also the actual capabilities of local GPs. This recognizes that not all GPs wish to or are able to provide all of these services to their patients, and does not penalize them for not doing so.

Acknowledgements
We thank all of those Health Authorities who provided data for this study, and we thank the Health Technology Assessment Programme for funding the study. We are grateful to Karen
Gerard for further advice on health economics. The views expressed, therein, are those of the authors alone, and do not necessarily reflect those of the Department of Health.

Contributors
J.P., S.G., H.S., P.L. and A.L. obtained funding for the study. P.P. and H.K. obtained data and undertook initial data cleaning. P.P. and S.G. analysed the data, with help from J.P., H.S., P.L. and R.K. provided advice on matters pertaining to the 1991 and 2004 contracts and aided in data interpretation, and V.L. provided economic advice. A.L. provided advice on historical aspects of GP minor surgery and on data interpretation. S.G. and P.P. wrote the paper, with advice from all authors. All authors approved the final manuscript.

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Date Accepted 16.3.04.