Primary health care on the agenda?

a discussion document

Linda Marks

Primary Health Care Group
King's Fund Centre for Health Services Development

Linda Marks is project coordinator with the Primary Health Care Group at the King's Fund Centre for Health Services Development and a health policy analyst at the King's Fund Institute. She previously worked as a primary care planner in an inner London health authority and has carried out comparative research on public health policy. Her current interests include collaboration between family practitioner committees and district health authorities, local public health policies and quality assessment in primary health care.

The **Primary Health Care Group** is a multidisciplinary team based at the King's Fund Centre for Health Services Development. Its aims are to improve primary and community health services, particularly in inner London; to encourage experiments with new ways of working; to disseminate 'good practice'; and to contribute to debates about primary health care policy. The group provides information and advice about primary care developments; works with NHS managers to establish and evaluate demonstration projects; organises workshops and conferences; and publishes papers and reports.

The group's current interests include strengthening the management of primary care services; collaboration between district health authorities and family practitioner committees; decentralising community health services; and services for disadvantaged groups. The work is financed by the King's Fund and the Department of Health and Social Security.

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Primary Health Care Group
King's Fund Centre for Health
Services Development
126 Albert Street
London NW1 7NF
Tel. 01-267 6111

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Preface

The publication of the Green Paper 'Primary health care: an agenda for discussion' in April 1986, provided an opportunity for the London Project Executive Committee of the King's Fund to contribute to the debate on the future of primary health care. A series of workshops was held in order to explore some of the major themes in the Green Paper. The background papers* prepared for each of these workshops form the basis of this discussion document. In its emphasis on general practice this document takes its cue from the Green Paper. In addition, many of the examples are drawn from inner cities - reflecting the priorities of the King's Fund London Programme. It is hoped that the questions raised will be of general interest to those concerned with developing policy in primary health care.

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Linda Marks
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* 'Primary health care: an agenda for discussion. Background papers to the London Programme workshops' by Linda Marks, December 1986; and *'Primary health care: an agenda for discussion. A response from the King's Fund London Programme'*, December 1986. Both available from the King's Fund Centre.

Creating an agenda for primary health care

In April 1986, after a delay of two years, the government's consultative document on primary health care finally appeared.[1] 'Primary health care: an agenda for discussion' proclaimed that 'the primary health care services have never before been comprehensively reviewed'.[2] Many hoped that this long-awaited Green Paper would help transform primary health care. This was particularly true for those concerned with inner cities where lowest standards coexist with some of the greatest needs. How far, for example, would the government draw on the comprehensive review of primary care in inner London carried out in 1980-81 under the chairmanship of Professor (now Sir) Donald Acheson,[3] or on a second major report to appear in 1981, concerned with the primary care team (the Harding report)?[4] The first half of the 1980s had also seen discussion of the Black report 'Inequalities in Health';[5] a flowering of interest in the philosophy of primary health care developed by the World Health Organisation (WHO); the growth of community health initiatives; and a renewed commitment to public health within many local authorities. Management reorganisation of the NHS in 1984 had reawakened debates on accountability, performance indicators and how best to monitor service quality. Developments of this kind could be seen as broadening the primary health care agenda. In addition, attention was increasingly directed to the links between general practice and secondary care, primary and community care, and primary care and public health.

The government's document, however, reflected only part of this spectrum. Primary health care was defined as 'all those services provided outside hospital by ... the family practitioner services — and by ... the community health services'.[6] In other words, the services provided by health care professionals constituted the parameters of primary health care. It therefore came as no surprise that proposals in the document were largely focussed on professional contracts and how they might be modified to enhance or reward performance.

There was widespread disappointment at the narrowness of this 'agenda'. The Lancet, for example, compared it to 'a great-aunt in a green hat — terribly sensible, rather conservative, and not very exciting',[7] while the Health Service Journal drily commented that seldom had 'the gestation period of an elephant resulted in the production of a mouse'.[8] Despite accusations of tinkering, traditionalism and political compromise with the medical profession, the Green Paper has nevertheless stimulated debate on future directions of primary health care. A wide range of organisations responded with alternative sets of proposals for primary care;[9] others limited themselves to detailed comments on the few firm proposals in the consultative document.

The policy debate in primary health care has also been influenced by a number of other documents which were published at around the same time. First of these was the review of community nursing services in England, chaired by Mrs Julia Cumberlege and published separately to coincide with the Green Paper in April 1986.[10] It was intended that comment on this report would form part of the primary care

debate. (Separate reviews of community nursing were being carried out in Wales and Northern Ireland.) The 14 recommendations focussed on the creation of neighbourhood nursing teams (serving populations of 10-25,000), better use of nursing skills, changes in nurse training and involvement of local communities in their health care. Planning and management at a local level would be integrated under a neighbourhood nursing manager (who could be a health visitor or district nurse). In Chapter 10 of the Green Paper a number of the Cumberlege recommendations were rejected — the proposal to dispense with part-reimbursement to GPs for practice nurses, the possible amalgamation of FPCs and DHAs and the possibility of a salaried doctor service. However, the proposals for neighbourhood-based planning and management for the nursing profession were concurrent with (and may well become subsumed within) broader plans within DHAs for locality-based management — which themselves were a logical extension of the new management arrangements outlined in the Griffiths report.[11]

The Social Services Committee invited evidence on the proposals contained in each of these documents, and its report published in February 1987[12] contained 62 specific recommendations for improving primary care, including audit of professional performance and the experimental introduction of a salaried service. It was quick to recommend that 'the Government bring together the conclusions of its reviews of primary health care, community nursing and community medicine* and consider carefully the compatibility of their conclusions before reaching decisions on the future of primary health care'.[13] It is clearly not easy to integrate independent contractors working with dispersed practice populations with managed (and accountable) DHA staff with an increasing commitment to geographically-defined populations. Information systems and accountability arrangements will need to be explored, as well as vintage problems associated with demarcating professional boundaries, and achieving cross-agency coordination. In the interest of such coordination the Committee recommended that the separation of FPCs and DHAs be reviewed 'because in the long run we can see no logical reason for separation'.[14]

In earlier reports the Social Services Committee had emphasised that the success of 'care in the community' hinged on coordination of — and cooperation between —health and local authority services. This theme was echoed in the report of the Audit Commission 'Making a reality of community care' published in December 1986.[15] In addition to highlighting the uneven pattern of local authority services for priority groups, and the inadequate transfer of funds from long stay institutions to community and local authority services, the report exposed the contradictions between supplementary benefit policies (which favour private residential care and thus tend to confirm people in residential settings), and policies for care in the community (which promote appropriate support to people along a spectrum of community settings). Likewise, the report argued that the system for distributing the Rate Support Grant acts as a deterrent to the expansion of local authority-based community services.

The Audit Commission highlights one of the major challenges facing primary health care - its changing role in relation to the care of older people and of mentally

* The Committee of Inquiry into the Future Development of the Public Health Function and Community Medicine. Report unpublished at time of writing.

or physically disabled people. Management challenges of this nature were barely addressed in the Green Paper. Even more surprisingly, no mention was made of the broadly-based approach to primary health care espoused by the World Health Organisation.

In 1977, the World Health Assembly resolved that 'the main social target of governments and WHO in the coming decades should be the attainment by all the citizens of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life.'[16] This became encapsulated in the WHO slogan 'Health For All 2000'. The principles of primary health care — the key to achieving HFA 2000 — were subsequently spelled out in the Declaration of Alma Ata (1978).[17] Primary health care is here defined as 'essential health care based on practical, scientifically sound, and socially acceptable methods and technology made universally accessible to individuals and families in the community by means acceptable to them, through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's health system of which it is the central function and main focus of the overall social and economic development of the community'.[18] This approach was endorsed by the UK government as were the 38 regional targets subsequently developed to guide strategic policy development in the European member states.[19] Despite this double endorsement there is no mention of this ecological, participatory and sociopolitical approach in the government's consultative document.

Some policy questions

The Green Paper outlined six aims for primary health care, with which few would disagree: raising standards of care; making services more responsive to consumers; promoting health and preventing illness; giving patients the widest range of choice in obtaining high quality primary care services; improving value for money and enabling clearer priorities to be set for family practitioners in relation to the rest of the service.[20] Many considered, however, that the proposals intended to transform these aims into reality would not do so. Indeed, progress towards these aims may well depend on how far primary health care becomes a planned service which is both accountable and participatory.

Accountability

While accountability arrangements are basic to the achievement of minimum standards of service delivery and of effective monitoring, the primary health care field encompasses diverse groups of professionals, only some of which are managerially accountable.

There is the clear distinction between DHA staff, located within formal management structures, and family practitioners, who are independent contractors. Griffiths-style management is not currently an option for this group. While FPCs are now directly accountable to the Secretary of State for Social Services, and are charged with additional planning and management functions, their constituency —

family practitioners — is fragmented and subject to professional rather than managerial regulation.

It is therefore not surprising that proposals for achieving improved standards in general medical practice in the Green Paper (the good practice allowance and capitation fees as a greater proportion of practice income) take the form of financial incentives for individual practitioners. These are unlikely to prove adequate to meet the public health and preventive challenges of primary health care which must depend on coordinated care for defined populations. In contrast, the Cumberlege report focuses on defining populations and their health needs and developing a management structure which promotes flexibility in responding to local needs for nursing care.

Consumer information or user participation?

A major dimension of accountability is the nature and extent of people's involvement in primary health care. The International Conference on Primary Health Care, held at Alma Ata, had declared that 'people have the right and duty to participate individually and collectively in the planning and implementation of their health care', and further that primary health care 'develops through appropriate education the ability of communities to participate'.[21] In the inner city this would mean encouraging the participation of disenfranchised groups in developing appropriate health care — already a focus for some community health projects.

Both the Green Paper and the Cumberlege report seek to increase the responsiveness of the service to users. In the former it is suggested that enhanced consumer choice in a competitive market will help ensure service quality — through better dissemination of information, ease in changing doctors, simplified complaints procedures and a practice income more heavily reliant on numbers of practice patients. Consumer feedback on primary health care is to be achieved through practice-based patient participation groups (in the Green Paper) and through neighbourhood-based local health care associations (in the Cumberlege report).

Information, redress, and the ability to influence service quality are unarguable consumer rights. They reflect, however, just part of the spectrum of user participation and fall far short of the participatory model espoused by WHO, in which community participation is the foundation of successful primary health care.

Policy framework or policy vacuum?

The fragmentation of responsibility for primary health care services, combined with the independent status of family practitioners, has meant that the responsibility for setting primary care agendas and ensuring coordinated policies is at best blurred. In the inner city, for example, many GPs operate in isolation from their colleagues, other professionals, the activities of DHAs and the neighbourhoods where they practise. With no representative planning or policy-making forum, it is difficult for FPCs to identify — let alone influence — GPs' current activities or future plans. The same is true for dentists, pharmacists and opticians.

Policies agreed by DHAs in areas such as care in the community, maternal and child health, arrangements for discharge from hospital and so on, have implications for workloads in general practice, and the composition of primary care teams. Yet

individual GPs may often remain unaware of district policies and their likely effects on general practice.

The Green Paper encourages greater GP involvement in services currently jointly provided by DHAs; child health services are singled out in this respect. The report of the Joint Working Party on FPC/DHA Collaboration also identified areas for joint working.[22] Arising out of the recommendations of this report, two DHSS-funded development projects[23,24] have been established to demonstrate how FPCs and DHAs can work together to improve primary health care. Despite these and other initiatives — and the statutory duty now incumbent on the newly (1985) independent FPCs to collaborate with their corresponding DHAs — structures for joint planning of primary care services are slow to emerge.

Collaboration between FPCs and DHAs is crucial, but only part of the picture. Care is increasingly being provided within a community setting and collaboration is required between GPs, FPCs, DHAs, local authorities and voluntary organisations if comprehensive care is to be provided. Health promotion and public health present similar collaborative challenges which need to be grasped at both local and national levels.

Time for a new approach?

A new approach is needed for agenda-setting in primary health care. It should draw on the public health and participatory model espoused by WHO; build on the experiences of local projects and initiatives, and seek to create planning and management structures which achieve change at both district and local levels.

The following chapters review current approaches in four key areas of primary health care: raising standards; monitoring quality; user involvement; and planning and management of primary health care services. Possible issues for a new agenda are suggested.

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Raising standards in primary health care

Raising standards in primary health care presents a number of challenges. First, there are decisions to be made about which groups of people should be involved in setting which standards. Second, once standards have been agreed, there are different routes to achieving them. For example, should more effort be expended initially on improving the worst standards of care or should 'excellence' be the focus for encouragement and dissemination? Third, the areas and activities for which standards need to be set inevitably reflect the scope of primary health care. Is a broad, WHO definition to be adopted or a service-led model? This chapter explores these issues in more depth.

Who sets the standards?

Progress in setting standards in primary health care is slow. This is due partly to conceptual problems in linking health outcomes to professional intervention, partly to the difficulties of deciding where primary health care begins and ends, but is also a result of organisational complexity. Different authorities, varying priorities and the blend of managerial and professional accountability, all play their part. Inevitably, there is disagreement about who should be involved in setting which standards. What are the roles of researchers, practitioners, users, specialists in community medicine, FPCs, DHAs, CHCs and so on? What falls within national guidelines and what is more appropriately addressed at local, neighbourhood or district levels?

In relation to primary *medical* care, a clear distinction is drawn in the Green Paper between 'objective' criteria for a GP's eligibility for a good practice allowance — an indication of a high standard of care — and issues more suited to peer review. In the former category are included, for example, a GP's availability to patients; ensuring that immunisation has been provided for an agreed proportion of certain groups of patients, and attendance at postgraduate courses. Assessment of prescribing patterns and hospital referral rates are included in the latter category.

The boundaries between what can be considered solely a matter of technical/professional judgement and what can justifiably be a matter for managers and users of the service as well as for professionals are not sacrosanct. Many consumer groups have argued that participation by users is a right at all levels of decision-making and that all users of services should have the right to a minimum accepted standard of service delivery. In Health Maintenance Organisations, a rapidly expanding sector of US health care, professionals act within a clear management framework and management control is exercised over the whole range of care.[1] Procedures are codified; standards are set in relation to criteria for hospital admission, management of inpatients (length of stay, drug regimens, investigations) and the use of ambulance services; and protocols are devised for the management of common disorders such as hypertension. Styles of communication (with patients and other colleagues) may be monitored. A relatively high proportion of patients will be seen by 'allied health personnel'. Within the UK context, increased em-

phasis on accountability and the 'new managerial revolution in public administration'[2] are likely to reinforce the role of GPs as gatekeepers and rationers of expensive services. Management changes and pressure from users are increasingly likely to erode professional control over setting and monitoring standards.

Approaches to raising standards in general medical practice

Getting rid of the worst: the Acheson report

Concern about the organisation and delivery of primary care services in inner London, particularly in the context of reductions in acute services, led to the setting up of a study group chaired by Professor Donald Acheson. Its report documented the variable quality of primary care in inner London and contained 115 recommendations related to improvements in resources, practice premises, equipment and staffing, as well as in team work, group practice and links with secondary care. After a two year delay the government made available £9 million over three years ('Acheson money') to improve practice premises, increase training and encourage innovation in primary health care in inner cities. Despite a number of exciting projects the response to Acheson represents a short-term, piecemeal and fragmented attempt to improve primary care in the inner city.[3]

A main feature of the Acheson report was its emphasis on the varying standards of care provided in London. Recommendations took their cue from the practical problems facing the 'worst' practices and were based on extensive evidence, a recognition of the practical difficulties facing primary care workers in inner London, and the needs of people living in deprived socio-economic environments. Echoing the recommendation of the Royal Commission (1979) that 'additional financial resources should be provided to improve the quality of primary care services in declining urban areas'[4] a plea for more resources was made.

Although little has changed in the inner city, the cutting edge of the quality debate has now moved away from how to get rid of the worst to how to promote and measure the best. This neatly avoids a crucial question for inner city care. How far can general practice be successful when care is provided in poor quality buildings with poor access and facilities? Not new and exciting problems perhaps — but persistent.

Professional regulation

Guidelines on clinical standards emanate from training bodies and various professional organisations. For example, in June 1983 the Royal College of General Practitioners launched its 'quality initiative', a strategy for improving patient care via professional self-regulation. Doctors were asked to describe their services and introduce principles of quality assessment into everyday clinical practice.[5] A parallel initiative 'what sort of doctor?'[6] and subsequent reports and quality bulletins expanded on the clinical services and practice organisation considered fundamental to 'quality' general practice. Professional development of the primary health care team, patient information, and collaboration with DHAs in setting local standards of

service were included. One of these bulletins set out 'the basic range of services that the College believes should be available in every general practice'.[7]

Practices may volunteer for peer review carried out under the auspices of the 'what sort of doctor' working parties. Constructive criticism may be offered in areas such as professional values, accessibility, clinical competence and the ability to communicate. Inevitably, the work of the RCGP is focussed on general medical practice; no attempt is made to locate the role of primary medical care within the broader WHO approach. Good primary health care thus becomes equated with good general practice

Success in raising standards even within this framework is limited by the boundaries of exhortation and the danger of preaching to the converted, namely members of the RCGP (currently one third of all GPs). Guidelines are general and it is not clear how standards are to be set or monitored. Collaborative arrangements with DHAs are not spelled out. While interest in quality assessment in DHAs is growing (and is reflected in appointments of directors of service quality), relatively little attention has been directed to primary health care. Thus there are few precedents for translating 'good' primary health care into locally relevant targets.

Relying on the market

Current financial arrangements for independent contractors do little to foster good quality primary care and provide few incentives for them to expand their role beyond responding to patients' symptoms. In the case of dentistry, for example, fee structures work against the provision of preventive care. A recent study[8] of general practitioners suggests that those who try and extend the range and quality of their work are more likely to find themselves out of pocket than their less innovatory neighbours. The Green Paper is concerned to weld income to performance, proposing, for example, a 'good practice allowance'(GPA) and a practice income more heavily dependent on list size. In addition, consumers would be provided with more information and would more easily be able to vote with their feet. These proposals were not generally welcomed and were particularly not welcomed in inner cities. It was argued that the GPA would serve to reward those practices already providing services of high quality while further demoralising those unable to achieve such standards. How could quality general practice be equated simply with expanding lists even assuming mobile, critical and informed consumers? Evidence from inner cities demonstrates that registering with a new practice is no easy matter, particularly if the prospective patient is elderly[9] or a hostel dweller.[10] Changing from practice to practice in pursuit of quality becomes a less than realistic prospect, particularly for those who experience difficulty in obtaining primary care, such as single homeless people. An approach based on the market is unlikely to redress inequalities in health care, ensure minimum standards or promote population-based preventive activities.

Raising standards in primary health care: the WHO approach

Conspicuous by its absence from recent policy documents (with the exception of one brief reference in the Cumberlege report) is the influential and widely supported approach to primary health care promoted by the World Health Organisation. This moves away from professionally-led conceptions of primary care towards an an ecological and public health approach, built on community participation and collaboration across the many different agencies (national and local) which influence people's health and the environments in which they live and work.

Reflecting this ecological and sociopolitical approach to health care, the European targets for achieving HFA 2000[11] range over the themes of equity, participation, healthy environments, health promotion, appropriate care, multi-sectoral collaboration and the development of a health care system based on primary health care. The intention is that these targets be integrated into national strategy and into local policy development.

The first of the European targets reads: 'by the year 2000, the actual differences in health status between countries, and between groups within countries should be reduced by at least 25%.'[12] Documented inequalities in health status between socio-economic groups, sexes or localities could thus form a starting point for target setting, policy development, service organisation and professional practice. In inner cities, for example, the health needs of single homeless people, homeless families, hostel dwellers and other multiply disadvantaged groups would receive priority.

Some of the 'innovative ideas'[13] funded from Acheson money and the inner city partnership scheme are consistent with this WHO approach. They include community development projects in primary care, 'patch' planning and advocacy projects.

There is increased interest in operationalising the WHO targets. In its Charter for Action,[14] the Faculty of Community Medicine itemised the separate responsibilities of central and local government, health authorities, health professionals, training institutions and individuals for achieving HFA 2000. The Charter highlights the comparatively poor health status of the UK, which has the highest death rate in the world for heart disease, rising mortality from alcohol and drugs and only small declines in preventable infections and cervical cancer. At a local level a number of district health authorities[15] have adopted the Health For All approach in their planning and in approaches to health promotion. Paddington and North Kensington Health Authority Health Promotion Group for example, is developing a strategy based on the key HFA themes of reducing inequalities, community participation and intersectoral collaboration.[16] The danger of targets being distorted to reflect the priorities of specific professional groups has also been highlighted.[17]

Following the HFA approach, and of particular relevance to cities, is the European WHO initiative 'Healthy Cities' set up in 1986.[18] Attention is directed to all aspects of city life which may influence health, including housing policy, city employment, and environmental design. Part of this task will be the development of indicators to monitor progress (such as traffic accident rates or levels of air pollu-

tion). This will involve data collection at local level across primary and secondary care and across health, local and education authorities. The intention is that cities participating in the project will develop and share models of good practice.

The 1980s have also witnessed the re-adoption of a public health approach by a number of local authorities in the UK. Over one third now possess some form of health committee, some with a commitment to developing a new public health approach. This means critically examining the effects of local government policies on health and rebuilding relationships with local communities as well as briefing local authority representatives on health authorities and reviewing strategic plans.[19]

A number of health and local authorities (sometimes jointly) have produced local health profiles and 'mini Black reports'[20] which document inequalities in health status at a local level. They draw on a tradition of community health profiles, produced from the mid 70s, through which community health groups have attempted to draw attention to local people's views about health and health services and the interrelationship between social deprivation and health needs. For example, one of the recommendations from 'Health in Glyndon' carried out by the Greenwich Health Rights Project is that 'health and local authorities must become involved in issues which have been shown to have a damaging effect on health: unemployment, low incomes, health and safety at work, the provision of public transport, housing and local environment'.[21]

While many of these recommendations imply policy changes at a national level, the separate spheres of influence of local decision-making bodies need to be spelled out. It is likely that multi-disciplinary and multi-agency forums are needed to address these questions at a local level. They should involve providers, managers and users of services, set objectives and operationalise local targets for primary health care. If the spirit of the WHO message is to be kept, they will need to rest on the bedrock of community participation; particular effort will be needed in inner cities if disadvantaged groups are to participate in this process.

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Towards assessing quality

Taking the health care system as a whole, WHO has argued that its quality may be gauged by the quality of the primary health care sector. This emphasis is not reflected in the burgeoning literature on quality assessment and quality assurance, the bulk of which relates to clinical practice in the acute sector.

Assessing the quality of primary health care raises a number of questions. The previous chapter explored broad approaches to standard setting; quality assessment demands that procedures be integrated into professional activities and planning and management arrangements. This chapter outlines two models for quality control and describes a range of initiatives in primary health care.

Quality and primary health care

In primary care (as in the acute sector) quality assessment involves a continuous and systematic monitoring of performance against agreed objectives. The quality of each aspect of health care may be initially gauged by asking questions in relation to its appropriateness, accessibility, efficiency, acceptability, effectiveness and the extent to which social equity is promoted.[1] These 'dimensions of quality' will need to be operationalised for each service and clear criteria developed against which performance may be monitored. The result is not a straightforward recipe for management action, however. Criteria for each aspect of each quality dimension may be given different priorities by budget holders, professionals, managers and users. In a climate of financial stringency, for example, the search for economy may well override a concern with equity. The priority accorded to competing interests will inevitably reflect political realities.

Assessing quality also implies some agreement over the scope and standards of 'good' primary health care. If a broad definition is adopted new measures will be needed in order to monitor progress towards HFA 2000. How might progress towards community participation or collaboration across different agencies be measured and monitored? Many reports — notably the Black report and its update, The Health Divide,[2] have made recommendations for reducing inequity in health status — also the number one target of HFA 2000. This 'outcome measure' is rarely the starting point for 'quality control' in primary health care, however.

In the emphasis on 'outcomes', the targets of the European Region of WHO reflect a different approach to that reflected in literature on quality. While the assessment of outcomes (in terms of health status of individuals, or social or population based measures such as a reduction in inequalities) is fundamental to 'quality', attention has traditionally been directed to 'structure' and 'process' variables. 'Structure' refers to the setting of health care: equipment; resources; staff (and their qualifications and training); and administration. For primary health care, this includes the location of premises, hours of opening, the provision of diagnostic facilities and information technology. Process refers to activity. Routine indices for measuring activity in primary care include the numbers of clients seen by health visitors, district nurses and other health professionals. In relation to primary medical care, there is no systematic national collection of routine activity data, though

the national morbidity studies coordinated by the RCGP indicate problems brought to general practice and the nature of care provided. There is no national monitoring of standards for effectiveness of diagnosis (as measured, for example, by late referrals from primary to secondary care) nor for the quality of interaction between health workers and patients. Current performance indicators in primary care are of limited relevance to WHO targets or to assessments of outcome in terms of changes in individual or community health. Ideally, management action would be directed towards modifying 'structure' and 'process' variables in order to influence outcome — improved health status. Action might include experiments with different forms of service delivery, new styles of teamwork or staff selection policies.

Models for quality assessment in primary health care

There are at least two 'ideal-type' models for assessing quality in primary health care: a policy and planning model, and a more reactive, problem-centred approach. In the former, concern with quality is an integral part of planning and management arrangements. It rests on clear aims for primary health care services and presupposes operationalisation at local level of the principles of 'good' primary health care. This may be in terms of the broad agenda set by WHO — or a more limited concern with effectiveness and efficiency. Whatever the agenda, monitoring systems will need to be established jointly between GPs, FPCs, DHAs and local authorities. Thus, for example, for those general practices providing follow-up care, monitoring of protocols agreed between secondary and primary care sectors will need to be carried out if quality of care is to be maintained. In this case, quality assessment may require information from, and participation of, health workers; departments of community medicine; community unit management teams; FPCs; CHCs and local community groups. The latter model rests on identifying — and responding to — poor outcome measures. Problems relevant to primary care identified by professionals and/or managers might include low rates of uptake for preventive services, low birth weight, high perinatal or infant mortality rates, overuse of Accident and Emergency services for primary medical care, high incidence of avoidable mortality and morbidity, preventable handicap, avoidable infectious diseases, or screening failures. Charlton et al,[3] identified 14 disease groups where mortality should be substantially avoidable where medical care is sought and provided in good time. They suggest that either 'local informal reviews' or 'more formal standardised confidential district enquiries' could be set up to identify avoidable factors. Local programmes could then be initiated.

The extent of user-identified problems clearly depends on the participatory mechanisms built into the management and planning of services. One-off surveys may provide some indication of user satisfaction but cannot replace systematic user input. Only users can comment on how accessible or appropriate services may be. There are still relatively uncharted areas such as the effects on informal carers of caring for chronically ill people at home. Data of this nature could be routinely collected and used to monitor the quality of service provided. Although many voluntary organisations and community groups are acutely aware of the shortcomings of

local services, this information is rarely fed in at local level — and even more rarely acted upon.

Ways of setting and monitoring standards

Audit in general practice

Despite a profusion of principles, specific — and nationally accepted — guidelines for good general practice are slow to emerge. A number of practices and primary health care teams engage in self evaluation, setting objectives and targets against which to measure their progress. The Cumberlege report provided a protocol for a primary health care team agreement which could also be used for assessment purposes. Uptake rates for preventive measures, case analysis techniques, management protocols for specific conditions, educational activities and patient feedback are all audit techniques which may be used within a practice setting by a primary health care team — given the existence of an efficient patient record system. An Oxford-based initiative 'Rent an Audit' seeks to help primary care teams carry out audits and is preparing packages for teams without the resources to carry out their own.[4]

Increasingly, practices which seek to promote and monitor the health of their practice populations are identifying groups at risk of specific disorders such as hypertension or diabetes, providing continuing care, and targeting at-risk groups such as older people. For example, one initiative for tackling inequalities in relation to the uptake of preventive services within a practice population was to mark 'missing' preventive care on records (both of the patient and of other household members) — so that preventive care could be discussed whenever the opportunity arose.[5] It has been strongly argued[6,7] that all general practitioners should accept responsibility for auditing the state of the practice health and combine a public health and population-based approach with traditional clinical skills. The first task of these 'community general practitioners' would be to produce a report on the state of the practice health in the form of an 'annual practice report'. This would include social and environmental influences on the health of the practice population and would provide information which could be acted on by the community. Such a report would begin to meet the twin aims of professional and public accountability. If a report was produced by each practice this would provide family practitioner committees with information for planning services in collaboration with health and local authorities.

Peer review

Professional groups are beginning to set up their own forums for setting and monitoring standards. At a local level, these may include quality circles, professional forums and links with academic departments. The involvement of professional organisations in peer review is exemplified by the 'what sort of doctor' initiative of the RCGP.

Family practitioner committees

There is already a well-established role for FPCs to monitor standards of premises, family practitioners' hours of availability, out of hours cover and telephone answer-

ing arrangements. There is potential for monitoring all GP item-of-service payments, such as immunisation, cervical cytology, night visits, contraceptive and obstetric services. Complaints provide further indications of service quality — or the lack of it. Independent authorities since 1985, FPCs are now keen to take an active role in planning and monitoring services. Despite a lack of resources and manpower to effect the transition from 'pay and rations' administrative bodies to organisations with planning and monitoring functions, many FPCs are succeeding in carving out a distinctive role. For example, Barnsley FPC (in conjunction with the Centre for Health Economics at York University)[8] is computerising profiles of need based on social data for each Barnsley ward. Each practice can then be provided with detailed demographic information as well as practice-based data on list characteristics, distribution of patients, and assessments of population mobility. This will enable GPs to identify groups with specific needs, plan ancillary staff and devise preventive programmes. Comparative information (eg on prescribing patterns, immunisation and vaccination uptake, hospital referral rates) will also enable GPs to compare their performance with other practices in the area.

A planning paradox for FPCs, however, is that independent contractors are exactly that: a GP is not obliged to perform specific duties or to provide information — only 'to render to his *(sic)* patients all necessary and appropriate personal medical services of the type usually provided by general medical practitioners'.[9] Northumberland FPC suggested in its response to the Green Paper that the GP contract be changed so that the basic practice allowance forms a greater part of practice income and that it includes those minimum services to be provided. Currently — short of referring 'breaches of contract' to the General Medical Council — the only 'sticks' available to FPCs concerned to maintain standards of care are withholding rent and rates rebates and initiating complaints procedures.

A first task for all FPCs concerned with service monitoring is to build contacts with family practitioners and encourage forms of representation, involvement and information exchange, which may act as a baseline for planning. The role of local representative committees is crucial for this. For example, Newcastle-on-Tyne Local Medical Committee has drawn up a proposal that practices (rather than individual practitioners) should be collectively responsible to the FPC for providing a package of guaranteed minimum services for acute, chronic and anticipatory care.[10] The LMC would play the major role in advising the FPC on appropriate annual targets for care of specified chronic conditions and for various preventive measures. Standards would be monitored by establishing a computerised information system linked to the FPC register. This, it is argued, could form the basis of a new general practitioner contract. The Lancet[11] pointed out that only a minority of practices would cooperate; that GPs would need a grounding in population medicine and that FPCs are unequal to the task of providing the necessary management information. It could be added that protocols for preventive services and for the continuing care of people with chronic conditions would need to be agreed between DHA staff and practices involved, and monitoring procedures established.

District health authorities

DHAs maintain overall responsibility for ensuring standards in preventive care. Thus they continue to provide preventive and screening services such as immunisation and vaccination and developmental screening. In inner cities, they provide a greater proportion of those primary care services which are shared between family practitioners and district health authorities.

While standard setting in terms of uptake targets for preventive services, or reductions in avoidable mortality and morbidity, form a legitimate part of their planning role and management responsibilities, planning for primary health care is accorded low status in most DHAs, and arrangements for joint planning between DHAs and FPCs are weak. Setting standards involves cooperation between health and local authorities, users of services and voluntary organisations, yet few DHAs (and fewer FPCs) incorporate systematic user feedback into their planning structures. With many DHAs now contemplating decentralisation of their community health services, however, and some FPCs interested in developing neighbourhood planning, opportunities for local primary health care planning may increase.

Users of services

Participatory mechanisms at all levels of decision-making are fundamental to the WHO strategy for primary health care and it is argued that 'ways must be found of building up this process of community involvement so that communities can regularly communicate their opinion on health matters and needs to the national policy-makers. Eventually, the synthesis of local priorities should dictate national priorities'.[12] The example of maternity services in the UK demonstrates how users can influence the choice of treatment as well as the style of service delivery. Ways of encouraging user involvement are further discussed in the following chapters.

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From consumer to participant

Debates on the role of 'consumers' in the planning and delivery of health care services are linked with wider — and longstanding — debates on democracy in the NHS and on the boundaries of professional monopoly.[1] User involvement in primary health care encompasses self and lay care, self-help groups, voluntary organisations and the myriad local and community groups providing support, practical advice or community action for health. It has been estimated that there are about 10,000 such groups,[2] including advocacy projects, women's health groups and community development projects. While many of these groups emphasise the importance of user participation in planning health services,[3] the extent to which they mesh with primary health care professionals or with planning structures is variable. The first part of this section outlines three different approaches towards the role of 'consumers' reflected in recent policy documents; the second part describes ways in which users and user groups link with service managers and providers.

The role of consumers

The market model: health as commodity; patient as consumer

The Griffiths report and the consultative document on primary health care both draw on a market model in which the consumer influences the quality of the product through the exercise of choice. The Griffiths report drew attention to the failure of the NHS to take account of patients' views, contrasting this with the world of business where consumer satisfaction is at a premium. It was suggested that managers should 'ascertain how well the service is being delivered at local level by obtaining the experience and perceptions of patients and the community. These can be derived from CHCs and by other methods, including market research, and from the experience of general practice and the community health services'.[4]

As independent contractors, family practitioners are more sensitive to 'the market'. The Green Paper suggested that enhanced consumer choice in a more competitive primary care market would ensure service quality, for 'the individual members of the public, as recipients of the services are often better able to judge the quality of delivery of services than the NHS bodies responsible'.[5] Ease in changing doctors, a simplified complaints procedure and the encouragement of patient participation groups would all enhance this process.

Health Maintenance Organisations (HMOs) represent a further extension of a market approach. Consumers 'shop around' for cheaper options and more comprehensive benefits before reviewing annual subscriptions to their HMO. Facilities are often custom built, housing a wide range of services under one roof. They open long hours; receptionists are trained, and visiting consultants reduce the need for outpatient attendances. New patients choose their doctors and their views on the quality of care are regularly canvassed.

This consumer approach to quality leaves a number of questions unanswered. For UK general practice, for example, at which point does the popular doctor find that list size limits provision of quality care; how are minimum standards for all prac-

tices to be ensured; how may population (as opposed to individual) health needs be identified and met — and how will those who do not fall into the category of critical, mobile and informed consumers be guaranteed quality health care?

The neighbourhood approach

In 1981 the Black report suggested a special health and social development action programme for selected areas. The Acheson report, published in the same year, suggested the creation of neighbourhood planning teams for the inner city, comprised of professionals from health and social services, working in collaboration with 'neighbourhood groups and associations, voluntary organisations and representatives of the local community'.[6] As some DHAs now begin to establish locality-based management and planning systems for community services, methods for encouraging user involvement on a neighbourhood basis are being explored.

The Review of Community Nursing Services emphasised that health care needs should be defined at local or neighbourhood level, and that management organisation should be flexible enough to meet these needs. It was recommended that health care associations be 'established by local groups, the community health councils, the health care professional or the health authority — or any combination of them'.[7] Suggestions for canvassing the public's views included seminars and semi-structured discussions with users of particular services and local voluntary groups. There was no account, however, of how adequate representation was to be achieved nor how health care associations would mesh with existing community networks.

From information to participation

Consumer information, consumer redress and opportunities to comment on service quality are far removed from a vision of community participation which encompasses involvement at all levels of decision making. For WHO, fundamental to both the development of appropriate service delivery and health education, is the 'participation of the individual in health care as a competent actor in a community setting, rather than by passive compliance'.[8] Likewise, one of the 38 European targets for HFA is that 'by 1990, in all member states, primary health care systems should be based on cooperation and teamwork between health care personnel, individuals, families and community groups'.[9] Given, too, the first HFA target of reducing inequity, a major policy task is how to involve disadvantaged groups in developing services.

Working with disadvantaged groups and neighbourhoods has provided a focus for community development work, much of it originally located in local authorities. The community health movement, however, has drawn not just on this tradition but on the women's movement, women's health groups and the consumer organisations and self-help groups that flourished during the 1970s. This work is participatory, focussed on interest groups (pensioners, mothers and toddlers); issues; or particular neighbourhoods. Ironically, at a time when the importance of such work for health promotion and primary health care is being recognised,[10] the funding for community groups is increasingly under threat.

Developing links between users and the health care system

Participation in self care appeals both to those who wish to reduce dependence on (and therefore the expense of) statutory provision and to those who see participation as a route to empowerment. Not surprisingly it engenders wide support both nationally and internationally. Also important however, is user involvement in planning and policy making in health care. Maxwell[11] distinguishes five levels of participation: consumer protection (a minimum demand); public consultation; openness of managerial decision making; full participation, with communities sharing in the processes of health policy making; and finally a radical shift in the balance of power away from those providing the services towards those who use them. Despite this wide spectrum, debates focus on the 'weaker' forms of user participation and even then there is disagreement. For example, the government's recent attempt to simplify complaints procedures has met with some resistance. There is still an argument within the professions about the content and distribution of leaflets describing doctors' and dentists' practices. More complex issues such as the availability of assessments of clinical performance to user groups are barely addressed. However, a number of initiatives which seek to increase user participation in policy making are described below.

Initiatives in district health authorities

Attempts in DHAs to incorporate views of community groups into the planning and delivery of services include representation on planning teams or health centre planning groups, the setting up of local advisory groups based on health facilities or the employment of community health workers to identify local health needs and encourage participation of disadvantaged groups such as older members of ethnic minorities.

For example, West Lambeth HA has set up local advisory groups for each community facility (such as health centres and day care centres), to include local people, representatives of local voluntary and community groups, health and local authority workers and GPs. Assuming that difficult problems of representativeness are addressed, local people have a forum where they can identify the health issues that concern them most. If there is commitment at managerial level to respond to community needs then such groups will influence the nature and pattern of service delivery.

While this approach seeks to improve participation for users of certain health facilities, some authorities are seeking to enhance user involvement through 'patch' based approaches. As the only common element between service agencies, neighbourhoods are a sensible focus for joint planning at local level. Exeter HA and CHC have agreed a method of providing user input via local health forums which feed into locality planning teams. A primary care development project based in Tower Hamlets has identified information needs for one 'patch' in the district.[12] Not all questions of policy can be resolved on a neighbourhood or locality basis. For example, services for mentally handicapped people also require planning and coordination at district level. Many authorities continue to plan services by 'care

group' (for example older people, mentally ill or mentally handicapped people). User representation on these groups (with members drawn from CHCs, pressure groups or voluntary organisations) provides a systematic input into policy making and planning. In some districts, advocacy schemes are being developed which enable mentally handicapped people to state their own views about service quality.

Even where such structures exist, they are rarely accessible for disadvantaged groups. Some inner city DHAs are beginning to employ community health workers, interpreters, link workers and advocates in order to encourage participation and help identify and meet the health needs of local populations. Community development — and community health work — includes in its aims a reduction in inequalities and increased participation through encouraging local people to identify and articulate their health needs. It can lay the foundation for a productive interaction between providers and users of services. In some cases DHA staff are building links with community groups and incorporating elements of a community development approach. For example, Drennan[13] has explored the potential of a community development approach to health visiting appropriate for inner cities; and, also in Paddington and North Kensington HA, the health promotion group is developing a framework for a community development approach to health policy and planning at district level. In particular they aim to 'redress the underlying determinants of inequalities in health by facilitating collective responses to community-defined health needs and by enabling deprived communities to have an effective voice in policy decisions that affect their own health'.[14] In other cases, fruitful dialogues are maintained with community health projects and self-help group networks which remain outside health service structures.

Initiatives in family practitioner services

Family practitioner services have been the focus of few consumer-based initiatives. Primary care development projects have shown that GPs, for example, may remain unaware of local networks of voluntary, self-help and community groups. This means that information on community health needs may be unavailable to general practice — and that patients may not be made aware of local sources of support and information. GPs can act as a resource for local health initiatives or be instrumental in starting up a self-help group by introducing group consultations for appropriate conditions.[15] The main developments (encouraged in the consultative document on primary health care) are information for patients and patient participation groups. The first such groups were set up in the early '70s; there are now about 80 and a quarter of these are based in inner cities.[16] They may provide feedback to GPs, mobilise community work or act as pressure groups. However they are often initiated by GPs and lack the common bond which unites self-help groups. Most successful where communication is already good, their impact on the care of disadvantaged groups or on the poorest quality general practice is likely to be minimal.

A few inner city general practices have begun to work closely with community health workers in order to encourage a dialogue between providers and those who use the services and to increase participation. In the Wells Park Project,[17] for example, two community workers and one research and evaluation worker were at-

tached to a general practice. They explored ways in which patients could have greater access and involvement in the practice and established various community groups based at the practice. Such initiatives attempt to increase participation. A few inner city practices have gone further and are exploring a radical restructuring of professional and user power.[18]

Community health councils

CHCs have been active in attempting to increase user power. As part of a review of the different approaches CHCs have adopted in attempting to reach this goal, Fedelma Winkler gives examples of six successful areas of activity in City and Hackney CHC: the production of user information; the development of patient advocacy; campaigning for clinical audits; campaigns for an independent element in the complaints procedure; participation in decision making; and collective accountability for user representatives.[19] In each case she documents progress in equalising the relationships between users and providers of services.

Voluntary organisations

Voluntary organisations provide a major source of help and support for those who are neglected by, or who fall outside, mainstream services as a result of differences in language, culture or lifestyle. Thus the pitiful quality of health care received by single homeless people was initially highlighted not by primary care workers, but by campaigning groups such as Shelter. Voluntary and community-based organisations are a major source of information on the quality of primary health care. Closer links should be developed between such groups and primary health care teams as well as with policy makers and planners.

All these initiatives go beyond identifying needs of individual consumers in a 'one-off' market research style. Instead they seek to identify needs of groups with shared problems (but who traditionally have a weak voice) or who live in the same neighbourhoods, or who use particular services. One of the challenges for primary health care is to identify how the numerous groups and organisations involved in promoting user participation and identifying local needs can and should mesh with primary care services and planning structures. Which kinds of organisations are appropriate at local, practice, care group or district level? How can needs of disadvantaged groups be met and how could information from voluntary organisations be shared between all those responsible for delivering primary care services?

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Managing change in inner city health care

The Government's consultative document on primary health care did not recognise current management challenges and dilemmas. Largely concerned with independent contractors, the nature of their contracts and increased consumer choice in family practitioner services, it did not confront challenges such as the implications of changing demographic, social and managerial contexts affecting the nature and delivery of primary health care services, the effects on primary care of rationalisation and centralisation in the acute sector and possible management responses to the objectives and targets identified by the European Region of WHO. Divided responsibility for primary care, compounded by the lack of a management framework for independent practitioners who contract with the FPC to provide family practitioner services, make planning and management difficult at best. This chapter outlines a number of current management challenges related to general practice and to the changing boundaries between primary and community care, and primary and secondary care.

Inner city general practice: FPCs, facilitators and forums

Within their current remit FPCs can monitor certain aspects of general practice. Telephone answering arrangements, standards of practice premises, hours of availability and deputising services are all open to scrutiny. FPCs can also help GPs set up age sex registers, improve practice premises and devise practice leaflets. Recent initiatives in some FPCs reflect the potential for a far greater contribution to raising standards in primary care. For example, practice profiles enable primary care teams to plan services and assess their performance, and guidelines for good practice can be developed locally in conjunction with the local medical committee. However, the development role of FPCs is seriously hampered by constraints of manpower, time and resources — and new planning functions have not been matched by additional funds. In addition, FPCs do not have access to a flexible development budget which would enable them to respond to needs as they arise; neither are they able to buy or lease land which could be used for practice premises.

Independent contractor status has meant that the quality of primary medical care has often depended on the motivation and initiative of the GPs who provide it. For example, Camberwell CHC writes 'Many (GPs) are elderly, single handed and 80% are men. It is difficult for the single-handed GP to specialise in everything and keep in regular contact with all developments in the hospital, in the voluntary sector, the local authority and neighbouring practices'.[1] Various attempts have been made to reduce the isolation of GPs and encourage higher standards of care. For example, the primary care development projects in Camberwell (based in the academic department of general practice) and in Tower Hamlets have been successful in involving GPs in educational activities and in sharing information. The projects started by identifying GPs' needs and in helping to find ways of meeting

them. The primary care development project in Tower Hamlets gathered information about GPs' plans for practice organisation and service development and has made information available to both FPCs and DHAs. GPs have been informed of changes in community health services. Likewise, the Camberwell project has succeeded in informing GPs about various DHA resources, such as the services for community psychiatry and audiology, and in advising on premises. A monthly information bulletin is being sent to all GPs. This project has particularly shown the potential of educational activities in increasing cooperation between professionals.

Groups of GPs have set up GP forums in some parts of inner London and some academic departments are beginning to forge links with their local 'constituency' of GPs. A recent initiative in the general practice unit of University College and the Middlesex Hospital Medical School has resulted in a day release course for GPs practising in urban settings to enable them to meet the needs of inner city populations and to plan and evaluate their practice policies. Reflecting both the recommendations of the Acheson report and the HFA approach the course fills a gap in vocational training for inner city GPs.

Manpower policies in primary medical care

The Acheson report identified a compulsory retirement age for GPs as one way to improve the overall standard of general practice in inner cities. This recommendation was echoed in the Green Paper. The likely exodus of elderly GPs over the next few years has alerted inner city FPCs to the urgency of developing a medical manpower strategy which reflects inner city needs for primary health care. This is particularly urgent for an FPC like Kensington, Chelsea and Westminster which stands to lose almost a quarter of its GPs.

FPCs will be concerned that health care is appropriate for practice populations. At the very least this means knowing the ethnic mix of the population, ensuring the availability of women doctors and enabling appropriate attachments of DHA staff to general practices. Monitoring the quality of care will involve gathering information from health and local authorities, CHCs and voluntary organisations. Patch-based information will help FPCs define more precisely where services are required for deprived groups such as single homeless people and homeless families; where particular language skills are needed; and to inform decisions about the composition of primary health care teams. Where practitioners are not able to meet local needs, some FPCs have exploited their ability to employ salaried practitioners on a short-term basis. Both City and East London FPC and Camden and Islington FPC have employed salaried GPs with the specific remit of meeting primary care needs of single homeless people.

How far the needs of a local area should influence the selection and distribution of GPs is still an open question. However, many FPCs consider that advertisements should contain, in addition to list size and area classification, information on the nature and needs of local communities. Also, prospective applicants should be provided with practice profiles and requested to make proposals for the development of their practices.

The final decision whether a vacancy can be advertised in an area classified as intermediate or restricted (which covers most of inner London) rests with the Medical Practices Committee (MPC). It has been argued that although the MPC has had some success in reducing the number of underdoctored areas nationally, categorisation by list size does not constitute a flexible enough response to local circumstances and local health needs. Anomalies abound: the elderly GP in a restricted area is unable to secure a partner, while the GP with a small list in an 'open' area will still be entitled to the special allowance which is granted to encourage GPs to practice in underdoctored areas. For these reasons, some FPCs want more influence in determining the distribution of GPs in their area. In its strategy statement, Barnsley FPC states:[2] 'The Committee agree wholeheartedly with the view that greater local control be initiated so that FPCs in consultation with LMCs can consider applications for partnerships or single practice entry into the medical list on an individual basis taking into account such aspects as age of doctors, services offered, performance, workload, list sizes and demographic profiles, rather than raw patient/doctor ratio'. Based on GPs' own assessments of workload connected with certain groups, Jarman has developed an 'underprivileged area score' for identifying areas with a high GP workload.[3] Alternative suggestions have included using 'the proportion of the population not in employment due to permanent sickness as recorded in the national census,[4] or a combination of a theoretically informed index and grassroots analysis.[5]

An increase in the number of doctors or their more equitable distribution forms only part of the picture. A more creative approach to the composition of primary health care teams in the inner cities is also required. For example, the ancillary worker scheme could be extended to include reimbursement for counsellors, advocates and interpreters. This would do much to develop primary health care services which are suited to a particular locality's needs.

Primary and secondary care: changing the boundaries of clinical responsibility

The boundaries between primary and secondary care are not fixed. Accident and Emergency departments in inner city areas have always provided a certain amount of primary medical care and a proportion of the work carried out in out-patient departments could be provided in a general practice setting. In a climate of financial stringency, there is pressure within DHAs to transfer to general practice (and its open-ended budget) responsibility for 'duplicated' services (such as contraceptive services) and out-patient follow-up care, where appropriate. DHAs are not alone in wishing to extend the boundaries of traditional general practice. Many progressive general practices wish to extend personal care for individual patients into the hospital setting (through access to GP beds) and to provide follow-up and preventive care for their practice populations. Initiatives in extending the boundaries of care provided in a general practice setting include continuing care by primary health care teams for patients with chronic disorders such as hypertension, asthma or diabetes; care of terminally ill people at home; consultant clinics at health centres; attachment of (or direct access to) occupational and speech

therapists, physiotherapists or clinical psychologists; and GP access to diagnostic facilities and hospital beds. However, the variable quality of general practitioner services and the tradition of responding to individual demands rather than developing care for populations at risk has caused concern over too swift a transfer of care to a general practice setting. For example, studies comparing hospital clinic care with *routine* GP care for diabetes and hypertension demonstrated worse outcomes for people attending GPs.[6]

This underlines the necessity for GPs and DHA staff to develop protocols for patient care. For example, in order to guarantee a coordinated approach to child health services, every general practice, health visitor and clinical medical officer in Northumberland Health Authority took part in discussions to agree the content of pre-school health surveillance. In this case an evaluation of the screening programme was also established which will enable the quality of care to be monitored.[7]

From hospital to community: priority groups and primary care

The impact on primary care of policies for care in the community is largely undocumented, despite a recognition of its importance. The report of the Social Services Committee on community care pointed out that 'community care depends to a large extent on the continuing capacity of GPs to provide primary medical care to mentally disabled people' and went on to express concern that neither GP training nor GPs' present activities indicated a readiness to undertake this role.[8] In their evidence to the Committee, the RCGP stated that 'the needs presented by mental illness and mental handicap require a greater range of skills than those possessed by GPs. Team work in this field is essential (incorporating community psychiatric nurses, social workers, counsellors and psychologists) with concomitant needs for good communication, interprofessional working and joint training.'[9] However, in many areas, particularly inner cities, primary health care teams are weak.

The boundaries between primary and community care are unclear. Thus the responsibility for people discharged from hospital but under out-patient care remains ambiguous and GPs are rarely involved at an early enough stage in arranging medical care for those who have left institutional care to live in the community. The expansion in private residential care, sheltered housing schemes (local authority or privately funded) and part III accommodation, has not always been accompanied by adequate arrangements for medical cover. This raises more general questions of how independent contractors are to achieve representation on such policy and planning matters. One implication is that FPCs will need to help local authorities and DHAs in their aims to promote comprehensive care in a community setting, and encourage the participation of independent contractors.

Discharge policies

Concern with economy and 'throughput', along with the desire of many patients to be cared for at home, has resulted in increased day care and in reduced lengths of

stay in hospital. A number of studies of discharge procedures have shown that patients are often discharged too soon, and without adequate communication from hospital to community and local authority staff.[10] Demands for domiciliary nursing and, to a lesser extent, medical care are also increased by availability of more specialised home care, and as a result of longer waiting lists.

General practitioners and district nurses are in a good position to monitor the effects of acute policies on the community services, to assess the effects on carers and identify where support is needed. This should be incorporated into existing information systems and used to improve care and inform policy development.

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Ways forward

Primary care in general (and inner city primary care in particular) needs to change if it is to realise the goals envisioned by WHO or even meet traditional and everyday demands. Four broad categories of activity are suggested: developing local forums and targets; creating new kinds of care to meet the needs of inner cities; furthering joint working between FPCs and DHAs and locality planning.

Developing local forums and local targets

Multi-disciplinary and multi-agency forums for planning primary health care should be established at district level and reflect the priorities and plans of locally-based multi-disciplinary neighbourhood health teams. One example of the latter — the Speke neighbourhood health group (now defunct) — was a joint initiative of Liverpool Area Health Authority and Liverpool City Council and was set up to combine public policy and community health approaches in tackling local problems. Its membership included clinical medical officers, community nurses, social workers, environmental health officers, police, probation officers, housing, education, the media, voluntary and community groups. Initial discussions focussed on housing, fuel poverty, diet and nutrition, unemployment, uptake of benefits, social support networks and health care facilities.[1] The development of 'patch planning' in health authorities and the decentralisation of many local authorities (combined with a renewed public health interest in a number of these) may serve to strengthen such initiatives.

Ironically, at a time when patch and neighbourhood approaches are being developed and many health and local authorities are constructing 'health profiles' of their populations, community health projects with extensive experience in developing a neighbourhood community-based approach are increasingly under threat. If primary health care is to be truly participatory then district policies will need to be married with an 'enfranchising' community development approach.

Developing new types of care for London

London's health care is being squeezed at both ends. Over the last six years, there has been a 14% decline in London's acute beds and the closure of nine Accident and Emergency departments,[2] a traditional source of primary health care in inner cities. Acute hospitals are increasingly unable to admit 'social' or primary care admissions. West Lambeth CHC claims that 'primary care in West Lambeth has been hit by cuts in acute services without any corresponding increases in community care. For example, there is no night nursing service within the district, GP services are under constant pressure and few have time for more than the briefest consultation'.[3] Thus, some of the greatest changes in the balance of primary and secondary care are taking place where the 'family doctor' system is at its weakest. Compounding these problems, and of particular relevance for the social care of priority groups are the enduring financial problems of the rate-capped inner London boroughs. This means they are increasingly reluctant to enter into schemes involv-

ing future resource commitments. Traditional models of care — even if better organised and resourced — will not solve the problems of deprived inner city areas. High levels of drug abuse and poverty, and large numbers of single homeless people, hostel dwellers, homeless families, and elderly people living alone all challenge the appropriateness of existing patterns of care. Current screening programmes are not designed for a highly mobile inner city population; social admissions and 'low-tech' care fit uneasily into a framework of expensive high technology medicine.

A number of initiatives have attempted to address the health needs of inner city populations. The range is wide: open access counselling;[4] community development approaches in health visiting,[5] health promotion[6] and general practice;[7] salaried GPs to meet the needs of specific groups such as single homeless people;[8] walk in women's health clinics;[9] advocacy schemes;[10] mobile clinics;[11] walk in medical centres for young people.[12] Comparatively high levels of social problems are brought to inner city general practices. This means changing the membership of primary health care teams, more collaborative working and flexibility over the location of primary care.

One example of an attempt to meet the needs of an inner city population for care intermediate between home and hospital is the Lambeth Community Care Centre.[13] Patients unable to be cared for at home, or who do not require the high technology care of the local teaching hospital are referred by their GPs, who provide 24 hour medical cover. This is in part a response to the type of care needed where support networks are poor and domiciliary schemes difficult to implement. The Centre demonstrates how organisations and professional boundaries can be crossed in the interests of providing appropriate care.

Policies for collaboration between FPCs and DHAs

Since becoming independent authorities in April 1985, FPCs are expected to accomplish a new and expanded role in the planning and provision of primary care services — though the statutory duty for ensuring the availability of these services continues to rest with DHAs. If these authorities are to work effectively together, agreement needs to be reached over an agenda for primary health care, and joint forums set up which would enable such an agenda to be addressed.

The 'collaboration agenda' is a broad one. It includes collaboration between the professionals which constitute the family practitioner services (GPs, dentists, pharmacists, opticians); between the FPS and DHA staff, as well as between FPCs and the one (or more) DHAs to which they relate. It also involves FPCs getting to know their constituencies of practitioners — their current activities, their problems and their plans for the future. Topic areas where collaborative working is necessary include services for maternal and child health; screening programmes; health education; follow up care; access to diagnostic and paramedical services and care for priority groups.

To achieve joint working, linked information systems need to be developed. This would allow DHAs to relay to FPCs updated information on waiting lists or access and transport arrangements, for example, and FPCs to identify GPs use of hospital

facilities or changes in service provision. FPCs will need to be involved in developing joint policies for shared and/or overlapping services such as dentistry or school health, or for vulnerable groups such as single homeless people. The report of the Joint Working Group on Collaboration between DHAs and FPCs underlined the scope for joint use of specialist staff, interchange of staff, particularly at middle management level, and improved opportunities to transfer from one part of the service to the other.

Despite this wide and expanding agenda, many FPCs — and particularly those in inner cities — are still grappling with the problems described in the Acheson report — out of hours cover, telephone answering arrangements, quality of practice premises, and the development of primary health care teams. Surmounting the organisational obstacles in planning primary care and forming links between DHA staff and independent contractors are time consuming tasks and the lack of additional staff and resources to meet these demands is much lamented by FPCs.

Locality planning

Collaboration for primary health care goes beyond FPCs and DHAs to include local authorities and voluntary organisations. The move towards care in the community has highlighted the difficulties of all these agencies planning together: many of the same issues apply to the achievement of primary health care. One way of enhancing collaboration between service providers is to focus on integrating services within a defined 'patch', as the common element between different agencies. A number of local authorities have successfully decentralised their services; in the wake of the Griffiths re-organisation many DHAs (and the majority in inner London) are in the process of 'going local'. It is argued that the development of clear management structures down to locality level will enhance management accountability, render services more responsive to local needs, encourage user participation and help professionals overcome traditional boundaries and thus help develop multidisciplinary teamworking essential for primary and community care.

The recommendation of the Cumberlege report, that neighbourhood nursing teams be established to serve a population of between 10,000 and 25,000, is consistent with this patch approach; the current task for many health authorities is the integration of Cumberlege with generic patch management.

Some FPCs too are keen to explore localities as a basis for planning — despite the current complexity of GP catchment areas. In some cases GP practice populations will be largely coterminous with 'localities' (as in rural communities); in inner city areas arrangements will need to be flexible. Locality planning will be most effective where collaboration takes place across DHAs, the FPC, local authorities and voluntary organisations, and where user participation is a reality. It will be 'fairest' where autonomy within patches is balanced with equity between patches.

Beyond the narrow agenda

Primary health care stands at a crossroads of competing ideologies. This discussion document has summarised some of the policy dilemmas to be resolved. How will a balance be achieved between an independent contractor and free market model and accountability both to managers and users? How far will a public health approach permeate primary health care and collaborative arrangements emerge at local and national level which may enable such a broad and participatory approach to become a reality?

Collaborative working is an inevitable consequence of taking a broad approach to factors influencing health and health status. It forms the basis of primary health care; by definition it cannot be contained within narrow agendas.

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In April 1986 the government's Green Paper on primary health care was finally published. Despite the promise of an 'agenda for discussion', primary health care was defined in narrow professional terms. There was little critical analysis of the complexities of planning primary care. Neither did the consultative document explore the implications of adopting the World Health Organisation approach to primary health care, with its key themes of equity and participation.

In this discussion document Linda Marks reviews issues of standard setting, quality assessment and user participation and outlines some of the management challenges facing primary health care. In keeping with the concern of the London Project Executive Committee which funded this work, many of the examples are drawn from inner cities.