RESEARCH
REPORT
10

Developing Primary Care
Opportunities for the 1990s

David Taylor

King's Fund Institute
The Nuffield Provincial Hospitals Trust

ISBN 1 870607 25 2

Published by the King's Fund Institute
126 Albert Street, London NW1 7NF
and the Nuffield Provincial Hospitals Trust
3 Prince Albert Road, London NW1 7SP
for the Primary Care Development Fund

Design & print by Intertype
Cover photograph Adam Hinton/*Nursing Times*

No 10 in a series of research reports on current health policy issues

Developing Primary Care
Opportunities for the 1990s

David Taylor

Acknowledgements

The Primary Care Development Fund originated from an initiative taken by the Office of Health Economics. It received initial donations from the Department of Health, the Nuffield Provincial Hospitals Trust and the King's Fund. Technical support was also received from the General Medical Services Committee of the BMA, as well as from OHE.

The author particularly wishes to thank Bryan Rayner, Michael Ashley-Miller, Robert Maxwell, George Teeling-Smith and Norman Ellis for their support during the preparation of this report.

He is also grateful to all those participating in PCDF projects for their advice and comments, including Bilkis Abara, Lynne Carter, Angela Coulter, John Fry, Ian Goodrick, Sallie Guthrie, Richard Harding, Vic Hayes, Heather Hunt, Allen Hutchinson, Roger Jones, Sue Jones, Sue Lydeard, John Newton, Mary Nisbett, Tom O'Dowd, Sylvia Readman, Kate Saffin, Roy Slack, June Smail, Nigel Stott, Malcolm Taylor, Dianna White, Shirley Wragg, Keyvan Zahir and Ann Zamorski.

This report was produced with administrative and secretarial support from Christine Rivett-Carnac, and statistical information supplied by Robert Chew. It was designed by Intertype.

The author

David Taylor is a Fellow in Health Policy Analysis at the King's Fund Institute. He is also a Visiting Senior Research Fellow at the Centre for Health Economics, York, and is Chairman of the Lambeth, Southwark and Lewisham FHSA.

Contents

Boxes

Figures

Tables

Introduction

The Primary Care Development Fund (PCDF) was established in the Spring of 1989. The Nuffield Provincial Hospitals Trust, the Department of Health and the King's Fund each agreed to put forward an initial £100,000: the purpose of these donations was to provide finance for local research and demonstration projects designed to find and show ways of enhancing primary — and in particular general medical — care services. Technical and organisational support was provided by the pharmaceutical industry funded Office of Health Economics and the BMA's General Medical Services Committee. The first wave of 14 PCDF exercises, selected from some 250 applications, were (with one exception) completed by the Spring of 1991. The participants in each project have produced working papers and/or reports and articles detailing their activities and findings. The latter are outlined briefly in Box 1, and also in the Appendix.

This analysis is based on the available PCDF documents, and also on a series of personal interviews conducted with project organisers and their colleagues. Its objective is not to duplicate their work. Rather it is to present an appreciation of the significance of Primary Care Development Fund supported schemes for the future of UK primary care generally, and to offer a range of audiences amongst NHS service providers, users and purchaser groups with a point of common entry into a vital area of national health debate. It attempts to identify key primary care questions to be resolved in Britain in the 1990s.

The report examines:

- the historical development and current nature of general medical care in the United Kingdom, including the evolution of links between family doctors and other primary and secondary care professionals in the NHS and allied agencies;
- the immediate insights and questions generated by the PCDF projects;
- broader policy issues and options related to the above;
- the part that further investment in practice level research might play in achieving desirable change.

However, before this there are three sets of additional introductory points to stress. The first relates to the primary medical care system already established in this country. The United Kingdom's 34,000 family doctors provide an internationally unique, outstandingly comprehensive, service to virtually the entire population. And their surgeries offer most people a familiar (and in part because of this very popular — see, for instance, Ritchie 1981, and Cartwright and Anderson 1981) 'gateway' to other forms of NHS and allied social care.

As Figures 1 and 2 show, the General Medical Services (GMS) are supplied at relatively modest cost compared to that of the rest of the NHS. The current figure of approximately £2 billion represents only seven per cent or so of total UK NHS spending. Even if the cost of community pharmaceutical services is added, the total is equivalent to little more than £80 per person per year.

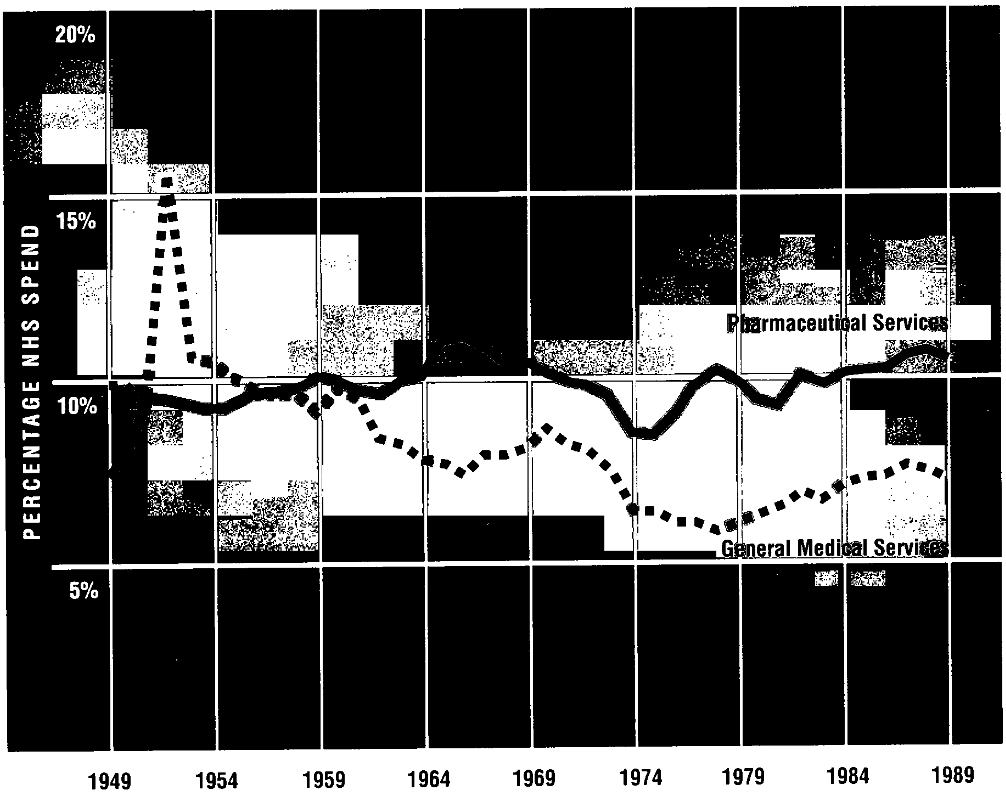
Historically, the British primary care system has been characterised by very low administrative/managerial outlays; within a structure of nationally defined financial incentives family doctors have worked at 'the coal face' of care, coming into frequent personal contact with patients on their lists with a minimum of bureaucratic intervention or additional staff support. They accept a high degree of responsibility for the decisions they make in response to each individual situation.

It is to a degree because of this apparent economy, coupled with the belief that in managing the gateway to secondary care GPs moderate demand for more expensive hospital and other community based forms of support (GMSC 1983), that the independent family practitioner based health services (FPS) have traditionally enjoyed strong political support in Britain. In England and Wales little was done in either of the health service reorganisations of the 1970s and early 1980s to alter significantly the basic FPS/FHS structure laid down in 1948.

But the second set of factors to stress is that in recent years this situation has to a degree changed. For a variety of reasons reform of the primary medical and health care system has gained priority on the UK's political agenda. The factors involved in this development range from apparent concern about the cost of GP prescribing of medicines to anxieties about the extent to which GP care standards are satisfactorily consistent. Substantial variations in rates of referral to hospital between practitioners have attracted special notice.

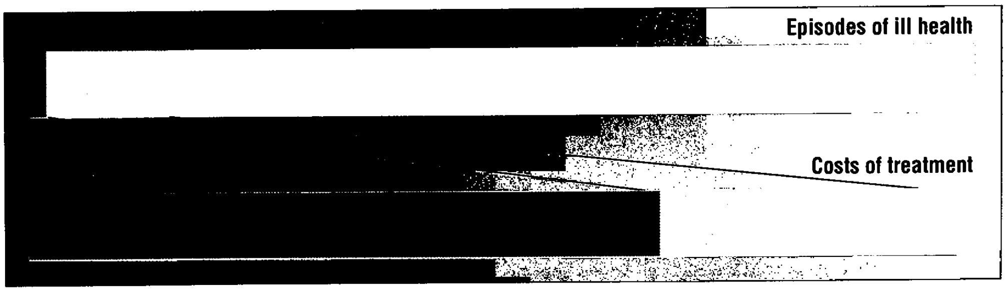
The quality of primary medical and allied community health support available to older

Figure 1 The proportion of NHS resources spent on General Medical and Pharmacutical Services, *UK 1949-89*



Source: Department of Health, Robert Chew (1991)

Figure 2 Hospital, primary and self-care treatment costs - a comparison



Note: Hospital cared for episodes tend to be of a more serious nature than those treated by GPs and other primary care professionals; hence like is not being compared with like, and transfer from secondary to primary care may not make savings anticipated on the basis of simplistic calculations. Nevertheless, the heavy concentration of cost in the hospital sector is revealing, both in terms of the nature of and long term potential for savings in the work being undertaken. In at least half of all reported incidents of ill-health no action is taken by those experiencing them. The skill of health service users in selecting which symptoms to act on and which to ignore has a significant influence on health service costs and outcomes.

Source: KFI approximations based on various sources

1

THE PRIMARY CARE DEVELOPMENT FUND PROJECTS

Project Title	Key Findings
Outcome of general practice referrals to hospital outpatient clinics. (Unit of Clinical Epidemiology — University of Oxford.)	Helped to demonstrate that GPs often refer patients to consultants for diagnostic confirmation and treatment advice, rather than treatment initiation. Showed that direct GP access to some forms of service (eg hearing aid provision) could reduce consultant workload, and that more attention should be paid to the transfer of OP follow up care back to GPs.
Are volunteers a resource which GPs can use in the care of patients? (GP initiated, Exeter.)	Showed the contribution of paid co-ordinators in organising voluntary effort, and the potential for increased practice community participation in care delivery.
Screening the health and welfare of people in York who attain the age of 75 years. (GP initiated, York.)	Indicated the potential value of postal questionnaires in identifying elderly individuals at special risk of declining health. Highlighted the vulnerability of those who are themselves carers.
The Ilford social health promotion team/Buttsbury women and children's health project. (Redbridge DHA/ general practice.)	Examined and demonstrated the value of link workers in supporting individuals/families with deprivation related problems, including those from ethnic minority backgrounds living in disadvantaged circumstances. Illustrated the needs of mothers with young children, and the value of closely targetting special help to particular individuals.
Factors influencing GP referral decisions. (Primary Care Research Unit — University of Newcastle Upon Tyne.)	Stressed the wide variety of factors influencing GP referral decisions, and the importance of avoiding simplistic assumptions about the 'right' rates and similarly crude interventions designed to achieve them.
Improving the clinical care of dyspepsia. (Primary Medical Care — University of Southampton.)	Showed that the development of a local protocol on the management of dyspepsia based on consensus techniques had only a modest impact on factors such as referral and use of diagnostic services. However, prescribing costs rose significantly amongst doctors using the protocol, particularly those who had previously been low prescribers.
The management of chronic disease in general practice. (Department of General Practice — University of Nottingham.)	Showed the potential value of chronic disease registers and an extended role for practice based nurses in supporting chronically ill people in the community.
The Liverpool antenatal care project. (General practice based.)	Suggested that practice based midwifery clinics could improve record keeping and hospital/GP communication during shared antenatal care, but did not reveal advantages in terms of care quality or consumer satisfaction.
Evaluation of parent held child health records in Oxfordshire. (Oxfordshire DHA, health visitor research.)	Indicated that health service users can reliably hold records, and obtain from doing so benefits related to an increased sense of responsibility and control.
Improvement of specific services and better use of decreased resources. (Bromley Local Medical Committee.)	Developed protocols for the treatment/management of a range of common conditions, showing how to establish consensus between GPs and consultants via the collaboration of all local GPs in surveys and subsequent feedback processes.
Enhanced diabetic care in South Glamorgan. (Department of General Practice — University of Wales College of Medicine.)	Demonstrated the contribution of practice based nurses to the care of diabetic patients in general practice, and the support role of specialist community nurses liaising between hospital based specialist providers and primary care teams.
Epilepsy care in Doncaster. (General practice based.)	Revealed the need for enhanced primary care support for people with epilepsy, and the potential for a specialist team to back-up the efforts of general practitioners.
Examination of discharge arrangements. (Northamptonshire Family Practitioner Committee.)	Showed the need for improved discharge arrangements, particularly in the context of geriatrics. Hospital based staff often fail to provide GPs with adequate information about the timing of discharges, and the needs of the patients involved.
Haringey primary health care development project. (Department of Community Medicine, Haringey DHA.)	Revealed opportunities for and difficulties in achieving better communication between general practice and other branches of the NHS. Developed protocols for several common conditions.

Note: See the Appendix to this report for further details of these projects.

chronically ill individuals and socially less advantaged families — notably in inner areas of cities such as London — has also received particularly critical attention. Relevant considerations include the poor quality of many practice premises in less affluent urban localities, which can have 'knock on' effects on other variables like practice staffing; the continuing isolation of significant numbers of GPs — even those working in larger partnerships — from their professional colleagues in both medicine and other disciplines (Huntingdon 1990); wide reported differences between 'good' and 'bad' practice standards as well as between 'rich' and 'poor' practices (Leese and Bosanquet 1989); and a lack of functional integration and communication between the various parts of the NHS primary/community care services, and hospital based provisions.

In April 1990 a new contract for general medical practitioners was introduced (despite continued opposition from within the medical profession) by the then Secretary of State, Kenneth Clarke. This action followed some three to four years of debate and negotiation about how to tackle issues such as those mentioned above, and also closely coincided with the separately engendered — and in some senses contrasting — plans contained in the 'Working for Patients' and 'Caring for People' White Papers. Controversy continues as to desirability or otherwise of the changes that the new contract introduced. To a lesser degree, perhaps, it has also surrounded the formation of new Family Health Services Authorities to manage — under Regional Health Authority supervision — the family practitioner sector.

This turbulent background helps in some respects to make the Primary Care Development Fund initiatives' findings especially timely and relevant to aspects of current national debate about the future of UK primary system. Yet the PCDF concept can in fact be traced back to a meeting organised by the Office of Health Economics before the reforms of recent years were announced. And it may, of course, be that further, largely unpredictable, changes in areas such as medical technology, consumer expectation and/or the organisation of non-health community services will create additional shifts in the environment in which professionals like practice based nurses and family doctors operate. Hence no attempt is made here to provide fixed and/or unequivocal prescriptions for the 1990s.

Nevertheless, the final set of introductory observations to make relate to the fact that it can be said with certainty that hospital care is moving towards the delivery of progressively more high-cost, high-technology interventions involving shorter patient stays on concentrated secondary care sites. Hence the role played by family doctors and other community based professionals in assisting people to cope with longer term problems in their own homes and other locally available settings in likely to acquire even greater importance. The broadly defined primary care system (involving all NHS community/FHS staff and allied groups such as some social service department personnel) will face major challenges in the coming decade, particularly in the context of supporting elderly and other individuals with chronic care needs.

In working to meet these Britain is fortunate in having strong traditions of general medical practice and community nursing care to build on. Notwithstanding the value of services such as district nursing (which is arguably as internationally unique as the GMS) NHS general medical practitioners and their surgeries appear logically to offer an attractive kernel around which a better, more co-ordinated, pattern of overall primary care might gradually be constructed. But in approaching the information generated by the Primary Care Development Fund's first set of projects from this starting point it must be recognised that achieving enhanced functional, let alone structural, integration will be no easy task. The sensitivities and ambitions of a wide range of both medical and non-medical care providers and managers — including general practitioners themselves — will have to be accommodated and/or modified. And the special needs of those groups of consumers who at present are at high risk of not being cared for to satisfactory standards by either Britain's family doctors or any other elements within the NHS and social services complex must in future be more fully understood if better primary/community health care is genuinely to be achieved.

1 | The evolution of UK primary care

Many of the tensions and problems of professional co-operation found in today's NHS can be traced back into the history of each groups' separate development. For instance, the roots of general medical practice in the United Kingdom are distinct from those of both the physicians, whose Royal College in London dates back to the sixteenth century, and the surgeons. Table 1 provides an outline chronology of the events which took the disparate array of health care providers operating in Britain towards the end of eighteenth century (see Loudon 1986) through to the qualified and regulated professional groups which deliver primary medical and nursing care today.

The 1858 Medical Requisition Act was of crucial significance in this process. It served, in the swiftly changing environment of Victorian Britain, to protect the public from 'quackery' in that it helped to guarantee basic standards of medical qualification and practice, and also to fuse together three previously competing and conflicting groups into one medical profession. Before then the apothecaries, the key progenitors of both today's family doctors and community pharmacists (see Box 2), represented a tradition which was separate from, and which in some respects challenged, that of the physicians and surgeons.

From the 1860s onwards demarcation disputes between general practitioners and the more specialised physicians and surgeons were metamorphasised into 'medical etiquette'. By the beginning of the twentieth century GPs were in nearly all parts of the country firmly established as the providers of primary care and the keepers of the gateway through which patients might be referred on to specialists. This arrangement proved desirable from a public viewpoint in that it helped to restrain the supply of probably unnecessary — and often hazardous — secondary interventions; from a sectional professional viewpoint it was also beneficial in that it ensured that both generalists and specialists had opportunities to charge for their services. Elsewhere in the world where there evolved more direct routes of specialist/patient contact the relatively weak economic basis for primary medical care impaired its development.

However, GPs remained of low status within the UK medical profession throughout the nineteenth and first half of the twentieth centuries. The control of medical education remained exclusively in the hands of hospital based specialists, even after the formation of the NHS in 1948.

From a primary health care development viewpoint a second area of concern which dates back to events in the nineteenth century and before relates to the availability of community nursing and midwifery services. The origins of these stem from the middle ages, and the work of informal carers, religious orders, charitable groups, private entrepreneurs and local Poor Law Committees. In the eighteenth and early nineteenth centuries the latter were free to employ Parish nurses to support chronically ill people in their local community. But the

2

THE CHANGING ROLE OF PHARMACY

In Britain the apothecaries of the nineteenth century — and before — diagnosed conditions and recommended treatments, as well as preparing and dispensing medically prescribed therapies. In most of Europe, however, the pharmacist's role has historically been more tightly restricted to the latter area. Today, pharmacists on the European mainland tend to enjoy higher status and greater monopoly over the supply to the public of over-the-counter medicines than is so in the United Kingdom, where there is a relatively high level of concern about the future of this professional group.

One option currently under discussion is an increased emphasis on the advisory role of pharmacists in relation to the treatment of minor illnesses, perhaps backed by more sophisticated forms of record keeping and an increase in the range of 'pharmacy only' medicines available for private consumer purchase. Another could be a closer physical integration of the general medical services and the FHS pharmaceutical sector, so that the contribution pharmacists make to the mainstream of primary health care provision could be enhanced. Also related to the possibility of changing the balance of professional inputs to the supply of medicines in the community, nurses may in future gain prescribing rights, initially in respect to a 'limited list' of pharmaceuticals needed to treat a range of common, chronic, conditions.

Ideally, local experimentation with alternative forms of pharmaceutical and allied information supply could help identify the most desirable ways forward. However, the network of regulations and jealously guarded professional interests affecting this area means that the practical opportunities for primary care research could be limited as compared to those in other contexts examined in this report.

Table 1 — Key events in the evolution of British primary health care 1800-1991

1815	**Apothecaries Act permitted apothecaries to charge for medical advice, and acknowledged the separate group of chemists and druggists. The latter evolved into pharmacists, the former into general medical practitioners. The term 'general practice' began to be used at this time.**
1832	**Provincial Medical and Surgical Association founded in Worcester — the progenitor of the BMA (1855).**
1834	**Poor Law Amendment Act reduced community based relief, demanded the provison of wards for the impoverished sick.**
1843	**Pharmaceutical Society of Great Britain incorporated by Royal Charter.**
1854	**Nightingale takes a party of nurses to Scutari.**
1858	**The Medical Requisition Act — General Medical Council formed, medicine established as a 'self-regulating' profession.**
1864	**District Nursing Associations formed in Liverpool, Manchester and Salford.**
1872-75	**Public Health Acts establish statutory basis for environmental health services.**
1886	**General practitioners gain representation on the General Medical Council.**
1887	**British Nursing Association and the Queen Victoria's Institute for Nurses founded. Rural Nursing Association formed in the following year.**
1902	**Midwives Act.**
1907	**School Medical Service established.**
1911	**National Health Insurance Act lays down a basic structure of general medical and pharmaceutical care for the working population. Local Insurance Committees, the forerunners of NHS Executive Councils, are formed.**
1916	**College of Nursing founded.**
1918	**Maternity and Child Welfare Act requires home nursing for infectious cases.**
1919	**Ministry of Health formed. Nurses Registration Act.**
1920	**'Dawson' report advocates primary health care centres.**
1925	**Queen Victoria's Institute becomes and Queen's Institute of District Nursing.**
1929	**Poor Law system ended, local authorities begin to develop a range of health services.**
1939	**The Emergency Bed Service set up, demonstrating the benefits of more co-ordinated use of hospital resources.**
1942	**The Beveridge report offers plans for a post-war 'welfare state'.**
1946	**The NHS Act.**
1948	**NHS established. Tripartite structure of hospital, family practitioner and local authority community services adopted. Executive Councils administer independent contractors' contracts.**
1952	**College (subsequently Royal) of General Practitioners established.**
1956	**Jameson inquiry into health visiting; Gillebaud report defends NHS costs and structure.**
1959	**Mental Health Act.**
1963	**Gillie report on the future scope of general practice recommends attachment of district nurses to family doctor practices.**
1965	**Doctors' Charter opens the way to a revitalisation of NHS general medical care provision. Ancillary staff scheme, GP Finance Corporation, general practice departments established in medical schools.**
1970	**Social Services Act (and Crossman's second Green Paper on the NHS).**
1974	**NHS reorganisation; Family Practitioner Committees take over functions of the Executive Councils. Community Health Services removed from control of local authorities and in England placed under Regional/Area/District Authority management.**
1979	**Nurses, Midwives and Health Visitors Act.**
1980	**New UK Central Council for Nurses, Midwives and Health Visitors set up.**
1982	**NHS reorganisation — Area tier eliminated. From 1982 all new GPs have to have three years vocational training.**
1983	**Griffiths Management Inquiry leads to the introduction of general rather than functional management in the NHS.**
1985	**FPCs gain increased independence. RCN Judge report.**
1986	**Cumberlege report on community nursing. Audit Commission report on community care.**
1987	**White Paper 'Promoting Better Health'.**
1988	**Griffiths review of community care.**
1989	**'Working for Patients' and 'Caring for People' published.**
1990	**New contract for general practitioners introduced and FHSAs established. NHS Management Executive publishes 'Nursing in the Community'. Delay in community care plan implementation announced.**
1991	**NHS Trusts begin functioning, some with community services. Provider/purchaser division introduced in the health service. 'Foster report' on future of FHSAs; NHSME report on primary and secondary care integration.**

3

THE ORIGINS OF SOCIAL WORK

The historical origins of the modern profession of social work lie in both the voluntary efforts of nineteenth century social improvers, and the Poor Law system of Victorian Britain. Although the responsibilities of Poor Law Guardians were transferred to the local authorities in 1929, many of the service structures and attitudes originally developed within Poor Law institutions lived on unchallenged until after the second world war.

The formation of the NHS in 1948 put a duty upon local authority health departments to provide, under the direction of Medical Officers of Health, a range of community services for children, mothers and other client groups, including people with mental health problems and learning disabilities. In the same year the Children's Act provided for 'comprehensive services' for those without a 'normal' home life, while the National Assistance Act made councils responsible for supplying accommodation for elderly and other individuals in need of such care.

During the 1950s and 1960s the scope and cost of local welfare services increased rapidly, and bodies such as British Association of Social Workers were established. However, social work remained fragmented and it was not until the passing of the Local Authority Social Services Act in May 1970 that the then Labour Government (acting on the recommendations of the Seebohm Committee) established local authority social service departments which were fully independent of medical control. The same legislation helped to create greater unity within the social work profession; yet as with the introduction of the Griffith's community care reforms two decades later the administration of the day declined to establish a single central government department responsible for the function.

Social work's slow emergence from medical domination during the latter half of the twentieth century, coupled with problems associated with the different organisational imperatives influencing NHS agencies and local authorities and practical barriers such as those stemming from boundary disparaties, may help to explain and to a degree justify the currently poor level of co-operation and collaboration observable between GPs and social workers in some areas. But in facing the future needs of a growing population of very elderly people, as well as those of groups such as individuals with chronic mental or physical disabilities/diseases who have diminishing levels of institutional support available to them, all the primary care professions need urgently to find more effective, mutually acceptable, ways of working together.

introduction of harsh restraints on Poor Law out-relief in the 1830s, coupled with (and generated by) the growing problems of urban life and demographic change in Victorian Britain, subsequently inhibited the emergence of appropriate home and locality based nursing care alongside improving general medical care. (Dickens in the 1840s drew attention to the inadequacies of community nursing and midwifery support for poorer people with the horrific figure of Mrs Gamp in the novel Martin Chuzzlewit.)

However, as Table 1 indicates, during the final decades of Victoria's reign attention began to focus on the need for enhanced community nursing provision. And in the first half of the twentieth century reforms such as the Midwives Act of 1902, the 1911 National Insurance Act and the 1919 Nurses Registration Act combined with trends like the expansion of local authority funded community health and (following the ending of the Poor Law system in 1929) hospital services considerably to enhance the quality and extent of support available.

But to a substantial degree 'worlds' such as those of general medical practice, district nursing, and health visiting (the latter originated from public health rather than nursing based initiatives) were still very distant one from another. This remained so even with the advent of the NHS. As noted earlier, the heritage of separate cultures and conflicting perceived professional interests is discernible today in the relations between hospital doctors and general practitioners and between doctors and professionals in nursing and other health care disciplines. Interactions between the health professions and social workers (Box 3) have also been impaired by sectional disputes. It is thus an important question for the future as to whether or not general management approaches will ultimately overcome such inter-professional friction, perhaps in time permitting more focus on the special management needs of services for particular consumer groups rather than those of separate provider interests.

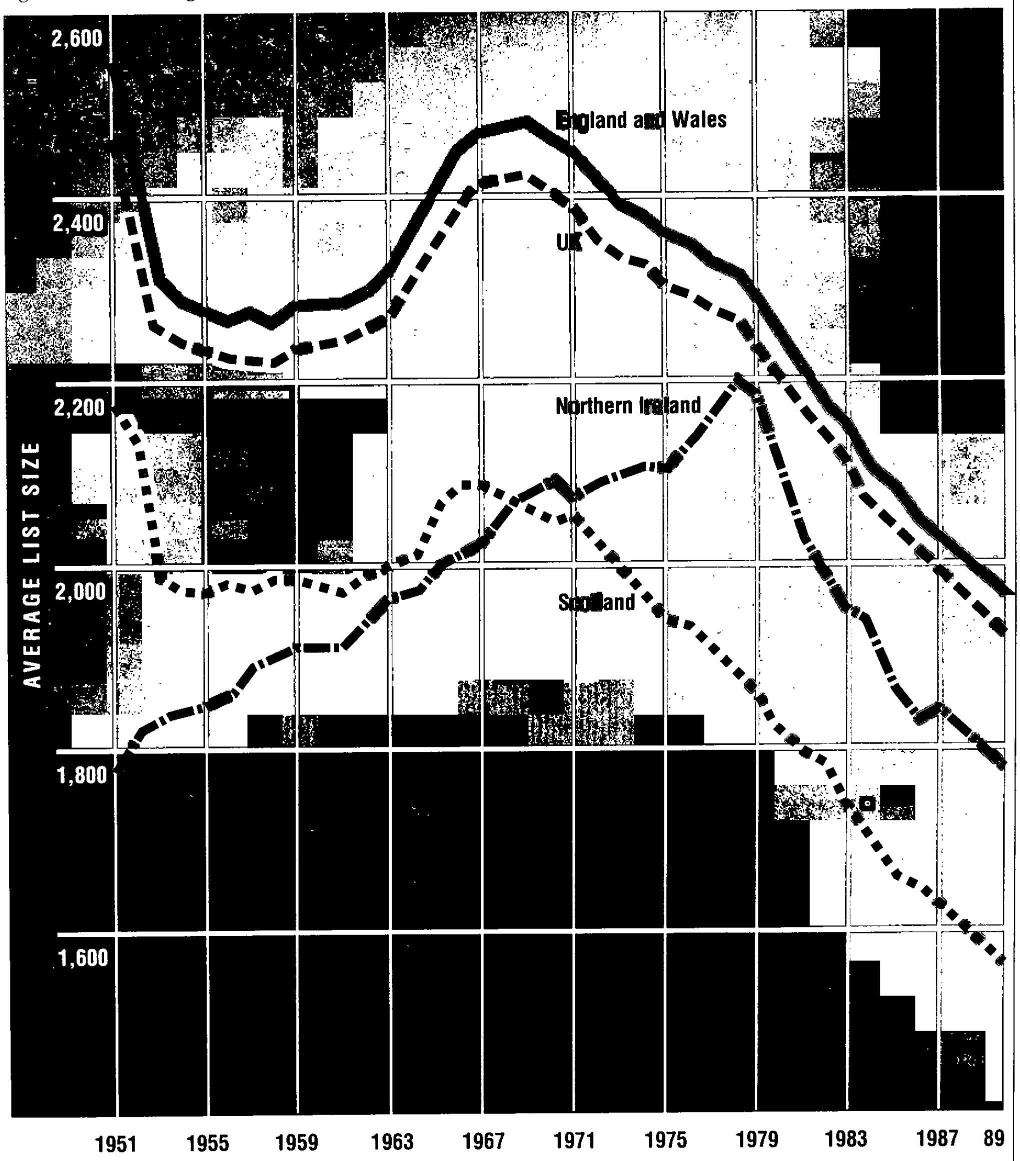
Primary health care in the NHS

The original tripartite structure of the NHS preserved the distinction between the independent practitioner services administered via the Executive Councils (the successor bodies to the Local Insurance Committees set up by the Lloyd George Act in 1911) and the local authority run community nursing and allied services. The unification of health care provision brought by the creation of the NHS was initially more apparent in the hospital sector. Here, building on wartime emergency experience, the previously existing elements of private, local authority and charitably run institutional care were drawn together under a system of Regional and local hospital management committees.

Despite the formation of the College of General Practitioners in the early 1950s general practice did not develop satisfactorily during the first two decades of the NHS's existence. Figure 3 shows that by the early 1960s average family doctor list sizes were rising; younger members of the medical profession were not entering general practice. The number of GP trainees dropped to a nadir of just 200 in 1965, compared with 400-500 in the early 1950s and a figure of over 2,000 today. Demand for practices was so low that there was little need to 'waste time' with postgraduate training.

Action to correct this undesirable situation was taken by the then Labour administration with the introduction of the 'Doctors Charter' of 1965, coupled with subsequent vigorous, professionally led, attempts to establish general practice as an independent specialism. The remuneration of family doctors was improved, and innovations such as the 'ancillary workers' scheme were introduced. Through the latter GPs were reimbursed for 70 per cent of the staff costs they incurred as a result of bringing personnel such as receptionists into their practices. The 'Doctors' Charter' triggered a long term series of internal

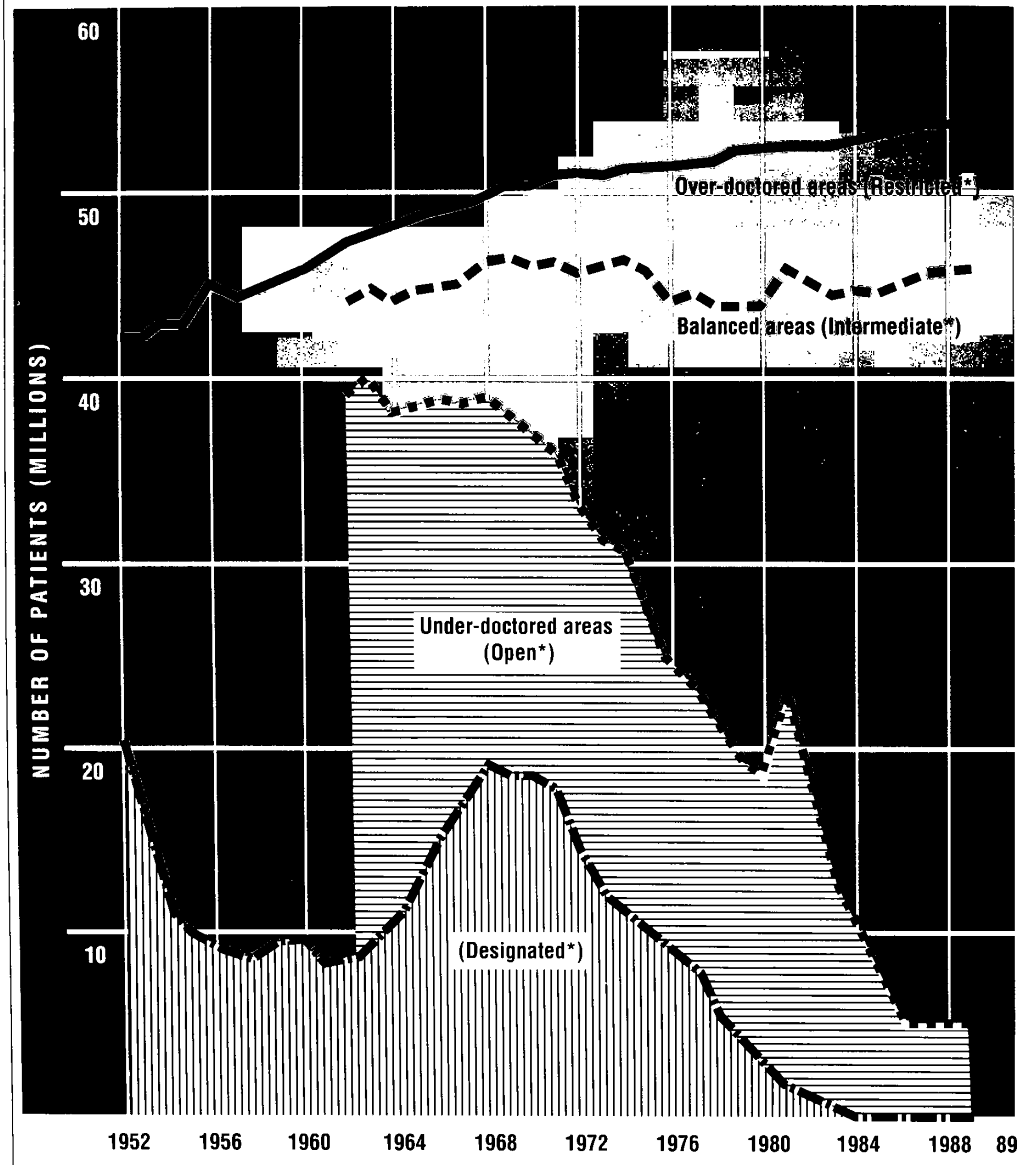
Figure 3 Average list size of unrestricted principals



Notes: All figures relate to 1 October.
Estimated figures for years 1988 and 1989.

Source: DH/Chew 1989.

Figure 4 Distribution of population residing in areas classified by MPC, England and Wales.



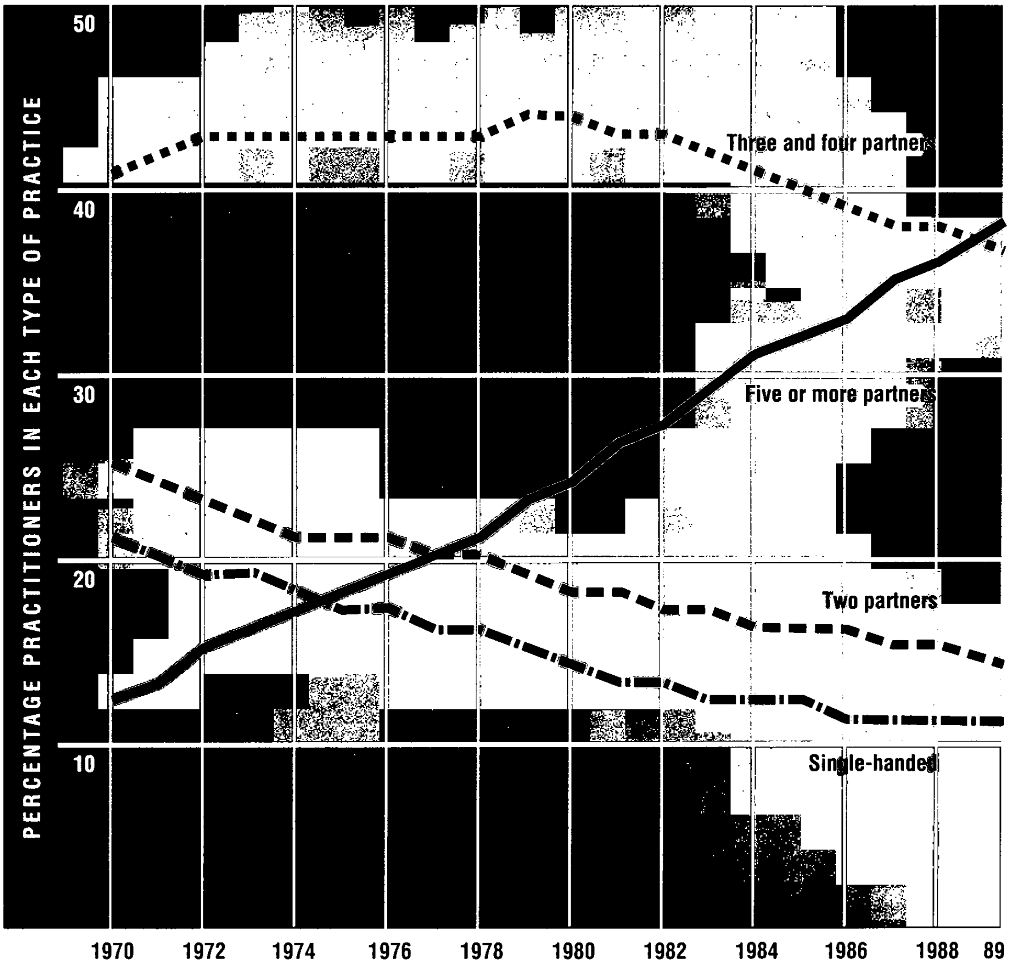
Notes: All figures relate to 1 October.
Estimated figures for years 1988 and1989.
MPC = Medical Practices Committee.
*Areas classified by MPC.

Source: Chew 1989.

developments in general medical practice, the significance of which should not be ignored or underestimated. Although the then Executive Councils were little more than administrative bodies concerned with 'pay and rations' the system over which they presided was not static, any more than it was in the period from 1974 onwards. The data contained in Figures 4 and 5 emphasise this fact.

In 1974 the first major re-organisation of the NHS removed the control of community nursing care from the local authorities and combined it with that of the hospitals, under new Area Health Authorities. But in practical terms the independent practitioner services were unaffected by this change. The freshly constituted Family Practitioner Committees (FPCs — which were coterminus with the 1974 NHS's Area Health Authorities) continued to work in much the same way as the Executive

Figure 5 The sizes of GP practices, 1970-1989.



Source: Chew 1991.

Councils they replaced. With the subsequent abolition of the NHS Areas and the introduction of measures to ensure the full independence of FPCs in 1984/85, the structural isolation of the Family Practitioner Services was, if anything, strengthened in England and Wales. (Although in Scotland the FPS are administered by sub-committees of the Health Boards, the practical situation was effectively the same. Only in Northern Ireland, with its integrated health and social care management system and atypical social circumstances, can it be argued that the primary services structure has been significantly different).

However, following the establishment of FPCs in the mid 1980s as full employing authorities government policies towards the primary care sector began sharply to alter. As Table I shows, government publications and initiatives relevant to primary health care over the last five years include the 1986 Green Paper on the sector; the 'Cumberlege Report' on neighbourhood nursing and the Audit Commission's study on community care, both of which were also produced in 1986; the 1987 White Paper 'Promoting Better Health'; the 1989 White Paper 'Working for Patients'; and the 'new contract' for GPs, introduced in 1990 — see Box 4. Other enquiries and recently proposed measures, such as the (1988) Acheson investigation into public health medicine in the NHS, the plans for social care laid down in the 1989 White Paper 'Caring for People', and the NHS Management Executive's 1990 'Nursing in the Community' paper and its 1991 document on the integration of primary and secondary services, also have considerable implications for the future of primary health in the UK.

4

THE 'NEW CONTRACT' FOR GENERAL MEDICAL PRACTITIONERS: AN OUTLINE SUMMARY

Service delivery, planning and monitoring

FHSAs will plan service development in order for the resources available to be used to best effect. LMCs should be consulted, and GPs supplied with aggregated information about health care provision and achievements in their areas. FHSAs are also to develop effective working relationships with DHAs and RHAs to ensure appropriate service provision, and will analyse GP referral patterns. GPs should produce for FHSAs annual reports describing their practice services and plans, to which the FHSA may invite them to add further data if it is needed.

Prescribing

FHSAs are required to establish rational prescribing policies for their localities, and to monitor individual practice prescribing.

Practice teams

The new contract requires FHSAs to determine the percentage of practices' staff costs to be reimbursed, with total spending now restricted to a cash limited amount in each area. Practice staffing is to be reviewed on a three yearly basis. Bars on the range of professionals employable which applied under the previous 'ancillary staff scheme' have been lifted.

Premises — cost rent and improvement grants

Standards were tightened and cost rents made payable in line with regional variations in costs. FHSAs can set the level of improvement grant payable within a defined range, and here again overall locality expenditure cash limits now apply.

Computers

The new contract enables help to be offered towards the cost of purchasing/leasing hardware and software for GPs. Training costs may also be met.

Medical manpower

FHSAs have rather more discretionary power in relation to defining satisfactory arrangements and local needs, both in relation to discussions with individual GPs and Medical Practices Committee decisions. Key changes include the introduction of a retirement age of 70 as from April 1991; use of Jarman indicators in considering manpower needs in deprived localities; GPs to be available for direct consultation for at least 26 hours over at least five days; newly appointed GPs to live within a 'reasonable' distance of the surgery; and FHSAs to be notified of GPs' other professional appointments.

Information for consumers

More information to be supplied — for example, medical directories must show sex, age/date of qualification, clinic sessions and practice staff offered by each practitioner. Special services (eg child health surveillance), languages and the availability of linkworkers may also be indicated. GPs to produce leaflets, changing doctors made easier and FHSAs to encourage consumer surveys.

Remuneration system

The new contract abolished a considerable number of established GP payments (such as seniority and childhood immunisation on a capitation basis) and modified the basic allowance and night payments system, as well as the higher capitation payment for patients over 75. The latter should now receive an annual home visit and assessment. New payments introduced include those for registration examinations of new patients; the achievement of defined immunisation and cervical screening targets; minor surgery; undergraduate supervision/education; child health surveillance; and health promotion clinic provision. Also, a deprived area supplement to the basic practice allowance was introduced, based on Jarman index measures.

Medical education

GPs are now entitled to a payment for each undergraduate medical student they are responsible for. As to post-graduates' medical education, they are entitled to receive a fee of a little over £2,000 a year provided at least ten half day education sessions are attended. However, travel costs and session fees must be paid from this, unlike the case previously.

Divided objectives?

Detailed issues related to some of the above are discussed later in this report. But in overview two main trends can be discerned within the NHS policy developments of the last few years. The first can be described as a move towards greater managerialism within the FPS. The reconstitution of the FPCs as Family Health Service Authorities (FHSAs) in September 1990, with new (reduced-size) authorities and general managers to run them, is its most obvious manifestation. The second is the emphasis given to the role of GPs as autonomous purchasers. Here schemes such as General Practice Fund Holding offer the prospect of family doctors — acting as purchasing agents for their patients — becoming more powerful direct guiding forces within the NHS as a whole, challenging and potentially over-riding bureaucratic control.

The FHSAs' responsibilities to play an active role in identifying and working to resolve in their localities problems of poor care are now explicit. In addition to liaising with and supplying information to other agencies and negotiating with service providers during the processes of planning, they have the authority to intervene directly in several ways. One example of the latter is their ability to employ facilitators to advise, support and help change the behaviour of practitioners in given contexts (Allsop 1990). Their control over the now cash limited resources for the GP ancillary staff and premises development schemes are a second. And the FHSAs' capacity to 'regulate by consent' in areas such as payment for health promotion clinic provision is a third.

The placement of FHSAs alongside DHAs in structures coordinated by Regional Health Authorities can be seen as a further aspect of the apparent move towards a more unified, 'managerialist' approach to health care delivery in Britain. However, the 'Working for Patients' reforms also contain considerable emphasis on the desirability of splitting health care purchase and supply functions within the NHS, and through the exercise of enhanced user and purchaser choice of creating competitive motors of service development. There is now good evidence that enhanced quality in hospital care should result from such extensions of 'consumer sovereignty' in the NHS, provided that adequate information on issues like operative and post-operative mortality is made publicly available (Luft et al 1990).

Here then, GPs seem well placed to continue their independent contractor role, responding flexibly to their patients demands in the pattern of care they themselves provide and acting as proxy consumers in relation to secondary and other forms of primary/community support. They have traditionally exercised informed choice in selection where to refer patients. In future circumstances where such decisions lead to pro-rata financial transfers (and where in the case of GP fund holders family doctors pay from their own allocated resources) primary care providers should become a major driving force for change throughout the rest of the NHS.

Ideally, any transition to the latter situation will be guided by RHAs, DHAs and FHSAs in a balanced manner, so that undesirable disruption in sectors such as the acute hospitals is minimised and the power of existing authorities is only slowly phased down. In this scenario initial moves to strengthen managerial — that is, strategic — leadership as part of a policy ultimately to reduce dependence on bureaucratic — unduly interventionist — planning and administration may be seen as part of a logical approach. But it carries a risk of perverse outcomes, and demands a great deal of vision and commitment on the part of NHS managers. If they cannot achieve this it may paradoxically end up weakening primary care providers.

For example, some individuals in positions of authority in the NHS are presently so concerned about the potentially destabilising effects of initiatives such as GP fund holding that they are trying to ensure that relatively rigid local contracting and allied 'co-ordinating' arrangements minimise the financial problems they believe might damage the secondary care sector. Although the government's December 1990 decision to slow the full introduction of weighted-capitation funding at the Regional level may have allayed some fears, distrust of and hostility towards the introduction of a partly primary care driven system of resource allocation is not uncommon amongst traditionally minded NHS staff and authority members. In the short term at least their response may effectively be to reduce the scope for choice enjoyed by NHS GPs (and so indirectly their patients) in the past.

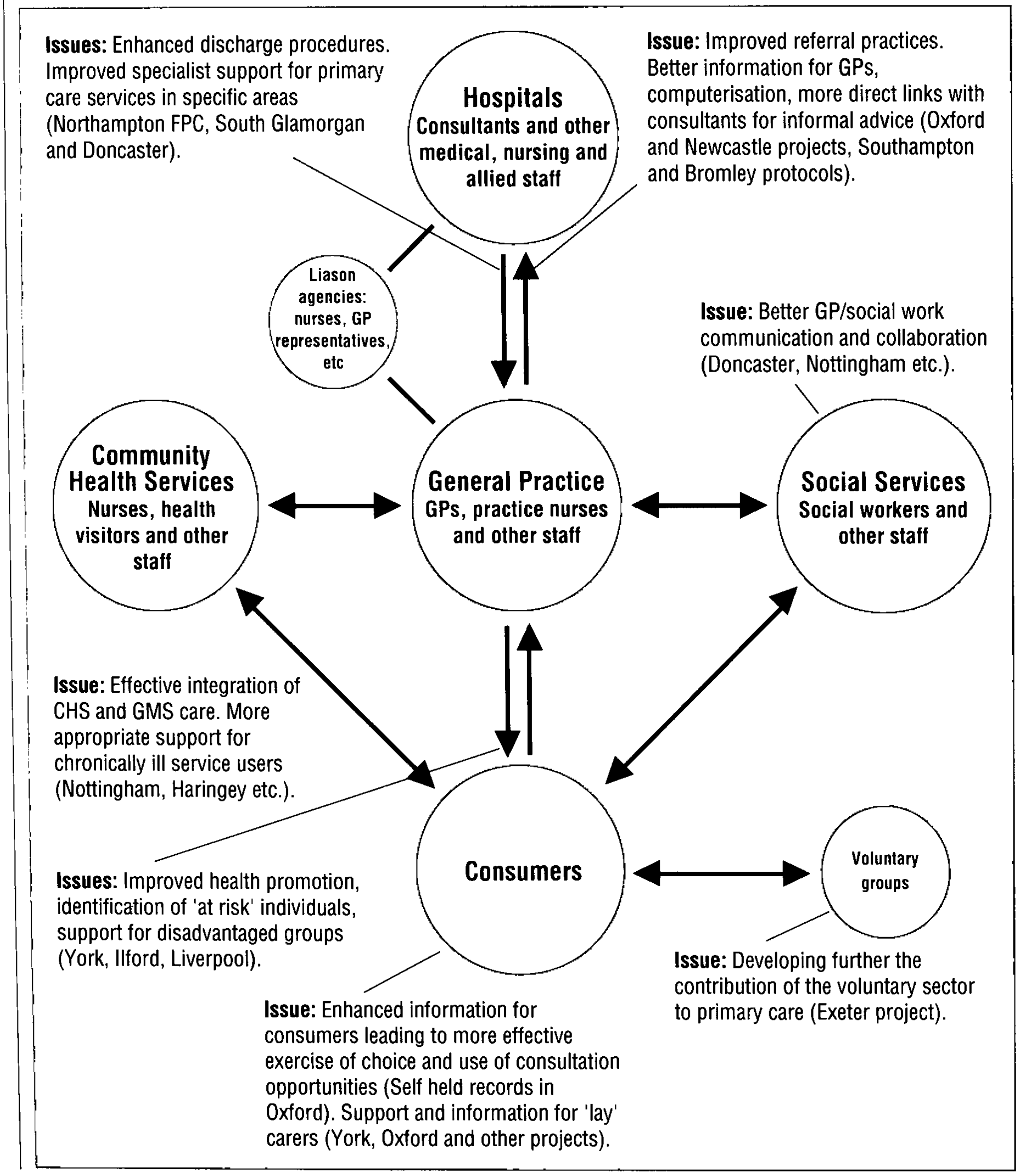
Such concerns should not, of course, be exaggerated. Nor should they be allowed to draw attention away from the other considerable challenges facing professionals such as family doctors. The latter are simultaneously being asked to show increased entrepreneurial drive; to share power with other co-workers; to accept more direction from FHSAs; and to preserve their traditional 24 hour a day commitment to their patients. However, in examining the findings of the Primary Care Development Fund initiatives and the options they raise for the future of British primary health care all the various pressures being created by the introduction of the 'Working for Patients' and 'Caring for People' reforms need realistically to be appreciated. Otherwise too great a gap between what are seen as desirable goals for the coming decade and what in practice is likely to be achievable could easily emerge.

2 The Primary Care Development Fund projects

Box 1 (page 4) and the Appendix to this report provide overviews of the nature and key findings of the 14 PCDF projects supported in 1989/90. Figure 6 offers a visual guide to the issues the studies raise. In essence, the latter comprise:

- opportunities to improve patients' access to care in the contexts of a) initial GP contact b) other services in the community obtained via GP contact c) hospital care following GP contact and d) GP and other community service care

Figure 6 Opportunities for care enhancement



received after discharge from hospital;

- opportunities to improve cooperation and the effective 'sharing of care' between doctors and other service providers, including consultants, nurses working in the community and hospital/community liaison posts, health visitors, midwives, community psychiatric nurses and social services staff;
- opportunities to raise clinical and patient support standards in the context of conditions and services like (non-insulin dependent) diabetes, epilepsy, childhood asthma, depression and antenatal care;
- opportunities to promote an enhanced sense of confidence, self-esteem, control and/or ownership amongst individuals involved in primary care, whether they be patients or service providers.

The mechanisms for attaining objectives relevant to these areas range from improved formal methods of practice organisation, record keeping and inter-professional information exchange through to the development of new roles for primary care staff such as practice nurses; the introduction of more effective screening procedures; the extended use of treatment protocols and self-audit and peer review techniques; increased patent participation in record holding and therapeutic decision making; and the build up of better communication networks between professionals and consumers. The discussion below draws from all the first wave of PCDF studies (and interviews conducted with project organisers) to show how in practice positive progress might be achieved. It begins with issues related to hospital/GP interaction, and then works on through those indicated in Figure 6, finishing with matters relating to individual service user and provider confidence and satisfaction.

Referral to hospital

Every year in the United Kingdom there are about 8 million hospital inpatient admissions and over 60 million outpatient visits. Of the latter approximately a third are classified as 'new'. Although a proportion of this workload is the result of direct, emergency, hospital admissions, inter-hospital transfers and outpatient department initiated repeat visits, a dominant determinant is the rate and pattern of GP referral.

The behaviour of family doctors in this area is thus a matter of significance for everyone concerned with the NHS. This is not only because of the 'Working for Patients' reforms and the managerial and financial implications of the shift towards 'weighted capitation' funding touched on earlier. It is also vitally relevant to patient wellbeing (and convenience) that referrals should be made appropriately. 'Too low' a propensity to refer, it may be argued, could result in late or under treatment. 'Too high' a rate could waste NHS resources and patient time, and increase the likelihood of inappropriate specialist interventions. (But it is worth stressing immediately that the achievement of optimal referral patterns is not merely a matter of volume: a clear understanding of why practitioners select which patients for further investigation and/or treatment is needed — Wilkin 1990.)

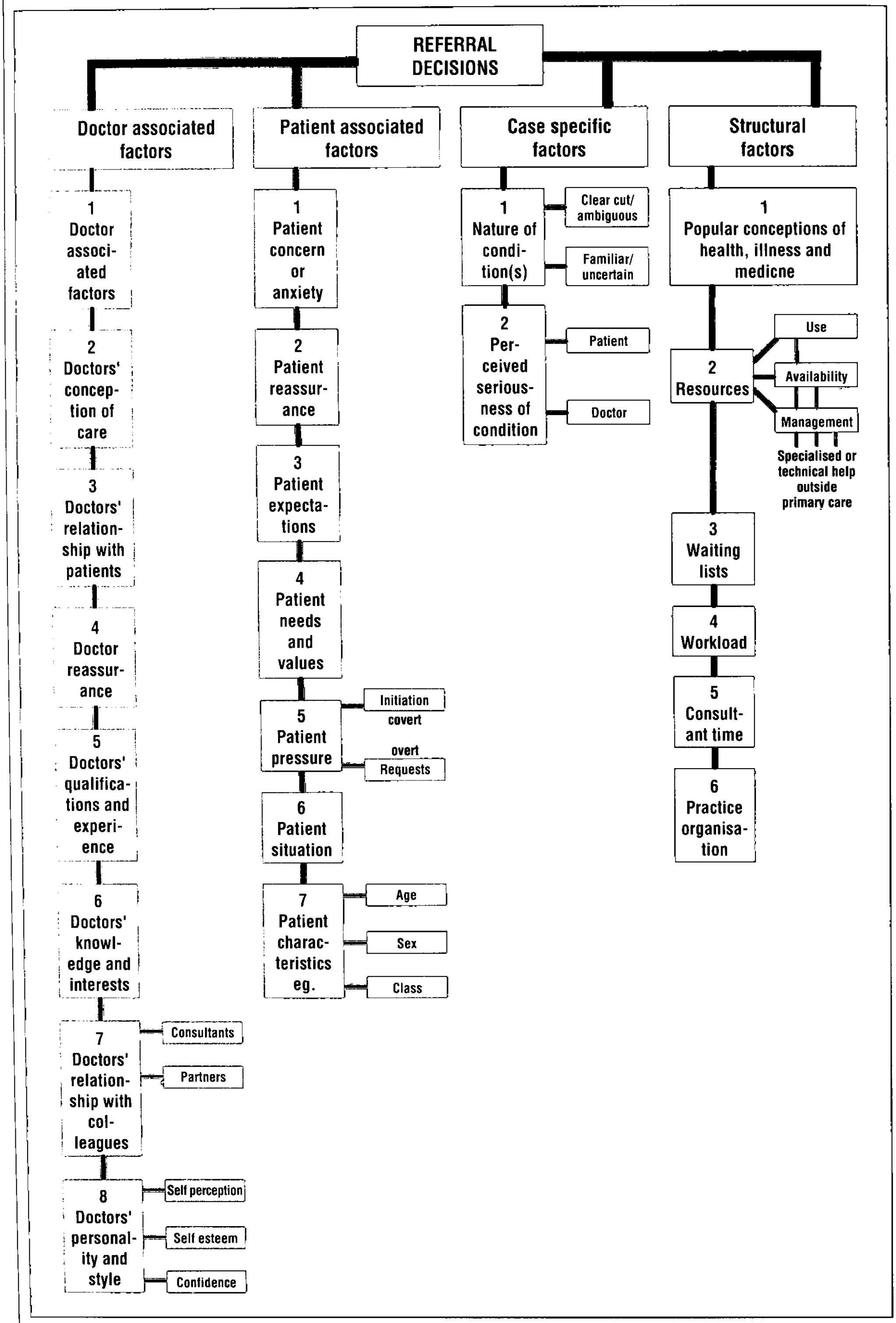
The wide differences in the frequency of referral between practices thus appear worrying. It has been argued that the sometimes claimed 20 fold plus variations in such rates are an exaggeration, and that a more accurate work-load and practice structure adjusted figure is in the order of three to four fold. (See Armstrong et al 1988, Noone et al 1989, Roland 1991). Nevertheless, this is still a substantial range; and it is of note that the PCDF supported Southampton project on dyspepsia (Jones et al 1990) in fact found a more than ten fold workload adjusted range of referral rates for gastro-enterological problems. It reported similar variations in prescribing, both in cost and volume terms.

Several of the other PCDF projects help to explain why such differences exist, how significant they are, and what may — or may not — be done to reduce observed ranges. For example, Hutchinson et al in Newcastle, in their 'ethnographic' study of the qualitative aspects of referral behaviour, identified four main groups of factors influencing referral decision — see Figure 7. Building on the earlier work of observers such as Dowie (1984) they emphasised influences such as differing GP confidence levels and coping strategies in the face of uncertainty, coupled with other variables related to patients, the complexity of their conditions and the services locally available/known.

The quantitative research conducted in Oxford by Coulter and Bradlow on the outcomes of GP referrals to hospital outpatient departments also indicated the importance of 'uncertainty containment' in the formation of referral strategies. Their findings, shown in Figure 8, together with other PCDF study results suggest that consultants sometimes underestimate the extent to which family doctors seek advice and diagnostic confirmation, rather than expecting them to initiate treatment.

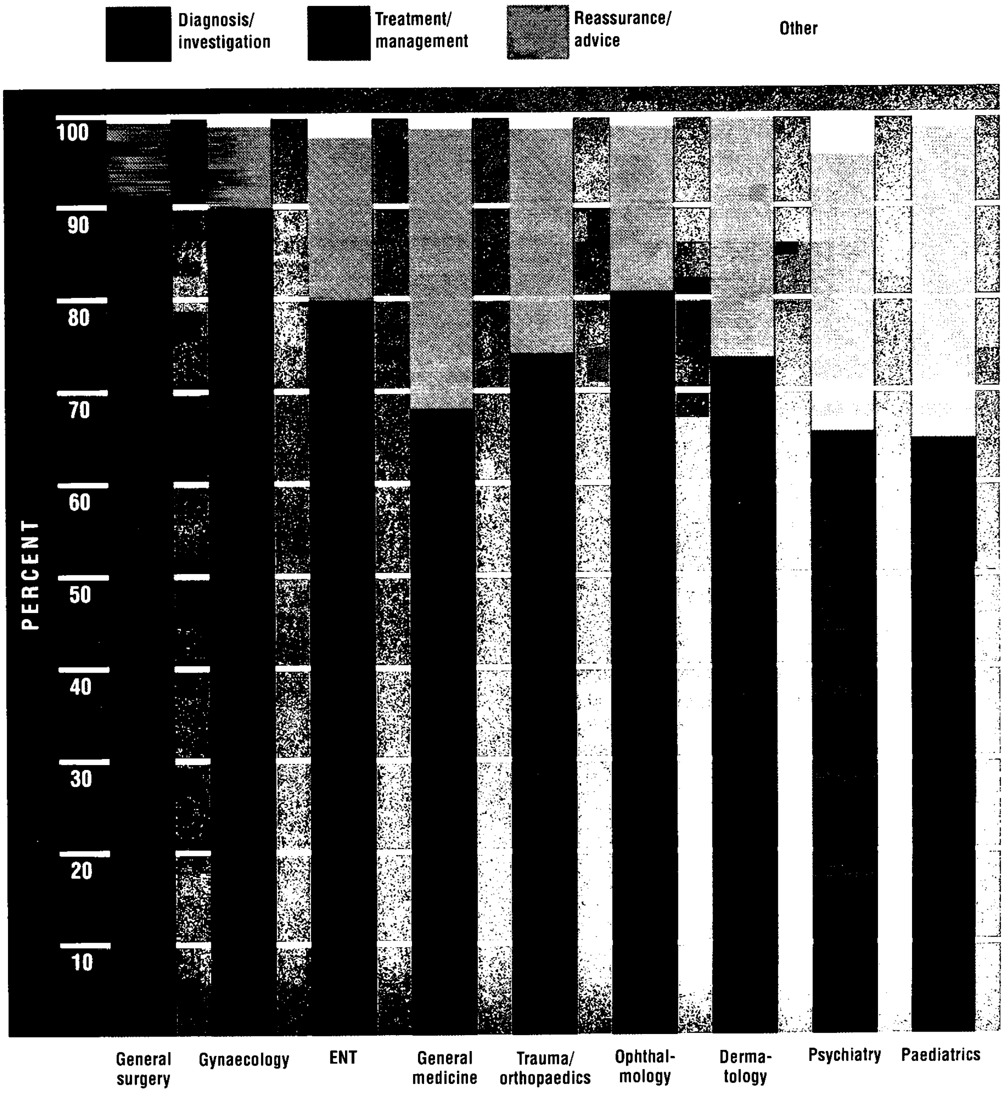
A preliminary conclusion to draw from the above is that it would be foolhardy to take too dogmatic a view of what the 'right' level of referral may be in any one practice or locality, much less for the country as a whole. The differing needs of individual practitioners and service users interacting in a complex environment and in

Figure 7 Factors influencing General Practitioner's referral decisions



Source: Hutchinson et al (1990).

Figure 8 Reason for referring patients to outpatient clinics by specialty



Source: Coulter and Bradlow 1990.

circumstances of considerable uncertainty will inevitably promote disparate referral behaviours, the end-point outcomes of which remain as yet largely unevaluated. The available evidence strongly supports the view that simplistic conclusions and policies should be avoided.

For instance, additional work from Oxford — which linked rates of subsequent hospital admission to outpatient referrals — indicates that for most specialties referral rates from GPs and admission rates by hospitals are positively correlated (Coulter et al 1990). This may throw some doubt on suggestions that practices with higher rates refer unnecessarily, although an alternative explanation could be that a substantial proportion of admissions are also questionable.

But in any circumstance some constructive rationalisation of referral processes should be possible (Coulter et al 1989b). Box 5 indicates the nature of the investigations needed to accomplish this within an audit framework. And even in the short term the research supported by the PCDF in Newcastle and Oxford, together with specific condition oriented studies and practical development programmes in areas like epilepsy, diabetes, dyspepsia, antenatal care, childhood asthma and haemoglobinopathies, provides a number of strong pointers as to how progress

5

AUDIT MANAGEMENT AND QUALITY ASSURANCE

Recently, terms such as medical audit, practice management and quality assurance have become accepted parts of health service 'jargon' (Hughes and Humphrey 1990). However, their definition is often unclear, and they may sometimes be subject to an undesirable degree of mystification. Briefly put, all three terms relate to the establishment of systematic processes for identifying objectives, assessing individual or unit performance, and then finding ways of improving the latter and/or redefining goals in a more appropriate manner. As such they may reflect an attempt to create cultures based on principles of continuous performance enhancement, rather than traditional static models which call merely for the occasional cathartic elimination of 'bad apples'.

Figure B5.a The audit cycle

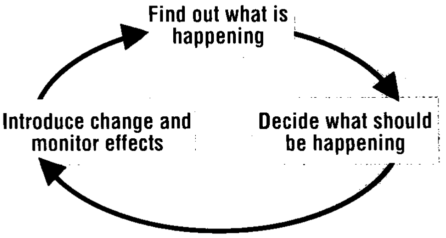


Figure B5.a outlines a basic audit cycle, which could involve:

- **defining standards, criteria, targets or protocols for good practice against which performance can be compared;**
- **systematic gathering of objective evidence about performance;**
- **comparing results against standards and/or among peers;**
- **identifying deficiencies and taking action to remedy them;**
- **monitoring the effects of action on quality.**

Figure B5.b The management cycle

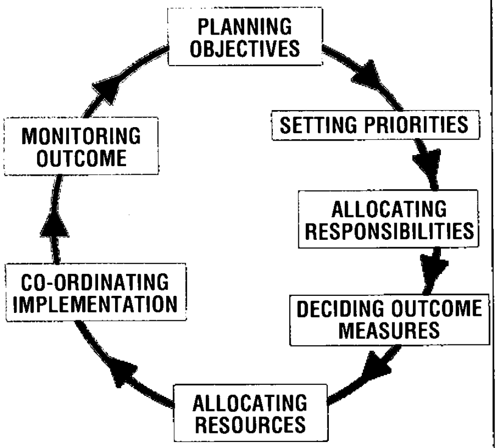


Figure B5.b outlines a model management cycle, in which achievement of quality is regarded as an all pervading, integral, part of the activities of an organisation and its individual members (Irvine 1990). As may be observed, there is a substantial overlap between the processes described in the two figures.

Perhaps the only significant point to add here is that in the context of audit, the contributions of professionals and other staff to the care of most patients include those of many individuals other than doctors. As the discussion in later sections of this paper suggests, clinical audit encompassing all aspects of therapy and support may prove much more valuable than just more narrow medical audit activity. Also, studies which focus in part at least on (output) outcomes for patients are more likely to be genuinely useful than those which are mainly input oriented; that is, turned inwards towards the examination of professional activities.

towards improved GP/hospital collaboration in the context of referral might be achieved. Key points include:

- informal (and reliably open) contact routes between consultants and GPs are of importance in maintaining the confidence of the latter and reducing the need for early, perhaps unnecessary, hospital referrals. Exercises such as the production of treatment protocols do not in themselves seem to be particularly potent stimulators of behavioural change amongst family doctors, however useful they may be as educational aids for the individuals most closely involved. (See, for instance, the Southampton experience — Jones et al 1990.) But if in the process of creating them consultants and family doctors can form closer personal contacts, and shared understandings as to how hospital based staff can best support their generalist colleagues in day-to-day decision making, then the likelihood of promoting over time a more consistent and efficient pattern of referral will be increased. During the years ahead purchasing authorities should be careful not to disrupt existing communication networks, or to fail to make adequate provision for the encouragement of consultant provision of advice to GPs via telephone contact and other appropriated means. (In the longer term it is possible that locally agreed treatment protocols will carry with them legal implications — with unpredictable effects on issues like GP referral behaviour.)

- in some areas of medicine GPs may have either never had a full opportunity to gain appropriate clinical skills, or have in effect been de-skilled as a result of the policies of local specialist providers. The PCDF epilepsy treatment project and the work of its initiator Dr Malcolm Taylor is relevant to the former type of problem (Taylor 1980, 1987). Those involving the support of people with diabetes to a degree illustrate the latter (Hayes and Harris 1984, Smail and Stott 1990) although in some teaching hospital catchment areas teaching requirements may also have led to 'institutionalised over-referral'. The provision of physician staffed community clinics and of services offered by specialist nurses (again in clinics or through other direct patient contacts and/or education of practice based staff) may prove an effective way of enhancing local care delivery, and avoiding 'marginal' referrals. Given the workload and other factors sometimes inhibiting direct GP/consultant liaison, communication and learning facilitated by specialist nurses during their contacts with practice based or attached nursing professionals may well prove to be the single most important future path to the more efficient sharing of care responsibilities. However, care must be taken to avoid 'dumping' of difficult-to-manage patients on staff whose key role is to support and work alongside GPs, not to replace them.

Discharge from hospital

A major area of concern about the quality of NHS care and intra-NHS co-operation relates to hospital discharge procedures, especially as they affect older and other more vulnerable patients. The Northamptonshire FPC (1990) study highlighted a number of problems in this context, and also pointed to methods for their possible solution. They include:

- lack of full information in discharge letters;
- failures of hospitals to ensure that GPs received discharge notifications in good time;
- defects in drug and other supply policies, so that on discharge some patients did not have necessary items such as enough medication to last over bank holiday weekends;
- a requirement for comprehensive nursing liaison services to ensure that elderly and other people with special needs are fully supported during transitions back from hospital to home.

This research in addition showed a need for more involvement of GPs and/or other primary care staff in hospital discharge planning, so to facilitate a more 'seamless' pattern of care. In this, the measures need to achieve better discharge performances quite closely mirror those discussed in the context of rationalised referral. However, enhanced record keeping and individual care monitoring at the practice level should have a particularly important role to play in ensuring that patients are not 'lost' on leaving hospital. Desirable innovations in this area are closely linked to those necessary to facilitate better support of people with chronic illness in the community.

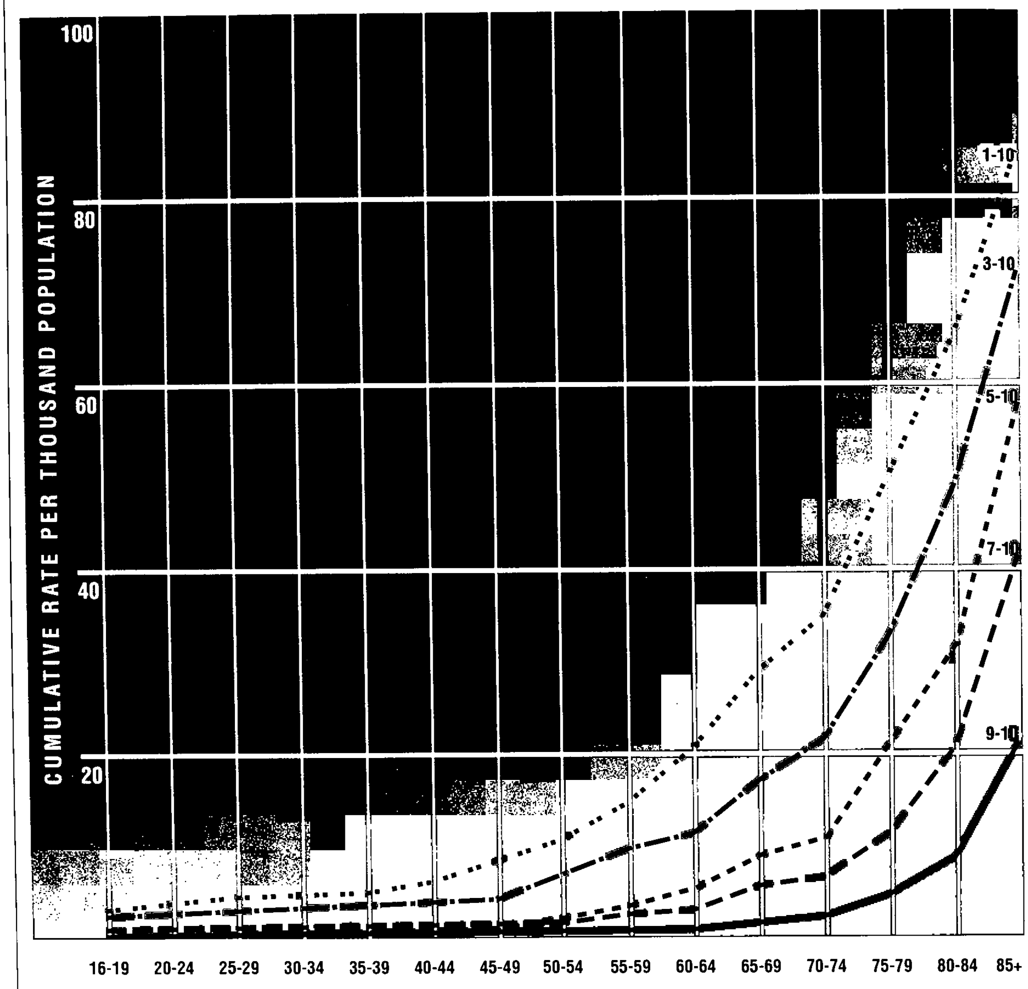
An important economic consideration to record here is that although GP referral practices are often seen as a major influence on NHS spending and patient wellbeing, failures on the part of secondary providers and their colleagues in the community to organise discharges efficiently could in fact be even more costly. Whereas 'unnecessary' referrals (which may themselves sometimes be a function of the seeming unwillingness of out-patient departments promptly and appropriately to pass the support of patients back to GPs) may often have low costs and some value for consumers and service providers alike, poorly organised discharges are clearly wasteful and may very seriously harm patient interests. There is evidence that they can eventually result in subsequent, otherwise avoidable, re-admissions to hospital (see Townsend et al 1988) which have considerable expenditure implications.

The support of individuals with chronic conditions

The 'ageing' of the population in countries such as Britain, coupled with the decline in the relative importance of acute infectious illnesses, has inevitably led to a rise in the perceived significance of the management of chronic conditions. The priority given to the latter has been increased because of growing social expectations that people should, despite impairments and disabilities, be entitled to live as full a life as possible 'in the community', and the partly related decline in the availability of NHS funded longer stay hospital places.

Research conducted two decades ago by local authorities in response to Parliament's passing of

Figure 9 Estimated prevalence of disability among adults in Great Britain by age and severity category



Source: OPCS 1988

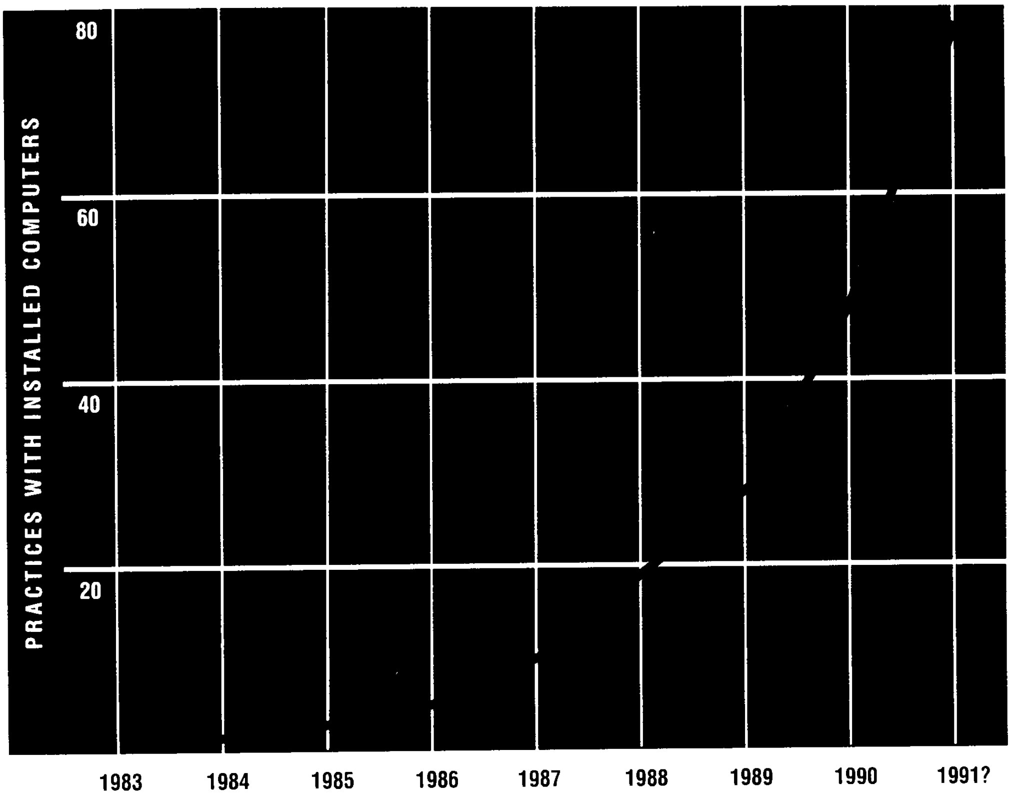
Note: 10 = most severe disability

the 1971 Chronically Sick and Disabled Persons Act showed that family doctors are the professionals most frequently in contact with, and known by, individuals with 'chronic care' needs. In the PCDF context the vital role of GPs in this area was perhaps most clearly shown by the field investigations and literature search conducted by Harding and Guthrie in York (Guthrie 1990). Their study focused on the support of people reaching the age of 75 amongst whom, Figure 9 shows, rates of chronic illness and/or disability are relatively high. But it carried with it important implications for all sections of the population. For instance, it identified informal carers of chronically ill people as themselves being at special risk of receiving inadequate medical attention and day-to-day support. (See also, for example, Parker 1990, Jones and Vetter 1984.)

The primary significance of the York research is that it convincingly demonstrated that a simple postal technique of first stage screening of the elderly population can effectively and efficiently help family doctors identify those at particular risk of having unmet care needs. This in turn suggests that the approach to this area introduced in the new contract might in future usefully be modified, a point discussed again later in this report. At this stage, however, the most important observation to stress is that more effective primary care systems for identifying the problems of individuals with chronic illness and co-ordinating their support would help to improve the quality of life experienced by a significant number of the community's least advantaged members.

First wave PCDF work relevant to this ranged from that touching on practice organisation and the

Figure 10 Growth in practices with computers



Source: DH estimates

maintenance of comprehensive patient record systems to that involving protocol development (see, for instance, the Bromley project) and the future role of practice nurses/nurse practitioners (particularly the work of O'Dowd and his colleagues in Nottingham). The specific condition oriented initiatives in Wales and Doncaster were also highly relevant to this area of care standard enhancement.

With regard to practice data handling, the rapid introduction of computer systems into general practice, illustrated in Figure 10, has provided reason for medium to long term optimism. Presently the capacity of many family doctors to use such resources in an optimal manner is, perhaps inevitably, limited — too frequently computers are being used only for relatively mundane tasks. But in time they could help significantly to improve both individual case management and overall practice service planning. In larger practices (and perhaps in future groups of smaller ones enjoying common service arrangements) non-medical practice managers may make a vital contribution to both information service/technology progress and service developments targetted at helping people in special need to obtain improved individual care.

A specific example of the type of innovation possible is that of computer held chronic disease registers. Although it currently appears that the accuracy of the latter in general practice is limited (Coulter et al, 1989a, found that only 72 per cent of patients receiving medication for diabetes were actually recorded as so doing on a sample of seven GP computerised registers: equivalent figures for asthma were 58 per cent and epilepsy 49 per cent) this should improve, perhaps particularly where computer usage during consultations is accepted. Notwithstanding the problems of confidentiality to be overcome, this could also lead to the creation of much more reliable FHSA/regional/national level morbidity and care need databases.

Turning to the area of treatment protocol development, the educative experiences derived by practitioners involved in work like that done during the Bromley LMC and Haringey DHA projects is clearly of value. Eventually, the use of protocols could help reduce hospital workloads not only by limiting the numbers of 'unnecessary' referrals, but also by cutting the need for duplicative investigations. However, as noted earlier in the context of referral, significant changes of behaviour amongst most practitioners are likely to require explicit, positive linkage between the 'ideal' patterns established by such investigations and the day-to-day incentives and structural restraints affecting individual practitioner behaviour.

In this respect, the PCDF supported study by the group based at the Queen's Medical Centre in Nottingham is arguably of special interest. It addresses centrally the role of practice based nurses in the care of people with chronic illness. Working within agreed guidelines in fields such as hypertension and asthma, the participants in this study are in effect testing the extent to which nurses can — acting to a substantial degree as independent practitioners — extend their primary care responsibilities to the overall benefit of chronically ill (and other) patients. The evidence produced so far suggests that the role of practice nurses can successfully be expanded (O'Dowd et al 1990).

Questions relating to the options for the future provision of community nursing are addressed in a later section of this report. Here, the main understanding to highlight is that the creation of a more integrated general medical and nursing service could offer many groups of NHS patients a real prospect of enhanced treatment during the decade ahead. Effectively unified family doctor and nursing primary provision at practice level might well provide not only more cost effective patient support, but also an improved balance between 'caring' and 'curing' oriented interventions in the primary sector.

The value of specialist nurse hospital liaison support and back up to practice based doctor and nurse expertise was illustrated well in both the South Glamorgan diabetes and Doncaster epilepsy reports (Box 6). These exercises also indicate how improved services in one area of general practice may also have significant 'knock-on' effects in others. For example, at a fairly simple level careful attention paid to foot-care needs amongst people with diabetes can enable practices to gain better chiropody for all patients who require them, not least as a result of the service access knowledge built up.

In the case of epilepsy, one group of individuals prone to experience it and who are particularly likely to benefit from enhanced primary care is that of individuals with learning disabilities. Often the medical needs of the latter tend to be not fully recognised by family doctors (Howells 1986, Taylor and Taylor 1986/1988, Wilson and Haire 1990). The 'skilling' of general practitioners such that they are better able to treat epilepsy could provide them with more confidence about their overall ability to help patients with intellectual disabilities, as well as the many other individuals who have epilepsy.

6

PRIMARY CARE SERVICES FOR SPECIFIC CONSUMER GROUPS

Experimentation with forms of provision designed better to link the particular skills of secondary service providers with the accessibility and broader support offered by primary/community care professionals is most widespread in the context of diabetes. In addition to the Glamorgan project supported by the PCDF, other initiatives have been reported in areas such as Camberwell, Sheffield and Wolverhampton (MacKinnon 1989, Evans 1991).

There is little doubt that extending general practice based services for the approaching 500,000 people with diabetes in the United Kingdom could increase their quality of life, and may possibly help delay the onset, or reduce the prevalence of, its potentially disabling sequelae. Even though there is fairly strong evidence to the effect that more attention paid to diabetic care in general practice will tend to increase prescribing costs (Teeling Smith 1990), and will probably demand the employment of additional nursing staff in both practice and hospital/practice liaison roles, resources might also be saved. This applies not only to hospital out-patient departments but also in relation to in-patient admission rates (Farmer and Coulter 1990).

With less prevalent conditions the viability of creating enhanced care provisions in each practice is likely to be more limited, although the need for enhanced primary care may be even greater than that with diabetes. There are, for instance, probably 300-400 thousand individuals with active epilepsy in the UK, of whom 10-20 per cent have a severe, intractable, form. But standards of treatment in general practice may frequently be of limited quality. The significance of the Doncaster project in this area was that it demonstrated a means of both supporting and supplementing family doctor services to a patient group with a wide variety of different, and on occasions very pressing, problems. Once again, community nurses played a critically important role in achieving such an end.

Examples of other areas in which augmented primary care might make major contributions to improved care standards include 'reactive' anxiety and depression, asthma, stroke, obstetric care, incontinence, and the support of terminally ill patients. The haemoglobinopathies and AIDS exemplify rarer conditions which are of particular significance in some localities, and so could require more specialised forms of primary care enhancement.

Facilitating health promotion and case finding

The ability of general practitioners to maintain their patients' health to the best possible standards depends not only on the skills necessary correctly to diagnose and to decide on therapy when patients happen to present themselves. It also demands that they are able to identify those at risk of becoming ill and initiate protective social and/or medical interventions wherever possible. Further, family doctors should be able to institute curative or ameliorative therapies as early as possible in those contexts where such action may circumvent more serious illness or subsequent functional loss.

Several of the provisions of the new GP contract were designed to enhance health promotion and early case finding in primary medical care. Relevant examples include:

- additional payments made to family doctors working in disadvantaged localities;
- incentives for home visiting and assessment of patients aged over 75;
- child health surveillance fees;
- health promotion clinic fees;
- new registration fees linked to health checks on new patients, plus service requirements explicitly demanding health checks on working age adults and 'young elderly' people at least once every three years;
- new practice information and annual report production obligations, designed to enable patients to identify practices with services relevant to them (languages, link workers, etc) and health authorities to plan and allocate resources more effectively.

Aspects of the PCDF studies are relevant to nearly all these areas. For instance, with respect to care provision in disadvantaged communities the report of the Haringey Health Authority project (Gregory 1990, Zahir 1990) clearly brings out the special

Table 2 Extremes of health and deprivation in Haringey (1981)

	5 'worst' wards	5'best' wards
All deaths under 65 (SMR)	116	77
Permanently sick persons(%)	2.5	1
Unemployed persons(%)	13.3	7.4
Overcrowded h/holds (%)	7.6	3.4
Council & Housing Assn. h/holds(%)	52.8	13.5
H/holds w/out bath or inside WC(%)	4	0.8

Note: all 'worst' wards located in Tottenham, all 'best' wards in Hornsey. Total number of wards in Haringey 23.

Table 3 Haringey health-related social characteristics (1981)

	Hornsey & Wood Green	Tottenham
Social Class IV & V (%)	11.8	20
Residents over 65 (%)	51.6	48.4
Residents in h/holds headed by someone born in the New Commonwealth or Pakistan(%)	20.2	37.4
Children 0-15 in above h/holds(%)	30.9	50.2
Average annual fertility rate per 1000 women 15-44 (1981/5)(rate)	56.9	70.2

Table 4 Primary care practitioners in Haringey (1987/88)

	Hornsey & Wood Green (pop. 100,974)	Tottenham (pop. 101,676)
General Practitioners	84	51
Pharmacies	37	20
Dentists	69	29

Table 5 Age and sex of GPs in Haringey (1987/88)

	Principals			Age		
	Male	Female	Total	<40	40-59	>60
Tottenham	37 73%	14 27%	51 38%	7 14%	28 55%	16 31%
Hornsey and Wood Green	55 66%	29 34%	84 62%	23 27%	43 51%	18 21%
TOTAL	92	43	135	30	71	34

Note: average list size in Hornsey 2,071. In Tottenham 2,434.

Table 6 General Practice partnership size in Haringey (1987/88)

	Single	2	3	4	5	6 or more
Tottenham	10 19%	7 27%	5 28%	2 15%	0 0%	1 11%
Hornsey and Wood Green	27 31%	11 25%	3 10%	2 9%	3 17%	1 8%

[Single-handed practices: Haringey 27%; NETHRA 20%; England & Wales 15%]

Source for tables 2-6: as quoted in Constantinides 1989.

problems faced by service providers and users in poorer parts of cities like London. A simple example is that some practitioners appear to be reluctant to carry powerful analgesics with them to use in home management of pain associated with sickle cell crises. They fear theft and contributing to local drug abuse problems.

At a more sophisticated level Constantinides (1989 — this study in Tottenham provided an important starting point for the PCDF supported work in Haringey) showed the distribution of general practices within broad areas may be subject to the 'inverse care law'. That is, less attractive districts populated by people most in need of good primary care may actually have fewer, less well staffed, practices than more affluent parts of the same larger locality. Tables 2-6 reflect Constantinides' observations.

It is of course possible for some patients to travel to family doctors' surgeries located some distance from their homes. But in general the poorer and less able people are the less there is a chance for them to do this. Hence active encouragement of consumers to choose 'better' practices cannot substitute fully for an equitable geographical distribution of the latter. In time new financial incentives for GPs could help correct such distortions, but concern must remain that the notably even distribution of family doctor services recorded at FHSA and Regional levels (see Figure 5, page 9 and Table 7) has not been satisfactorily achieved at locality level.

Future issues for consideration by primary care policy makers therefore include the role of the Medical Practices Committee (MPC), which currently helps control general medical practitioner numbers and their distribution, and the desirability or otherwise of the underprivileged area payments introduced in the new contract. There are some concerns that poorer areas have not had their needs for primary care provision fully recognised, and that the new UPA payments may on occasions offer doctors in such areas a perverse incentive to seek to run large list practices with minimal services. The introduction of some form of local performance targets, rather than payment of automatic deprivation compensation, may prove desirable — see page 35.

However, even if the geographical/social distribution of primary care facilities improves, this will obviously not in itself ensure optimal health maintenance. Effective techniques of risk identification, screening and patient education must also be introduced. Here, as Holland and Stewart (1990) have recently commented, considerable opportunities for service enhancement exist. This is arguably especially so in relation to the support of elderly people and the very young, but it applies in one way or another to all age groups. For example, the pioneering work of the Oxford Heart Attack and Stroke Project has shown how nurse facilitators can, via relatively simple developments in practice record keeping linked to systematic patient call and personal interview arrangements, contribute not only to better cardiovascular care but to many other forms of prevention (Fullard et al 1987, Fullard 1988).

The PCDF supported work of Guthrie and Harding validated (as noted above in the context of chronic illness) the usefulness of a simple postal screening system as a cost effective means for general practitioners to monitor the functional health status of elderly patients. The self-reported data generated in response to the questionnaire they used cannot in themselves be used to diagnose any specific condition. But they can be taken as a reliable guide to those who are likely to be in special need of medical or social support, and may be of value in the early identification of individuals whose condition is on the verge of a rapid decline.

The York based researchers noted that over 90 per cent of high scorers amongst the 75 year old respondents had seen their doctors in the past year, and over 55 per cent had consulted her or him in the past month. Given this level of existing regular contact between family doctors and their elderly patients, and the potential of tools such as that used by Harding and Guthrie to identify those at special risk, some aspects of the new contract's requirements for screening all over 75s annually appear questionable (Harding 1990). In time a more flexible and selective approach could be shown to be desirable, at least in some localities.

However, against this Holland and Steward (op cit) argue that at present there is "an unacceptably large gap between the problems that exist in this age group and those that we identify and treat or help". In moving towards better performance, politicians and other national policy makers may well take the position that it is a not unreasonable step to try to ensure that family doctors visit — or arrange for others to visit — all their elderly patients in their own homes at least once a year and assess thoroughly their needs. The fact that in many cases this will lead to some duplicative effort does not necessarily invalidate the view that the overall benefits of such a requirement will justify its costs, particularly in the light of the substantive literature supporting the kind of assessment and regular follow up encouraged by the new contract (Rivett 1990). The correct approach at this stage would thus seem to be one based on a sustained evaluation of the impact of the 1990 arrangements.

Similar points may be made as to the health promotion clinic concept introduced in the 1990 contract. Several of those participating in PCDF supported work expressed, in interviews given during the preparation of this report, concern that

Table 7 Number of General Practitioners† (GPs) in each RHA per 100,000 population

	1977	1978	1979	1980	1981	1982	1983	1984	1985	1986	1987	1988e	1989e	Annual Growth Rate 1977-87
United Kingdom	49	50	51	52	54	55	56	56	57	58	59	59	61	1.6
England	48	49	49	51	52	53	55	55	56	56	57	58	59	1.6
Northern	45	46	47	48	49	50	52	53	54	55	55	56	57	1.8
Yorkshire	46	47	48	49	51	52	54	54	55	55	56	57	58	1.7
Trent	45	46	46	47	48	50	51	51	52	53	54	54	56	1.6
E Anglia	48	49	50	51	53	52	56	55	55	55	57	58	59	1.6
NW Thames	54	55	55	57	58	59	61	61	61	61	62	63	63	1.2
NE Thames	50	50	50	51	53	54	55	55	55	56	57	58	59	I .3
SE Thames	61	60	62	63	53	66	56	55	55	56	57	58	58	-0.6
SW Thames	41	41	42	43	53	44	55	55	56	57	58	58	59	32
Wessex	48	48	49	50	53	54	56	56	57	57	57	58	60	1.7
Oxford	47	47	48	49	51	51	55	54	54	55	55	57	59	1.7
S Western	54	55	55	57	58	60	62	62	63	63	65	65	68	11
W Midlands	45	46	47	48	50	51	53	53	54	55	56	56	58	1.9
Mersey	46	47	48	49	52	52	54	55	55	56	57	57	58	1.9
N Western	45	46	47	49	51	51	53	53	54	54	55	55	56	1.7
Wales	50	51	52	53	55	56	59	59	60	61	62	63	64	2.1
Scotland	59	61	61	63	65	66	68	69	70	71	72	72	73	1.8
N Ireland††	56	55	57	60	60	60	59	59	61	62	62	63	64	1.0

Notes
†Including restricted and unrestricted principals, assistants and trainees.
††Including unrestricted and restricted principals plus assistants.

Source: Chew 1989

perverse outcomes could stem from this arrangement. Rather than giving all the help they can when individuals present in surgery at a time and for a reason convenient to them, practitioners may ask patients to return later to a special clinic. Thus rather than extending the support given to people with conditions like, say, diabetes or those at risk of ill-health because of ill-advised smoking, dietary and other habits the new system could paradoxically impair it, particularly for those whose time and financial resources are most stretched.

The employment of practice nurses to give personal 'clinic sessions' to patients on an opportunistic basis — that is, immediately after 'normal' GP consultations — could to a degree avert this hazard. But even this is not necessarily desirable, and is not an option available to all practitioners and the patients who choose to consult them. Future primary care research projects could help to define the opportunities for improving the likely benefit to cost ratio of provisions in this area.

As a rider it should be noted that the available data already tends to indicate that amongst people invited to attend health check clinics (for cardiovascular illness) the likelihood of acceptance is inversely related to their risk exposure (Walker et al 1990). Such observations reinforce the view that effective health promotion cannot only be a matter of routine primary care intervention. On the one hand broader public health measures, such as dietary quality regulations, transport safety controls and tax led incentives for healthier lifestyles, are needed. And on the other carefully targetted initiatives aimed at finding and positively supporting those individuals and communities most in need are also vital.

The Buttsbury Estate centred project run by a PCDF supported group in Redbridge (Hunt et al 1990) is an example of work of the latter type. It emphasised the role that link workers can play in helping relatively disadvantaged individuals gain better access to GP and antenatal care. It also served to reinforce local awareness of the special needs of socially isolated women living in poorer housing conditions with young children, and of their vulnerability to depression (Brown and Harris 1978, Taylor and Taylor 1989, Hunt 1989).

Many of the women who received active assistance from the Buttsbury team were members of ethnic minorities. Broad generalisations about the health care available to such groups must be treated with considerable caution. There is, for instance, data indicating that in some contexts the overall rates of contact between GPs and individuals with ethnic minority backgrounds are unusually high (Cameron et al 1989, Gillam et al 1989, Balarajan et al 1989) although the meaning of this finding is uncertain. Explanations may range from the existence of greater than average health needs to the possible role of communication problems in generating repeated — but not necessarily satisfactory — surgery visits. For example, some evidence indicates that prescribing rates are not raised in line with those for consultations although even here it would be unwise to leap to any premature conclusion.

Nevertheless, at the locality level the Buttsbury project did find women from minority groups who were effectively cut off from the world around them, struggling to cope in alien surroundings and in some cases isolated by language as well as 'know-how' and confidence needed to access support services. In this type of situation the personal help provided by sympathetic link workers, coupled with user-friendly services such as locally available children's play facilities, appears to be of crucial significance. The health not just of the women involved, but also of their families, could well benefit considerably from further investment in such primary care and linked antenatal provisions.

This conclusion is supported by the findings of Dance (1987). She found (in a randomised controlled study in Birmingham) that the birthweights of babies born to at-risk Pakistani women were significantly raised as a result of link worker support. Compared with the relatively disappointing findings of the Liverpool antenatal care study supported by the PCDF (which showed no differences other than in certain aspects of record keeping between the quality of antenatal care provided in GP practices with or without community midwife clinics — Ross 1990) the Redbridge research indicates the logic in this context of closely targetting support to a relatively small number of service users in most need.

Enhancing consumer confidence and self-esteem

Maintaining a sense of personal confidence, of adequate control over events and of belief in one's own self-worth, is important for everyone. People facing the challenges of living with illness and disability, especially if these are compounded by factors like poor housing or low income, are naturally especially vulnerable to additional psychological distress. But so too may be individuals like doctors, nurses and social workers. In trying to support their clients and provide treatment, comfort and advice to them in often difficult, uncertain, circumstances, they are themselves exposed to stress.

The results of lost service user or provider self-esteem are likely to include further incidents of morbidity and premature mortality. Over and above the obvious risk of depression attempts to cope with life via, say, smoking and excessive drinking have well known health sequelae. Violence and allied forms of abuse within families may also be related to individual despair and loss of self-worth. Amongst professionals disputes about rank and authority associated with attempts to restore or maintain personal morale add to service delivery problems, and can directly disadvantage patients.

For example, hierarchical and authoritarian systems of organisation may in some circumstances help protect those acting within them from psychological threat. But they can also mean that those 'at the bottom of the ladder' — often the vital point of consumer/provider contact — feel under-valued, and in some way pass this sense of inferiority on to people using health or social services. Since the latter are already vulnerable to loss of self-worth this danger needs seriously to be addressed. A major challenge for the NHS and allied agencies in the 1990s is to find ways of effective management which allow all service providers and users to interact and co-operate in ways which mutually enhance their sense of self value.

In the context of the 1989/90 PCDF studies there were two which generated findings of special relevance to the topic of increasing positive consumer and community involvement in service delivery processes. First, the Oxford based analysis of parent holding of child health records by Kate Saffin, a health visitor with research interests (Saffin 1990, Macfarlane and Saffin 1990). Second, a West country based examination of the value of practice based or linked volunteer groups, which may augment primary care delivery on a locality by locality basis (Goodrick, White and Nisbett 1990).

The parent held records project demonstrated that nearly all parents are able and willing to take part in such a scheme. It also found that despite initial fears expressed by family doctors, once they had experienced it all professionals involved accepted parent record holding and for the most part came to prefer the arrangement. Immediate benefits included more thorough event recording by doctors and health visitors.

However, Saffin also observed psychological benefits to the parents taking part, related to an increased sense of involvement, control and responsibility. The symbolic, as well as the practical, significance of parent 'ownership' of their child's health records appears to have been considerable. The extension of this approach into other areas of care, particularly where service users and/or their family and other carers are at risk of feeling powerless to control their own futures, may therefore be worthwhile. In the changing health care climate of the 1990s the role of 'lay' carers is in any case likely to demand increasing attention and support.

Antenatal care, learning difficulties, mental health and the support of individuals with chronic illnesses — cystic fibrosis, multiple sclerosis, stroke and its sequelae, rheumatoid arthritis etc — are all examples of fields in which the practical possibilities for patient 'empowerment' might usefully be examined. The sharing of local treatment protocols and priority assessments with service users is another possible topic for exploration here, as is the extent to which patient record keeping might serve to open up new research opportunities in primary health care. At present the demands of confidentiality seem in some cases to inhibit the build up of knowledge about care standards and patterns, to a degree serving to protect less competent service providers rather than vulnerable service users.

Turning to volunteer projects, the work conducted by the Exeter based team, and supported by the PCDF, identified a considerable number of such initiatives. The research and development undertaken shows that those taking part in them can be enabled to make a unique, personal, contribution to wellbeing in their communities. As well as the practical forms of care they offer volunteers can give friendship to those they come into contact with which has a 'normal', everyday, value quite distinct from that of the support offered by paid professionals. (See One-to-One 1990.) Voluntary initiatives can also involve those who may themselves be in need of some forms of help in helping others, so removing the sometimes destructive division between the cared for and the caring.

In this respect the most important underlying role of practice level volunteer projects is arguably to provide a route to enhancing service user and provider self-esteem, and to allowing individuals to value themselves and those around them. As Prochaska (1988) has pointed out, the UK has a long and powerful tradition of voluntarism. It has frequently involved, and involves, disadvantaged people in the provision of mutual assistance rather than the rich donating philanthropically to the poor. The utilisation of such an engine in the pursuit of better primary care is clearly desirable from many viewpoints.

But there is also today an element of distrust associated with voluntarism in the minds of many people. Some professionals may fear that their position and tasks could be made more difficult by the intervention of well-meaning but relatively unskilled individuals. More seriously, perhaps, there is anxiety that the use of volunteers may in some ways serve to disguise or draw attention away from inadequacies in the statutory services available in areas like primary health and community care.

Such concerns are to be respected. Yet so too are the efforts of those who wish to ensure that the community's total resources, formal and informal, are deployed as effectively as possible in the pursuit of greater wellbeing. The most desirable way to resolve such problems is arguably to try to ensure that as far as is possible voluntary groups are organised independently, and that they retain a sense of their critical consumer support and lobbying roles as well as their direct provider functions. Volunteers are not merely a resource to be 'used' as a cheap, semi-skilled, labour by professionals such as general practitioners, however worthy the motives of the latter may be.

The conclusion to draw is that although service providers like doctors and nurses may play a seminal role in establishing local primary care (and carer) support groups, they should as soon as possible form independent management committees and where necessary have their own paid staff. The research done in Exeter emphasises that the employment of salaried co-ordinators is often a vital step in securing the longer term survival and coherence of volunteer practice support groups. They not only carry out administrative and volunteer training duties; they can also help provide the discrete structures necessary to allow volunteers to work and cooperate with professionals as fully valued and respected individuals.

3 Better primary care in the 1990s?

Looked at positively, the reforms currently affecting the British primary care sector should lead to very significant service advances. The net impact of the 'Promoting Better Health', 'Working for Patients' and 'Caring for People' proposals, debates and changes has certainly been to move general practice and community based care more centre stage. Issues like the maintenance of high practice standards amongst all NHS independent contractors, the improvement of practice level management and the encouragement of more health promotional activity in primary care have all received considerable attention.

Further, the establishment of Family Health Service Authorities alongside DHAs and within the overall Regional framework offers prospects of better community wide care delivery, both at individual and collective levels. Ultimately a fully unified approach to identifying and meeting primary and secondary care needs and public health requirements should be possible.

Set against this, however, the tensions and conflicts associated with recent changes appear to have imposed some heavy costs in terms of lost professional good-will, and consumer confidence. Doubts about the wisdom and viability of some of the new policies remain. For example, in addition to specific concerns existing about issues like the funding of health promotion clinics and cervical cytology in general practice (see Box 7), some medical practitioners appear to believe that FHSAs could develop excessive powers and inhibit unduly professional freedom.

Such individuals may argue that the strength of British general practice has since the mid 1960s stemmed from its concentration of highly trained, relatively well paid staff at the level of consumer contact. Operating with high degrees of autonomy and a strong sense of personal responsibility (in a crisis the practical reality is that the buck more often stops with the family doctor than any other community based worker) the model of care provided by GPs has essentially been one characterised by devolved authority, both operational (referral, prescribing etc) and social. For many NHS patients the GP represents the highest level of social contact they 'possess' as part of their ordinary life.

Proponents of this view warn against the creation of structures which might draw human resources, and associated status and power, 'upwards' towards levels of management/administration which are not directly accessible to, or thus satisfactorily accountable to, service users. This may be attractive in terms of creating structures which — in theory at least — are capable of assessing overall community needs, and of tailoring service provision to fit cash limits. But to risk sacrificing the fundamental elements of Britain's arguably successful primary care system for no clearly predictable gain would be foolhardy. The subtle working of balanced social systems may be disturbed in unpredictable ways by interventions which, however well intended, are relatively crude.

But advocates of stronger management in the British primary care sector stress that, to date at least, the costs of additional FHSA management development have been modest and its impact limited (Huntingdon 1991). They call for more investment in and recognition of the potential advantages of a more coherently directed community primary health care network, particularly in areas like inner-cities where the performance of existing arrangements can be questioned.

Similar areas of debate relate to matters ranging from the introduction of the indicative amounts prescribing scheme and General Practice Fund Holding to the future ability of health and social care providers effectively to work together. In respect to the first of these, for instance, there are some fears that although the scheme may be regarded as balanced and reasonable as formulated at Departmental level, regional or local administrators will tend to interpret it as demanding cheap drug therapy rather than the optimally cost-effective use of available medicines.

More disturbingly, there is even greater uncertainty about the future of community care. The Audit Commission in its 1986 report 'Making a Reality of Community Care' stressed the need for unified budgets to meet the requirements of particular groups of disabled and/or chronically ill service users. Yet current government plans do not provide this. Combined with the lack of 'ring fencing' of local authority social care moneys, this could mean that in future large numbers of vulnerable people will still tend to fall between formally defined health and social service provider/purchaser responsibilities. The implications of this for primary care professionals are considerable.

In time a more unified NHS structure might to a degree help reduce such problems, at least in terms of user need identification, although even

7

SEEKING EFFICIENCY IN HEALTH PROMOTION

Initial responses to the introduction of the target linked system for GP remuneration for cervical cytology and vaccination services were, as with other aspects of the new contract, mixed. But despite some problems with data collection and service delivery in very deprived areas the initiative has on the whole proved successful, certainly in respect to immunisation. The FHS primary care practitioners have shown they can and do respond to the establishment of clear performance objectives linked to appropriate incentive payments.

However, in other areas of health promotion, and particularly in relation to Health Promotion Clinics (HPCs), the beneficial impact of the 1990 reforms has been less immediately apparent. Certainly the activities of a significant proportion of family doctors have been altered by the introduction of HPC payments. Some reports have speculated about some practices being able to earn many tens of thousands of pounds from the latter, and of HPC related outlays being responsible for significant 'over-payment' of NHS general medical practitioners as a whole in 1990/91.

But as the discussion in the main text shows, some negative service elements may have been associated with the introduction of HPCs. Not the least of these relate to the possible undermining of GPs' incentives to transmit to and gain from maximum amounts of information from their patients during everyday 'opportunistic' contacts, and the fact that the most disadvantaged communities may be comprised of individuals who are the least able and/or willing to attend special health promotion clinics. A review of the cost-effectiveness of the new contract arrangements conducted at the Centre for Health Economics in York (Scott and Maynard, 1991) casts some doubt on the economic logic underlying the initial HPC arrangements.

In time it may be that the system could be adjusted to accommodate local targets related to the sociological and epidemiological characteristics of individual FHSA, or even more desirably specific practice, populations. (See page 35): The establishment of realistically achievable outcome goals in health promotion (such as, say, practice level smoking reduction targets on an age specific basis) would, though practically difficult to monitor and assess, arguably contribute much more than a system geared only to paying out for the holding of clinics.

Movement towards this type of approach will also help to overcome some of the difficulties associated with the system of underprivileged area payments for GPs laid down in the new contract. To the extent that these help to encourage able doctors to practice in needy areas, they are desirable. But if they merely serve to compensate doctors for failing to achieve goals in areas like health promotion without providing an incentive to enhance future care standards in an appropriate manner they might prove actively destructive. The worst case analysis might even be that some GPs have been given a perverse incentive to run large list practices in poor localities, offering minimum standards of support to their patients.

here there are attendant hazards. For example, the practical effect of the separate FPC/FHSA arrangements within the NHS has over the past four decades been to 'ring fence ' the independent contractor element of primary health care spending. If this protection breaks down without newly responsible bodies understanding the danger of, and being prepared to resist, primary care resources drifting into high cost hospital/ specialist services which benefit relatively few individuals, then the overall interests of the community could well be harmed.

The most appropriate response to this combination of opportunities and threats facing UK primary providers is not, of course, merely to try to resist change. Ideally, it would involve all sides, nationally and locally, working together to share information, agree common objectives and facilitate progress which benefits the population in the most efficient, equitable and — given high levels of uncertainty — robust manner possible. Yet to achieve this very effective leadership will be required, not just from the NHS Management Executive; in England much is likely to depend at least in the next few years on the development of comprehensive and appropriate Regional health strategies, endorsed by all key actors.

The work supported by the PCDF in 1989/90 indicates a number of the elements which might usefully be pursued in such initiatives; and the conclusion of this report examines how research in general medical practice and other areas of primary health and allied care could further inform and contribute to development. But before then two specific areas of immediate importance to the future of the sector are discussed. First, the emerging role of the new FHSAs. Second, the relationship between nursing and medical services in the community.

The future of the FHSAs

In the past Family Practitioner Committees and, before them, the Executive Councils were regarded by most NHS staff not directly concerned with their work as anachronistic institutions of little relevance to the health service and its patients. Such attitudes still exist today. And from an objective standpoint it should be accepted that many of the most important and interesting initiatives taking place in primary care delivery and management are, as the PCDF projects indicate, happening at the practice and other field levels. Nevertheless, today's FHSAs occupy a pivotal position in the NHS structure, from which they may influence significantly the evolving relationship between primary and secondary health care provision. Thus the as yet largely unanswered questions as to how FHSAs will perform and progress should be of general concern. Examples include:

- **how will the new authorities relate to local professional groups, and how will the latter respond to their reduced representation on them?** Previously, FPCs were sometimes seen as syndicalist bodies which tended to be professionally dominated, often with an especially strong Local Medical Committee presence. The effect of slimming down the new authorities, which now out of eleven members include just one doctor, is to alter this balance. (FHSA general managers are executive 'board' members, along with the Chairman, five other 'lay' members and three other local professionals). This could result in more effective managerial pursuit of public interests. But it might also mean that the benefits of professional knowledge are lost, in some cases to the detriment of service provision. A revitalisation of other forms of local professional representation might also in time occur, again with uncertain results.
- **how will GP fund holders and FHSAs relate?** This issue is already recognised as crucial, and to a degree threatening, by many in the NHS. The logic of GP fund holding must in time relate to increasing competition between hospital based providers, as well as between alternative types of general practitioner and allied community care provider. At present the behaviour of GPFHs, who by the mid 1990s may be caring for around half the population, can only be guessed at. But what is clear is that their influence would be a major force within the NHS. One possibility is that in future FHSAs may in some ways help to group together and give coherent direction to GP fund holder power.
- **will FHSAs purchase or provide services?** At present the role of FHSAs is to a degree ambiguous, although the majority of observers believe that the natural position of FHSAs is on the purchaser side of NHS relationships. However, if in future the health care system in the UK comes to be characterised mainly by NHS hospital Trusts competing in an environment strongly influenced by GP fund holders, there may be a growing need — at least in some localities — for community care provider agencies which link some planning, resource redistribution and actual delivery functions. This scenario to a degree depends on how in future community Trusts within the NHS develop, and whether or not they prove able to perform long term health and ability maintenance functions (as opposed to acute rescue and rehabilitation roles) in close collaboration with local authority, voluntary and other key agencies. (See also below.)
- **how will RHAs, DHAs and FHSAs work together?** In the past FPCs worked independently of Regions. Hence entirely new patterns of communication, co-operation and direction are having to be established. At first, the need for relatively firm Regional intervention may be high, both in terms of establishing strategic direction and in setting standards of practice. But over time too strong a Regional influence could negate the value of investing in local managerial and planning expertise. In the case of DHA/FHSA relationships a recent publication from the NHSME entitled 'Integrating Primary and Secondary Health Care' (NHSME 1991) places emphasis on the desirability of joint appointments between the two authorities, and of their creating joint health needs assessments, forming joint agreements on priorities and drawing up joint strategies and plans. In one area, Bromley, there is already an experiment which will involve the local FHSA general manager (a former social services director) assuming managerial control of the DHA as well.
- **if the present FHSAs prove to be transitional bodies, what will follow them?** Further unions between independent contractor/community care and secondary care purchase and planning may in a number of respects prove desirable. Yet unduly rapid structural development could further stress the NHS. A report published at the same time as the NHSME document referred to above ('FHSAs ... Today's and Tomorrow's Priorities' — Yorkshire Health 1991) outlined four possible future configurations (see Figures 11a-d); yet at its launch Duncan Nichol, the NHS chief executive, stressed that in the coming few years the main emphasis will be on making existing arrangements work well. But if further transitions are at some time to be made, either nationally or locally, it is important that they are conducted as smoothly as possible. In some ways it would thus seem appropriate for FHSAs to begin their existences by planning for such an eventuality. A related point here is that any future change of government could well lead to structural adjustments in the NHS. Although committed to preserving elements of the service purchaser/ service provider distinction introduced by 'Working for Patients' the Labour Party has expressed an intention to abandon GP fund holding and to end the separate existence of FHSAs.

A significant point to make here is that at present people associated with FHSAs are well placed to experiment, and to suggest new approaches to institutionalised problems. In a sense, their strength lies in the fact that their future is

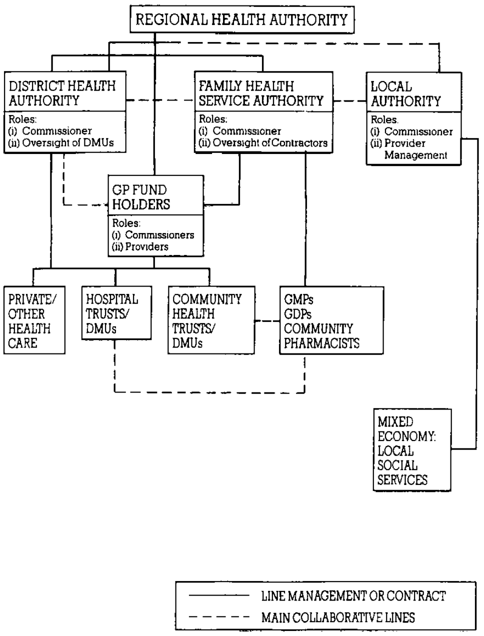


Figure 11a Dynamic status quo

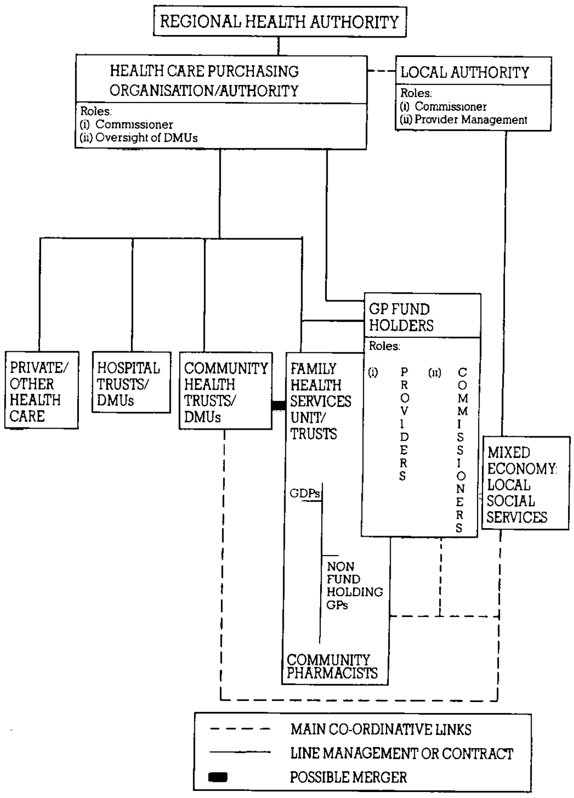


Figure 11b Commissioning HCPO/provider FHSU

Source: FHSA's; Today's and Tomorrow's Priorities. Yorkshire Health 1991

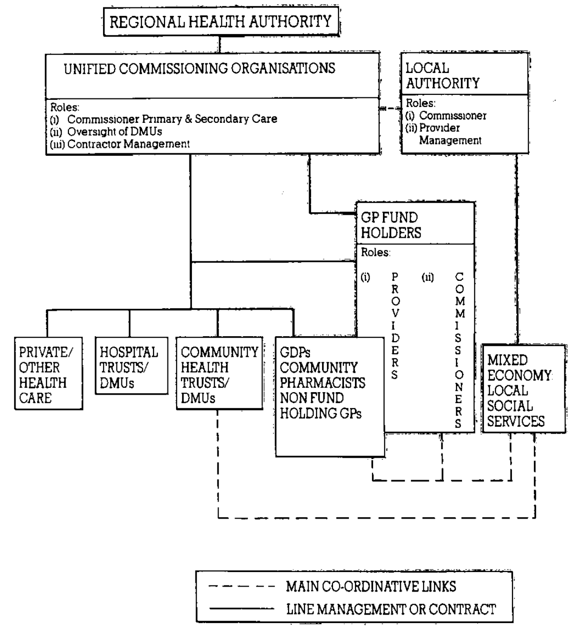


Figure 11c Unified commissioning

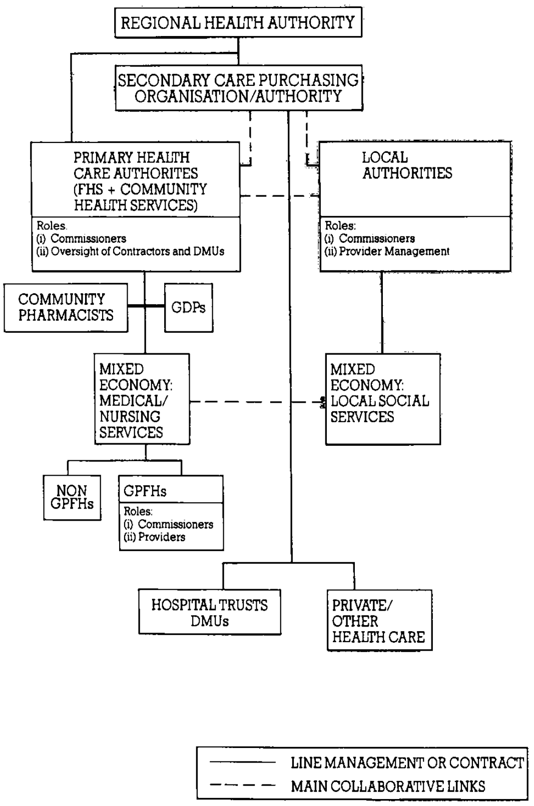


Figure 11d Primary health care authority (PHCA)

Source: FHSA's; Today's and Tomorrow's Priorities. Yorkshire Health 1991 uncertain. They have relatively little to lose by taking a degree of risk, and an incentive to be open minded in seeking ways forward. Provided the need to preserve the proven elements of the British primary care system is not neglected, health service users stand to benefit from increased flexibility — and openness — of thought amongst primary care managers.

There are already indications that senior figures in the health service will welcome original thinking, responsibly presented. The NHSME paper mentioned above comments, for instance, that the GP fund holding scheme might in time be developed in new ways, with FHSAs taking on greater responsibilities. It also notes that:

> *issues to be addressed will include those aspects of the contract and remuneration system which need adjustment to fit local circumstances and health priorities more closely. Consideration will also be given to whether greater discretion in managing the contract could be introduced to enable FHSAs to target efforts and resources on those practices and patients where there is greatest need.*

A related illustration of the type of issue which individuals in FHSAs might be able to help resolve is that of the in some respects counter-productive divide between health and social services. Recent attempts to clarify responsibilities (as well as to distinguish more precisely between 'free' NHS provisions and forms of social support chargeable to those able to pay) may not be successful in bridging gaps between logically complementary forms of care.

This prospect is disturbing, not least in that it could lead to a very substantial wastage of health service resources. It is of note that, as mentioned earlier, the MRC Epidemiology and Medical Care Unit, working in association with consultants from Northwick Park, reported in the late 1980s findings which suggest that the provision of fairly simple, short term, forms of social support can significantly reduce rates of hospital (re)admission amongst elderly patients (Townsend et al 1988). As well as helping to underline the frequently underestimated importance of discharge, as opposed to referral, practices in determining NHS workload and care quality, this research indicates the need for enhanced direct understanding in the experiences and practical needs of the health and social services' most vulnerable users.

The staff and members of FHSAs, together with the primary care professionals whose work they facilitate, could play a valuable role in identifying continuing LA/NHS care 'gaps', and promoting better arrangements. Indeed, even if they do nothing more than publicly and accurately to witness the consequences of failures to provide co-ordinated primary health and social support in the community for vulnerable individuals, families and groups, then the nation's investment in the new FHSAs might largely be justified.

Towards a general nursing service

The UK already has better standards of community nursing than those available in most other countries. The services offered by district nurses, together with those provided by their colleagues in areas like health visiting and community psychiatric nursing, are to a substantial degree as internationally unique (if less often recognised) as those of Britain's family doctors. Furthermore, the linkages between the latter and community nurses built up by staff attachments and allied initiatives mean that in many localities a good standard of collaborative working has already been achieved. And there are many ongoing projects aimed at still further improving community nursing. (See, for example, Hughes 1990).

But despite this background there is dissatisfaction with some aspects of community nursing provision, and community nurses themselves are reportedly in a state of 'deep malaise' (Hancock 1990). In some areas the level of family doctor and community nursing co-operation is not so advanced — see Box 8. And innovations in community nursing (such as the Peterborough 'Hospital at Home' service and similar initiatives, which can provide a high degree of domiciliary support to enable individuals to leave hospital early or — perhaps — to avoid admissions) have arguably been disappointingly slow to spread.

Morale amongst community nurses has been adversely affected by fears that they may be marginalised as a result of the current major reforms. For example, if the focus of provider attention is shifted too much towards freeing hospitals to achieve the highest possible numbers of operations this could undermine awareness of the value of community services designed to ensure the long-term wellbeing of patients in the community. It is probably because of such anxieties that some community nurses appear hostile to recent increases in numbers of practice nurses. Between 1988 and the middle of 1990 the total of the latter employed by GPs rose from approaching 4,000 to some 7,500 WTEs (NHSME 1991). The total number of district nurses is currently in the order of 14,000.

Commentators wishing to defend the existing DHA Community Health Service structure argue that its capacity to identify, co-ordinate and manage nursing care delivery in the community is a valuable asset, which any shift towards a more fragmented system would undermine. Some find the idea of more nurses being employed by family doctors extremely disturbing, particularly if this

8

PRIMARY CARE IN INNER LONDON

According to DH published Jarman Under Privileged Area (UPA) figures (based on 1981 census data) inner London contains some of the most deprived localities in the country. The validity of this view, and of aspects of the Jarman index itself, has recently been questioned (Davey Smith 1991, Carr-Hill and Sheldon 1991, Talbot 1991) and it is also of note that the pattern of medicine prescribing observed in inner London does not appear to co-incide with that observed in many other relatively high UPA scoring localities elsewhere in the country. However, this should not draw attention away from the fact that London has some unusually complex problems associated with the delivery of primary care which are not experienced in other parts of the country, and may have a particular impact on disadvantaged individuals/families/groups living in the capital.

These relate to the historic role of the London based teaching hospitals, which while conferring certain advantages on the community may have encouraged sub-optimal referral behaviours and drawn attention away from some primary/community care concerns; to the high costs of property and relatively unattractive living conditions now experienced by those resident in inner London, which may have deterred some doctors with a range of choices from settling there and has made it relatively difficult for those that do to develop good, adequately sized, practice premises; and to the complex local authority, DHA and FHSA boundary problems which exist in the most densely populated areas of the city. Pressures on teaching hospitals may have had a particular impact on less disadvantaged populations in London, which primary care developments have not yet necessarily compensated for.

The fact that there are high numbers of short-term residents and unusual, in certain cases newly formed, concentrations of people with special needs from other parts of the world also makes for unique care requirements. So too do problems like those of the homeless mentally ill, people who use illegal drugs, and those who are unfortunate enough to be affected by HIV/AIDS.

To the extent that collaboration between community nursing and social service providers and general medical practitioners is not as satisfactory in some areas of the capital as it is in much of the rest of the UK, such factors must be in large part responsible. A combination of high service demands (even in the case of the elderly population in central London whose numbers are limited, the isolation of urban life and poor housing available to the less well off may tend to increase dependency on public services) organisational fragmentation and limited primary medical care infrastructure (with relatively high numbers of one and two handed practices operating with small numbers of ancillary staff) is clearly likely to generate difficulties.

The most positive way forward is probably, first, openly to recognise the unique nature of 'the London effect' on health care delivery, not least to prevent London based observations from distorting policy-makers' views of health care needs in other parts of the country. And, second, to examine objectively and sympathetically not only the needs and expectations of London's health care consumers, but also those problems faced by its providers. The latter include, of course, not only general practitioners and NHS community services staff but also social services professionals, secondary care providers and those responsible for medical teaching. Only when all their disparate interests are understood are policies on issues like authority boundaries, NHS Trust structures and community (or community hospital) nursing care provision likely to be resolved in the London public's best interests. Without overt recognition of the special interests affecting the capital's health care system an objective pattern of health service purchasing will be difficult to achieve.

might result in their being 'used' as inferior 'bare-foot' physicians. However, the recent report 'Nursing in the Community', produced by a working party established by the NHS Management Executive, described a number of alternative models for the development of such services. (See also Constantinides and Gordon 1990). They were:

- stand-alone Community Trusts or DMUs. Here the unit manages all community nursing services in a locality, offering them to GPs, acute units, local authorities, voluntary agencies and independent sector purchaser/providers.
- locality management/neighbourhood nursing. In this scenario locally managed groups of community nursing and allied staff are deployed in given geographical 'patches', or around consortia of general practices, or based on health centres, under the overall direction of a unit or Trust.
- the expanded FHSA model. FHSAs act as agents for DHAs, commissioning community nursing services. Family doctors employ practice nurses, linking to more specialised FHSA commissioned provisions for additional and/or more sophisticated support. Primary Health Care Authorities or fully unified health care purchasing agencies might evolve from this approach.
- hospital outreach. Teams with a hospital based management system provide nursing care to specified groups in the community. Mental health and geriatric support services are examples of those which might be offered.
- GP managed primary health care teams. Practice based professional teams, working from either health centres, other large practices or groups of

> smaller ones could deliver all community health — and perhaps relevant social — services. The Management Executive report envisages GP management of the local enterprises so established.

'Nursing in the Community' did not prescribe any one definitive approach to the future development of the services it examined. This may in part have been due to conflicting interests affecting those on the working party involved, and in part to the common sense requirement not to impose further structural changes on a health service already under considerable strain. In the short term different models may suit different parts of the country, and it is arguably reasonable to allow flexible local experimentation rather than impose any one uniform top-down 'solution'.

However, there are limits to the extent to which 'laissez-faire' developments should be permitted within a national health service. For example, if variations in service structures were to mean that consumers or their representatives end up with no clear idea of what provisions should be available to them in their homes or immediate localities, or how to obtain them, this would be unacceptable. Even if the underlying organisational formats through which services are delivered vary, the experience of care received by patients should have consistency and predictability throughout the country.

A similar point applies to consumer confidence. Even if a complex, disparate array of service elements can be managed in a way such that it is actually 'all right on the night', this is not a satisfactory state of affairs if vulnerable service users and their carers are confused, and worried that they might not receive the help they need. One of the traditional strengths — and objectives — of the NHS has been its ability to relieve subjective patient anxieties about service access.

In this context it was noted in the introduction to this paper that the reported popularity of the family doctor service is linked to its familiarity. For most people for most of the time the GPs surgery is an accepted, trusted, 'front-door' to the NHS, via which they can obtain the health care they need. In looking to the future of the primary and allied community health services in Britain it seems sensible to build round this fact. There is a strong case for trying to as far as possible integrate community nursing and primary medical care in such a way that service users experience a continuity of and better defined focus of support throughout the various stages of their lives.

Although an enhanced role for nurses in general practice should not be achieved in a way which undermines their professional status — or stops patients obtaining direct access to their family doctor if they desire it — extensions of the activities of practice nurses into areas such as support of the chronically ill patients in their own homes may well prove desirable. Several of the 1989/90 PCDF projects demonstrate the potential of nurses significantly to enhance family practitioner care, although one warning note to sound is that some patients may at present be less likely to raise new or unusual clinical matters with nurses than they are with doctors (O'Dowd 1991). The key message to both groups of professionals central to primary care processes is that it is in their common interest, and that of their patients, to establish and agree the best possible — most cost effective and user friendly — ways of working together. Research designed to explore alternatives relevant to this goal (which might well ultimately involve nurse practitioners with extended remits in areas like limited list prescribing gaining partnership status in primary health care practices alongside doctors) could play a vital part in the development of better services during the 1990s.

4 Conclusions

During the twentieth century several quite distinct — if overlapping — systems of primary/community health and social care provision have developed in Britain. The family doctor services are the most important example of the independent contractor tradition within the NHS. The district nursing and health visiting services occupy a similarly key position relative to DHA managed community health care. And a third significant element within the overall pattern of support available is comprised of local authority social services. These have traditionally offered facilities which range from residential provisions and professional social worker assistance to home adaptations, home helps, and forms of home care such as assistance with bathing.

The evolution of these institutions has been fragmented and largely characterised by opportunistic reactions to other events within society, rather than coherent planning. But despite this — or perhaps even because of it — it has proved in the main fortunate for the UK population. Notwithstanding economic restraints limiting the extent and nature of the services offered in some specific areas, the British system is very comprehensive as compared to that available in most other nations. A strong, fairly evenly distributed general medical service exists. For most service users most of the time this is satisfactorily linked to other forms of primary care and the hospital based secondary service providers. And unlike the situation in many other countries, the status of primary doctors is currently high, a fact which should serve to benefit service users.

Nevertheless, during the latter half of the century growing emphasis has attached to the needs of consumers with complex inter-related problems. Instances include those commonly faced by older people with chronic conditions like arthritis, stroke and loss of mental faculty, or indeed younger individuals with only partially treatable forms of ill-health like cystic fibrosis, schizophrenia, multiple sclerosis or AIDS. A major challenge facing the NHS and other 'welfare state' agencies is better to integrate the care their various branches provide. Ensuring reasonably consistent standards of service quality and efficiency in each part of a highly disseminated delivery structure without introducing unduly costly, rigid or otherwise interventionist managerial arrangements is another.

The wave of far reaching changes now affecting the British health and social system clearly provides opportunities for improvements in such contexts. But it equally clearly brings threats to the established pattern of, in many respects successful, primary care services. For example, were general medical practices eventually be forced to group together into unduly large and anonymous units with large — but low status — supporting staffs, rule (rather than personal responsibility) dominated operational procedures, and an ethos of top-down management imposed by people without direct day-to-day care responsibilities, much that is good about the existing family doctor service would certainly be lost. The achievement of better primary care depends critically upon extending high levels of self-esteem and independent responsibility to all those involved in its use and provision, rather than merely the imposition of control from 'above'.

Similarly if financially hard pressed local authorities in some parts of the country are for one reason or another encouraged to withdraw forms of basic home care in the probably ill-advised hope that NHS community services will be extended to compensate for such action, then vulnerable consumers will suffer. Avoiding perverse consequences stemming from well intentioned ideas is particularly difficult in areas where there are high degrees of uncertainty. At present the reasons, and extent of justification, for many forms of primary care provider behaviour are poorly understood, as the work on referral rate variations quoted in this report illustrates. There is if anything an even greater lack of firm information about service user expectations and outcomes. Performance in the primary health and social care sector is difficult to assess because people in it frequently have to deal rapidly with ill defined phenomena and ambiguous patient demands/needs, in circumstances where the consequences of either errors or correct judgements may perhaps be of great significance but will probably not be easy to observe.

However, Britain is also fortunate to have an established tradition of research in general medical practice. Primary care is likely always to attract practitioners whose orientation is more towards 'energetic pragmatism' (Buckley 1990) and immediate problem solving than to academic reflection. Yet pioneers such as William Pickles (a Yorkshire GP whose observations on the spread of common acute infection in his country practice

9

KEY ISSUES RAISED BY THE 1989/90 PRIMARY CARE DEVELOPMENT FUND PROJECTS

ISSUE	AREAS FOR FURTHER INVESTIGATION
Nursing in general practice	Enhanced contributions from practice based nurses, effectively placing a general nursing service alongside the existing FHS general medical service, have been demonstrated to improve care for many groups. Problems remain, however, as to how best to achieve nationwide development, and particularly as to the extent to which the management of community nursing services can successfully be achieved within individual practice structures.
Local treatment protocols, primary care secondary care integration	Methods successfully for agreeing local treatment protocols relating to the handling a wide range of conditions have been pioneered. The challenge now is to build on these effectively to ensure that service delivery is improved. In addition to the contribution that practice based nurses may make here, the NHS Management Executive has recently indicated its willingness to investigate the possibilities open for adjusting locally aspects of the GP contract/remuneration system to fit local priorities and needs.
Special care needs in disadvantaged communities	Challenges exist as to both assessing accurately the extent and nature of special health and allied care needs amongst particular communities/families, and devising methods cost effectively to target and deliver appropriate support to those who require it. Important questions about the distribution of general practice resources and the future role of the Medical Practices Committee as opposed to that of local FHSAs will need to be addressed in the next few years.
Chronic disease registers, practice based information systems	Here again, the PCDF projects have helped to highlight the potential of a new approach - the problem is successfully to apply it throughout general practice. Development of comprehensive practice level records of the health status of their populations could be the most useful basis for developing broader pictures of health care need and district wide service delivery priorities, as well as for monitoring individual care requirements.
Screening elderly patients	Many GPs believe they already know the needs of most people on their list, including the over 75s, and a proportion question the efficiency of the non-selective annual assessment (and visiting) procedures demanded by the new contract. However, other medical authorities in the Department of Health and elsewhere remain convinced of the desirability of the arrangements recently introduced. Perhaps in time, given the obvious differences in the circumstances of people living in, say, richer semi-rural areas as opposed to poor rural or inner-urban ones, experimentation with locality specific alternatives will be judged desirable.
Health promotion clinics	The new contract arrangements have been questioned on the grounds of efficiency, and the fear that the individuals and localities most likely to benefit are those less likely to be in need of the services in question. Further detailed assessments of the impact of the health promotion clinics, and of how to benefit all sectors of the population with regard to disease prevention and health maintenance, are required.
GP referral behaviour	This clearly varies considerably, particularly within small populations of GPs with differing personal and practice needs. Some rationalisation of behaviour is likely to be beneficial for both service users and providers, but if this is pursued without an adequate understanding of why GPs refer it could create significant diseconomies.
Hospital discharge procedures	Inadequate inpatient discharge procedures may be considerably more costly to the NHS and harmful to its patients than 'unnecessary' GP referrals to outpatient departments. In this context monitoring of activity in each locality and management intervention designed to ensure the achievement of defined standards would certainly promote enhanced service performance.
Prescribing standards	It has been suggested that the number of GP consultations resulting in a prescription might desirably be halved (Harris 1991). However, the only PCDF supported study to produce firm data in this area showed that the use of a protocol actually increased prescribing costs. Precise definitions of therapeutic objectives and acceptable standards of treatment will clearly be needed to ensure that attempts to economise in this area do not help create perverse outcomes. The role of nurse practitioners and pharmacists in treating 'minor' and/or chronic illnesses also deserves further investigation.
Service user information and involvement	In most provider/consumer relationships the wellbeing of the latter demands a strong element of discretionary choice between, and so control over, suppliers. In health care this is difficult to achieve appropriately, not least because of the lack of patient knowledge about treatment options and outcomes. But enhanced consumer involvement in areas like record holding would promote more balanced relationships. The available opportunities for extending the arrangements pioneered in Oxford amongst parents should thus be explored.
Support for family and other informal carers	Many of the most onerous burdens of care in the community are willingly carried out by unpaid, informal, carers. Helping them through appropriate recognition and practical support, as well as by caring for carers' own needs, is one of the most important tasks of any health professional. They need to be more fully aware of how best to achieve this.

enhanced understanding of incubation periods and disease transmission patterns) paved the way for the formation of a primary medical care culture which, at its best, is capable of critical self evaluation and testing new approaches to service delivery.

The value of practically oriented research and development conducted in general practice is essentially that it can guide and inform innovation in a step-by-step process. Care providers and managers can learn from it as they continue to give care, without the need to invest resources in large numbers of extra staff, elaborate data processing facilities or complex training programmes (Fry 1988). This does not mean that larger scale and/or more classically academic research designed to generate fundamentally new understandings is not needed. Rather that activity aimed at bringing 'pure' research findings into practical use as part of a continuous process of improvement is also vital, especially as this may also create additional original knowledge.

For instance, there is no absolute, correct answer waiting to be discovered about how best to ensure an appropriate sharing of health care responsibilities and knowledge between the primary and secondary levels. Hospital based and practice or other community based doctors, nurses and other personnel can, to a degree at least, successfully work together in a variety of ways. What arguably is needed to resolve 'the question of shared care' is activity which stimulates competitive selection, so that satisfactory NHS arrangements can be formed by field level evolution as well as by managerial decision.

The initiatives supported by the Primary Care Development Fund in 1989/90 add to and extend the general practice research tradition, not least in that they involved many individuals other than family doctors. Health visitors, psychologists, economists, sociologists, nurses and people without formal academic qualifications all took leading roles. As the material summarised in Box 9 indicates, their findings touch on many issues vital to the future of primary health care in Britain in the 1990s in a manner which helps take general practice research forward from a simply medical to a broad clinical (multi-professional) base.

Depending on the availability of resources it thus seems justified to conclude that a further round of PCDF projects would be worthy of support in the relatively near future. In addition to studies aimed at further resolving some of the issues identified in Box 9 several other areas of enquiry might usefully be pursued. They include:

- how to achieve more effective communication and collaboration across the primary health care/LA social care interface;
- the utilisation and impact of information technology in general practice;
- the nature of successful 'management' relationships within primary care teams and between them and other agencies, like FHSAs and RHAs;
- the scope for developing new forms of fair, multi-professional GP practice partnerships, and ensuring that existing partnerships are free from any form of exploitation, including the implicit sale of 'good will';
- the existing quality and required standard of general practice premises, particularly in urban areas, and the working of the FHS 'capital programme';
- the working of 'new contract' arrangements in areas such as the cash limited ancillary staff scheme, and its impact on the future of single handed and smaller GP practices within the NHS;
- the potential for increased collaboration between GPs and other independent contractors like dentists, pharmacists and opticians, and the relevance of the latters' services to overall community health issues;
- disease and disability specific projects which attempt a comprehensive examination of the most effective and efficient ways of management from a user group, rather than provider group, oriented viewpoint.

Following on from the last point, any future PCDF work might most desirably focus more directly on consumers' expectations and the end-point outcomes of the care they receive, rather than analysing mainly the activities of its providers. It is of course a laudable achievement to help extend the concept of primary health care research so that it can be seen to serve as a shared learning experience for members of all the disciplines involved in providing community services. But to gain better understanding and recognition of patients' problems as the central driving force of all primary care provision, and to involve service users as full participants in practice level research, might prove to be an even more notable advance. If further modest investment in primary health care research can serve better to reveal and focus attention upon the fundamental consumer oriented objectives of agencies like the NHS, as well as helping to define ways of achieving them and the nature of the forces opposing success, then it would certainly be justified.

Appendix

Projects supported by the Primary Care Development Fund in 1989/90, in alphabetical order by name of principal applicant/organiser.

Outcome of General Practice Referrals to Hospital Outpatient Clinics: Methods for Peer Review.

Angela Coulter (Jean Bradlow, Dr Martyn Agass, Dr Charles Martin-Bates, Dr Alastair Tulloch) (Unit of Clinical Epidemiology, University of Oxford)

This project (the field work for which took place in 1988/89) involved a follow-up study of outpatient referrals originally identified in a large study concluded in 1983/84. Its aims were to describe referral outcomes for certain 'tracer' conditions; to assist in the development of referral guidelines; to help GPs evaluate their referral decisions; and to explore the value of routine data usage in medical audit and outcomes research. Five 'tracer' conditions were identified (back pain, deafness, otitis media, menstrual disorders and varicose veins) and in relation to these a number of conclusions and/or issues for further investigation were identified.

For example, many referrals for deafness resulted only in the supply of a hearing aid. This suggests that direct GP access to hearing aid clinics could be in consumers' interests. In the case of back pain, the frequency of repeat referrals raised concerns as to the adequacy of support given to sufferers of this frequently chronic condition. And in relation to otitis media, the number of follow-up consultations in hospital outpatient departments suggested that more attention needs to be paid to the transfer of follow-up care to GPs.

More broadly, the study also suggested that consultants may in many cases over-estimate the extent to which GPs refer patients to them to initiate treatment, and under-estimate the extent to which they are seeking diagnostic confirmation and treatment advice. With regard to audit, the authors stressed that analysis of GP/hospital activity is only an interim step towards evaluations based on an understanding of patient outcomes.

Are Volunteers a Resource which the GP can use in the Care of Patients?

Dr Ian Goodrick (Dianna White and Mary Nisbett) (General Practice based)

In the mid 1980s, following the example of another GP linked scheme established in Norfolk, doctors and others working near Exeter formed a league of friends designed to enable (trained) volunteers to use their energies to help support patients and their families in a given area. This project has aimed to identify other voluntary groups working in the context of primary care, examine and compare key aspects of their structures and working practices, and communicate about the opportunities revealed to interested audiences.

Its findings have several significant implications for the organisation and delivery of voluntary effort — see main text. Perhaps the most important are:

- appropriately organised practice based volunteer projects can enable patients to stay in their own homes for longer periods than would otherwise be possible, and may shorten periods of admission to hospital;
- paid volunteer co-ordinators play a vital role in administering successful schemes, acting if they wish as full members of the primary care team;
- effective projects depend on well run training programmes, and the matching of volunteers to service users' needs.

Screening the Health and Welfare of People in York who Attain the Age of Seventy-Five Years.

Dr Richard Harding (Sally Guthrie) (General Practice based)

Concern has been expressed about GPs' 'new contract' obligations annually to visit and assess the needs of patients aged 75 and over. The PCDF supported project in York looked at an alternative way of identifying elderly patients in need of medical and other support, which its proponents believe could prove more efficient than the current arrangements. The organisers obtained a high degree of co-operation from other general medical practices in York, ensuring a broad, representative sample.

Either they or patients' own GPs contacted all the 651 individuals in the sample population attaining the age of 75 by sending a birthday card (a technique also pioneered in Scotland — special care was taken to record dealths so to avoid distress to relatives) together with a simple 10 point Activities of Daily Living (ADL) questionnaire. This asked questions such as 'do you have a relative you can depend on for help?', 'can you prepare your own meals?', and 'do you have any difficulty with your hearing nowadays?'. Patients' GPs were contacted by letter simultaniously so that their knowledge of the individuals concerned could also be assessed.

The hypothesis tested was in essence that only (the quarter or so) respondents scoring two or more negatives would require further investigation. A 90 per cent patient response was achieved. Subsequent in-depth interviews of a randomly selected 30 per cent of all respondents confirmed the value of the ADL postal questionnaire as a first stage screening tool. Overall about three per cent of the sample population proved to be high scorers not previously known to their GPs; the author's research and the accompanying literature review indicates that one group of elderly people at especially high risk of suffering unidentified/unmet needs are themselves carers of other sick individuals. They may be particularly prone to accepting stoically avoidable problems as 'merely an aspect of ageing'.

The Ilford Social Health Promotion Team/Buttsbury Women and Children's Health Project.

Heather Hunt/Dr V Crowhurst (Bilkis Abara) (Redbridge District Health Authority/general practice)

This project was originally proposed by local family doctors, working closely with Redbridge DHA's principal psychologist in primary care. Its focus became the Buttsbury Estate, a complex of some 600 dwellings with few facilities, a high 'deprived area' index and high proportion of ethnic minority and single parent families. It attempted to develop services and initiatives designed to support the social, psychological and health development of women and their pre-school children living there.

Specifically, its objectives included enhancing pre-school and allied play facilities, including providing a playbus; improving the use of child health and also antenatal care facilities; and supporting women with pre-school children by helping to establish appropriate support networks and allied measures. Perhaps the most important experiences reported by the team responsible relate to the effectiveness of a link worker in helping isolated women to be able to use health services, and to come into supportive contact with other people in the local community. Such relatively low cost measures may play a vital role in helping prevent or relieve mental ill health amongst vulnerable sections of the population — see main text. They are also potentially of value in reducing the incidence of low birth weight and the consequently increased rates of infant death or injury in some populations. However, the Buttsbury project was not able to raise the funds necessary for it to continue after the PCDF grant was exhausted.

Factors Influencing GP Referral Decisions.

Dr Allen Hutchinson (Vic Hayes and John Newton) (Primary Care Research Unit, University of Newcastle-upon-Tyne)

This study involved repeated interviewing of a small sample (approximately 20 in the final analysis) of doctors in order to build up a model of the qualitative factors associated with observed variations in referral. It identified several series of issues, including doctor related factors (need for reassurance, class, negotiating skills); case specific factors (clarity of diagnosis/prognosis); and structural factors (workload, hospital 'demand' for patients, practice organisation).

The study identified the importance of processes such as informal networking between family doctors and consultants, and the potential value of inter-practice reviews of referral, in helping to build consensus about 'good practice'. Such innovations should in time help to moderate extremes of variation.

However, as in the case of other PCDF projects, the authors concluded that significant variations in referral rates between general practitioners would continue throughout the foreseeable future, and that it is impossible tightly to define a 'right level' of referral. Indeed, in this very complex field too interventionist an approach on the part of managers trying to rationalise service provision could cause considerable harm.

Improving the Clinical Care of Dyspepsia. Management by Consensus.

Dr Roger Jones (Sue Lydeard, Joan Dunleavy, Dr John Bain) (Primary Medical Care, University of Southampton)

Dyspepsia is a very common condition; in any six month period 40 per cent of the population have significant dyspeptic symptoms, which account for 3-4 per cent of all the consultations in general practice. This project examined GP treatment and referral of dyspeptic patients, aiming to establish a consensus on the most desirable patterns of response and to measure its impact on resource usage.

The study clearly demonstrated that general practitioners and specialists can reach fairly ready agreement on how dyspepsia should be managed. Some 70 per cent of GPs in the locality were prepared to provide workload figures to the researchers, and other support was also forthcoming. There was encouraging, if variable, involvement of GPs and specialists from most disciplines in consensus meetings held as part of the project.

Nevertheless, despite such success and the impressive volume of carefully analysed quantitative data, as well as the qualitative guideline materials produced, the impact of the exercise on referral and the ordering of investigations was modest. This adds to concerns as to how to translate specialist/generalist concord on protocols for behaviour into a practical reality. In the case of prescribing, costs in the study group rose significantly, with the sharpest increases being amongst the lowest original cost prescribers. The guidelines produced appeared to 'sanction' the use of ulcer healing drugs for patients for whom definite diagnoses had not been made.

Unduly rigid prescriptive approaches could, as discussed in relation to other projects, prove harmful. Thus defining sensitive yet effective ways to rationalise patterns of therapeutic activity while raising clinical care standards remains a priority challenge in primary care.

The Management of Chronic Disease in General Practice.

Dr Tom O'Dowd/Sue Jones (Ann Zamorski, Lynne Carter, Shirley Wragg) (Department of General Practice, University of Nottingham Medical School)

The objective of this project was to demonstrate how the care of chronically ill patients, who normally receive most of their medical support from primary level practitioners, may be enhanced. It involved the construction of chronic (as opposed to specific) disease registers in three general practices of very different sizes and structures. The organisers hoped to show that such registers may be used to ensure regular contacts with vulnerable clients, and to support those with multiple conditions and needs in a flexible, efficient and effective manner.

Diagnostic criteria relating to three conditions were used as indicators for inclusion on the registers — hypertension, diabetes and asthma. In each practice responsibilities for patients' care were randomly divided between doctors and practice nurses, and defined procedures were established. Patients have been surveyed so that the effectiveness of the support they receive could be evaluated. For example, service users' knowledge of their condition(s) and how best to control them were assessed through 'before and after' interviews.

The goal of this part of the project was to compare the performance of practice nurses with extended chronic care roles against that of general practitioners, and to estimate economic and care outcome variables associated with differing mixes of professional expertise in primary care delivery. The results available to date indicate that nurses generally perform well in the support of patients with chronic conditions.

The Liverpool Antenatal Care Project

Dr Michael Ross (General Practice based)

This initiative was predicated on the belief that antenatal care in Liverpool has historically been 'over-centralised', with large hospital clinics and poor hospital/primary care communication. It sought to demonstrate a possible remedy for this perceived problem through the introduction of a pilot scheme involving community midwifery clinics based in four randomly selected practices. Four other control practices did not have community midwives attached. The experiences and satisfaction of women attending during the study period were recorded and compared, using postal questionnaires.

The results indicate that in the midwifery practices co-operation cards were significantly more likely to be completed, suggesting that a midwifery clinic could help to improve GP/hospital communication during shared antenatal care. But there were no other significant differences observed in care quality or consumer satisfaction between the two practice groups. (The overall service user response rate was around 60 per cent.) However, attendees at one of the three local maternity hospitals were significantly more pleased with the attention they received than were the remainder. A particular problem area (also identified in another PCDF supported project) was found in relation to parentcraft classes. Attendance was low and many women said they doubted their potential value.

Overall, such findings emphasise the need for service user needs centred research as a prerequisite for a service change, rather than as an exercise to be conducted subsequent to reform. This project also suggests that enhanced service performance in antenatal and associated forms of care may depend more on targetting intensive care to vulnerable individuals than extending generally provisions like clinics, although the reasons for variations in patient satisfaction between neighbouring hospitals might be explored further.

Evaluation of Parent Held Child Health Records in Oxfordshire

Kate Saffin (Oxfordshire District Health Authority)

During the 1980s one part of Oxfordshire developed a system through which parents gained responsibility for holding their young children's health records. Elsewhere in the district traditional professionally controlled arrangements remained. Through direct 'audit' interviews (involving 480 parents attending child health clinics) postal questionnaires (sent to 120 health visitors and 350 GPs, with another sent to 1000 parents) and checks of clinic data the research health visitor who conducted this project examined the quality of record retention and completion. She also analysed the attitudes of both professionals and parents to the alternative ways of record holding.

Findings include the fact that although doctors (more than health visitors) without experience of parent held records (PHR) expressed relatively high levels of reservation about such a system, virtually all who came to use it eventually favoured it; that parents did not lose records with any significantly greater frequency than clinics; and advice to parents included with records was found to be positively received. Although about a quarter of the general practitioners reported some difficulties in recording information they did not wish to share with parents, the overall position appears to be that parent held records are more thoroughly maintained than those otherwise held.

This may well have important implications for the support of other patient groups. It is also of note that the symbolic/social significance of service user record holding seems to have a considerable potential to influence the nature of professional/patient/parent interactions. The latter tend to feel more 'empowered', a finding which could have considerable relevance to the care of all patients and welfare service consumers at-risk of becoming unduly dependent or passive in their relationships with care providers.

Improvement of Specific Services and Better Use of Decreased Resources

Roy Slack (Pauline Armstrong, Dr David Armstrong, Dr John Fry) (Bromley Local Medical Committee)

Through processes of joint consultation between GPs and consultants in the locality guidelines/protocols regarding the treatment of a range of conditions were drawn up. The topics covered ranged from rheumatology, asthma and insulin dependent diabetes to obstetrics, depression and the support of people with terminal illnesses. The initiative resulted in the production of high quality written materials made available to all general practitioners, in addition to which those family doctors and specialists personally concerned with aspects of this study had opportunities to establish and/or reinforce their personal contacts.

Considerable effort was made by the organisers to establish GP 'ownership' of the Bromley protocols. For example, questionnaires about the issues addressed were sent to all local doctors, and the results incorporated into the project findings. As such the latter represent a distillation of local experience and best practice, rather than merely advice from on high which might be (or be seen as being) of little practical relevance to field level practitioners. But the extent to which this initiative has actually influenced the patterns of treatment offered by general practitioners in Bromley has not been measured; judging by the experience of other projects it may well be limited, particularly amongst those least disposed to cooperate with and/or compare themselves to their peers.

Enhanced Diabetic Care in South Glamorgan

June Smail/Dr Antonia Wigley/Dr Nigel Stott (Department of General Practice, University of Wales College of Medicine)

This project was based on a strategy for improved community diabetic care developed by the local LMC at the instigation of the Professor of General Practice, in cooperation with consultants, the then

FPC and the Community Nursing Service. Its objectives included helping GPs to establish systems of diabetic care and monitoring in a manner which would prove self-propagating in the long term; demonstrating the ability of the LMC to stimulate interest in and concern for clinical standards; and promoting constructive collaboration between local primary care teams and specialist clinic staff.

The role of practice nurses (the number of which expanded very significantly in South Glamorgan during the course of the project) in the primary care team, and that of specialist community nurses in liaising with them in helping to promote better care for (non-insulin dependent) diabetic patients, proved to be of particular significance in this project. Overall it provided a powerful example of change 'management', and of the ability of primary care teams to provide sophisticated support for patients with chronic care needs, utilising where necessary support from specialist providers.

The project's organisers justifiably claimed success in stimulating a process of innovation diffusion which proved to have been much more rapid than was initially expected. They stressed the need for continuing outcome evaluation and reporting of results, and have established a mechanism of maintaining the 'audit' phase of project during the early 1990s. General practitioners will play a key role in this vital aspect of primary care development. But the place of the general practice nurse in providing the tangible means through which extended support and more structured procedures can be offered in primary care seems to be particularly worthy of further examination.

Epilepsy Care in Doncaster. An Experiment in Shared Care.

Dr Malcolm Taylor (Sylvia Readman, Avril Stewart, Dr Harvey J Sagar) (General Practice)

The driving force for this initiative was the interest in and commitment to epileptology developed by Dr Malcolm Taylor, who during the period of PCDF support of the project in Doncaster was still practicing as a full-time family doctor. Working with a consultant neurologist, a specialised liaison nursing sister and a (British Epilepsy Association) social worker he established a local clinic service to support family doctors in their care of patients with epilepsy, and to facilitate more effective care sharing between primary and secondary providers. Co-operation cards were produced to aid this process, as was so in the case of several other PCDF projects.

The liaison nurse working in Doncaster offers individual support to patients, as well as transmitting her expertise to other local primary care professionals. In some localities she runs clinic sessions directly.

The success of this experimental service is probably indicative of unmet and/or inadequately met medical need in other parts of the country. However, the extent to which the team in Doncaster has been able to extend the skills and enhance the organisation of other primary care providers seems relatively limited; in some respects they may have acted more as an intermediate level specialist referral service.

Whether this is the only way forward in providing the relatively complicated treatment necessary for the optimal treatment of patients with challenging manifestations of epilepsy may require further examination. What for the moment is clear is that the overall incidence and prevalence of the condition are sufficient to mean that at any one time the average GP will have 12-15 patients with active epilepsy. (Some four per cent of the total population will have a seizure at some point in their lives, and more than one in every 200 people have recurrent events.) Since many of these are already vulnerable because of conditions like stroke, learning difficulties, or the occasionally encountered social stigma associated with epilepsy itself the provision of better care to this section of NHS users is clearly a matter of priority.

Examination of Discharge Arrangements

Julie Wood (Northamptonshire Family Practitioner Committee)

In 1986 the Northamptonshire FPC made a decision to conduct survey work relevant to primary care provision in its locality. This eventually led to its project on discharge arrangements which was in part supported by the PCDF. Following a similar enquiry in Oxford, GPs were asked (during the Spring of 1989) a series of questions relating to liaison between family practitioners and the DHA provided community services, and between family practitioners and hospitals in relation to discharges.

The large volume of systematically analysed results indicated particular problems of communication in the areas of gynaecology and geriatrics, with communication generally being less satisfactory in Northamptonshire than in Oxfordshire. The adequacy of information in discharge letters relating to issues like requirements for visiting patients on discharge, social and other support needed and prognosis details, was strongly questioned. GP involvement in discharge discussions was found to occur in

Northampton only half as frequently as in Oxfordshire.

Recommendations were made in areas such as the supply of discharge letters to both GPs and patients, drug provision policy (allowing for extra medication to cover weekends and bank holidays), and the role of liaison sisters. Here it was argued that a liaison service should be available to all elderly people leaving hospital, not just those discharged from geriatric departments.

Haringey Primary Health Care Development Project

Dr Keyvan Zahir (Barbara Gregory) (Department of Community Medicine, Haringey District Health Authority)

The objective of this project was to augment communication and cooperation between different branches of, and professionals in, the NHS. It was hoped that this could help to rationalise and enhance the efficiency of the GP referral process and the sharing of care between GPs and DHA community and hospital based providers. In particular the activities of the co-ordinator were intended to facilitate the shared management of selected chronic diseases.

Some difficulties were encountered in preparing agreed strategies. However, guidelines/protocols were eventually established in three areas — childhood asthma, haemoglobinopathies (sickle cell disease and thalassemia) and rheumatoid arthritis. During the preparation of these significant numbers of family doctors and consultants were brought together in consultation meetings, and this 'action research' helped to forge some valuable personal contacts and informal communication channels.

The project's organisers conclude that it reinforced the findings of an earlier General Practice Review conducted in Haringey (Constantinides 1989 — see main text) particularly in relation to the need for more liaison and co-ordination facilities between DHAs and the new FHSAs. But whether in practice such a route towards the solution of the problems which exist in this field would be effective, or whether or not some more far reaching reform of the current structural division between services like community nursing and family doctor care might be required, arguably demands further consideration. Perhaps the most important contribution of this study as compared to the rest of the PCDF supported work in 1989/90 is the reminder it offered of the current conflicts of interest which exist between the various branches of the NHS, as well as the potential which exists for greater future unity and co-operation.

References

Allsop J (1990). *Changing Primary Care: The Role of Facilitators.* King's Fund Centre. London.

Audit Commission (1986). *Making a Reality of Community Care.* HMSO. London.

Balarajan R, Yeun P and Raleigh V S (1989). *British Medical Journal*, 299, 958-960.

Brown G W and Harris T O (1978). *The Social Origins of Depression.* Tavistock. London.

Buckley E G (1990). *The British Journal of General Practice*, 40, 357-358.

Cameron E, Badger F and Evers H (1989). *Primary Health Care*, October, 22-23.

Carr-Hill R A and Sheldon T (1991). *British Medical Journal*, 302, 393-96.

Cartwright A and Anderson R (1981). *General Practice Revisited.* Tavistock Publications. London.

Chew R (1989). *Compendium of Health Statistics.* Office of Health Economics. London.

Chew R (1991). Personal communication.

Constantinides P (1989). *A Review of GP Services in Tottenham.* Enfield and Haringey FPC/Haringey DHA.

Constantinides P and Gordon P (1990). *The Health Service Journal*, 100, 1518-1519.

Coulter A, Brown S and Daniels A (1989a). *Journal of Epidemiology*, 43, 25-28.

Coulter A, Noone A and Goldacre M (1989b). *British Medical Journal*, 299, 304-308.

Coulter A, Seagroatt V and McPherson K (1990). *British Medical Journal*, 301, 273-276.

Dance J (1987). *A Social Intervention by Linkworkers to Pakistani Women and Pregnancy Outcome.* MA Thesis. University of Warwick.

Davey Smith G (1991). *British Medical Journal*, 302, 359-60.

Dennis N (1989). *The Primary Health Care Development Fund Projects: progress report for the King's Fund London Project Executive Committee.*

Dowie R (1984). *General Practitioners and Consultants - a Study of Out-patient Referrals.* King's Fund. London.

Evans T (1991). Personal communication.

Farmer A and Coulter A (1990). *British Journal of General Practice*, 40, 56-58.

FHSAs - Today's and Tomorrow's Priorities (1991). Yorkshire Health/NHSME.

Fry J (1988). *General Practice and Primary Health Care 1940s - 1980s.* The Nuffield Provincial Hospitals Trust. London.

Fullard E, Fowler S and Muir-Gray J (1987). *British Medical Journal*, 294, 1080-1082.

General Medical Services Committee (1983). *General Practice: a British Success.* BMA. London.

Gillam S J, Jarman B, White B and Law R (1989). *British Medical Journal*, 299, 953-957.

Goodrick I, White D and Nisbett M (1990). Personal communication.

Gregory B (1990). *Primary Health Care Development Project: Final Report.* Haringey Health Authority.

Guthrie S (1990). *Screening 75 Year Olds in York.* MA Thesis. University of York.

Hancock C (1990). *THS*, November, 10.

Harding R (1990). Personal communication.

Harris C M (1991). *In* Griffin J (Ed) *Factors Influencing Clinical Decisions in General Practice.* Office of Health Economics. London.

Health Departments of Great Britain (1989). *General Practice in the NHS: the 1990 Contract.*

Holland W W and Stewart S (1990). *Screening in Health Care.* The Nuffield Provincial Hospitals Trust. London.

Howells G (1986). *Journal of the Royal College of General Practitioners*, 29, 24-32.

Hughes J (1990). *Enhancing the Quality of Community Nursing.* King's Fund Centre. London.

Hughes J and Humphry C (1990). Medical Audit in General Practice. King's Fund Centre/NW Thames RHA. London.

Hunt H (1989). *Clinical Psychology Forum*, 22, 19-23.

Hunt H, Crowhurst V and Abara B (1990). Buttsbury Estate Women and Children's Outreach Health Project. Reports. Redbridge DHA.

Huntingdon J (1990). *Health Service Journal*, March, 324-325.

Huntingdon J (1990). Personal communication.

Hutchinson A, Hayes V and Newton J (1990). *Factors influencing General Practitioner Referral Decisions.* Health Care Research Unit. Newcastle upon Tyne.

Irvine D (1990). *Managing for Quality in General Practice.* King's Fund Centre. London.

Jones D A and Vetter N J (1984). *Social Science and Medicine*, 19, 511-514.

Jones R, Lydeard S, Dunleavy J and Bain J (1990). *Improving the Clinical Care of Dyspepsia: Management by Consensus.* University of Southampton.

Leese B and Bosanquet N (1989). *British Medical Journal*, 298, 932-934.

Loudon I S L (1986). *Medical Care and the General Practitioner 1750-1850.* Clarendon Press. Oxford.

Luft H S, Garwick D W, Mark D H, Peltzman D J, Phibbs C S, Lichtenberg E and McPhee S J (1990). *Journal of the American Medical Association*, 263, 2899-2906.

MacFarlane A and Saffin K (1990). *British Journal of General Practice*, 40, 106-108.

MacKinnon M, Wilson R M, Hardisty C A and Ward J D (1989). *British Medical Journal*, 299, 552-54.

NHS Management Executive (1991). *Integrating Primary and Secondary Care*. NHSME. London.

Noone A, Goldacre M, Coulter A and Seagroatt V (1989). *Journal of the Royal College of General Practitioners*, 39, 404-407.

Northamptonshire Family Practitioner Committee (1990). *An Examination of Discharge Arrangements. Final Report*. Northamptonshire FPC.

Nursing in the Community (1990). The NHS Management Executive. London.

One-to-One (1991). *The One-to-One Resource Pack*. One-to-One. London.

Parker G (1990). *With due care and attention*. Occasional paper 2 (2nd Ed). FPSC. London.

Prochaska F (1988). *The Voluntary Impulse*. Faber and Faber. London.

O'Dowd T, Jones S, Zamorski A, Carter L and Wragg S (1990). *Management of Chronic Disease Information Pack*. Unpublished.

O'Dowd T (1991). Personal communication.

Ritchie J, Jacoby A and Bone M (1981). Access to Primary Health Care. HMSO. London.

Rivett G (1991). Personal communication.

Roland M (1991). *In* Griffin J (Ed) *Factors Influencing Clinical Decisions in General Practice*. Office of Health Economics. London.

Ross M (1990). End of Grant Report for the Liverpool Antenatal Care Project. Unpublished.

Saffin K (1990). *Community Outlook*, September, 11-13.

Scott T and Maynard A (1991). *Will the new GP Contract lead to Cost Effective Medical Practice?* Centre for Health Economics. York.

Secretaries of State for Health (1986). *Green paper on primary health care*.

Secretaries of State for Health (1987). *Promoting Better Health*. Cmnd 249.

Secretaries of State for Health (1989). *Working for Patients*. Cmnd 555.

Secretaries of State for Health (1989). *Caring for People*. Cmnd 849.

Smail J and Stott N (1990). *Enhanced Diabetic Care in South Glamorgan*. Final report to the PCDF. Unpublished.

Talbot R J (1991). *British Medical Journal*, 302, 383-86.

Taylor M P (1980). *Journal of the Royal College of General Practitioners*, 30, 456-64.

Taylor M P (1987). *Journal of the Royal College of General Practitioners*, 37, 116-119.

Taylor M P (1990). *Practice Nurse*, May, 29-31.

Taylor M P, Redman S, Stewart A and Sagar H (1990). Doncaster Epilepsy Project Reports. Unpublished.

Taylor J and Taylor D (1986). *Mental Handicap - Partnership in the Community?* OHE/MENCAP. London.

Taylor J and Taylor D (1988). *The Assessment of Vocational Training in General Medical Practice*. Centre for Health Economics. York.

Taylor J and Taylor D (1989). *Mental Health in the 1990s: From Custody to Care?* Office of Health Economics. London.

Teeling Smith G (1991). In Griffin J (Ed) *Factors Influencing Clinical Decisions in General Practice*. Office of Health Economics. London.

Townsend J, Piper M, Frank A O, Dyer S, North W R S and Meade T W (1988). *British Medical Journal*, 297, 544-47.

Waller D, Agass M, Mant D, Coulter A, Fulher A and Jones L (1990). *British Medical Journal*, 300, 1115-1118.

Wilkin D (1991). *In* Griffin J (Ed) *Factors Influencing Clinical Decisions in General Practice*. Office of Health Economics. London.

Wilson D and Haire A (1990). *British Medical Journal*, 301, 1379-1381.

Zahir K (1990). Personal communication.

48572 020000 0485

Other recent King's Fund Institute publications include:

Competition and Health Care: A comparative analysis of UK plans and US experience
Research Report No 6, Ray Robinson, 1990. £6.95 + 70p p&p

GP Budget Holding in the UK: Lessons from America
Research Report No 7, Jonathan Weiner and David Ferriss, 1990. £5.95 + 60p p&p.

New for Old? Prospects for nursing in the 1990s.
Research Report No 8, Virginia Beardshaw and Ray Robinson, 1990. £7.95 + 80p p&p.

Home and Hospital Care: Redrawing the Boundaries
Research Report No 9, Linda Marks, 1991, £7.95 plus 60p p&p

Assessment and Case Management: Implications for the implementation of 'Caring for People'
Briefing Paper No 10, Virginia Beardshaw and David Towell, 1990. £5.95 + 60p p&p.

Medicines, the NHS and Europe. Balancing the public's interests
Briefing Paper No 11, David Taylor and Alan Maynard, 1990. £5.95 + 60p p&p.

All things come (to those who wait?) Causes and consequences of the community care delays
Briefing Paper No 12, Melanie Henwood, Tessa Jowell and Gerald Wistow, 1991. £5.95 + 60p p&p.

Copies of this and other reports are available either:

Over the counter: King's Fund Centre Bookshop
126 Albert Street
London NW1 7NF

By Post: Department D/KFP
Bailey Distribution Ltd
Learoyd Road
Mountfield Industrial Estate
New Romney
Kent TN28 8XU

Cheques should be payable to Bailey Distribution Ltd. Please add 10% for postage and packing.

KING'S FUND INSTITUTE

The King's Fund Institute is an independent centre for health policy analysis. Its principal objective is to provide balanced and incisive analyses of important and persistent health policy issues and to promote informed public debate about them.

Assessing the performance of health care systems is one of the Institute's central concerns. The Institute is also concerned with health policy questions which go wider than health services proper. These centre on the scope of public health policy and on social and economic determinants of health.

The Institute is independent of all sectional interests. Although non-partisan it is not neutral and it is prepared to launch and support controversial proposals.

The Institute publishes a range of documents which include occasional papers, briefing papers and research reports. A publications list is available.

ISBN 1 870607 25 2
£5.00