BRIEFING PAPER

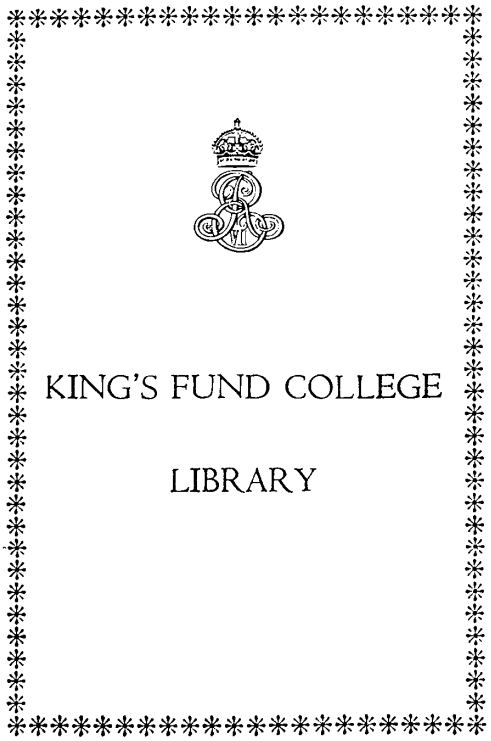
PROMOTING BETTER HEALTH?

AN ANALYSIS OF THE GOVERNMENT'S PROGRAMME FOR PRIMARY HEALTH CARE

LINDA MARKS

KING'S FUND INSTITUTE

No 7 in a series of briefing papers on current health policy issues.



ISBN 1 870607 09 0

Published by the King's Fund Institute
126 Albert Street, London NW1 7NF

Copies are available at £3.95

J7819 / DESIGN & PRINT / REDESIGN / 01-533 2631

PROMOTING BETTER HEALTH?

AN ANALYSIS OF THE GOVERNMENT'S PROGRAMME FOR PRIMARY HEALTH CARE

LINDA MARKS

CONTENTS

SUMMARY

Promoting Better Health is the culmination of the first ever government review of primary care services. This Briefing Paper critically reviews its proposals, assesses financial implications and highlights major omissions in this long-awaited White Paper.

Strategic policy development and a strong management ethos have been slow to emerge in primary care. Problems of coordination and teamwork have remained endemic in a set of services mainly provided by independent contractors on the one hand and managerially accountable community health service staff on the other. The White Paper, however, is notable in its attempts to enhance the accountability of general medical services, a process made easier by the transformation of Family Practitioner Committees (FPCs) into independent authorities in 1985. Yet the White Paper also reproduces some of the failings of the much-criticised Green Paper which preceded it. Primary care is defined in narrow, professional terms. Some of the proposals designed to improve standards might achieve quite the opposite effect, and few attempts are made to harmonise plans for primary medical care with new organisational and management arrangements in community health services. It also contains a few unheralded additions. Charges for eye tests and dental examinations and cash limits for FPCs in relation to certain directly reimbursed expenses were unexpected and controversial. Prevention is afforded much higher prominence, arguably at the expense of other aspects of general medical practice. However, the White Paper follows the Green Paper in its encouragement of audit, its concern to tie practitioners' income more closely to performance and to increase the monitoring role of FPCs.

This Briefing Paper critically reviews these developments and assesses their costs and policy implications. It concludes that, despite welcome attention to issues of accountability and value for money, some basic questions remain unanswered. It is not clear which agency is to take the lead in monitoring preventive services and in coordinating care for priority groups. Dental and optical services are increasingly privatised, but the boundaries of this process remain undefined. Finally, although there is no specific mention of primary care authorities, the Health and Medicines Bill has cleared the ground for enhanced financial control of a new and expanded organisation.

INTRODUCTION

For the last 20 years, primary health care policy in the UK has received scant attention. Of low status compared with the acute sector and largely ignored in the debates on care in the community, primary care services have only recently come to occupy a prominent, though not central, position on the health policy stage. Traditionally a divided service – provided by independent contractors on the one hand and salaried community health service and local authority staff on the other – coordination and teamwork have proved major challenges. Since the mid 1980s, however, key themes of consumerism, accountability and value for money have finally entered the primary care debate. In addition, major organisational shifts have taken place which promote a more strategic approach to the planning and management of primary care. In April 1985, FPCs became independent authorities, directly accountable to the then Secretary of State for Social Services, and invested with additional management and planning responsibilities. Many FPCs have begun to identify their contractors' current activities and future plans, provide information which enables contractors to assess their performance and collaborate with district health authorities (DHAs) in planning and providing shared services such as immunisation and vaccination and child health surveillance.

Community health services too have undergone major organisational changes. As a consequence of the management reorganisation of the NHS prompted by the Griffiths inquiry (DHSS, 1983), over one-half of the DHAs in England and Wales have now decentralised their community health services (Dalley and Shepherd, 1987). A major recommendation of the review of community nursing (1986), chaired by Mrs Julia Cumberlege, that neighbourhood nursing teams be established, has reinforced a patch-based approach to community-based services provided by DHAs. This opens up new possibilities for FPCs, GPs and community nursing staff to plan and monitor services on a locality basis (Jarman and Cumberlege, 1987). The recent Griffiths Report (1988) suggests changes in the relative responsibilities of DHAs and local authorities in organising care for priority groups and advocates an enhanced role for GPs in ensuring that social service needs of their practice populations are met.

These new organisational arrangements are timely given changing demands on primary care. Increased day surgery and reduced lengths of stay in the acute sector, more care being provided in a community setting for people with long-term disabilities, and larger numbers of very elderly people, all have implications for the workload and organisation of general practice (Martin, 1987) and community nursing. In addition, many practices are keen to expand into providing minor surgery and follow-up care for patients who might previously have attended hospital outpatients departments. Last, but not least, general practice is increasingly viewed as the most appropriate location for preventive activities. All these changes serve to further extend the remit of GPs and the role of primary health care teams.

The government's response to providing a much-needed review of primary care arrived in the form of the White Paper, *Promoting Better Health* (Cm 249, 1987). This was itself the culmination of five years' activity which included a long-awaited Green Paper, *Primary Health Care: an agenda for discussion* (Cmnd 9771, 1986); ten ministerial road shows (as part of an extensive consultation process); three reviews of community nursing (Cumberlege, 1986; Department of Health and Social Services, Northern Ireland, 1987; Welsh Office, 1987); a consultative document on complaints in the family practitioner services (DHSS, 1986) and a Social Services Committee Report on primary health care (House of Commons, 1987a). The White Paper was accompanied by an enabling bill, the Health and Medicines Bill (1987), and a circular on community nursing services (DHSS, 1987) broadly in favour of a flexible approach to the implementation of the Cumberlege Report. Also issued simultaneously was a consultation document concerned with access by DHAs to FPC patient registers.

Extensive activity has not been matched by enlightened debate, however. The publication of the White Paper was overshadowed by the simultaneous eruption of concern over the cash crisis in the hospital service and shortages of specialised nursing staff. In addition, the Health and Medicines Bill did little to foster a broad debate on the changing context of primary care and the management and organisational challenges which it faces. Most of its original 17 clauses related to finance; not surprisingly, initial media reaction was largely focused on new and unexpected proposals to introduce charges for dental examinations and eye tests. In addition, the inclusion of a clause extending the power of the Secretary of State in directing health authorities to generate additional income served to divert debate away from primary care to acute sector finance.

From mid-December 1987 to late March 1988, Standing Committee A considered the Health and Medicines Bill which was reported to the House of Commons in April. The bill was tidied up but fundamentally unaltered, with the exception of additional clauses concerning the successor company to the General Practice Finance Corporation and amendments to increase exemptions from charges for dental appliances and eye tests. The bulk of the detailed proposals in the White Paper, however, required negotiations with the professions. The degree to which primary care services change in practice will not be clear for some time.

This briefing paper summarises the White Paper proposals, draws comparisons with the consultative document which preceded it (the Green Paper) and comments on financial and policy implications. Discussion is limited to proposals already enshrined in government documents; no attempt is made to comment on the myriad alternative proposals for financing and managing primary health care which have emerged in the context of the government's internal review of the NHS.

BOX 1
SUMMARY OF WHITE PAPER PROPOSALS

REMUNERATION

- Fee for health check for patients registering with NHS for the first time
- Incentives for achieving target levels for immunisation, vaccination and screening
- Deprived areas allowance
- Incentives for minor surgery
- Allowances for providing child health surveillance
- Encouragement to doctors to provide comprehensive regular care for elderly people
- New post-graduate educational allowance
- Reimbursement for training costs of professional staff
- Dental practices in designated areas
- Post-graduate and vocational training allowances
- Fee for providing domiciliary eye-testing
- Allowance for pharmacists who supervise the supply and safe-keeping of medicines in residential homes
- Allowance for pharmacies which maintain records for certain patients
- Fund to attract and improve pharmacies in deprived areas

INFORMATION/AUDIT

- Proposed that GPs provide FPCs with Annual Reports
- Information technology and computerisation to be encouraged
- Information to GPs on prescribing rates and referral patterns
- Dental advisers to be introduced
- Dental Estimates Board to be given new powers

CONTRACTUAL CHANGES

- Health promotion to be part of terms of service
- Criteria for Basic Practice Allowance to be tightened
- Retirement at 70 and end of 24-hour retirement for doctors
- Compulsory retirement for dentists (age not specified)
- Revised dental contract to encourage quality and greater commitment to the NHS

LOCAL FLEXIBILITY

- Distribution of doctors to be determined locally
- Regional variations to be introduced in cash limits for cost-rent schemes

CONSUMER CHOICE/RESPONSIVENESS

- More information on practice leaflets and expanded medical and dental lists
- Easier to change doctors and make complaints
- Public views on services to be sought by FPCs
- Encouragement of women doctors
- Minimum standards of doctors' premises to be reviewed
- Dental surgeries and waiting rooms to be inspected
- Vouchers to be made available for contact lenses; voucher schemes to be extended for adults whose spectacles are damaged through physical or mental disability

HEALTH PROMOTION

- Increased funds for water fluoridation
- Initiatives to improve dental awareness among the young
- NHS contract for dentists to place greater emphasis on prevention
- Health education materials in pharmacies

STATUTORY CHANGES RELATED TO PRIMARY CARE (Health and Medicines Bill)

- Removal of statutory duty of community dental services to screen school-age children
- Charges for eye tests and dental examinations
- Sight test to be specified
- Abolition of General Practice Finance Corporation
- Retirement age to be specified for doctors and dentists
- 24-hour retirement to be abolished for doctors and dentists
- Dental Estimates Board to be renamed Dental Practice Board and its monitoring powers to be extended
- Training expenses to be remunerated via FPCs
- FPCs to hold cash-limited budget for reimbursing expenses of those providing family practitioner services

THE GOVERNMENT'S PLANS FOR PRIMARY CARE

Key Objectives

The proposals in the White Paper are designed to meet six key objectives for primary care services:

- to make services more responsive to the consumer;
- to raise standards of care;
- to promote health and prevent illness;
- to give patients the widest range of choice in obtaining high quality primary care services;
- to improve value for money;
- to enable clearer priorities to be set for family practitioner services in relation to the rest of the health service.

These objectives have met with general agreement, as have many of the proposals designed to achieve them (see Box 1). The introduction of a compulsory retirement age and the end of 24 hour retirement; better information on prescribing patterns and referral rates; measures to improve inner city primary care and ensure a fairer and more flexible distribution of doctors, dentists and pharmacists are all long overdue. Few cavil at significant measures for increasing consumer choice and providing better information through practice leaflets and up-to-date and better distributed FPC lists. Proposals to enhance the accountability of doctors and dentists through more detailed specification of their terms of service demonstrate that independent contractors are not exempt from attempts to increase professional accountability. However, the White Paper is also open to the criticisms directed at the Green Paper (Marks, 1987), particularly in the following respects: the definition of primary care adopted; basic assumptions over how standards might best be improved; and in the stance towards the organisational and management challenges facing primary care in the 1980s.

Problem areas

Primary health care narrowly defined

Neither the Green nor the White Paper draws on the approach to primary health care developed by the World Health Organisation and reflected in the 38 targets developed by the European Region (WHO, 1985). These targets, which were intended to guide national and local priorities, reflect an ecological and public health approach and a concern to promote equity, community participation, health promotion and joint working across different sectors.

For WHO, such an approach to primary health care is the key to 'Health For All by the Year 2000'. Yet, in both Green and White Papers, primary health care is defined in narrow, professional terms, expressed in the Foreword to the White Paper as services 'provided by family doctors, dentists, community pharmacists, opticians and community nurses'. Rejigging contracts of those providing family practitioner services in order to reward or enhance performance becomes a major route for improving primary care.

Improving standards?

Even within the narrow parameters set by the documents, concern was expressed throughout the consultation process that proposals intended to raise standards would not in fact do so.

For example, the Green Paper proposed a 'Good Practice Allowance' (GPA) as a means for linking performance to remuneration. In addition, it was argued that raising the proportion of income gained from capitation fees would improve standards through encouraging doctors 'to practise in ways that will encourage patients to join their lists' (Chapter 3, para.13). There was widespread opposition to each of these proposals. It was argued that the GPA, firmly targeted to the GP pocket, ignored the contribution of other members of the primary care team. It would also further distance struggling inner city practices from those which could more easily meet the criteria for receiving the allowance. If it acted as a reward for those practices already providing quality primary care, it would lower the esteem (as well as the income) of practices falling outside this category. Likewise, the proposal to increase the proportion of practice income made up of capitation fees did not take account of 'manageable' list size and the location and nature of practices. Rural practices with low lists would be particularly vulnerable. A second plank of the argument – that consumer choice acted as an adequate guarantor or reflection of quality – was also questioned. Yet none of these proposals was completely abandoned in the White Paper. The GPA was dropped to be replaced by a system of incentives for reaching specific (and locally agreed) targets.

The proposal on capitation fees – opposed by the General Medical Services Committee (GMSC) and the Royal College of General Practitioners – was sustained, although in the first instance, capitation fees would only rise from the current 47 per cent to 50 per cent of the average GP's income.

Neither White nor Green Papers addressed the knotty problems of how minimum standards for clinical activity in primary medical care might be established, implemented or monitored. Both documents shared a commitment to competition as a means of improving standards. The combination of proposals on capitation fees and increased consumer information would, it was argued, encourage competition between doctors for better informed patients. As a further competitive spur the private sector was encouraged. Despite widespread opposition to the Green Paper's 'health care shops' the government promised in the White Paper to look further at the feasibility of an integrated approach to service provision if 'firm and costed proposals are received for consideration' (para.1.16).

Organisational and management challenges neglected

General practice needs to adapt and change if it is to meet the challenges of the 1980s. Demographic changes, early discharge and day care arrangements in

the hospital sector, implementation of locality management in community units, care in the community and the trend for GPs to provide continuing care for patients with chronic disorders all have major implications for the organisation and management of general practice. Likewise, much is being demanded of the newly independent FPCs now charged with additional planning and management duties. If the proposals in the White Paper come to fruition, FPCs will become involved in a wide range of planning and monitoring tasks. These include:

- setting targets for (and monitoring uptake of) preventive services;
- more rigorous monitoring of practice premises (with dental surgeries and waiting rooms now included);
- monitoring new conditions for payment of the Basic Practice Allowance;
- providing more comprehensive information on family practitioner services;
- eliciting the public's comments on the quality of services provided.

Yet FPCs and their local professional committees are new to management and planning responsibilities and lack the information and planning resources of DHAs and local authorities. Primary care planning in DHAs has traditionally been one of the weaker areas and collaboration between FPCs and DHAs now depends on each of these authorities clarifying their agenda for primary care. For FPCs in particular, new relationships will need to be forged between independent contractors, local professional committees and the FPC, and a balance achieved between the interests of local professionals and FPC planning priorities.

Despite the fact that collaboration between FPCs and DHAs is crucial to the development of primary care, there was little discussion in the White Paper of resources and additional skills required or of how successful joint working might best be achieved.

AFTER THE GREEN PAPER: HOW THE AGENDA CHANGED

The White Paper confirmed many of the proposals contained within the Green Paper. A few proposals disappeared, such as cost-related charges for medicines and charges for routine medical checks, and others, notably the GPA and health care shops, appeared to be rejected but re-emerged in another form. However, there were some unheralded additions. These fell into three major areas: charges for dental examinations and eye tests; cash limits and practice – as opposed to primary health care – teams; and accountability arrangements. Charges and cash limits had not been the subject of previous consultation and were the focus of lengthy and fierce debates as the Health and Medicines Bill proceeded through its Committee stage in the Commons. Charges for eye tests provoked the most serious outcry; this proposal succeeded in pushing 22 Tory backbenchers into the division lobby with the opposition before the bill was read for the third time. Proposals for charges were subsequently defeated in the House of Lords.

The charges debate

> *The Government intends therefore to take powers in the Health and Medicines Bill to remove sight testing from the NHS for those who can afford to pay so that those who can afford to pay will no longer get a free NHS sight test (White Paper, para. 2.10).*
>
> *Dental examinations are an increasing proportion of dentists' work. The Government believes that it is reasonable for patients to contribute towards the cost of this part of the dental services (White Paper, para. 2.13).*

The most striking addition, and the one which engendered most fierce opposition from professional and consumer bodies as well as the government's own backbenchers, was the imposition of charges for dental examinations and eye tests. For dental services the existing complex system of charges was to be replaced by a fully proportional system with 75 per cent of the cost of NHS dentistry to be met by the consumer – up to a ceiling of £150.00. For the first time, the dental examination was to be included, at a cost to the consumer of about £3.00. The entitlement to a free eye test would be removed but the cost to the consumer would be determined by the practitioners carrying out the test. However, if the total fee paid by the DHSS for most of the tests carried out by ophthalmic practitioners was transferred to the consumer, the cost would be £9.30. Exempted from charges were children under 16; students up to age 19; 16 and 17 year olds (for dental examinations); those receiving income support; expectant and recent mothers (for dental examinations) and wearers of complex lenses and those with partial sight (for eye tests). This meant that about 38 per cent of the population would receive free dental services, while roughly 30 per cent would receive free eye tests.

It was expected that charges would generate £170 million to be channelled into new developments in primary care. This would be part of £600 million additional expenditure. By the third reading of the bill, however, a number of amendments had been agreed which increased exemptions for the eye test. This would reduce expected income by between £7 and £8 million, increasing numbers eligible for a free eye test by about 750,000.

The arguments which accompanied the passage of these clauses were concerned not only with matters of interpretation but also with the basic principles underlying the NHS. It was alleged that the introduction of charges for examinations which involved screening and preventive aspects represented a major breach of principle.

While the government argued that the precedent for this could be traced to the imposition of charges for dental and optical appliances, introduced by a Labour Government in 1951 (another breach of principle, which had led to the resignation of Aneurin Bevan), it was pointed out that charges for procedures which combined diagnosis, screening and prevention constituted a new departure. It was argued that eye tests were not just about prescribing spectacles any more than dental examinations were just about deciding on a course of dental treatment. MPs of both main parties claimed that the preventive thrust of the White Paper was weakened by these measures and that 'the signal from the government will be that check-ups are an optional extra for which they can safely ask the public to pay' (House of Commons, 1988a).

A less clear-cut but related breach of principle was the implied separation of optical and dental services from general medical services. This was clear from the increase in dental charges (from 20 per cent of overall revenue for general dental services in 1978-9 to 30 per cent in 1986-7) and in the proposed ceiling for routine dental treatment of £150.00 – as opposed to £5.00 in 1979 (House of Commons, 1988b). The proposal to apply charges to the initial screening emphasised this division – not easily sustainable in medical terms. As Rosie Barnes pointed out in the House of Commons, 'we are debating the principle that the NHS should be free at the point of use. There is no logic in having an NHS which provides free check-ups for some parts of the anatomy, but not for others. We must ask ourselves if this is an organ by organ charging system?' She went on to express a widespread concern among opposition MPs 'If it is teeth and eyes now, what is next on the agenda? What is the logic in charging for check-ups for eyes and teeth but not for other organs? As far as I can see, none' (House of Commons, 1988c).

These issues of principle – increasing privatisation of primary care services and the new charges – were fleshed out by debates which took their cue from the likely consequences of any deterrent effect. While the numbers deterred from visiting their dentist or optician would partly depend on the size of the charge, assessment of adverse consequences would also be influenced by the value of the examinations themselves. Both these aspects were widely debated.

Charges for eye tests were of particular concern. Quite apart from any deterrent effect, charges for eye

tests were criticised on other counts. Ophthalmic medical practitioners (who do not sell spectacles) would be unable to offset reductions in fees against the sale of spectacles. This legislation would therefore place them at a disadvantage in the market place. It was also argued in committee that previous legislation aimed at reducing the cost of spectacles might be weakened to the extent that optometrists offset the costs of 'free' eye tests against increased profits from the sale of spectacles.

For dental services, while there was little dispute over the sustained increase in treatment volume over the years, the opposition argued that treatment per course had gone down each time the charges had risen – and that the rate of increase was adversely affected by charges.

Related to arguments over this deterrent effect was concern that the burden of charges would fall disproportionately on those with low incomes. For example, elderly people (of whom over 96 per cent wear glasses) are vulnerable to serious eye conditions and rapidly deteriorating eyesight. While regular sight tests are of particular importance for this group, 6.5 million pensioners would not be eligible for free eye tests. Likewise, those who required regular eye tests as a result of illnesses such as diabetes, would be unfairly penalised.

Concern over any deterrent effect is in direct proportion to the perceived usefulness of the tests. While prescribing spectacles or undertaking courses of dental treatment are obvious sequelae of eye tests and dental examinations, it was argued that these procedures were not 'appliance led' and should not, therefore, be subject to the same charging mechanisms.

Dental examinations are important for the early detection of oral cancer and other diseases of the oral cavity as well as systemic diseases such as Crohn's disease, or AIDS, which also affects the mouth. Likewise diseases of the eye such as glaucoma, painless and amenable to treatment in the early stages, can be detected via the eye test. Diabetes and hypertension can also be detected through examination of the eye, although the eye test was not proposed as a major screening device for these diseases.

In support of the importance of the eye test beyond spectacle prescriptions, the opposition quoted in the Commons a recent survey by the British College of Optometrists, which demonstrated that 8.6 per cent of 70,000 eye examinations studied required medical investigation unrelated to the need for spectacles. In this context it was pointed out that GPs possessed neither the training nor the equipment to carry out diagnostic tests of this kind. To the extent that the charges acted as a deterrent, the eventual costs to the NHS would be greater (House of Commons, 1988d).

Finally, a further consequence of increasing the divide between general medical services and dental and optical services would be increased referral for eye tests to hospital ophthalmic departments – at no cost to the patient – but at a much higher cost to the NHS.

These arguments resulted in a number of government amendments to the bill. Diabetics referred by their GP or clinic would receive free eye tests as would people with glaucoma. In addition, help would be provided for those with incomes just above qualifying levels. It was estimated that this would extend by 750,000 those entitled to a free eye test.

Thus, while some concessions were made in relation to specified medical criteria, charges for screening remained, with the justification that the income generated could be better deployed elsewhere. This, in turn, raises another important question. How far are future developments in primary care to be dependent on the extension of charges or the redeployment of existing budgets?

Cash limits for FPCs and the development of practice teams

The charges debate reflected concern over a fundamental breach of principle. Proposals encapsulated in clause 16 of the Health and Medicines Bill are of a different order: they allow for extensive changes in the way that primary care may be organised.

As with charges, there was no consultation over the intention to introduce cash limits for FPCs in relation to certain directly reimbursed expenses – the ancillary staff reimbursement scheme, improvement grants and the cost-rent scheme. The ancillary staff reimbursement scheme was introduced in 1967; it allowed each GP to claim 70 per cent of the salaries of two whole time equivalent (wte) staff. Despite this encouragement to extend practice staff, take-up has been disappointing with no FPC in the country reaching the maximum number of ancillary staff allowed. Large variations exist – a take-up of 0.88 wte per GP in Camden and Islington compared with 1.47 in Northumberland for example.

The cost-rent scheme, introduced in 1971, provides GPs with what amounts to an interest-free loan on capital borrowed to provide new purpose-built premises. These two schemes, along with grants for improvements to premises (about £277 million in 1987-88) will now form part of an annual amount allotted to Family Practitioner Committees or Health Boards. It is clear that as well as simplifying methods of payment an important aspect of this new budget is the enhancement of the planning and management role of FPCs. For example, in the White Paper it is stated that:

> *the government will increase the assistance available to doctors in improvement grants and under the cost rent scheme...For these purposes funds will be allocated to family practitioner committees and health boards, and new investment will be targeted on premises where the greatest improvement is required (para.3.51).*

The initiative for undertaking improvements will thus no longer rest solely with the GP but will be a matter for negotiation between GPs and the FPC.

The same is true for the ancillary staff scheme. The

clause allows for an extension of the categories and numbers of staff eligible for direct reimbursement through the scheme. In principle, GPs could apply for direct reimbursement of a wide range of staff, including, for example, counsellors, physiotherapists, link workers or interpreters. The number of staff reimbursed (in whole or some part) again would be a matter for the FPC to decide. Mrs Currie put it succinctly:

> *We will not necessarily restrict him (the GP) to two practice staff, we will not necessarily restrict the proportion that we will reimburse to 70 per cent and in future we will not restrict the type of practice staff who can be employed. Exactly what he or she will get will depend on his or her negotiations with the family practitioner committee (House of Commons, 1988e).*

In theory, FPCs could reimburse 100 per cent of the cost of ancillary staff.

The extent to which FPCs develop this role will be a function of the size of the budget and the administrative resources for managing it. In relation to the latter, the government committed a 4.4 per cent increase in real terms for the overall administrative budgets for FPCs for 1988-9. However, the intended size of the cash-limited budget for ancillary staff was not made clear, nor the basis on which it was to be calculated. This provided a focus for opposition concern during the committee stage. Attempts to ensure that the budget would not be less than the maximum currently allowed, (i.e. the equivalent of two wte staff per GP), or that it would reflect staffing required for meeting local needs, were not successful. While the government confirmed that existing commitments would be recognised, extra resources would depend on negotiations with the professions and on charging for eye tests and dental examinations. There was no indication of how far staff under the scheme would be guaranteed continuity of employment. This aroused concern among opposition MPs that the clause would result in less money being directed towards ancillary staff than is currently the case. In addition, if the budget for ancillary staff failed to keep pace with salary increases, FPCs would need to choose between reimbursing fewer staff or a smaller proportion of their salaries. Whatever the size of the budget, however, the clause is notable for its emphasis on developing the role of FPCs. There has been little discussion of the reasons why the ancillary staff reimbursement scheme has been so poorly exploited so far, or how priorities would be determined locally (and competing claims assessed) or how the proposals relate to policies on the attachment of community health service staff (including physiotherapists, chiropodists and psychologists) to general practice. For example, many GPs are unable to take on practice staff because of the unsuitability of their premises; many are loth to do so because of their contribution of 30 per cent of the salary. While, in the case of practice nurses, outgoings can be easily recouped (through item of service payments for cervical smears and the like, which can be carried out by nurses), the financial benefits would be less clear for services rendered by physiotherapists or chiropodists, for example. In addition, this proposal flatly contradicts the recommendation contained in the Cumberlege review of community nursing services in England that GP-employed practice nurses be phased out in favour of integrated nursing teams, providing a clear management structure and training opportunities for nursing staff.

In summary, one of the major changes introduced in this bill is that FPCs will now hold a budget for reimbursing all or part of the salaries of a wide range of health service staff. They will also bear responsibility for deciding how and where those staff may best be deployed. This broadens their remit as employing authorities and arguably clears the legislative path towards the development of extended primary care authorities.

Calling professionals to account

It is no easy task to inject 'accountability' into a world dominated by independent contractors running small businesses and more familiar with peer review and professional standards than with management. However, both the White Paper and the Health and Medicines Bill bear witness to determined attempts to enhance the accountability of those providing family practitioner services – to the consumer, to FPCs and in relation to resources expended. A combination of methods is intended, including legislative changes, contractual amendments and proposals related to information and audit.

The legislative changes outlined above provide a clear indication that FPCs are to further develop their planning and monitoring role in relation to GPs and their use of ancillary staff. Dentists too are to be more closely monitored. The Dental Estimates Board (to be renamed the Dental Practice Board) will be able to impose a limited period of prior approval for treatment in certain circumstances, an expansion of its current duties. While this expanded role of both the Dental Practice Board and FPCs is enshrined in legislation (in Clauses 12 and 16 respectively) the bulk of proposals designed to increase accountability depend on negotiations with the professions over contractual changes and alterations to the remuneration system.

In relation to general medical practice, the government announced its intention in the White Paper to tighten the qualifications for receiving the Basic Practice Allowance (BPA). In order to receive the full amount, GPs would be expected to provide more than the current requirement of an average of 20 hours per week in direct patient services for a minimum list of 1,000 patients. How much more is subject to negotiation. In addition, certain health promotion tasks would need to be carried out in order to receive the allowance. This attempt to include certain kinds of health promotion as part and parcel of being a GP – and therefore not liable to additional payments – represents a major advance towards clearer specification of the GP contract. Likewise, the introduction of payments for reaching specific targets in relation to selected services represents a first step towards performance-related pay.

Dentists' contracts are to undergo major revision; NHS services will be provided for a minimum number of hours and the requirement to provide preventive advice will be clarified. In addition, a new remuneration system will be devised to incorporate incentives for 'high efficiency and high standards' (para.4.26). This revised contract would allow FPCs and Health Boards to inspect dental surgeries and waiting rooms. Greater emphasis on information from GPs to FPCs (and vice versa) and from both to consumers provides another route through which professional accountability may be increased. Unusual referral patterns and prescribing rates will be assessed by FPCs with the assistance of independent advisers. The White Paper also proposes that GPs should provide annual reports for FPCs to enable them to carry out their planning and monitoring role. Finally, practice leaflets and expanded medical and dental lists would provide consumers with more information. In addition, a simplified complaints procedure (as well as the proposed consumer surveys) would ensure that consumer views on the quality of service became known.

All these changes point towards greater accountability – particularly of GPs. A contradiction remains, however. Financial incentives remain the main route through which changes in practice are to be encouraged. Financial incentives are precisely that; they do not provide a guarantee that specific services will be provided. The immense variation in the extent to which GPs receive item of service payments demonstrates this point. In addition, it is not clear how large the incentive needs to be to alter behaviour in any particular setting. Thus while the contract remains largely unspecified, financial measures to increase accountability still fall far short of ensuring predictability.

Information for consumers will promote greater responsiveness to user choice among GPs. However, it is likely to be less effective in areas where there is little choice of GP, for those who are restricted in their choice through lack of mobility or for those who do not choose to collect and critically compare outcome measurements of general practices within their locality.

The prime responsibility for population-based services such as child health and screening fell to local authorities prior to 1974, and to health authorities following the 1974 reorganisation of the health service. Increasingly, GPs are taking responsibility for these areas. The effectiveness of public health measures of this kind depends on adequate monitoring systems and a population-based approach. Financial incentives for GPs and increased information for consumers on their own are unlikely to guarantee adequate population coverage.

PLANNED DEVELOPMENTS AND AVAILABLE RESOURCES: WILL THEY MATCH?

The government outlines an ambitious programme of developments in family practitioner services which raises two related questions. First, will additional resources (from charges, rejigging professional contracts or exchequer funds) be adequate to meet new developments? Second, what level of incentive is needed to ensure significant improvements in standards? Given that much of the government's programme for raising standards depends on forging closer links between remuneration and performance it is important that a consensus is reached about the level of incentive needed to achieve change so that an estimate can be made of additional resources required.

Negotiations with the medical profession will need to clarify proposed changes in a number of different areas. First, changes in the remuneration system will involve negotiating a new balance between item of service payments, target-related incentive payments and basic contractual duties. Second, the criteria for special allowances such as the deprived areas allowance need to be explained. Third, levels need to be set for financial incentives, allowances and sessional payments. The cost of these developments will depend on GPs' take-up rate of various allowances. As this is largely unpredictable, it is not clear how these changes will affect the overall amount of cash available to the family practitioner services. Furthermore, there is no indication how additional resources will be allocated between different branches of the family practitioner services, or prioritised within any one of those services. It is therefore not possible to identify the relative importance attached to the many proposals contained within the White Paper.

The White Paper promises resources for at least 15 different proposals. It also encourages increased effort in other areas, including computerisation, studies on referral patterns, consumer surveys, annual reports (from general practitioners to FPCs) and practice leaflets – though no specific mention of additional funding is made for these.

This section outlines proposals for which additional resources are required, considers some of the practical implications of these proposals, and speculates on the adequacy of available funds.

Counting the cost

Fees for reaching specific targets for immunisation and vaccination, screening and to meet the costs of call and recall systems

It is not yet clear how these targets (to be locally agreed between FPCs and DHAs) will be set. Will practices which have already reached their targets be rewarded, or will incentives be targeted to encourage better performance from those practices providing restricted preventive services? Plans will need to be carefully formulated to avoid penalising the high achievers or demoralising the low achievers. If a target-related fee is to replace item of service payments it may act as a positive disincentive for GPs, particularly those in inner cities, who may be unable to meet specified levels of cover. Various studies have shown a direct correlation between the social class structure of practice populations and their immunisation rate (Mant *et al.*, 1986; Jarman *et al.*, 1988). This has implications for target-setting and the organisation of primary care services.

Possible costs of providing such an incentive may be gauged by estimating how many GPs provide population-based preventive services. A study of London FPCs (Jarman, 1981) indicated that only a small proportion of immunisation and vaccination was carried out by GPs. For example, average payments for each unrestricted principal in the Kensington Chelsea and Westminster FPC area in 1977/8 was £45.00 (with a fee of either 80p or 1.15p per vaccination). The average payments for inner London GPs were £87.00 and for outer London GPs £143.00. These figures signify low levels of service and wide variation between London FPC areas. More recent figures from one London health authority indicate that despite a campaign to encourage GPs to carry out immunisation and vaccination, four-fifths of this service is still provided by community health services (Greenwich health authority, personal communication). These uncertainties raise problems in setting the level of the incentive and in estimating the likely overall cost of the scheme.

An allowance is proposed for GPs who complete an agreed training programme and provide child health surveillance

The form this allowance might take – target-based, item of service, or some combination – is not specified. Currently, GPs provide a small proportion of these services. A survey (Macfarlane and Pillay, 1984) to determine the division of labour in pre-school child health services in England showed enormous variation in the participation of clinical medical officers, health visitors and GPs in child health clinics. In North Western Region, 80 per cent of child health clinic sessions were held by clinical medical officers and only 6.3 per cent by GPs. In Mersey, only 3.7 per cent of sessions were carried out by GPs compared with 33.2 per cent in Oxford RHA. As in the previous example, estimating the likely resource implications of the new allowance is likely to prove difficult.

A fee will be paid to provide an initial clinical assessment for patients registering for the first time with an NHS doctor

While this represents a negligible amount for the average GP, there is likely to be substantial variation across the country influenced, for example, by numbers of overseas students.

Deprived areas allowance

This allowance is in recognition of the special difficulties facing general practice in inner city areas.

Two problems need to be overcome before it could be introduced. The first concerns the definition of a deprived area. The under privileged areas sub-committee of the GMSC accepted the scoring system developed by Professor Brian Jarman based on GP perceptions of workload associated with selected census variables (Jarman, 1983). But there will always be practices working with deprived populations which fall outside the 'official' boundaries of deprived areas. In addition it is not clear how far the income of GPs working outside deprived areas – however defined – would be reduced in order to recompense GPs working within deprived areas.

Additional resources for the extension of the direct reimbursement scheme for ancillary staff and to allow for the training of these staff

Currently, the ancillary staff reimbursement scheme allows for each principal to claim 70 per cent of the cost of two wte staff. Take-up of this scheme is poor. The national average in 1987 was 1.26 wte per GP. In inner cities, take-up is even lower. FPCs who are to hold funds for direct reimbursement will need to consider whether to deploy increased resources towards those practices keen to expand their practice teams or to encourage those GPs who have failed to exploit the current allowance. As in the case of child health services, there is scope for even greater diversity between practices unless policies and priorities are carefully thought out at local level. It remains to be seen whether resource allocation in this area will reflect current levels of take-up or will be gauged to encourage the further development of practice teams.

Funds will be made available to FPCs and HBs to render the cost-rent scheme more sensitive to local variation

More money is promised for premises improvements though the exact amount again depends on negotiations with the professions and new charges. The funds would be cash limited; FPCs and Health Boards would be required to target resources.

Incentives are proposed to encourage GPs to undertake minor surgery

Currently few GPs in the UK perform minor surgery, in contrast with other countries and despite evidence on its cost effectiveness (Wall, 1987). In its response to the Green Paper, the GMSC highlighted the omission of minor surgery and called for an extension of item of service payments in this area, a proposal duly reflected in the White Paper. However, take-up of this payment will depend on how many GPs work from suitable premises, and on whether the extra payments make personal investment in equipment and instruments worthwhile.

Dentists are to be encouraged to practise in designated areas, and more funds are to be made available for vocational training schemes

Market forces have not guaranteed an equitable geographical distribution of dentists, and increases in the numbers of dentists (3,000 over the last decade) have not ameliorated the situation. The White Paper points out that in the Trent Region there are 'nearly twice as many people per dentist as in the North West Thames Region' (para.4.17), and in order to promote a more even distribution financial assistance will be provided for setting up practices in 'designated areas'. While this measure is described as a means to 'reinforce the effect of market forces on distribution', it is not clear which level of payment will be required to provide effective reinforcement of existing market forces, so that a more equitable distribution of dentists is achieved.

Extensive redistribution would be necessary to effect a fairer spread of dentists. Resources required to implement this measure would depend partly on the definition of a 'designated area', raising the same uncertainties as the deprived areas allowance, and the level of payment required to act as a genuine financial inducement. Birch (1987a) points out the danger of regional specific fees attracting dentists to 'regions of relative underprovision from other regions of underprovision, with the level of provision in the overprovided regions being left unaffected'. He notes that replacing item of service payments with a system of capitation fees would be one way of encouraging dentists to practise in areas where more dentists are needed.

Pharmacists are to be provided with additional funds

In order to develop the role of pharmacists, funds will be made available for:

- keeping records relating to elderly and confused patients on long-term medication;
- continuing education and in-service training;
- supervision of the supply and safekeeping of medicines in residential homes;
- pharmacy practice research;
- attracting pharmacies to inner cities and to improve standards of pharmacies in inner cities.

Again, the extent to which these allowances may be taken up is a matter for speculation. It is not clear to what extent estimated take-up of any of the special allowances in dentistry, pharmacy or general medical services will influence the overall level of resources made available, or the level at which specific incentives are set.

Family Practitioner Committees will be provided with 'extra powers' and 'extra funds' to carry out their enhanced management duties

Few details are provided in the White Paper on how FPCs are to carry out the extensive range of tasks allotted to them. While they are encouraged to work with departments of community medicine and to seek independent medical advice on referrals, their needs for resources – of skill, time and management – are not addressed in any detail. How are they to monitor that GPs are providing a comprehensive service for elderly people, for example, or ensure that population-based preventive services such as child health surveillance are being adequately implemented? Public health activities of this kind extend far beyond FPCs' current remit. A recent study, funded by the NHS Training Authority, found considerable barriers to

organisational achievement in FPCs including a lack of purpose, corporateness and ability to delegate (NHSTA, 1988).

In conclusion, there are a large number of areas where extra resources will be needed. Moreover, estimating additional funds required is no easy task, given uncertainties over take-up of new allowances, and the levels at which incentives need to be set in order to prove effective. The following section indicates some of the additional resources likely to be made available.

Assessing resources

According to the White Paper (para.2.5) gross expenditure on family practitioner services is to be increased in real terms by 5 per cent in 1988/9; 2.5 per cent in 1989/90 and 3.5 per cent in 1990/91. This amounts to a total of £570 million additional expenditure (at 1987/8 prices). This will meet increases in the numbers of 'doctors, dentists and other professionals' and the cost of medicines. During the second reading of the Health and Medicines Bill it was clarified that (subject to negotiations with the professions) expenditure by 1990/1 would be in excess of £600 million in real terms over and above current expenditure. Dental charges and eyesight tests were initially expected to contribute £170 million overall to the total additional expenditure of £600 million though subsequent amendments reduced this figure by £7-£8 million.

The extent to which this estimated £600 million will fund new developments depends on a number of factors. First, the estimated 5 per cent growth in real terms for 1988/9 is based on a national inflation rate of 4.5 per cent per annum. However, the inflation rate for the NHS as a whole often runs at a higher level than the national rate. Moreover, the government has estimated that the FPS need an increase of 0.4 per cent per annum simply to meet demands from larger numbers of elderly people (House of Commons 1987b) Estimates of additional resources, therefore, need to be adjusted to take account of increased demands.

A second source of uncertainty is the extent of any possible deterrent effect of imposing charges. In Committee, Tony Newton admitted:

> *it would be foolish of anyone, particularly anyone representing a party which is interested in market mechanisms and which recognises the effect of price, to suggest that any changes in price, however small, would have no conceivable effect in the short term (House of Commons, 1988f).*

Teasing out the relationships between charges and patient demand is a complex matter. There have been changes in the pattern of dental disease and steady increases in dental manpower, as well as sharp increases in the cost of dental treatment. Downturns in treatment volume in 1972, 1978 and 1985 onwards mirror increases in dental charges in 1971, 1976 and 1977 and in particular from 1985 onwards. The British Dental Association argues that charges have exerted a permanent effect on treatment volume (BDA, 1988). This is borne out by studies on the effects on utilisation of increases in both dental and prescription charges. In a study comparing utilisation per capita in exempt and non-exempt adult non-elderly groups from 1979 – 1985, Ryan and Birch estimated that a 10 per cent increase in charges led to a 1.8 per cent reduction in utilisation (Ryan and Birch, 1988). There is also evidence that the type of treatment provided is affected by charges. In a study of the use of dental services by older people, Birch showed that those not exempt from charges were four times more likely to receive emergency care only, 340 times more likely to receive only a check up and when obtaining treatment to receive 40 per cent less than exempt patients (Birch, 1987b). Birch argues that the deterrent effect of charges for eye tests and dental examinations are likely to be greater than for changes in the cost of treatment. While reductions in service utilisation also serve to release resources, this is at the risk of reducing the impact of the NHS on health status. In addition it is not clear whether resources released through reductions in utilisation would be made available for other FPS developments, or simply reduce the exchequer contribution to the NHS (Birch, 1988).

Third, the abolition of outdated allowances such as the vocational training allowance will generate some income. However, major restructuring of the balance between item of service payments and basic contractual duties would be required if resources for the proposed developments outlined above were to be generated from this source.

While the picture will be clearer once negotiations with the professions are completed, there are real uncertainties that available resources will not be adequate to ensure effective implementation of the White Paper proposals.

CONTRADICTIONS AND CONUNDRUMS

The underlying objectives of the White Paper are sound. The methods adopted for achieving them, however, expose a number of contradictions and betray a less than integrated approach to the development of services for primary care. Problems largely derive from viewing general practice in isolation from other sources of primary care, emphasising health promotion at the expense of other aspects of general practice, and adopting a cautious approach towards quality assurance in general practice.

General practice viewed in isolation

Many population-based primary care services, such as child surveillance, immunisation and vaccination, cervical cytology, contraceptive services and well-women clinics are currently provided by both GPs and DHAs. Many such services were the responsibility of local authorities until the 1974 reorganisation of the NHS, and GPs have only gradually taken on more of this work. In some parts of the country – and particularly in inner cities – community health services still carry out the bulk of these activities. In addition, preventive work with under 5s and older people falls within the remit of health visitors either as part of primary health care teams or as part of nursing teams organised on a geographical basis. As more care takes place within a community setting a wider variety of DHA staff are being attached to general practice – physiotherapists, community psychiatric nurses and psychologists, for example. Some practices are developing close links with voluntary organisations and there have been numerous attempts to integrate social workers into primary health care teams.

Changes are also taking place in the organisation of community services, notably the development of neighbourhood nursing teams and of locality management. Defined localities are being developed as a basis for planning and organising community services.

Against this backdrop of the changing nature of the primary health care team and the context within which it operates, it is surprising to find so little discussion in the White Paper of the continuing primary care responsibilities of the community health services, and how these might relate to planned changes in general practice. This is particularly striking as many of the proposals in the White Paper have clear implications for the future management of community health services.

First, an extension of the preventive role of GPs implies reductions in community health services – at least over a period of time. Any savings currently produced in this way are ploughed back into the overall DHA or community budgets; no indication has been given that a transfer of funds will accompany the transfer of functions. While a reduction in clinical medical officers, for example, may be envisaged, overall responsibility for maintaining standards in population-based preventive care still rests with DHAs. As general practice is provided with greater incentives to undertake these services, community unit managers will face the task of monitoring the uptake of preventive services falling largely outside their control. This raises questions of which authority – FPC or DHA – is to become the lead agency for these services, how changes in responsibility are to be managed, and how monitoring is to be carried out.

Second, great emphasis is being placed on proposals to extend the categories of staff eligible for direct reimbursement (in whole or in some part) via FPCs. In policy terms, the emphasis is squarely placed on the 'practice team' rather than the 'primary health care team' and on employment by – rather than attachment to – GPs. While a lack of suitable premises may be one stumbling block here, particularly in inner cities, there are other problems. The Cumberlege Report highlighted how practice nurses lying outside management structures had poor access to training resources and professional nursing advice. The extension of categories of staff falling within the practice team is likely to raise similar problems. Over time, this proposal is also likely to affect manpower planning in DHAs. If a few practices employ a physiotherapist, for example, this may have implications for the number of community physiotherapists needed by a district. The fact that GP practice boundaries cut across DHA boundaries makes this planning task more complex. Clearly, FPCs and DHAs will need to work closely together to ensure continuity in providing appropriate levels of service.

Third, the White Paper emphasises prevention. Crucial to the implementation of health promotion policies in primary care is the work of community nurses. Indeed, as the Health Visitors Association (HVA) put it:

> *much of the work to reach targets for health promotion and preventative services will be done by health visitors and other community nurses and (the HVA) questions who is going to get the money for achieving the vaccination and immunisation targets (Health Visitor, 1988).*

Some preventive work will be carried out by practice nurses, but with a total of 3,000 practice nurses for almost 30,000 GPs (House of Commons, 1988g) this can provide only a partial answer at present. Increased demand from GPs for attachment of health visitors to their practices in order to carry out additional preventive duties is therefore likely. Yet, immediate and urgent problems such as child abuse inevitably push health promotion further down the list of priorities for DHAs and for the health visiting staff they employ. This will inevitably be reflected in the priorities of nurses attached to general practices.

The changing balance of service between community units of DHAs and general practitioners, along with the staffing and organisational issues involved, are key questions but almost totally neglected in the government's programme. Future partnerships between community health services, voluntary agencies, local authorities and GPs are largely ignored.

Health promotion on centre stage?

The Foreword to the White Paper emphasises the need to 'shift the emphasis in primary care from the treatment of illness to the promotion of health and the

prevention of disease'. Clearly the imposition of charges for eye tests and dental examinations is at variance with this, a point that has been made repeatedly by both sides of both Houses of Parliament. Likewise, the intention to remove the statutory obligation for the community dental service to screen children of school age, without ensuring monitoring of alternative coverage provided by general dental practitioners, further works against the preventive thrust of the proposals.

For general medical services, however, a large number of additional incentives are proposed to encourage preventive activities. GPs will be offered incentives to meet preventive targets as well as fees for holding health promotion clinics. They will be required to provide basic screening services for their practice populations and encouraged to provide comprehensive regular care for elderly people. Clearly GPs will need to develop a more proactive approach, using record systems which enable them to target non-attenders. While such an approach reflects the policy of the Royal College of General Practitioners and is already standard procedure in forward looking practices (see, for example, Marsh and Channing, 1988), for many GPs it will require new ways of working and the investment of additional resources.

Most commentators have welcomed the emphasis on prevention, despite the lack in the White Paper of any critical appraisal of the effectiveness of specific preventive tasks carried out by GPs. However, a wholesale emphasis on this aspect of general practice serves to steer debate away from some of the other major challenges facing primary care. Foremost among these is the difficulty in monitoring the quality of diagnosis and clinical care. Commenting on the preventive emphasis in the White Paper the Lancet (1987) noted that:

> *many of the preventive activities proposed are of unproven effectiveness, and divert attention from the more difficult and basic issues of acceptable standards of service provision and diagnostic and treatment skills. Moreover, the key issue of how high clinical standards can be set and maintained in a service provided by independent contractors bereft of a secure academic base and of any hierarchical structure beyond a vocational training programme is ignored.*

A second major challenge facing general practice is providing appropriate care for each of the priority groups. As in preventive services, care for priority groups involves setting up monitoring systems and providing coordinated care. The Green Paper confidently stated that 'the move towards the provision of care in the community has been assisted by the increasing involvement of a wider range of professional groups who with appropriate training are participating in the primary health care teams and by increases in the number of support staff' (Chapter 2, para.29). Yet, there is evidence that many GPs lack information on local services for priority groups (Ineichen and Russell, 1980), that the primary medical care needs of people with learning disabilities are not always met (Howells, 1986) and that physically disabled people criticise the quality of their primary care services (Beardshaw, 1988). There is no discussion of the primary medical care of mentally ill or mentally handicapped people or of the ideal balance between the work of an extended primary care team and that of a hospital 'outreach' service. Yet, the quality of primary care for these priority groups is fast creeping up the policy agenda. While the White Paper does propose changes in the remuneration system 'to encourage doctors to provide comprehensive care for elderly people', there is no discussion of how this will be achieved or how GPs would relate to other care providers. There is in any case little knowledge about the quality of care received from GPs by elderly people (Wilkin, 1986).

In his 'agenda for action' for community care (1988), Sir Roy Griffiths argues that the GP contract should be amended to ensure that GPs inform social services of community care needs of patients registered in their practices. This should form part of a more systematic approach by GPs to 'identifying the potential community care needs of their patients' (para.8.2).

It has also been argued that with increasing numbers of elderly people being cared for in residential homes, and given the extensive visiting often involved, attention needs to be directed to what GPs are expected to provide under 'general medical services'.

These form part of wider questions over the boundaries of GP responsibility for those who require extensive medical care in a community setting, the willingness and capacity of GPs to provide appropriate primary medical care for mentally ill and mentally handicapped people living in the community, and the kinds of primary health care team (or community team) which best meets the needs of these groups. The importance of preventive activities should not cloud the need for clear policy statements on these other areas. Additional demands will not all be absorbed by individual GPs but require, as a first step, new thinking over the division of labour within expanded primary health care teams.

By narrowing the focus of health promotion into the role of individuals and their GPs and by narrowing the focus of general practice into preventive care, some complex policy debates are neatly evaded.

Quality assurance: part of the way

A major objective of the government's programme is to raise standards in primary care. This is to be achieved through increased accountability, financial incentives and consumer information. While it is difficult to predict the extent of change at this stage, it is clear that for some practices at least, certain proposals may have the opposite effect. The emphasis on prevention provides a partial approach and the White Paper is largely concerned with process rather than outcome measures. Target setting and increasing the proportion of income represented by the capitation fee are fraught with difficulties. For example, reaching preventive targets can be more problematic in inner city areas (Mant *et al.*, 1986) due to a combination of reduced uptake of preventive services in deprived areas, highly mobile populations and poor premises with less facilities for primary care teams. Yet, the

White Paper states that 'those whose standards fall short will have to improve their performance if they are to maintain the level of remuneration they receive at present' (para.3.10). Setting local targets on the fine line between a penalty and an incentive will be a complex task. Likewise, the intention to increase the proportion of income represented by the capitation fee – encouraging longer lists – may serve to reduce quality. While a number of studies demonstrate that list size does not play a major part in determining the quality of patient care (Knight, 1987; Butler and Calnan, 1987), a 'manageable' list size will inevitably vary with the location and nature of different practices – and inner city populations may generate higher workloads. There is the possibility that financial incentives towards larger lists and more prevention will discourage some GPs from taking on to their lists 'unpopular' time-consuming clients such as homeless people and those with long-term dependencies. Indeed the notion of 'consumer choice' as a vehicle for enhancing quality may ring hollow for those who currently experience difficulty in being accepted on to GP lists, or who are unable to 'shop around' due to lack of mobility or geographic isolation. In any event, if GPs are to take on additional responsibilities in the fields of prevention and screening, minor surgery, continuing care and extended medical care for elderly people in nursing homes they will need shorter lists and not longer ones, unless they obtain much more support.

The preponderance of incentives for preventive services again provides only a partial approach to the quality of care. There are few incentives, financial or otherwise, to improve care or set up monitoring systems for people with long term dependencies such as mentally ill and mentally handicapped people. Neither are there allowances to help meet increased workloads which may result from trends in acute hospital care such as longer waiting lists, earlier discharge and day care services. The intention to make payment of the Basic Practice Allowance dependent on carrying out health promotion and preventive activities (assuming ways can be found of monitoring this) represents a further increase in workload. This combination in the White Paper of increased contractual duties, longer lists, and the tendency to ignore (in terms of standards or workload) treatment of acute illness and the management of chronic illness in general practice may prove a less than acceptable package in terms of quality of care.

Part of the approach adopted for raising standards is to foster competition between practices – and to further reward good practice through financial incentives and higher payments for larger lists. This will serve to improve standards in some areas. There is evidence, however, that practices in affluent areas with an expanding population are more likely to respond to economic and professional incentives. It is unlikely that practices in deprived areas will be more responsive to the new incentives in the White Paper than they were to previous financial inducements (Bosanquet and Leese, 1988). If standards are to be improved overall, FPCs and others will need to target resources to less good and struggling practices, or as the British Medical Journal put it, 'What is really needed is extra payments for a bad practice, paid only after audited deficiencies have been corrected' (1987).

Improving quality in general practice depends on getting the measure of changes in health status, patient satisfaction, extent of appropriate referrals to acute services and other agencies and accurate and timely clinical diagnosis. It involves critical assessment of activities, including preventive activities, within general practice, and – from an efficiency point of view – involves comparing costs of alternative methods of providing essential services against such outcome measures.

The White Paper, however, is largely concerned with 'process' measures such as tightening up the terms and conditions of service, encouraging self audit through better information on prescribing patterns and referral rates, tying income more closely to performance, and an increase in the monitoring role for FPCs. There is no assessment of how the work of different members of the primary health care team might be more efficiently carried out. For example, the White Paper proposes that GPs be remunerated for carrying out preventive tasks. Many of these tasks will be carried out by nursing staff employed by the DHA but attached to general practice. This represents a double payment for a single service (and fails to recognise the importance of a team approach in health promotion). Ironically, too, value for money may not always be the result of forging closer links between incentives and performance. Teamwork and peer group contact may be more effective routes to changing patterns of activity (Horder *et al.*, 1986).

Finally, the combination of a demand-led service with the independent contractor status of GPs has delayed research and debate on questions of resource distribution to FPCs. It has been clearly demonstrated that FPCs vary widely in their expenditure per head of population (Bevan and Charlton, 1987). Understanding the reasons for inequalities in provision and developing appropriate policy responses represent new challenges for those concerned with policy in primary care.

CONCLUSIONS

Despite the title 'Promoting Better Health', the White Paper on primary health care is largely concerned with improving the accountability of independent contractors, and with smoothing the path for changes in the organisation of family practitioner services. The monitoring and planning roles of FPCs are to be strengthened and the legislative path is cleared for FPCs to control the budget for a wide range of ancillary staff. For the first time, too, FPCs, jointly with DHAs, will be asked to set targets for selected preventive and screening services, and financial incentives for GPs will be linked to achievement of these targets. It is proposed that information flow between FPCs and GPs be increased, thus creating a base for planning and audit. Accountability of FPCs and GPs to consumers will also be encouraged.

This focus on accountability is long overdue. It is impossible to plan integrated primary care services, or monitor standards of service delivery, while the bulk of primary care falls outside any management or information framework. However, this focus also explains some surprising gaps in the White Paper. First, there is little analysis of the changing context of primary health care. Policies for care in the community and changes in acute services have important implications for the organisation of general medical services and for the composition of primary care teams. Yet, health promotion and prevention are the only aspects to be discussed in any detail, again largely in isolation, with no mention of the role of other sectors of the NHS, local authorities or voluntary organisations. Second, community health services have undergone major changes in the last few years, notably the implementation of the Griffiths proposals for general management, the development of performance indicators and of the Korner minimum data set, new ways of organising community nursing services and the decentralisation of planning and management. While the White Paper does include a section on community nursing services, there is little discussion of the rather contradictory organisational implications of the Cumberlege Report and the White Paper. Neither is there any discussion of what the wider changes in community health services mean for primary medical care. While the importance of collaboration between FPCs and DHAs is recognised there are few pointers to how this may be achieved. Important issues such as which organisation is to take responsibility for monitoring population-based preventive services are left vague.

Third, and implicit in the foregoing discussion, the starting point for the White Paper is family practitioner services, and of these the general medical services receive the most detailed attention. More general debates on primary health care, inc.uding those fostered by WHO are not mentioned. This is despite the interest of many health authorites in working towards the targets developed by WHO and, more importantly, despite the commitment of this government towards Health For All by the Year 2000, for which primary health care is the key.

The debates provoked by the White Paper have largely focused on cash limits for FPCs and on charges for eye tests and dental examinations. There is concern that the former indicates the thin end of the wedge as far as the open-ended budget of FPCs is concerned, while the latter heralds complete privatisation of dental and optical services. With paying patients already contributing around 80 per cent of the cost of dental care, and with no guarantees that charges will not rise further, privatisation is a clear possibility.

The extension of the budgetary and monitoring role of FPCs could be seen as heralding the development of new primary care authorities. While the Society of FPCs has promoted this change in their status since FPC independence in 1985, various other bodies, including the National Association of Health Authorities, have vigorously opposed such a development, arguing instead for the reintegration of FPCs and DHAs. The recent Griffiths report on community care indicates further realignments in community health services, local authorities and GPs. Given the new tasks being required of FPCs, it seems likely that if primary health authorities are now to be developed they will be new and expanded authorities and not just FPCs or community health services under another name.

REFERENCES

V.Beardshaw (1988), *Last on the List: Community Services for People with Physical Disabilities*, King's Fund Institute, London.

G.Bevan and J.Charlton (1987), 'Making access to health care more equal: the role of general medical services', *British Medical Journal*, 295, 764-66.

S.Birch (1987a), *Market forces and market failure in the general dental service: the efficiency and equity implications of manpower redistribution*, (Unpublished paper), Department of Community Medicine, University of Sheffield, Sheffield.

S.Birch (1987b), *Patient charges and utilisation of services among the elderly*, (Unpublished paper), Department of Community Medicine, University of Sheffield, Sheffield.

S.Birch (1988), *Patient responses to health care charges: Implications for NHS performance*, Department of Community Medicine, University of Sheffield, Sheffield.

N.Bosanquet and B.Leese (1988), 'Family doctors and innovation in general practice', *British Medical Journal*, 296, 1576-80.

British Dental Association (1988), *Memorandum to the Social Services Committee*, BDA, London.

J.R.Butler and M.W.Calnan (1987), 'List sizes and use of time in general practice', *British Medical Journal*, 295, 1384-86.

Cmnd. 9771 (1986), *Primary Health Care: An Agenda for Discussion*, HMSO, London.

Cm. 249 (1987), *Promoting Better Health. The Government's Programme for Improving Primary Health Care*, HMSO, London.

J.Cumberlege (1986) *Report of the Community Nursing Review, Neighbourhood Nursing – a Focus for Care*, HMSO, London.

G.Dalley and G.Shepherd (1987), '"Going local" gathers speed' *Health Service Journal*, 97,850-1.

DHSS (1983), *NHS Management Inquiry* (the Griffiths Report), DHSS, London.

DHSS (1986), *Family Practitioner Services Complaints Investigation Procedures*. Primary Care Review Consultation Document.

DHSS (1987), *Health Services Development. Community Nursing Services and Primary Health Care Teams*, DHSS, London. (HC(87)29 HC(FP)(87)10).

DHSS and Welsh Office (1987), *District Health Authority Use of Family Practitioner Committee Patient Registration Data*, DHSS, London.

DHSS, Northern Ireland (1987), *Nursing Care in the Community: An Initial Study*, DHSS (NI), Belfast.

Sir Roy Griffiths (1988), *Community Care: Agenda for Action*. A Report to the Secretary of State for Social Services, HMSO, London.

Health and Medicines Bill (1987), HMSO, London.

J.Horder, N.Bosanquet and B.Stocking (1986), 'Ways of influencing the behaviour of general practitioners', *Journal of the Royal College of General Practitioners*, 36, 517-21.

House of Commons (1987a), *Primary Health Care*. First Report from the Social Services Committee, Session 1986-7, HC 37-1, HMSO, London.

House of Commons (1987b), *Public Expenditure on the Social Services*, Memorandum received from the DHSS, Social Services Committee, Session 1986-7, HMSO, London.

House of Commons (1988a), *Official Report*, Standing Committee A, Health and Medicines Bill, 9 February, c.575, HMSO, London.

House of Commons (1988b), *Weekly Hansard*, 14 April, c.365, HMSO, London.

House of Commons (1988c), *Weekly Hansard*, 14 April, c.375, HMSO, London.

House of Commons (1988d), *Weekly Hansard*, 14 April, c.398, HMSO, London.

House of Commons (1988e), *Official Report*, Standing Committee A, Health and Medicines Bill, 23 February, c.822, HMSO, London.

House of Commons (1988f), *Official Report*, Standing Committee A, Health and Medicines Bill, 9 February, c.618, HMSO, London.

House of Commons (1988g), *Official Report*, Standing Committee A, Health and Medicines Bill, 23 February, c.874-5, HMSO, London.

G.Howells (1986), 'Are the medical needs of mentally handicapped people being met?', *Journal of the Royal College of General Practitioners*, 36, 449-53.

R.Hull (1987), 'Government proposals for primary care: white hope, elephant or sepulchre?', *British Medical Journal*, 295, 1436.

B.Ineichen and O. Russell (1980), *Mental Handicap and Community Care: The Viewpoint of the General Practitioner*, Research Report No. 4, Department of Mental Health, University of Bristol, Bristol.

B.Jarman (1981), *A Survey of Primary Care in London*, Royal College of General Practitioners, London.

B.Jarman (1983), 'Identification of underprivileged areas', *British Medical Journal*, 286, 130.

B.Jarman and J.Cumberlege (1987), 'Developing primary health care', *British Medical Journal*, 294, 1005-08.

B.Jarman, N.Bosanquet, P.Rice, N.Dollimore and B.Leese (1988) 'Uptake of immunisation in district health authorities in England', *British Medical Journal*, 296, 1775-78.

R.Knight (1987), 'The importance of list size and consultation length as factors in general practice', *Journal of the Royal College of General Practitioners*, 37, 19-22.

Lancet Editorial, (1987) 'Primary health care: government's worthy words and the gloom', *Lancet*, 5 December, 1308-8.

J.A.Macfarlane and U.Pillay (1984), 'Who does what, and how much in the preschool child health services in England', *British Medical Journal*, 289, 851-2.

D.Mant, A.Phillips and M.Knightley (1986), 'Measles immunisation rates and the good practice allowance', *British Medical Journal*, 293, 995-7.

L.Marks (1987), *Primary Health Care on the Agenda?*, King's Fund Centre for Health Services Development, London.

G.N.Marsh and D.M.Channing (1988), 'Narrowing the gap between a deprived and an endowed community', *British Medical Journal*, 296, 173-6.

E.Martin (1987), 'Medical manpower planning: factors influencing workload in general practice', *Journal of the Royal College of General Practitioners*, 37, 530-1.

NHS Training Authority (1988), *Meeting the Challenge*, NHSTA, Bristol.

M.Ryan and S.Birch (1988), *Estimating the effects of health service charges: Evidence on the utilisation of prescriptions*, Centre for Health Economics, Discussion Paper 37, University of York, York.

H.Saul (1988), 'Is practice income from allowances under threat?', *Financial Pulse*, January 9.

D.W.Wall (1987), 'A review of minor surgery in general practice in the United Kingdom', *Family Practice*, 4,4, 322-9.

Welsh Office (1987), *Nursing in the Community – A Team Approach for Wales*. Report of the Review of Community Nursing in Wales, Welsh Office, Cardiff, 1987.

World Health Organisation (1985), *Targets for Health for All: Targets in support of the European Strategy for Health for All*, WHO Regional Office for Europe, Copenhagen.

KING'S FUND INSTITUTE

The Institute is an independent centre for health policy analysis which was established by the King's Fund in 1986. Its principal objective is to provide a balanced and incisive analysis 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. Many of its projects focus on trying to determine whether health care systems achieve their objectives. 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's approach is based on the belief that there is a gap between those who undertake research and those responsible for making policy. We aim to bridge this by establishing good relations with the scientific community, and by gearing our work towards making the most effective use of existing data. One of our key objectives is to undertake informed analyses and channel them to politicians, civil servants, health managers and professionals, authority members and community representatives.

The Institute adopts a multidisciplinary approach and seeks to make timely and relevant contributions to policy debates. A high priority is placed on carefully researched and argued reports. These range from short policy briefings to more substantial and reflective policy analyses.

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.

Other publications from the King's Fund Institute

Healthy Public Policy: A Role for the HEA Briefing Paper No 1, Virginia Beardshaw. £2.00.

Public Expenditure and the NHS: Trends and Prospects Briefing Paper No 2, Ray Robinson and Ken Judge. £3.95.

Promoting Innovation in Community Care: From Small Scale Developments to Mainstream Provision Briefing Paper No 3, David Hunter. £3.00.

Community Physicians and Community Medicine Research Report No 1, Sarah Harvey and Ken Judge. £4.95.

Health Finance: Assessing the Options Briefing Paper No 4, Ray Robinson et al. £4.95.

Griffiths and Community Care: Meeting the Challenge Briefing Paper No 5, David Hunter and Ken Judge. £3.95.

Health Care Variations: Assessing the evidence Research Report No 3, edited by Chris Ham. £6.95.

Last on the List: Community Services for People with Physical Disabilities Research Report No 3, Virginia Beardshaw. £7.95.

Medical Negligence: Compensation and Accountability Briefing Paper No 6, Chris Ham, Robert Dingwall, Paul Fenn, Don Harris. £5.95.

Further details about the Institute and its publications can be obtained from:

Publications Officer
King's Fund Institute
126 Albert Street
London NW1 7NF
Telephone: 01-485 9589