Primary Health Care: An Agenda for Discussion

Background Papers

London Programme Workshops

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The publication of "Primary Health Care: An Agenda for Discussion" was welcomed by the London Project Executive Committee of the King's Fund as an opportunity to contribute to the debate on the future of primary health care. In order to prepare a response which would contain practical recommendations for improving inner London primary care, it was decided to hold a series of six workshops reflecting some of the major themes in the Green Paper. Six background papers were prepared for these workshops under the following titles:-

1. Raising standards of inner city general practice: persuasion, pressure or payment?

2. Retirement at 70: an opportunity to transform inner city general practice?

3. Getting the measure of primary health care: setting and monitoring standards

4. Health Maintenance Organisations: inspiration or illusion?

5. Consumers and primary care: beyond market research

6. The management challenge: changing the pattern of primary health care.

Background Paper 1

RAISING STANDARDS OF INNER CITY GENERAL PRACTICE: PERSUASION, PRESSURE OR PAYMENT?

Raising the standard of general practice forms one of the major themes of the Government's discussion document on primary health care. This workshop is focussed on how this might be achieved in the inner city.

1 GREEN PAPER PROPOSALS

Proposals for improving the quality of general medical services fall into two major (and related) categories: financial incentives and increased consumer choice. In relation to inner cities, there are additional suggestions, including experimentation with different contractual arrangements.

Linking pay to standards.

There is little dispute that current contractual arrangements do little to foster good quality care. Building on proposals linked to the 'Quality Initiative' of the RCGP, the Green Paper suggests performance be linked to remuneration through the introduction of a Good Practice Allowance (GPA). A distinction is drawn between 'objective' criteria for receiving the GPA and assessments more suited to peer review. 'Objective' criteria might include:

- "personal availability for patients, both for surgery consultation and in terms of out of hours care";
- "provision of a wide range of services including preventive activities based on systems for identifying certain patients for periodic review."
- "ensuring that immunisation has been provided for an agreed proportion of patients in relevant categories"
- "attendance at recognised post-graduate courses"

Examples of criteria considered more suited to peer review include assessments of prescribing patterns and of hospital referral rates.

Linking standards to consumer choice.

It is proposed that the capitation fee would provide a major proportion of practice income, thus encouraging doctors "to practise in ways that will encourage patients to join their lists". The GPA, too, would be paid on a capitation basis. More information on what practices offer, and increased freedom in choosing and changing doctors would, it is argued, serve to enhance the quality of care.

Inner-cities: financial incentives and short-term contracts.

The creation of short-term salaried posts for GPs and extra money for doctors prepared to work in the inner cities are two of the proposals directed towards the inner cities.

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experiment with short term contracts represent small steps forward. Much remains to be done, however, and the following sections outline some of the initiatives which have attempted to improve standards of inner city health care.

Primary Care Development Projects

Independent contractor status is one of the factors that has isolated many GPs from their colleagues, other professionals, the activities of district health authorities and the communities they serve. The primary care development projects in Camberwell (based in the academic Department of General Practice) and in Tower Hamlets (based at the Centre for the Study of Primary Care) have shown that isolation can be reduced and standards of care raised without recourse to financial incentives. The projects started by identifying GPs needs and are finding ways of meeting them. They have collected the basic information needed to build links between GPs and hospital and community staff. The Camberwell Project has particularly shown the potential of educational activities in increasing cooperation between professionals.

In each case, channels of communication have been opened up through the activities of specially funded project workers. What resources will be required for FPCs and Departments of General Practice to build on this work?

Improving service quality through monitoring and information

A concern with service quality is shared by professionals (as in the recent quality initiative of the RCGP), users of services, and those involved in planning and management. From an inner city perspective special attention needs to be directed to improving the lowest standards of care.

The role of FPCs.

Inspection of practice premises, monitoring of the use of deputising services and information on accessibility of general practice are three areas where many inner city FPCs have played an active part. Some have gone further, giving GPs feed back on their activities in the form of practice profiles. Involvement of FPCs in performance review seems likely to increase. For example, Newcastle-on-Tyne Local Medical Committee [2] has recently drawn up a proposal that general practices (rather than individual practitioners) should be collectively responsible to the FPC for meeting agreed standards of acute, chronic and anticipatory care. Standards would be maintained by the establishment of a computerised information system linked to the FPC register.

Such an initiative assumes FPC/DHA collaboration, team work, appropriate computer technology and GP participation in the scheme. Is this one way for FPCs to develop monitoring activities?

What can individual practices do?

Although an overall monitoring function might eventually be adopted by FPCs, a number of individual practices and primary health care teams are attempting to set and monitor standards through practice audit. Practice reports would be one way of disseminating information to users of services thereby increasing practice accountability. Attempts by GPs to plan services for their practice populations are still relatively rare. In an inner city context this might involve

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RETIREMENT AT 70: AN OPPORTUNITY TO TRANSFORM INNER CITY GENERAL PRACTICE?

One of the few firm proposals to emerge in the Green Paper is the introduction of a a compulsory retirement age for GPs. It is proposed that "doctors should be able to retire at 60 but that there should be compulsory retirement at 70. Doctors aged 65 and over would need the approval of the FPC or Health Board to stay in practice."

This echoes one of the recommendations of the Acheson Report of 1981. It has been suggested that one of the reasons for the failure to act on this proposal was the cost involved [1]. The Green Paper does not clarify superannuation or compensation arrangements: these will no doubt be a matter for negotiation with the profession.

The likely exodus of elderly GPs over the next few years provides an opportunity for FPCs to implement a manpower strategy which reflects inner-city needs for health care. To achieve this, they would need to exert influence over the selection (and subsequent activities) of GPs, having first developed a clear view of the kinds of GP required and of the organisation of primary health care services best suited to particular inner-city locations.

RETIREMENT AT 70. HOW MANY VACANCIES?

In Greater London there are over 240 GPs over the age of 70 (6%) and a further 500 (approx) over the age of 60. In four inner-city FPCs (Kensington, Chelsea & Westminster, City & East London, Camden & Islington and Ealing, Hammersmith & Hounslow) there are 102 GPs over 70 (9.4%) and 175 aged between 60 and 69. While the number of vacancies would not match the number of retirements, given that a proportion of elderly doctors have small and declining lists, in one East London DHA alone, there would be 19 vacancies over the next 3-4 years of which 6 would be in single-handed practices.

With the abolition of 24 hour retirement it may be anticipated that increasing numbers of the over 65s would choose to retire.

From a purely administrative point of view, FPCs will need to be aware of the retirement plans of GPs so that practice populations can be informed, posts advertised and practice profiles for prospective candidates prepared. With large numbers of applicants for many inner city posts, FPCs are now in a position to be more selective.

THE MEDICAL PRACTICES COMMITTEE: HELP OR HINDRANCE?

The Medical Practices Committee is concerned to promote an even distribution of GPs throughout the country. Within inner London, most practice areas are classified as Intermediate or Restricted, and the approval of the MPC has to be sought by the FPC before a vacancy may be advertised. It has been argued that although the MPC has had some success in reducing the number of underdoctored areas nationally, categorisation by average list size is not a flexible enough method of response to local circumstances and local health needs. Anomalies abound: the elderly GP with a large list in a restricted area is unable to secure a partner, while the GP with a small list in an open area will still be entitled to a special allowance. For these reasons some FPCs want more influence in determining the distribution of GPs in their area.

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information should FPCs provide on the services/styles of working they would like to see developed. and on the support they might offer?

The Green Paper points out that "the need for more comprehensive and accessible information is increasingly being recognised by the profession itself." How far might proposals. such as the production of an Annual Practice Report be included in a "job specification" for GPs - thus meeting the twin aims of public information and professional accountability?

b) Selection Procedures.
The FPC is responsible for advertising, shortlisting and interviewing, a recommendation is then made to the MPC. With many applicants for each inner city post there is scope for each FPC. in conjunction with its LMC. to make a strategically informed choice of candidate.

c) Equal Opportunities Policies.
How might FPCs work towards equality of opportunity for independent contractors?

FROM RETIREMENT TO RECRUITMENT: BARRIERS TO CHANGE.

Among the many barriers to FPCs implementing a medical manpower strategy are the following:

a) Restriction of new practices.
The Green Paper "would welcome views .... on whether the arrangements for controlling the entry of new doctors into practice, particularly in inner cities, are unduly restrictive". Are the criteria used by the MPC to decide on whether vacancies may be advertised or new practices established due for clarification and review? Additionally, might alternative criteria be used to decide MPC areas - currently "parts of local government districts, groups of parishes or wards, or parliamentary divisions".

b) No resources for development
Newly appointed GPs face many problems in building up neglected inner city practices. Small lists mean a low income which may make it difficult to employ additional staff, introduce computerisation, or improve practice premises. Currently, FPCs are unable to provide financial help to GPs in these circumstances. Should FPCs have access to a budget which is flexible enough to meet these and other development needs?

c) Partnership agreements.
Partnership agreements are private: if problems develop, doctors can set up independently with small lists, with the effect of increasing the number of single-handed practices. The BMA has produced a standard partnership agreement. What scope is there for FPCs to encourage partners to use these agreements and how could FPCs secure commitment to fairer terms between partners? Each application to set up a partnership is considered by the MPC, and representations from individual doctors can be heard in parallel with those of the FPC.

d) Monitoring: paper tigers?
The FPC may administer GP contracts, but a GP undertakes only "to render to his patients all necessary and appropriate personal medical services of the type usually provided by general medical practitioners."

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Background Paper 3

GETTING THE MEASURE OF PRIMARY HEALTH CARE: SETTING AND MONITORING STANDARDS

One of the major objectives of the Green Paper is "to encourage the providers of services to aim for the highest standards". A distinction is drawn between professional standards "very much a matter for professional bodies" and standards of service delivery open to assessment by "objective criteria". There is little attempt to operationalise these "highest" standards of primary health care - or to identify minimum acceptable standards of service delivery. Those concerned to improve the quality of primary health care will need to consider the different areas where standards should be set: the mechanisms for monitoring standards and which professional, statutory or voluntary organisations should be involved.

1 SETTING STANDARDS.

There are a number of approaches to improving primary health care.

a Getting rid of the worst: the Acheson Report.

The 115 recommendations of the Acheson Report (1981) arose from a review of problems in the organisation and delivery of primary health care in inner London. Proposals were related to improvements in resources, practice premises, equipment and staffing as well as in team work, group practice and links with secondary care. While some progress has been made, many inner city areas have yet to find ways of overcoming the problems described in the Acheson Report. How realistic is the Government's aim to encourage the highest standards of care when the Acheson recommendations have still not been implemented?

b 'Quality' in primary health care.

In its "quality initiative" and the closely related "what sort of doctor?" the RCGP has indicated the clinical services and practice organisation it considers evidence of quality general practice. A recent publication sets out the basic range of services that should be available in every general practice [1]. The Society of FPC Administrators and the RCGP are keen to foster links between administrators and faculties in order to relate the quality initiative to particular local situations.

In the NHS as a whole, there is increased interest in quality assessment - as witnessed by the appointment of Directors of Service Quality in many DHAs. The dimensions of quality [2] are taken to be accessibility, relevance to need, effectiveness, availability, equity, efficiency and economy. What progress has been made in translating them into local primary health care standards and targets?

Fundamental to assuring standards is an assessment of outcomes - in terms of health status, uptake of services or reduction in inequalities, for example. While health status is influenced by many factors other than medical care, quality of primary health care services may be gauged from analyses of preventable handicap, avoidable deaths [3], avoidable infections, or take up of preventive services.

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purposes. A further development which might meet the twin aims of professional and public accountability would be the production of an annual report for the practice population. In addition to details about the practice, this might include information about morbidity, mortality and uptake of preventive services.

b Peer review

Practices may volunteer for peer review, carried out under the auspices of "What sort of doctor" working parties of the RCGP. Constructive criticism is given to practices in areas such as professional values, accessibility, clinical competence and the ability to communicate.

c FPCs

The Green Paper stresses the need "for FPCs to develop more systematic means of measuring quality and detecting shortfalls in the provision of services". There is no discussion, however, of the resources and powers required to do this effectively nor of the range of services falling within their 'quality control' remit. There is a well- established role for FPCs in monitoring standards of premises, hours of availability and telephone answering arrangements and there is potential for monitoring all item of service payments. Complaints provide a further indication of service quality - or lack of it. A number of FPCs are providing GPs with practice profiles and comparative information through which to assess aspects of the quality of their services. The development and monitoring of performance indicators for family practitioner services will involve collaboration between FPCs and local representative committees, and improvements in information exchange between independent contractors and the FPC.

d Users of services

The discussion document suggests that "the result of the contractual nature of the organisation of primary health care services is such that the individual members of the public as recipients of the services are often better placed to judge the quality of delivery of the services than the NHS bodies responsible for them".

Is greater freedom in changing doctor likely to improve service quality? There is no discussion of community participation in the planning of health services, nor of how primary health care may be made more relevant to people who need services but use them infrequently. Participatory mechanisms at all levels of decision-making - a plank of the WHO strategy - are not discussed in the Green Paper. The Cumberlege Report does however suggest the formation of neighbourhood-based health care associations.

e DHAs

DHAs maintain overall responsibility for ensuring that public health and preventive services are available for populations. Thus, they continue to provide preventive and screening services and first stage diagnostic services (through A and E Departments). In inner cities, they provide proportionately more of these services and collaboration between FPCs and DHAs is correspondingly of more importance. Collaboration in setting objectives, sharing information and monitoring standards involves each authority knowing the activities and plans of the other. This is currently not the case; planning for primary health care is of low status in most DHAs, and mechanisms for joint planning with FPCs are slow to emerge. With many DHAs now contemplating decentralisation, opportunities for local primary health care planning may increase, though it is not clear what role FPCs will be able to play in setting local targets.

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HEALTH MAINTENANCE ORGANISATIONS: INSPIRATION OR ILLUSION?

Health Maintenance Organisations (HMOs), a growing component of the US health care system, contract to provide (or ensure the delivery of) a stated range of health services for an enrolled population. There is a fixed payment which is independent of service use. Originally non-profitmaking and designed to provide health care for groups of employees, great diversity now exists within this overall capitation and contract model. Comprehensiveness of agreed services varies; enrolments range from about 3,000 to over one million; the population may be homogeneous or heterogeneous; and the organisations may be run on a non-profit or (increasingly) on a profit basis. There are currently about 19 million HMO members.

HMOs may directly employ staff to work in centres owned by the organisation; they may contract with group(s) of physicians to provide services for a fixed capitation fee; or contracts may be with a large number of individual doctors working from their own offices, who have formed 'independent practice associations' (IPAs).

1. ASPECTS OF HMOs

The diversity of HMOs combined with changes in an increasingly cost-conscious fee-for-service system, has made comparison difficult. However, the following qualities are typically ascribed to HMOs:

a) Cost-containment

Federal encouragement of HMOs is one response to the high costs of the US medical system. By competing with each other (and with alternative systems) in providing attractive packages, costs may be controlled with minimum federal intervention.

In HMOs the providers of services have as much interest as the insurers in containing costs. This contrasts with traditional fee-for-service systems in which there is no financial incentive for providers to control admission to hospital, length of stay, or number of diagnostic tests. HMO physicians are encouraged to play an effective 'gatekeeping' function. They are given comparative information on the number of referrals they make, and receive bonuses if the number of inpatient admissions is reduced.

While HMOs may be up to 40% cheaper than the fee-for-service system, most of these savings accrue from reduced hospital admission rates and earlier discharge. It is perhaps worth noting that HMOs are being compared with one of the most expensive ways of providing care.

b) Management control

Closely linked with cost containment is increased management control over the whole range of care. Procedures are codified; standards are set in relation to criteria for hospital admission, management of inpatients (length of stay,

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and management control. In this respect, however, the Green Paper steers well clear of the radical scrutiny of clinical activities adopted in the HMO model. Instead, a distinction is drawn between professional standards "very much a matter for professional bodies" and standards of service delivery open to assessment by "objective criteria".

In addition, by creating autonomous FPCs, the government has further separated primary and secondary care. Integration of primary care and hospital care under the same financial and management umbrella is fundamental to the HMO concept.

3. LIMITATIONS OF THE HMO CONCEPT

Clear evidence of the effects of HMOs on the quality of care is lacking, partly due to the variability of provision, and partly to self-selectivity which is an inevitable consequence of voluntary enrolment. However the following problems have been identified:

a) Inequalities of access

It has been argued that since HMOs must charge the same premium for all members of a group - such as a particular workforce for example - access to services for individual members of that group will be improved. However, this system does not provide equal access for all. Most HMOs are unenthusiastic about underwriting individuals who are not part of a group, such as the self-employed, unemployed people and those working for small companies. For those who are members, authorisation will be required before emergency treatment can be sought outside the HMO network. Poor people have access to HMOs mainly through Medicaid, though there is a fear that HMOs serving the poor will become 'Medicaid HMOs'; in addition enrolment may restrict their choice of doctor.

b) Comprehensiveness of coverage

Few HMOs implement comprehensive screening programmes; the 'at risk' population who fail to come forward for treatment are therefore no better off. Whereas 100% cover is provided for certain types of care, domiciliary care may be only partially covered. No provision is made for long-term institutional care.

c) Inequalities in outcome

A recent large-scale study[1] comparing the health outcomes of populations served by HMOs with those using a fee-for-service system showed that the only group with worse health outcomes under the HMO system was a low-income group, with health problems on enrolment. The reasons were not clear; it was speculated that this might be due to reduced access to Accident & Emergency (as only HMO-approved departments may be used); greater difficulty in arranging transport to central locations, and greater responsibility placed on individuals to follow up their treatment.

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Background Paper 5

CONSUMERS AND PRIMARY CARE: BEYOND MARKET RESEARCH

The debate on the role of consumers in health and in the delivery of health care is linked with far wider - and longstanding- debates on democracy in the NHS, the "spectrum of participation" and professional versus user control. Recent documents have highlighted the role of consumers in the following ways.

1. QUALITY OF CARE AND THE MARKET MODEL

a) The Griffiths Report

The Griffiths Report drew attention to the failures of the NHS to take account of patients' views, in contrast with the business world where consumer satisfaction is at a premium . The Report suggested that management should "ascertain how well the service is being delivered at local level by obtaining the experience and perceptions of patients and the community. These can be derived from CHCs and by other methods, including market research, and from the experience of general practice and the community health services".

Newly-appointed Directors of Quality Assurance have been assigned this task in many DHAs, but quality of acute care has taken precedence over primary health care and community health services.

b) The Green Paper

The independent contractor status of family practitioners allows for the extension and reinforcement of a market model. It is suggested that services are not just to be responsive to consumer needs, but that enhanced consumer choice in a competitive market will ensure service quality. The discussion document argues that "the individual members of the public, as recipients of the services are often better able to judge the quality of delivery of services than the NHS bodies responsible". Five changes are suggested so that the public may more easily improve service quality. First, the FPC and individual practitioners should disseminate information on GP practices (and guidance on practice leaflets has already been provided by the GMSC); information should include surgery hours, out of hours cover and so on. This would allow a more informed choice of doctor. Second, consumers should be free to change doctor without first having to contact the FPC or the doctor whom they wish to leave. Third, capitation fees would become a greater proportion of GPs' income, thus creating a financial incentive to compete for patients. Fourth (and the subject of a separate document), complaints procedures are to be simplified; and lastly, patient participation groups are to be encouraged as a form of consumer feedback. Views are also welcomed on whether "the entry of new doctors into practice, particularly in inner cities is unduly restrictive". More doctors would mean more choice and, according to this argument, better quality services.

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a) Initiatives in DHAs

A number of DHAs have attempted to incorporate views of community groups in the planning and management of services. Initiatives have included the formation of "user groups" or "local advisory groups" comprised of users and providers of services in particular health facilities. Some inner-city authorities are employing community health workers, interpreters, link workers and advocates in order to encourage local participation and help identify and meet the health needs of local populations. These workers rely on 'soft money' and opportunities for career development are poor.

A number of authorities with well-established care-group planning teams have ensured user representation with members being drawn from CHCs, pressure groups or voluntary organisations. This provides a structured and systematic user input into planning. A more recent development associated with decentralisation of services is the development of locality planning teams.

b) Family Practitioner Services

FPS have been the focus of few consumer-based initiatives. The main development, and one encouraged in the Green Paper, is patient participation groups. The first groups were set up in the early 1970s; there are now about 80 and a quarter of these are based in inner cities. They may provide feedback to GPs, mobilise community work or act as a pressure group. GPs generally set them up and provide support. Patient participation groups lack the common bond which may unite self-help groups, for example; in addition the problems of those who do not attend cannot be addressed. Most successful where communication is already good, it is not clear how they will succeed in improving the quality of poor inner city practices.

A few inner city practices employ community health workers in order to encourage local participation in health and health care. Location in a general practice has disadvantages as well as benefits; differences in approach and questions of professional autonomy may make constructive dialogue difficult.

c) CHCs

A number of CHCs see a major part of their role as giving users increased power through campaigning for more information, for advocacy schemes which help patients negotiate with health professionals, and for increased participation in decisionmaking. A CHC observer is now able to attend FPC meetings, and increasing user involvement in planning of primary health care services may be anticipated.

d) Voluntary organisations

Voluntary organisations are a major source of help for those who fall outside standard health care delivery systems, as a result of differences of language, culture or lifestyle. Thus the pitiful quality of health care received by single homeless people was highlighted not by primary care workers but by campaigning groups such as CHAR. Such organisations provide a major source of information which is rarely tapped and less often acted upon.

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THE MANAGEMENT CHALLENGE: CHANGING THE PATTERN OF PRIMARY HEALTH CARE

1. BROADENING THE AGENDA

The "agenda for discussion" set out in the Green Paper is largely concerned with independent contractors, the nature of their contracts and increased consumer choice in family practitioner services. An agenda for primary health care would encompass broader issues such as a UK response to the objectives and targets identified by the European Region of WHO; the changing demographic, social and managerial contexts which affect the nature and delivery of primary health care services and the effects on primary care of rationalisation and centralisation in the acute sector.

This workshop focusses on some of the organisational implications of new patterns of care.

a) Primary and secondary care: changing the boundaries of clinical responsibility

It is recognised that much of the work of out-patient departments could be carried out by GPs; there is concern too, that the variability in GP referral rates seems to reflect little other than personal differences. Initiatives in extending the boundaries of general practice include GP follow-up care for patients with chronic disorders such as hypertension or diabetes; consultant clinics at health centres; attachment of (or direct access to) occupational and speech therapists, physiotherapists, clinical psychologists and access to diagnostic facilities and GP hospital beds. However, the variable quality of general practitioner services and their focus on responding to individual demands rather than on developing care for populations at risk has caused concern over transferring care to a general practice setting. Studies comparing routine hospital clinic care with routine GP care for diabetes and hypertension demonstrated worse outcomes for people attending GPs.

In a climate of financial stringency for DHAs, there is pressure to transfer to general practice (and its open-ended budget) responsibility for 'duplicated' services (such as family planning) and appropriate out-patient follow-up. Which safeguards should be imposed and who will be responsible for monitoring the quality of care provided?

b) From hospital to community: priority groups and primary care

The report of the Social Services Committee on community care pointed out that "community care depends to a large extent on the continuing capacity of GPs to provide primary medical care to mentally disabled people". They expressed concern that neither GP training nor GPs' present activities in this area indicated a readiness to undertake this role. The responsibility for people discharged from hospital but under out-patient care is ambiguous and GPs need to be involved at an early stage in arranging medical care for those who have left institutional care to live in a range of community settings. This raises more general questions of how independent contractors are to achieve representation on such policy and planning matters. What role can the FPC play in helping local authorities and DHAs promote comprehensive care in a community setting?

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Some FPCs too are keen to develop a locality-based approach to planning, despite the current complexity of GP catchment areas. A number of patch projects have succeeded in involving local GPs. Which kinds of information will each authority need to make available for a patch approach to be developed, and how could locality planning be integrated into existing FPC structures? How can the gulf in attitudes and ways of working of different professionals be bridged?

c) A primary health care authority?

A number of organisations, including the Society of FPCs and the Greater London Association of CHCs have argued for the creation of a new primary health care authority. While it is unlikely that a further reorganisation is imminent (whether to reintegrate FPCs within DHAs or to expand FPC control) this suggestion raises a number of questions. How could Griffiths-style management be imposed on independent contractors; and if a new management style was not imposed would primary health care services as a whole lapse into non-accountability? How would the boundaries between primary and secondary care be drawn and where for example, would CPNs and other staff spanning hospital and community services be based?

3. PRIMARY HEALTH CARE IN THE INNER CITIES: NEW TYPES OF CARE?

Over the last six years there has been a 14% decline in London's acute beds and the closure of nine A and E departments - a traditional source of primary health care in the inner cities. The decline in the level of hospital provision has not been matched by a levelling up of primary health care. Some of the greatest changes in the balance of primary and secondary care are thus occurring where the family doctor system is at its weakest. In addition, community health services, which provide a greater proportion of preventive care in inner city areas, are competing for declining resources.

Compounding these problems, and of particular relevance for the social care of priority groups, are the financial problems of the rate-capped inner London boroughs. This means that they are increasingly reluctant to enter into schemes involving future resource commitments.

The deprivation of inner London is well known: high levels of drug abuse, poverty, mental illness, elderly people living alone and a large population of homeless people. This has resulted in new kinds of provision including salaried GPs and mobile health clinics.

One recent initiative is the Lambeth Community Care Centre, which provides care intermediate between home and hospital; patients are referred by their GPs, who provide 24 hour medical cover. In part a response to the level of care needed in an inner city area, where support networks are poor and domiciliary care schemes difficult to implement, the centre demonstrates how organisational and professional boundaries can be crossed in the interest of appropriate care.

Which initiatives in the provision of primary health care would best meet the needs of inner city populations - and where are the primary care planning forums in which they might be discussed?

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