The Emperor's New Clothes

Family Practitioner Committees in the 1980s

JUDITH ALLSOP
and
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King Edward's Hospital Fund for London

In England and Wales, family practitioner committees (FPCs) administer the family practitioner services which, together with the community health services, form the front line of the NHS. Family practitioner services are provided by independent contractors – doctors, dentists, opticians and pharmacists – and cost the NHS in 1984-85 over £4 billion, approximately 90 per cent of which was derived from taxation. Yet FPCs have been described as the cinderellas of the NHS, keeping such a low profile that many were virtually invisible to the communities which they served.

In 1985 new legislation changed their status, clarified their role and extended their functions. FPCs were reconstituted as health authorities in their own right, now responsible for planning and developing primary care services and expected to assess need, identify priorities, and inform the public.

This is the first comprehensive study of FPCs. It analyses the political environment in which they operate and illustrates many of the ways in which they can influence the provision of primary care. The authors conclude by suggesting an agenda for change and development.

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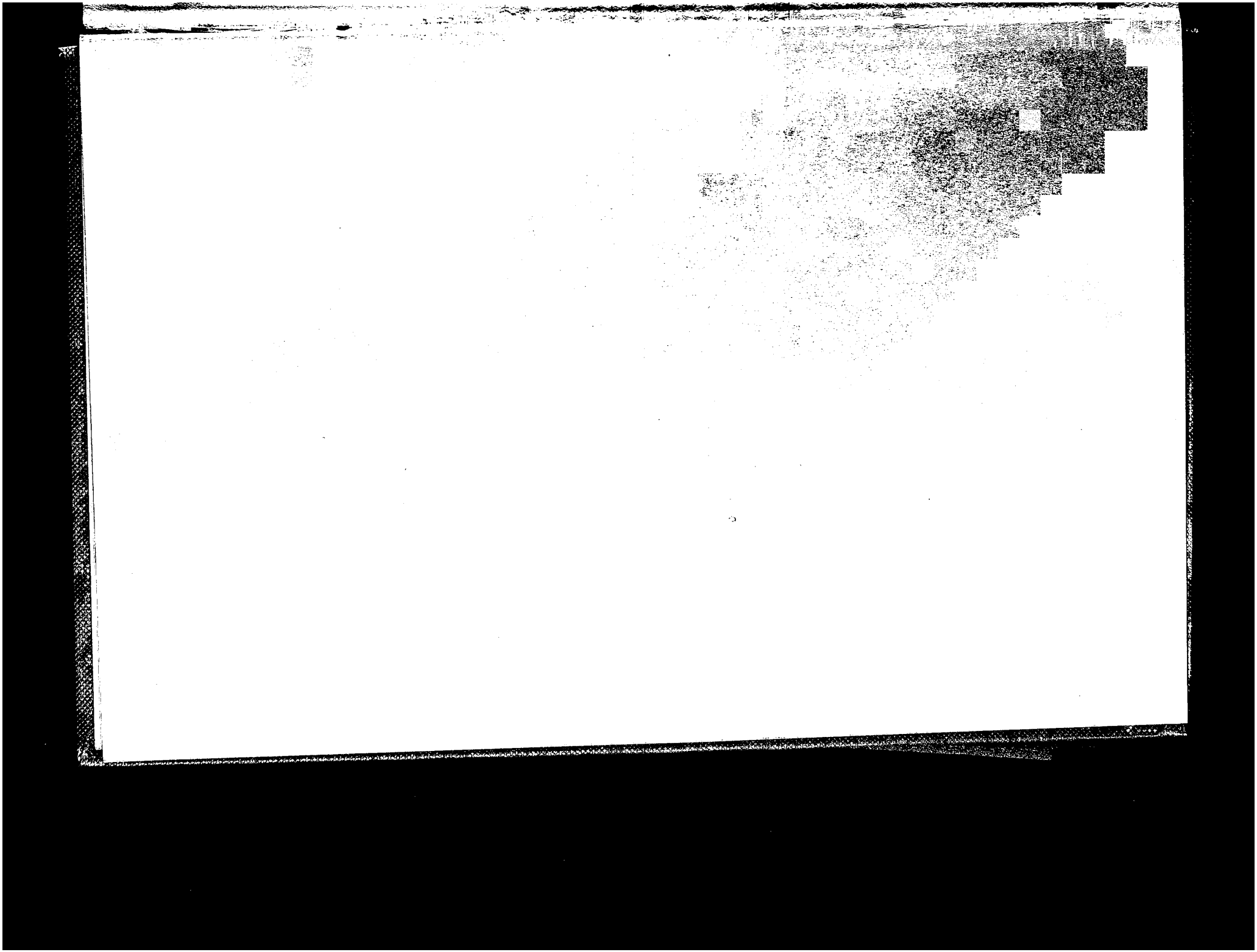

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Contents

Glossary

A and E	Accident and Emergency
ACHCEW	Association of Community Health Councils in England and Wales
AHA	Area Health Authority
BDA	British Dental Association
BMA	British Medical Association
BMJ	British Medical Journal
CHC	Community Health Council
CIPFA	Chartered Institute of Public Finance and Accountancy
DHA	District Health Authority
DHSS	Department of Health and Social Security
DMO	District Medical Officer
DSC	Dispensing Sub-Committee
DSRG	Dental Strategy Review Group
FPC	Family Practitioner Committee
FPS	Family Practitioner Services
GDP	General Dental Practitioner
GLC	Greater London Council
GMSC	General Medical Services Committee
GP	General Practitioner
GPFC	General Practice Finance Corporation
ICRF	Imperial Cancer Research Fund
JCC	Joint Consultative Committee
KCW	Kensington, Chelsea & Westminster
LDC	Local Dental Committee
LHPC	London Health Planning Consortium
LMC	Local Medical Committee
LOC	Local Optical Committee
LPC	Local Pharmaceutical Committee
LRC	Local Representative Committee
MARU	Medical Architecture Research Unit
MORI	Market and Opinion Research International Ltd
MPC	Medical Practices Committee
NCVO	National Council for Voluntary Organisations
NHS	National Health Service
NHSTA	National Health Service Training Authority
OHE	Office of Health Economics

OMP	Ophthalmic Medical Practitioner
OPCS	Office of Population, Censuses and Surveys
PJ	Pharmaceutical Journal
PPA	Prescription Pricing Authority
PSGB	Pharmaceutical Society of Great Britain
PSNC	Pharmaceutical Services Negotiating Committee
RCGP	Royal College of GPs
RCC	Rural Community Council
RDC	Rural Dispensing Committee
RDO	Regional Dental Office
RHA	Regional Health Authority
WHO	World Health Organization

Foreword

Family Practitioner Committees have long been the Cinderellas of the National Health Service (NHS). They are in fact a much older institution. They were first established as 'Insurance Committees' as a result of Lloyd George's National Health Insurance scheme of 1911. They were renamed Executive Councils and given wider functions in 1948; and renamed again at the 1974 reorganisation of the NHS. But they still retain the functions normally found in a health *insurance* scheme rather than a national *health service*, administering contracts fulfilled by independent contractors.

Their work has attracted little attention. Bodies charged with the main tasks of administering four sets of contracts, each negotiated centrally, and dealing with local complaints have not seemed worthy of the close attention given to virtually every other part of the NHS about which a galaxy of books has been written. This is why this book was commissioned by the King's Fund London Committee; and thus it has a special value.

The decision to re-establish FPCs as statutory bodies in their own right without a fourth change of name was seen by many as one of the prices eventually paid for streamlining the administration of the hospital and community services, by abolishing the area level with its coterminous links both with FPCs and local authorities. It would hardly be expected to give much of an enhanced status to bodies which are largely unknown by the general public. Rather it would make them still more forcibly the poor relations of the large and powerful health authorities with which they were expected to coordinate. It was seen as the final confession that all the talk about unifying and integrating the NHS had been finally abandoned after painful and not wholly resolute attempts to do so. After massive reorganisations, the old tripartite NHS had been recreated with only a slight redrawing of the frontiers. The self-employed contractors had never wanted to be integrated. With statutory FPCs, on which they are to continue to hold half the membership, the old quiet life of independence and self-policing – or some would say non-policing – would be resumed.

This book however shows that not all FPCs are the dull, reactive bill-paying agencies which many assumed them to be. By bringing together some of the good things which FPCs have done, way beyond the call of statutory duty and defined responsibilities, the authors

show what innovative bodies they could become if they made, and were enabled to make, full use of their opportunities. By working closely together with health authorities they could help to bridge the many gaps which are to be found between family practice and community care. They might help to pull some of the murkier parts of our primary health care system substantially nearer to the standards of the best.

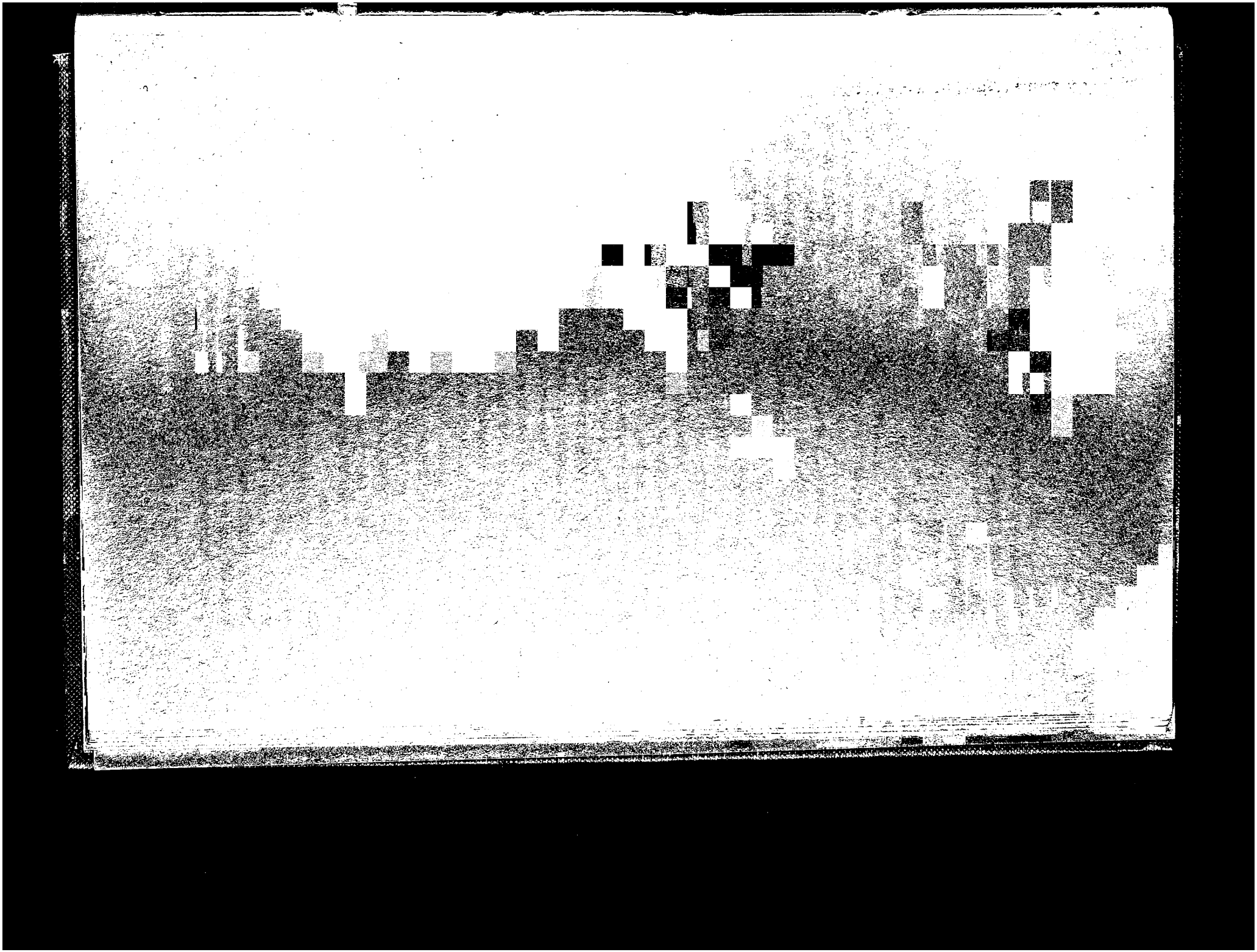
FPCs have demonstrated that they can be catalysts of change in a whole variety of ways. They can arrange training for practice managers and receptionists, initiate young GPs into their administrative functions, and arrange conferences for local practitioners. They can inform and support GPs in planning, financing and operating the complex schemes for the improvement of premises or the acquisition of new ones, and ultimately cajole them into taking action. They can monitor the use of deputising services – a sensitive issue – both for quality and limits of use. They can advise on answering services, encourage age/sex registers, rota schemes, and even local peer review. They can promote the take-up of ancillary staff. They can arrange shared payment schemes for nurses with district health authorities (DHAs); secure practice vacancies in areas of growing population; and engineer practice outlets for scattered rural communities. They can develop special services for the homeless, arrange for GPs to buy diagnostic equipment more economically through DHA contracts, negotiate open access to DHA diagnostic facilities and monitor its use, improve recall arrangements for cervical cancer and the take-up of immunisation and family planning services. They can even locate practitioners who can speak Chinese.

As this book points out, all these things have actually been done by some FPC somewhere. But no FPC anywhere has done anything like them all. FPCs have now been given clear policy objectives and clear accountability. They are to become managers rather than administrators, as some have already shown they can be. Under the new rhetoric they are responsible for seeing that their primary care services are available, comprehensive, evenly distributed and of good quality. However they must still achieve this through negotiation, persuasion, bargaining and advocacy. Very few sanctions are at their disposal. And if they use these sanctions too freely, it will be much harder for them to be welcomed as friendly encouragers and persuaders.

If the FPCs are to seize their opportunities, many of their officers will need training for their new roles. More staff will be needed, particularly at senior levels. Moreover, these tasks cannot be accomplished without resources for information gathering – particularly

from the consumers of their services – and for the creation of a much higher public profile. Whether the resources to do all this are made available will ultimately determine whether their new clothes are rhetoric or reality.

Brian Abel-Smith



Introduction

This book aims to provide an account of the range of work carried out by Family Practitioner Committees (FPCs), the bodies which are responsible, in England and Wales, for administering the contracts of family practitioners: general practitioners (GPs), dentists, opticians and pharmacists.* It is based on information and data collected during the early part of 1985. We attempt to clarify the role and functions of FPCs, to give an analysis of the political environment in which they operate, and to illustrate some of the ways in which FPCs can influence the provision of primary care services in their areas. The final section reviews our findings, and speculates on the possibilities for change and development in the future.

The King's Fund London Project Executive Committee commissioned us to carry out this work in late 1984 because new legislation, which came into effect on 1 April 1985, intended to give FPCs free-standing, self-employing status. They now function as health authorities in their own right, as they did between 1946 and 1974; but their responsibilities have been extended and more clearly defined. Apart from a short descriptive pamphlet for students going into FPC administration (Parr and Williams 1984), the recent members' guide published by the National Health Service Training Authority (NHSTA) (Barnard and Wood 1985) and scattered references in specialised journals, little has been written on FPCs. In fact, very little appeared to be known about FPCs in any area at all, but particularly about how they had interpreted their discretionary powers. It was felt that a book which explored this area could be useful as an introduction to their work. It could also help to develop the debate about the role of the committees; and it might provide a stimulus to further investigation.

Unlike other health authorities, where the organisational structure and scope of activity have undergone considerable change since 1946, FPCs have remained virtually static. Klein (1973) has commented that their history is one of non-evolution. Although their administration was moved from the control of the Area Health Authorities (AHAs) to the District Health Authorities (DHAs) in 1982, this made little material difference either to the scope of their activities or to the way in which they have carried them out. In 1979,

* Primary care services are organised differently in Scotland and Northern Ireland and are outside our remit.

the Royal Commission on the National Health Service recommended their full integration with the health authorities in order to facilitate joint planning and a more balanced development of primary care services (Royal Commission on the NHS 1979). However, when in 1983 the Conservative government announced a new status for FPCs this initiative was supported by the contractor professions and by the Association of FPCs who both, for different reasons, saw advantages in independence. It was opposed by most other interested groups.

The importance of FPCs lies in their administrative relationship with the family practitioners who provide primary care. The World Health Organization in its 1982 Alma-Ata declaration (see Appendix III) defined primary health care as the critical element in any health care system, the key which would permit individuals, families and communities to attain a level of health that would enable them to lead a socially and economically productive life. The need for an effective primary care system has become increasingly evident. The numbers of dependent people in the community, both the elderly and the chronically sick, are growing, while recent evidence suggests that rising unemployment creates more demand for health care at all levels (Beale and Nethercott 1985). Yet there are many defects in the present system. The community health services provided by the DHAs do not always link well with family practitioner services (FPS); the quality and scope of care varies considerably between practices; and some services, particularly those concerned with the prevention of ill health, may not be provided at all, or if they are, may be provided ineffectively. Resources are not being well used (see Bosanquet 1986 for a discussion of medical services).

The change in FPC status, bringing more explicit responsibilities for planning primary care, could be seen as part of a recent concern on the part of the Department of Health and Social Security (DHSS) to improve quality and standards. Yet there are intrinsic structural problems. FPCs lack the power either to direct or to control practitioners; and professional pressure groups have, in the past, blocked change. Ultimately the implementation of policy will depend on the firmness of decision-making in each FPC as well as on the actions of individual family practitioners in their surgeries, shops and consulting rooms (for a discussion of this theory of the policy process see Barrett and Hill 1984; Kogan 1984). It was these factors which led to our choice of title for the book.

The political environment of FPCs

One particular model of the political environment underlies our approach. It is drawn from Alford's theory of structured interest groups in health care (Alford 1976). Alford distinguishes between those which represent 'the corporate interest', the state and professional leaders who aim to meet the health care needs of communities and populations; 'the professional monopolisers', who seek to preserve their own autonomy in decisions about methods of practice and patient care; and the groups, largely unorganised, who represent the 'community interest' and are concerned to improve the range and quality of services for their particular group or population. Alford argues that while health care is dominated by professional interests, the main contenders for power are the 'corporate rationalisers' who advocate greater efficiency and more effective services. The community interest tends to be repressed.

In this model, the FPC can be seen as a focus for the interplay of various interest groups. The change in FPC status could be interpreted as an attempt by corporate interests to control both FPCs and practitioners from the centre. In each FPC area, individual GPs, dentists, pharmacists, and opticians are concerned with their own personal goals and security and with their own professional identity. These professional interests are well organised. Each group has a local representative committee whose purpose it is to promote its own professional concerns, both in terms of quality of service and conditions of practice. These committees have close links with the national professional bodies. They nominate members for appointment to the FPC, as well as to other local committees associated with the DHA. Half the FPC membership is drawn from the contractor professions.

Bachrach and Baratz (1970) have remarked that organisations are frequently biased in favour of the social and political values of particular groups within them. These groups are not only likely to win in conflict situations, but they determine which issues should go on the policy agenda; and they can exclude others altogether. In the past FPCs actions have been widely perceived as reflecting, almost exclusively, professional interests. By contrast, the community interest is weakly represented. The lay members of the committees are not elected, and concepts of the constituency they serve are vague. Some CHCs have been excluded from FPC meetings, and many have been unable to build purposeful relationships (Thorne 1983). We hope to show that some FPCs have taken a more active role, using the powers available to them, in developing the quality and appropriateness of

services provided by practitioners. In future the onus will be on all FPCs to do so.

The structure of the book

Formally, the FPC acts as a mediator between the state (in this case represented by the DHSS), the professionals (the GPs, dentists, pharmacists and opticians under contract) and the population for whom it is responsible. It must see that practitioners keep to their terms of contract and that public money is properly spent, at the same time ensuring that their practitioners receive proper remuneration, and helping them to develop their services. Finally, the FPC must see that the public has access to adequate services.

However, there is a central paradox in the FPC's role. It does not manage services directly, and it cannot tell practitioners where to practise, what services to provide, or how to provide them. Although it pays the practitioners, it does not control their budgets. So how is it possible for FPCs to ensure that a certain range and standard of care are provided? The manner in which FPCs have managed this tension is the dominant theme of the book. As a compensation for the lack of executive powers, they have attempted to use influence, persuasion and cajolery in negotiating change, with varying degrees of vigour and success.

We have structured the book around particular issues. In Section One, chapter 1 describes FPCs and their role and functions, drawing out the reasons for the change of status in 1985 and its possible consequences. Chapter 2 considers how FPCs may provide information, and help individual members of the public. In the past FPCs have been particularly weak in this area, but now new obligations have been placed upon them. Section Two is concerned with the contractor professions. Chapters 3 and 4 give an account of the FPC's role in relation to general medical services, in the context of changes in general practice. The FPC can assist GPs in two important areas: in the attachment of practice staff and in practice premises. Chapter 5 considers the FPC and general dental, optical and pharmaceutical services. Chapter 6 discusses the problems of providing primary care in rural areas. Section Three explores the ways in which some FPCs have been working with DHAs to share services, and jointly to develop policies. FPCs now have a statutory duty to 'collaborate', and this is an important new area of work. Chapter 7 considers the issues concerned with planning for primary care, while chapter 8 argues the case for joint strategies between the contractors, the FPC and DHAs in the area of preventive health care. The final

chapter comments on the possible outcomes of the change in FPC status and suggests an agenda for the DHSS and FPCs in implementing change.

General approach and methods

When we began this study our main aim was to find out the ways in which FPCs were, in practice, developing their role in order to meet the needs of individuals and communities. We were interested in the services which FPCs provided for the public: information, publicity and handling complaints. We wished to know how FPCs dealt with the location of practitioners and the standard of premises, whether they had attempted to improve access for particular groups, and how they collaborated with other health authorities. We are very conscious that we collected our material at a time of unprecedented activity and change. However, we believe that this was to our advantage for, as a consequence, the administrators and others to whom we spoke had consciously reflected on their organisational past and many already had well-articulated views on their organisational future. This made the process of gathering information interesting and illuminating.

The illustrative material about the ways in which FPCs have used their powers is based on three sources: on a small number of long interviews with FPC administrators, community unit administrators and health development workers (marked in the text as 'interview'); a request for information on recent innovations and 'good practices' sent to all FPCs (marked in the text as 'questionnaire'); and a search through the available literature. These were later supplemented by discussions with other FPC administrators, with members of all four professions and, in some cases, with their professional associations. The 'new' data which we have collected – the data that is derived from interviews and questionnaires – represents the perceptions of individuals. We have attempted to put their accounts into context and to reproduce their explanations as accurately as possible. We hope that we have done them justice. Some of our interviews were carried out with 'community unit administrators' who were members of community unit management teams in the DHAs. Following the implementation of the recommendations of the Griffiths enquiry, these units are now led by a unit general manager. We have retained the terminology in use at the time of the interview.

Two other factors affected the methods we adopted: our initial lack of knowledge about FPCs; and the time-scale to which we were working. We would fully acknowledge that we learnt about FPCs as

we went along. Although one of us has been a member of an FPC for some years, and this was some initiation into the area, the lack of previous work and the arcane language of DHSS circulars inhibited easy understanding. The King's Fund and ourselves felt that with the changes now taking place, it was important to provide an introduction to the work of FPCs quickly. The above-mentioned factors have inevitably meant some sacrifice of coverage and of analytical rigour. It would not be possible to generalise to all FPCs, for example, from our discussion of particular instances. This would need a larger study.

Two further points require explanation. We have not attempted to distinguish in the text between the actions of the committees themselves – that is, the chairpersons and appointed members – and the actions of administrators and their staffs. This calls for a separate investigation in its own right. By the FPC we mean, unless otherwise stated, both these elements. Having said this, FPC administrators normally play a crucial role in steering policy-making in their committees.

A considerable amount of our discussion is concerned with GPs and general medical services. This accurately reflects the work of FPCs themselves. One administrator commented that about 90 per cent of officer time was devoted to this area. For example, half of the staff of the committee was concerned with patient registration. The central position of general practice is paralleled at all levels from FPC to DHSS. The new directions in which FPCs are being asked to develop mainly concern GPs. Virtually the whole of chapters 7 and 8 on collaboration and planning and collaboration and preventive health care concern the relationship of GPs with other parts of the health service and to other health workers. The importance of adequate strategies for care in the community and for the prevention of ill health cannot be overestimated, and the role of GPs and their relationship to other health workers remains a key organisational issue.

In addition to the sources of data mentioned above, we have had many informal discussions with administrators and practitioners. We are very grateful indeed for their time and for their help. These contacts have helped to increase our knowledge of what is still a very private world. It is a world which is familiar to those who work within it, but one that is often puzzling to, and misunderstood by, outsiders – even those managing and providing services in other parts of the NHS and local government.

SECTION I

Family Practitioner Committees and the Public

1
Family Practitioner Committees: role and functions

This section gives a brief survey of the scope of work of the family practitioner committees and outlines the services for which they are responsible. We argued in the introduction that there had been little change in the role and functions of FPCs up until 1985, and also that the consequences of the new legislation still have to work themselves through. We shall, therefore, discuss the tasks of FPCs which derive from the 1946 NHS Act and describe their present organisation, structure, and funding. These have remained largely unaltered by recent changes. We will also look at the case for changing FPC status, at the new regulations which have been introduced, and at the change of emphasis which they have brought.

FPCs are responsible for the family practitioner services (FPS). These include the clinical services provided by general medical, dental and ophthalmic practitioners; and the prescription dispensing provided by retail pharmacists and appliance contractors, some doctors and dispensing opticians. They are an important element of NHS primary care provision, which also includes the community health services provided by the DHAs. Family practitioners are under contract to provide their services under terms and conditions drawn up as part of the 1946 NHS Act. These terms and conditions have also changed very little in subsequent years. It should be noted that the new management arrangements introduced at central government level in the wake of the Griffiths inquiry report (DHSS 1983c) do not include responsibilities for FPCs. The remit of the NHS Management Board (which has general management functions in relation to the health authorities) does not extend to the FPS. These are the responsibility of a separate section of the DHSS, which has direct accountability to the Secretary of State.

FPCs and their administrative officers are accountable to the Secretary of State for Social Services. They are responsible for seeing that the family practitioners keep to the terms of their contracts, and, that as a consequence, 'services are provided to patients who are entitled to receive them and that these patients have adequate care and attendance' (DHSS 1981c). This in effect links the family practitioner element of the health services to the aims and objectives of the NHS as whole. The intention of the NHS Act was to provide comprehensive care, equally available to all and covering all necessary forms of health care. These objectives emphasised service provision under the

NHS. In 1979, they were elaborated by the Royal Commission on the NHS, which stated that the NHS should encourage and assist individuals to remain healthy, provide equality of entitlement to services, a broad range of services of a high standard, equality of access to those services free at the time of use, satisfy the reasonable expectations of users and remain a national service responsive to local needs (Royal Commission on the NHS 1979, page 9).

The White Paper which preceded the 1946 Act claimed that it was possible to provide a comprehensive primary care service for the community within the independent contractor system (Ministry of Health 1944). The retention of this arrangement was the political price paid by Aneurin Bevan in order to persuade the contractors to join the NHS. Doctors refused to contemplate a salaried service run by local authorities or health boards, and they did not wish to be compelled to join health centres (Willcocks 1967, Pater 1981). Initially, Executive Councils were set up to administer the services provided by contractors. In 1974, the name of the councils was changed to Family Practitioner Committees when they became coterminous with the Area Health Authorities (AHAs). The antecedents of these arrangements have been traced back to the insurance committees set up under the 1911 National Insurance Act, when local committees entered into arrangements with panels of doctors to provide medical services on a capitation basis (Klein 1973, Honigsbaum 1979).

The organisation of FPCs

There are 90 FPCs in England and eight in Wales. Their boundaries reflect those of local authorities, rather than of health authorities; the latter were reorganised in 1982 into 192 districts in England and 9 in Wales. An FPC may now relate to more than one DHA: 40 FPCs relate to one DHA, 20 to two, and 30 to three or more (Ellis 1985). Surrey and Lancashire relate to seven health districts.* From the DHA side, 14 English DHAs overlap with more than one FPC. In Wales, seven of the FPCs are coterminous with seven DHAs; the eighth FPC covers the remaining two Welsh DHAs. FPCs vary considerably in size. Nine – Birmingham, Kent, Essex, Hampshire, Hertfordshire, Lancashire, Nottinghamshire, Staffordshire and Surrey – have registered patient populations of over one million. Kent has a staff of 163, Birmingham 109. Bury, Calderdale, South Tyneside, Isle of Wight and Powys have populations under 200,000. Powys is the smallest of all, with a population of 109,690 in 1984

*Questionnaire.

and only 15 staff (DHSS 1985d). The Arthur Andersen report (1984) on Family Practitioner Services administration recommended that the number of FPCs should be reduced to 60 or 70. This, however, is not acknowledged by the DHSS to be a priority at the present time.

The cost of Family Practitioner Services

Expenditure on FPS is very largely 'open-ended'. According to Frank Dobson MP, FPS forms one of the only three remaining uncapped areas of public expenditure, the other two being the Falklands Airport and the Assisted Places Scheme at public schools (quoted in *The Family Practitioner Services* II, no 11, 1984, page 218).* The payment of practitioners and the reimbursement of various expenses are determined by national negotiations between the DHSS and the professions' negotiating bodies. Costs are also affected by the numbers of patients seeking services and by the response of practitioners to their treatment needs. The Royal Commission on the NHS (1979) commented: '... There is no way of controlling absolutely the amount of illness and disease. While it is possible, for example, to defer many surgical operations for six months or a year because of limited resources, similar action cannot be taken in the field of general medical care' (page 351). The costs of FPC administration have been cash-limited for some years, but they form a relatively small part of total expenditure on FPS.

In 1983/4, spending on the NHS was £13,700 million in England and Wales, while spending on the family practitioner services was £3,200 million; approximately 24 per cent of the total. The share of NHS resources going to the family practitioners declined after the 1950s but, following a low point in 1983, it has since been rising. In 1950 it was 33.5 per cent, in 1983 22.8 per cent. Recently, the FPS have been growing at a faster rate than the rest of the service. In input volume terms, that is what money can actually buy for the service, the DHSS claims that NHS expenditure has increased by 7 per cent and the FPS expenditure by 8 per cent between 1978/9 and 1983/4 (Barnard and Wood 1985).

Future trends in expenditure are difficult to predict, as the Government is hoping for savings resulting from the computerisation of FPCs. Efforts have been made to control the drug bill by the introduction of limited list prescribing. Charges for dental treatment, for prescriptions and for ophthalmic services have continued to rise. This

* *The Family Practitioner Services*, journal of the Society of Administrators of Family Practitioner Services, is available from the Hon. Editor, Cheshire FPC, 28 Nicholas Street, Chester, CH1 2PH.

has increased patients' contributions to their health care.

Table I Family Practitioner Services: England 1983–4. Gross costs

	£m	%	%*
NHS	12,919	100 1983/84	100 1982/83
family practitioner services	2,949	23	(25)
General Medical	862	29	(28)
Dental	584	20	(19)
Optical	73	4	(7)
Pharmaceutical	1,430	47	(46)

Source: DHSS 1985a.
* Dowson, S and Maynard A (1985)

Table 1 shows the trends in the share of the expenditure going to different elements in the services. They relate to England only. Spending on pharmaceutical services and on general medical services lead, at 47 per cent and 29 per cent respectively. The former includes payment to pharmacists for prescribed medicines. The sums spent for 1983–4 net of patient charges were as follows: general medical services £862m, dental £584m, pharmacists and appliance contractors £1,430m and opticians £73m.

The structure of FPCs: members and officers

Each FPC in England and Wales usually has 30 members appointed by the Secretary of State from names provided locally.† There are 15 lay members and 15 professional members: the latter include eight doctors (one must be an ophthalmic medical practitioner), three dentists, two pharmacists, and two ophthalmic opticians. One of the lay members must now be a nurse. The FPC has a large number of statutory subcommittees to carry out its work, as well as an administrative staff headed by an administrator. The full list of committees is given in Appendix II. These committees always contain both professional and lay members; and in some cases they include professional members appointed by the local representative committees.

† A few committees have more than 30 members, to ensure representation of all the health districts within their locality.

The day-to-day work of the FPC, the servicing of committees and the development of policy, is carried out by appointed officers. Administrative structures vary, but most FPCs have sections dealing with finance, secretarial functions, patient registration and complaints. Some FPCs have specially appointed officers to deal with planning. Unlike DHAs, there has always been a direct line-management relationship between the administrator of the FPC and the other officers. The administrator is accountable to the committee for the administration of FPS. Traditionally there has been a large gap between the administrator and other staff in terms of pay scales and status, although this is gradually changing. Some FPCs are now developing a management team approach.

The administrator has played, and probably will continue to play, a key role in determining the policies of the FPC. The style and mode of operation of the administrator, particularly in relation to the discharge of the more discretionary functions, has tended to determine the policies of particular FPCs. Policies may have emerged as a consequence of day-to-day decision making, or they may have been more consciously articulated but, until the recent legislation, FPCs did not have any obligation to present either strategy or annual plans. They were remarkably unaccountable for what they did, or did not, do. Even if specific policies were developed, these were rarely formally presented to a wider forum than to the committee itself. There have been exceptions. We shall discuss some of these in subsequent chapters. In certain FPCs, the Committee Chair has also played an active part in determining policy but, we would argue, his or her ability to do so has depended upon the commitment and capabilities of the full-time staff.

The overall role of the FPC

The full range of FPC functions prior to 1985 is given in Appendix I. These remain the basis of FPC's work, but there have been substantial changes of emphasis and definitions. Paragraph3 of the circular on management arrangements for FPCs states:

> Their role is concerned with administering, managing, planning, monitoring and investigating and adjudicating. In carrying out their duties, Committees are required to be sensitive to the needs of the community they serve; to collaborate with other bodies, particularly health and local authorities; as far as lies within their power, to enable practitioners to practise effectively and efficiently; to act within the Regulations governing arrangements

> for the administration of FPS; and overall to exercise rigorous regard to the use of public funds, for example by keeping under review entitlement to FPS remuneration and compliance with contracts and to ensure value for money in relation to payment made. ... (DHSS 1985c).

Arguably 'good' FPCs were already engaged in some, or all, of these activities prior to 1985.

We have divided the tasks of the FPC into four main categories, and we elaborate briefly on each. Subsequent chapters comment on these tasks in more detail. First, FPCs have a pay and support, or administrative role. Secondly, they have a regulatory or monitoring role: they must see that the practitioners keep to the terms of their contracts. Thirdly, FPCs have a responsibility to adjudicate and to resolve conflicts between practitioners and their patients. Lastly, they have a service development and (until 1985) a largely discretionary role. FPCs should see that services of a certain quality are available to those who are entitled to them; and they should plan to ensure that this occurs.

The administrative role

The FPC has a number of routine administrative tasks, which have sometimes been referred to as the 'pay and rations' function. They agree to, and hold the contracts of practitioners; they maintain a register of patients in their area and a list of doctors, dentists, pharmacists and opticians; they calculate and pay fees, allowances and reimbursible expenses; they authorise treatment claims and the payment of dentists; they monitor prescriptions, pay pharmacists and appliance contractors; they authorise sight tests, dispense claims and pay opticians. They undertake administrative tasks for the DHSS, and for other bodies such as the Prescription Pricing Authority, the Dental Estimates Board and the Medical Practices Committee (MPC). It is not our concern to examine these areas of activity here; further details can be found in the National Health Service Training Authority (NHSTA) Guide (Barnard and Wood 1985). These activities are important, because they bring the FPC administrator into regular contact with practitioners. They are the basis for building the good relationships upon which the use of more discretionary powers depends. FPCs can do a good deal to support those in contract with them. They can, for instance, help GPs to improve their practice premises and assist them to employ practice staff; these areas are discussed in chapters 3 and 4. Some FPCs set out

to foster contact by providing information about the FPC, publicising grants and running training programmes for the practitioners' staff. Nottingham, for example, prepares a quarterly newsletter, in conjunction with the LMC, which is circulated to all practitioners.*

Certain FPCs have run study days for GPs on such topics as Cost Rent and Improvement schemes for practice premises. In recent years, North Yorkshire FPC has run study days for both ophthalmic and dental practitioners (North Yorkshire FPC 1983). In 1984, Greenwich and Bexley FPC organised a series of open days for GPs and their staff.* Most FPCs are visited by GP trainees during their period of vocational training, as it is clearly important for future practitioners to be aware of the administrative aspects of general practice. Approximately one-third of the FPCs who returned our questionnaire mentioned as one of their 'good practices' the fact that they provided training courses or study days of some kind. These enable the FPC administration to get to know the attitudes and the problems of service providers. As FPCs move into a period of greater change, this kind of contact will be increasingly valuable.

The quality of the staff employed by practitioners is as important - in some circumstances even more important - than that of the contractors themselves. Receptionists are the patient's first point of contact; while practice managers will, in the future, be taking much of the responsibility for introducing new technologies. Some FPCs are particularly active in providing courses for these groups. Over the past two years, for example, Hampshire has provided courses for over 700 receptionists. Nottingham has developed training in a variety of directions. They hold regular one-week courses for doctors' receptionists and for practice managers. As a result, a local practice managers' association has been formed which discusses areas of mutual concern. A practice nurses' group has also been formed as a consequence of FPC short courses. This group provides a source of advice for local doctors when they are appointing nursing staff. In 1985, Nottingham hosted a national meeting for practice nurses, and provided a course administrator.

Such training work has enabled active FPCs to make contact with local educational institutions, a contact which can bring benefit in terms of student placements and provide support for the FPC's own research activities.

*Interview

The regulatory and monitoring role

The FPC's regulatory role centres on ensuring that family practitioners keep to the terms of their contract and practise within the regulations laid down by the DHSS. This regulatory role can be interpreted in two ways. It can be reactive: when incidents occur which suggest that a practitioner may not be complying with the regulations, these can be investigated. Alternatively, by monitoring aspects of service, the FPC can take a more active role. Monitoring can mean measuring resource inputs, service outputs, and the outcomes of service provision; or it can mean establishing standards. Shaw (1982) has suggested that monitoring has two purposes: to ensure that value for money is being obtained; and to make sure that services of a certain standard and quantity are available. FPCs can do little about the former, as they have no direct control over the payment of practitioners or over the content of their work, beyond certain broad parameters. They cannot require them to carry out particular services. But they do have powers (if they choose to use them) over certain aspects of the quality of service provision; in relation to practice premises or deputising, for example. There are prerequisites to monitoring standards, however. The area to be monitored has to be specifically identified; there must be clear criteria; there must be a flow of information available; and there has to be a process of systematic review. Information needs to be analysed and translated into policy. This is a difficult area, and few FPCs have approached it in any structured way, except perhaps in relation to practice premises. Statistics have been produced for the DHSS, but on the whole these have not been used in the process of policy-making and managing change.

It is possible to monitor the standards of practice premises, the adequacy of deputising services, and the GPs' use of them, practitioners' hours of availability to patients, and their accessibility; and, finally, the degree to which they comply with their terms of service.

FPCs have been handicapped in pursuing their role by the lack of precision in the terms of the contracts, and by the absence of clear definition of standards. Frequently, they have failed to use available data. They have often lacked crucial information on, for example, the services practitioners provide and the premises from which they practise. They have rarely developed systems for review. Most importantly, there have been disincentives to monitoring and regulation. By taking a tough line, FPCs can lose the goodwill of practitioners and gain little credit for themselves. In this respect there is a potential conflict between the regulatory and the planning and devel-

opment function, as the latter depends upon goodwill. Over-vigorous policing can lead to a loss of room for manoeuvre in negotiation. We look at some of these issues in subsequent chapters, but we illustrate here some of the general difficulties in ensuring that contractors keep to their terms of service.

If an administrator believes that requirements are not being met (either as a result of processing claims for payments, a visit to practice premises or a complaint from a member of the public) the matter can be dealt with on an informal basis. If this fails then, ultimately, the service committee procedure can be used. Service committees exist for each profession, and the procedures are quasi-judicial. In this case, their purpose is to adjudicate between the individual practitioner and FPC. The administrator brings the complaint and, if it is sustained, the penalty falls on the individual practitioner. This is a cumbersome procedure; it offends the rules of natural justice; and it is an ineffective mechanism for improving overall standards. There may be a deterrent effect on other practitioners, but only if the case is given publicity by the local representative committee.

O'Donnell neatly illustrates this point in a recent report in the *British Medical Journal*. Here, the FPC had referred the complaint to the General Medical Council, rather than to their own service committee. After a visit by the FPC, following an anonymous tip-off, three GPs were found to have a drawer full of pre-signed prescription certificates: 'a practice alleged to be on the increase'. O'Donnell comments: 'FPCs should surely try to find out where it's happening and advise offenders to stop' (O'Donnell 1984). The FPCs' difficulty stems from the absence of any defined management role, and a lack of sanctions apart from the service committee which may, as in the case above, be used like a hammer to crack a nut. Klein, in a study of complaints against doctors, found that very few complaints were actually brought by FPCs to their service committees (Klein 1973).

Klein argues that FPCs should be using the letters and complaints they receive from members of the public as a source of information about standards of service. If letters containing grumbles and grievances were systematically recorded over a period of time, this information could be used to attempt to improve services generally. Many complaints, for example, are about the rudeness of practitioners. These cannot be treated as formal complaints, but if a number of instances arise the doctors involved should be informed and the matter discussed, possibly in the presence of the secretary of the local representative committee.

On the basis of a questionnaire sent to FPC administrators, Klein

claims that administrators have one of two basic approaches to dealing with complaints: the 'legalistic' and the 'conciliatory'. Some administrators dealt with complaints strictly by the letter of the regulations. Either there was a breach in the terms of service; or there was not. The former would be dealt with by a service committee, and the latter dismissed with no further action. The 'conciliatory' administrators tended to take a wider range of actions to deal with complaints.

FPCs share the responsibility for regulation and monitoring with a number of other organisations: for example, the Dental Estimates Board and the Prescription Pricing Authority. The local representative committees also have some responsibility for professional matters such as deciding, in certain situations, on competence to practise.

The adjudication and the conflict-resolution role

In a number of areas the FPC will need to take action, invoking statutory procedures, in an attempt to resolve conflict between practitioners and patients. This situation arises as a consequence of the independent contractor status. There are procedures for dealing with patients' complaints, for example, and a committee which allocates patients who cannot get on doctors' lists (see Appendix II, for details of these). These are discussed further in the following chapter, as they are ways through which the FPC can help individual members of the public.

FPCs may also have to resolve conflicts of interest between practitioners. This, again, involves FPC members. In rural areas, the dispensing sub-committee decides who shall dispense medicines, and their decisions can affect the income of pharmacists and doctors (see chapter 6). The proposed new contract for pharmacists, discussed in chapter 5, will involve setting up yet another FPC sub-committee, as the financial interests of pharmacists are at stake.

In such cases, the interests involved are manifest. In other FPC committee work they are latent; but nevertheless present. For example, the Standing Joint Committee (or as it is sometimes called, the Practice Vacancies Committee) which deals with GP practices, must recognise that their agreement for one practice to take another partner or to open a branch surgery can affect the numbers of patients registering with, and therefore the income of, other nearby doctors. It should not be forgotten that the contractor professions are running small businesses. This consideration affects their relationship with the FPC and its officers.

The planning and development role

FPCs have an obligation to see that the population of their areas have access to primary care services, and receive proper care and attendance. Some FPCs have introduced plans, procedures and policies derived from this general responsibility, in order to identify needs and establish priorities. Usually, this has meant working with other statutory authorities. There is great variation in the extent to which FPCs have worked in this direction. Section III of this book gives some examples. Recent circulars have put great emphasis on the planning role, and for the first time FPCs will have to produce annual profiles and forward plans for the DHSS (see Ellis 1985 for details). Arguably, the whole rationale of the new status for FPCs is to give them a stronger role in helping to plan primary care services.

The case for change

The 1985 NHSTA guide for FPC members states that 'the underlying intentions of the change in FPC status are to increase the emphasis on primary health care within the NHS as a whole; to facilitate collaboration between District Health Authorities (DHAs) and FPCs; to enhance FPC efficiency and to improve accountability' (Barnard and Wood 1985, para 5). The expansion and strengthening of primary health care has come to be seen as increasingly important, both in its own right and as a counterweight to the drift towards high-cost hospital medicine. The guide declares: '... primary care plays a vital part in helping people to lead healthier lives; in avoiding and preventing illness; in the diagnosis and treatment of illness, and in the provision of comfort and support for the community' (para 3).

The growing emphasis on primary care is world-wide. The 1978 Alma-Ata declaration, sponsored by the World Health Organization (WHO), listed seven principles. These are reproduced as Appendix III. Although there is a well-developed primary care sector in the UK, there are still many ways in which the service fails to reach the WHO objectives. St Yves (1984) has pinpointed four areas in which our primary health care fails: it should be more fully integrated with activities of other sectors involved with community development, such as housing and education; the activities of the health authorities should be more fully integrated with each other; the local population should be actively encouraged to involve themselves in the form and implementation of health care; and the majority of interventions should be undertaken at the most peripheral level practicable.

Due to central government policies for encouraging community care, changes in the primary care sector and in family practitioner services have become more compelling. Since the mid 1970s, priority has been given to developing non-institutional care for people who are mentally ill, mentally handicapped, elderly or physically handicapped (DHSS 1976; DHSS 1981b). Reductions in acute sector beds have created pressures on family practitioners and on the community health services. Throughout the existence of the NHS, attempts have been made to provide the right organisational framework for continuity of patient care. In 1974, when hospital and community services were put under one organisational umbrella, FPCs were still left in an ambiguous relationship to the AHAs. Although the planning of primary care was supposed to take place jointly, in practice liaison was poor.

The 1979 Conservative government chose to establish the FPCs as autonomous, self-employing authorities. This took legislative form under the NHS Act of 1977, as amended by the Health and Social Security Act of 1984. The belief was that relatively simple organisational linkages established between DHAs and FPCs would achieve integration of services. Taylor, for example, supporting autonomous FPCs, argues that '... a more sophisticated approach may be to stimulate co-operative interaction between groups via careful analysis and adjustment of incentives influencing the behaviour of grass-roots actors' (Taylor 1984). Alongside the new status enjoyed by FPCs, there will be much closer scrutiny and a clearer delineation of tasks than has previously been the case.

Another reason for FPCs' new status is certainly the desire for greater efficiency in the use of resources. This is consistent with the Thatcher government's overall approach to economic policy, and its endorsement of a more managerial approach to running the NHS, as expressed in the Griffiths report on health service management (DHSS 1983b). Whether 'greater efficiency' in this case means greater value for money in carrying out prescribed functions, or a reduction of spending on FPS, remains to be seen. The open-ended nature of FPS expenditure has long been a matter of government concern, although an acceptable and workable solution for control has not yet been found. Binder Hamlyn Fry and Company, a firm of management consultants, were commissioned to inquire into the possibilities of cash-limiting FPS but their report was not published. The DHSS now wishes to exercise tighter control over FPCs; their new status was intended to be a 'nil-cost' exercise.

It is possible that two further factors have influenced policy in this area. The government has shown some interest in curbing the powers

of the 'professional monopolies'. An advisory policy paper on the professions, although again not published, was widely leaked to the press in 1983 (see *The Guardian* 19 February 1983). Since that time, new guidelines have been introduced, which enable the FPC to control GPs' use of deputising services; while the limited list, whatever the arguments for and against, has reduced the GPs' freedom to prescribe. The new regulations, it could be argued, emphasise the needs of consumers at the expense of professional interests.

The government has also committed itself to increasing competition and to supporting the role of the private market in health care. Dispensing opticians have lost their monopoly over dispensing, with a view to extending choice and bringing down the cost of spectacles. Market principles could be extended to include other aspects of the work of family practitioners.

Criticism about the value and role of FPCs has not been limited to the present government. Frank Dobson, the Labour Shadow Minister for Health, spoke for many when he declared in the debate on the committee stage of the Health and Social Security Bill: 'Family practitioners' [committees] functions were ill thought out in the first place. In many cases, I think it must be recognised that they have been fairly badly carried out or not carried out at all' (Parliamentary debates, 1984, col 259).

Dobson wished FPCs to be given positive duties to identify what was wrong with family practitioner services in their areas; to identify groups who were not receiving proper primary care, or localities where care was poor or non-existent; to consult with other organisations; and to plan on an annual basis. Although the legislation changing the status of FPCs did not spell out these objectives, subsequent circulars have in fact covered many of these points. A substantial body of opinion, Dobson included, saw the solution to the weakness of FPCs as being their full integration into DHAs.

The 1984 Act brought important changes in the way in which FPCs will have to carry out their duties in the future. These changes aimed to increase the political visibility of the committees, together with their influence over practitioners, yet at the same time made them more accountable to the DHSS and thus more subject to central control. Chairpersons of FPCs are now directly appointed by the Secretary of State for four years. Unlike their counterparts in the districts and regions they do not receive any payment, but it is clear that they are expected to devote a substantial amount of time to FPC work. The lists of potential members, submitted by local statutory, voluntary and professional groups, must be long enough to give Ministers a choice. The process has been closely vetted by senior civil

servants at the DHSS. Many committees have had new chairpersons appointed, and many have lost large numbers of their former members, particularly among the ranks of lay people. It is now specifically laid down that members, once appointed, and whatever the source of their nomination, are obliged to act corporately, not as delegates representing a particular interest group (Barnard and Wood 1985). This is intended to reinforce a commitment to the community, rather than to narrower interests. The *British Medical Journal* has expressed its regret at what it perceives as the loss of doctors' influence on the committees (*BMJ* 1985e).

One explicit purpose of these changes is to increase the extent of collaboration between FPCs, DHAs and local authority social service departments: 'to secure and advance the health and welfare of the people they serve' (DHSS 1985a). There is now a statutory duty for FPCs and DHAs to collaborate. FPC members will be expected to take part in the activities of the Joint Consultative Committees (JCCs), which are allocated sums of money through joint finance arrangements to spend on agreed projects. JCCs were set up as part of the 1974 reorganisation, in order to promote joint planning between the health and social services for care in the community; in 1984 their membership was extended to voluntary organisations. Under the new arrangements, FPC officers will be expected to become members of the joint care planning teams which plan developments for the priority services. Collaboration is expected at both officer and member level.

The FPC's planning function has also been strengthened. The guide suggests that members '... need to be aware of the current distribution and levels of family practitioner services within their area, so that they may form a view about the future arrangements in the light of local needs and national policies' (Barnard and Wood 1985, para 51). In future, FPCs will have to identify objectives, and develop policies and proposals for their areas. They will be required to compile a profile and strategy statement every five years, as well as an annual programme which details proposals for up to two years ahead.

The requirements for FPCs are outlined in the DHSS circular Management Arrangements for FPCs (DHSS 1985c). Lines of accountability are also strengthened. FPC members are to be 'corporately responsible and accountable through their Chairman to the Secretary of State'. However, this statement masks an ambiguity which also affects DHA members. Members are responsible to the communities they serve, to the interest groups of which they are members, and to the staff whom they employ. This is the political

reality which members have to negotiate.

Mechanisms have been introduced to ensure accountability and policy implementation and to supplement existing audit and service committee procedures. They extend to FPCs the review process already used by the DHSS with regions; and by regions with their DHAs. The DHSS will carry out annual scrutinies on the basis of the analysis of key documents; and periodically more detailed performance reviews will take place. Each FPC now has a link with a liaison officer in the Department, who works with a group of FPCs. These measures are all designed to increase central control; for two lessons have been learnt from the 1970s. It is acknowledged that there has been an implementation gap between the policy requirement of the centre and activities of the health authorities at the periphery (Hunter 1979, Elcock and Haywood 1980). Second, and perhaps more importantly, the revelations of the Public Accounts Committee reports on the NHS in the early 1980s have led to tighter financial control (Harrison and Gretton 1985).

The process has been aided by the development of performance indicators, enabling comparisons to be made between different FPCs. These have been collected since 1982/3, but have not yet been published. Currently they record the population statistics of FPCs and measure inputs to FPS: the numbers of practitioners, FPC staff and gradings. From these, it is possible to establish averages and variations. They also record certain aspects of activity; for example the number of claims for items of service, for night visits, for cost rent improvements and for the number of complaints processed. For purposes of comparison, FPCs are grouped by 'type'. The inner London FPCs, for instance, form one group; the larger non-metropolitan counties another. At present these indicators have a strictly limited value, but they will form part of the dialogue between the DHSS and the FPCs and they can be used to generate questions. It is hoped that they will eventually be used to measure standards of service and desired levels of performance (Klein 1982).

The first full performance reviews of FPCs took place in the summer of 1985, as the start of a five-year rolling programme, covering 18 FPCs in the first year. FPCs will have to think much more systematically about their priorities and their performance than in the past. Performance review is therefore part of a learning exercise by the DHSS and FPCs, and it will help to change the culture of the organisations involved (Pollitt 1985). Both committee chairpersons and their administrators will need to become skilled in justifying the actions they have, or have not, taken. Initial experience suggests that the DHSS is concerned with accessibility to services – for example,

for homeless people – and about future plans for practice improvement as well as about staff structures and possible savings.*

The new regulations for FPCs also require them to become more accountable. Since 1983 they have been obliged to open the non-confidential part of their meetings. Now, they are expected to develop and strengthen their links with CHCs and to provide more information to press and public. We discuss these relationships in the following chapter.

Objectives, accountability and resources

The interest the DHSS is currently taking in primary care and in FPCs is long overdue, and it should be welcomed by all those who are concerned with improving services for patients within the NHS. Although the main thrust of the changes is clear enough, the outcomes and consequences are not. We discuss three issues here: the absence of concrete targets and objectives; the complex network of accountability; and the question of resources.

The change in FPC status has brought a higher profile for FPCs, with a greater accountability for the discharge of a range of duties relating to administration, regulation, adjudication and service development, in addition to a wider duty to be more responsive to, and provide plans for local communities. In the new regulations, the strongest emphasis is on improving the processes of management. FPCs are instructed to plan, to inform, to collaborate, to monitor, to adjudicate, to be responsive. Little mention is made of objectives to fulfill, targets to be set, standards to be reached. These are left to the FPCs themselves to determine at the local level. To some extent this is understandable, and it is a consequence of institutional arrangements. Family practitioners are the actual providers of services, and to a large extent they determine what they will provide. Communities vary greatly in their social ecology and in their pattern of services. The DHSS cannot have detailed knowledge of local circumstances, nor can they negotiate with local groups. FPCs are thus expected to identify objectives locally, in consultation with other groups, within the very broad framework of objectives originally set out for the NHS.

Conversely, it could be argued that the DHSS's emphasis on managerial processes at the expense of managerial targets is an abrogation of responsibility. An FPC will go through the difficult process of setting objectives and writing plans – for which it is ill-

*Interview

equipped both in terms of existing information and managerial skills – only to become a hostage to fortune. There is no clear line of control; and there are no identified budgetary resources with which to realise their plans and proposals. Their achievement will depend on negotiation, and on the resource allocation decisions of others, inside and outside the DHSS: the DHAs, family practitioners and the local authorities.

The responsibility to set a strategic framework for policy locally without the power to allocate spending or control decisions is not unique. It could be argued that it is the essence of management. However, for FPCs this responsibility will be combined with few guidelines, potentially conflicting lines of accountability and very small administrative budgets. Their strongest line of accountability will be to the DHSS. We have already discussed the mechanisms for this. But what will the committees be accountable *for*? It can only be for a smoothly running organisation, for they have not been given specific targets to achieve in terms of patients' services: a basic standard of practice premises, for example, a cervical cytology recall scheme, or a network of primary health care teams. The DHSS is itself accountable to Parliament. There has been growing pressure from a number of sources for a clearer definition of policy and performance targets within the NHS, so that achievement can be assessed and public money managed to the best advantage. So far, the focus has been on districts and regions and FPCs have hardly been mentioned. Expectations have now been raised, and they should also be subject to scrutiny (Harrison and Gretton 1985).

FPCs are also accountable to the contractors to whom they provide support, and to the public whom they serve. Once again, what they are accountable for is not clear and, as we suggested in the introduction, the mechanisms for ensuring accountability are confused. There is a potential conflict between the demands of the providers, the public and the DHSS which the FPC may have to resolve. FPCs have been told to become more active in a number of directions. These have not been costed. Their administrative budgets, even when compared with other parts of the NHS, are ludicrously small. The proportion of the FPS expenditure attributable to administration varies between one and three per cent, depending on the committee. In the regions, management costs are nearer to six per cent; and this does not include the total cost of administration (DHSS 1985a).

In the ensuing chapters we elaborate on the role and functions of FPCs in relation to the public, to the contractors and to the DHAs in the area of planning and collaboration. Part of our aim is to explore

the possibilities of identifying more concrete objectives for FPCs, and we shall return to this issue in the final chapter.

2
Family Practitioner Committees: the public and the individual

The NHS by its very nature as a complex and bureaucratic organisation, is provider-orientated rather than patient-orientated, as anyone who has been woken up at dawn in hospital or suffered from block booking in an outpatient clinic can testify. Its response to the consumer has been characterised as essentially defensive or reactive (Taylor 1983).

Betz and O'Connell (1983), in a discussion of changing doctor-patient relationships in the American context, argue that the public is becoming increasingly distrustful of professionals, and that this distrust has transformed the exchange between doctors and patients. As a result, they claim, professionals and their clients have become separated into two communities: the producers of services, who are oriented towards technical performance; and the consumers, who often have little power. While clients respect the professionals' expertise, suggest Betz and O'Connell, they do not always assume that professional decisions are made with the client's best interests in mind. A CIPFA paper on consumers and the NHS (Harrison and Gretton 1984) claims that the NHS as an institution is not geared to communicating with its consumers, nor to receiving suggestions and criticism from them. Hence some people may not know of their entitlements; while others will be unable to convey their needs.

Before 1974, when Community Health Councils (CHCs) were introduced, consumers of health care were, in Klein's phrase, the ghosts in the NHS machinery (Klein 1983). CHCs are the independent statutory bodies which represent the interests of the public in the health service, district by district. With a few exceptions – Cornwall and the Isles of Scilly, Bristol and Weston, Liverpool – there is one CHC for each DHA: 282 in the UK as a whole. Each one has 18–24 members, half of whom are appointed by the local authority, one third by local voluntary organisations, and one sixth by RHAs. Their secretary and other staff are appointed by the RHA. As their budgets are small and their brief is vague, it is perhaps inevitable that many of them have interpreted their role in a negative or reactive fashion. However some of the more active CHCs have produced valuable work which has contributed greatly to local knowledge (Kensington, Chelsea and Westminster (KCW) CHC 1977; Exeter and District CHC 1983).

Certainly since the late 1970s, consumerism has become an

increasing force in the NHS, although there is endless debate both about the meaning of the term and about the implications of introducing the language of the market into a debate over social policy. It is frequently pointed out that patients cannot be true consumers, as in the case of health services perfect market conditions do not apply. The NHS has a monopoly of many forms of care, while the patient, unlike rational 'economic man', is not free to make informed choices based on payment for services rendered. And buying health care, writes Klein (1983, page 152), is not like buying a car or a refrigerator or having one's boiler repaired; most people will be entirely dependent on the NHS. Moreover, the patient will quite often be – literally – naked and defenceless in the face of medical dominance and professional technical expertise, as Strong (1979) has noted, for the territory labelled 'clinical judgement', as Levitt remarks, is fiercely defended (Maxwell and Weaver 1984). Various studies have shown that patients and doctors agree in defining the 'good' patient as one who is deferential and who does not question the doctor's decisions (see *Journal of the Royal College of General Practitioners* (RCGP) 1983). The confined, inner world of 'patienthood' has been vividly described by the neurologist Oliver Sacks, in his lucid account of recovery from an accident (Sacks 1984). A recent article on alcoholism, published in the *British Medical Journal* provides a perfect example of professional paternalism. The problem drinker, it warns, can be spotted by 'his brash, jocular, overfamiliar manner, *inappropriate to the circumstances of a medical consultation*' (Paton, Potter and Saunders 1981, our emphasis).

Betz and O'Connell (1983) predict that what they call the general movement towards accountability in health will result in the rationalisation of the exchange relationship between doctor and patient in a number of ways. Firstly, there will be greater clarity of goals and procedures for reaching these goals; secondly, there will be more patient contribution to the health exchange, both within the doctor–patient relationship and in consumer contributions to health care management. Lastly, they claim, there will be a new structure of controls on the delivery of health care, controls which are more formal, and more oriented towards results. Already, the NHS management inquiry, conducted by Roy Griffiths (DHSS 1983b), has recommended radical changes to alter the management culture of the NHS. These include particular emphasis on the implications for patient care. The health service, declared the *Health and Social Service Journal* in a faintly disapproving tone, is now 'plunging headlong into instigating quality assurance and consumerism' (30 May 1985, page 1). Griffiths, perhaps surprisingly, concluded that a

great deal of importance was attached to community views at all levels, but he found the process of consultation so 'labyrinthine' that in many cases the result was 'institutionalised stagnation' (page 14). The report stressed the need to ascertain how well the service was being delivered at local levels, and suggested the investigation of patient and community perceptions, possibly by the use of market research. North West Thames RHA is among several authorities who have now produced discussion documents on improving customer relations and communication. Theirs includes areas such as face-to-face contacts between customers and staff, telephone contacts, printed material and signposting.* Some health professionals have expressed doubts about the investment of NHS time and resources on such 'consumerism'. Adam and Mitchell (1985), for example, demand an assurance that attempts to achieve improvements in this area do not simply represent a cynical attempt to camouflage a reduced level of patient care.

In theory, FPCs can be a source of advice and information for individuals on how to obtain general medical, dental, pharmaceutical, and optical services and on how to make the most appropriate use of them. They can also be a channel for voicing discontent about the services. But how accessible are they to the public?

Publicity and accountability

A number of studies have commented on the invisibility of FPCs; others agree to ignore them altogether. Bone's survey of patient registration found that less than one-fifth of her sample had heard of them (Bone 1984). Their role has frequently been perceived, by both insiders and outsiders, as one of providing the administration for a service run by professionals: administering contracts, rather than promoting health at local level (May 1985). The majority of FPCs have been indifferent to public relations, as the then President of the Society of Administrators reluctantly acknowledged in a recent conference address. This, he argued, had ultimately been to their detriment (*The FPS* II, no. 10, 1984, page 196).

This indifference to the outside world is manifested in many of the ways in which FPCs present themselves to the public. The Which campaign report on registering with a doctor (Consumers' Association 1979) noted that they were not listed in the telephone directory in any consistent way. Patients' medical cards will only show the name and address of an FPC if they were issued after 1974. Earlier

* North West Thames RHA Management Development and Training Unit (8 May 1985). Customer Relations: proposals for implementing a strategy (unpublished).

cards refer to the now defunct Executive Councils. Their administrative offices are typically situated on the outskirts of urban areas, rather than in the centre. Many are difficult to reach by public transport. During the 1970s, five London FPCs were housed together in what soon became known as the 'notorious' Wembley complex. They are only now (in 1985) being dispersed to more accessible locations. On the buildings themselves, the signs we saw were sometimes discreet to the point of invisibility. Just one FPC office that we visited possessed a large and unusually legible sign: it read AREA HEALTH AUTHORITY.

Although they administer such large amounts of public money, FPCs, unlike their predecessors the Executive Councils, were until recently exempt from the provisions of the Public Bodies (Admission to Meetings) Act 1960. In spite of continued exhortations from the DHSS to admit outsiders to their meetings, they had no formal obligation to do so. It was left to their discretion. A succession of DHSS circulars stated that arrangements might be made for CHC observers to attend meetings, although the Royal Commission (1979) reported (page 149) that only one in four CHCs was in fact allowed in. In August 1983 a circular finally informed FPCs that they were required to admit the press and the interested public to their meetings, and requested them to supply the CHC observers with the relevant non-confidential papers (DHSS 1983c). The new regulations following Section 3 of the Health and Social Security Act (March 1984) impose a duty on FPCs to consult CHCs and to provide them with such information as they may reasonably require. CHC observers may speak at FPC meetings, although they may not vote. But after so many years of obscurity and neglect, it is currently a matter of some speculation as to how these obligations will be carried out. One CHC chairman recounted that although he was allowed to attend the meetings, he was made to sit at a separate table and treated as an 'odd man out' (May 1985).

In their capacity as public bodies, it might reasonably be expected that FPCs should have produced annual statements of their policy objectives and performance targets; perhaps listing their achievements in local terms. In October 1983 Michael Cocks, MP for Bristol South, circulated all 98 FPCs in England and Wales asking for copies of their annual reports. Frank Dobson MP, speaking in the Standing Committee on the Health and Social Security Bill on 16 February 1984, reported that about half of them did not reply (Parliamentary debates 1984, cols 266–67). Of those which did, 29 furnished current annual reports, six furnished statistical data, and nine provided out-of-date reports. Some declared that they had abandoned the

practice of producing reports altogether, because it was too expensive. Dobson concluded that probably two-thirds of FPCs did not produce an annual report at all. We regret to record that on our travels, we were told more than once that compiling reports wasted valuable staff time and resources. We were surprised when one administrator, whose FPC has a reputation for innovation and efficiency, informed us that he could not supply us with his as the only copy had been sent to Michael Cocks, who had not returned it. Another administrator took approximately nine months to answer our written request for a report.

The few reports which we did manage to acquire vary considerably in their style and quality, but they do (implicitly) reveal local priorities and preoccupations. Reference to a few examples will suffice. The report from Croydon (1984) is amateurishly presented and unattractively laid out, making it difficult to read. Valuable space is wasted in listing the names of all committee chairmen since the inception of the Croydon Insurance Committee in 1913. In our copy, this information even occurs twice; evidently this is a mistake. The two reports which we have from North Yorkshire, by contrast, make fascinating reading (1983, 1984). They ramble on, almost in stream-of-consciousness style, seeming to record every passing nuance of feeling in the committee throughout the year. There is a mass of interesting material here, but as sources of reference they lack organisation or analysis. Birmingham summarises the committee's response to circulars and local reports, which is useful (Birmingham FPC 1982; 1985). But if we were to award a prize, it would have to go to Norfolk (1984). Their report is well written, clearly laid out and professionally presented. As a source of information, it is as valuable to the interested professional as it would be useful to the lay inquirer.

Some FPCs have organised publicity that is specifically directed at informing consumers that they exist. Barnsley has produced a clear and informative leaflet describing its services. In 1979, Nottingham set up display stands manned by FPC staff in local libraries and shopping centres, and publicised them in the local newspapers.

The DHSS information sheet, sent to all FPC members in 1985, declares: 'Ministers wish all FPCs, as health authorities in their own right, to keep the public, CHCs and the media informed of their activities.' In Management Arrangements for Family Practitioner Committees (DHSS 1985c) under the heading 'Information', FPCs are asked to meet the 'reasonable demands' of other authorities and bodies for information concerning the FPS, subject to confidentiality and – a vital caveat – 'as far as their resources will allow'. Resources

are constantly cited as the 'final frontier' in any debate over freedom of information. But as FPCs eventually become more visible, it is likely that consumer demands upon them will increase.

Providing information about contractors

While patients have a choice of doctor, in practice this is limited not, as in transactions of a commercial nature, by cost, but by availability. The range of choice is also limited by geography, by knowledge, and to some extent by preference. If a patient wishes to consult a woman doctor, or an NHS doctor who practises homeopathy, or both, the choice is likely to be very limited indeed. Simpson (1979) found that when people move into a new area and change their GP, most of them choose the nearest or most convenient practice, particularly if they have to rely on public transport. Ritchie, Jacoby and Bone (1981) asked their sample of over 5,000 people how they would go about finding a doctor if they were to move to a new area. Forty per cent mentioned personal recommendation; 20 per cent would simply go to the nearest doctor's surgery. Fourteen per cent were uncertain what to do.

Yet one of the minimum requirements of FPCs is to provide up-to-date information on the family practitioners in their areas, together with information about locations and opening or surgery hours. This medical list should be widely distributed, and made available in post offices, libraries, police stations, CHCs and Citizens Advice Bureaux. However, in 1979, a Which survey found that only 17 per cent of their members (an educated section of the population) used the FPC medical list to find a doctor (Consumers' Association 1979). A survey of patients not registered with GPs, carried out in an area of Brent (Lovell, Allsop, Barron and Tachakra 1983), found that libraries were the only reliable source for lists of medical practitioners. Only half of the post offices had the required information.

The amount of information given on the medical list is still minimal. The Patients' Liaison Group at the Royal College of General Practitioners has recommended that additional information should be made available about practices and about the services which GPs offer. They also suggest that GPs should produce practice leaflets giving details about their services (Patients' Liaison Group 1984). The health development worker in Tower Hamlets has been compiling a list of local doctors, with full details about the clinics they run.*

* Interview

So far, FPCs have not provided this type of information, but the GMSC has recently decided that doctors should be encouraged to produce patient information leaflets, and to make them available to prospective, as well as to existing, patients. It has also been reported that the BMA has written to the DHSS, asking for the information on FPC Medical Lists to be extended (*The Times*, 23 November 1985, page 3).

Patients do not have a right to be included on a *particular* doctor's list; simply to be registered with a doctor. This is because doctors may choose whether to include a patient on their list or not. A doctor may decline to take on a patient for a variety of reasons. These need not be specified to the FPC, nor to anyone else. The doctor's list may be full: there is a maximum limit of 3500 for a single-handed practitioner, while partners in a practice must average out at 3500. A doctor may decide that he or she cannot or does not wish to have any more elderly people on the list; or he or she may not want to take on a registered or unregistered drug addict or a woman living in a women's refuge. Patients may be characterised as being 'troublesome', 'demanding' or 'uncooperative'. Doctors can also remove patients from their list without either they, or the FPC, having to give a reason. This can cause considerable friction between the FPC and the public, and much distress to the individual patient.

Several studies indicate that there are problems with registration, particularly in the inner city. Kensington, Chelsea and Westminster CHC found that there were people who had multiple rejections (KCW CHC 1977). In her very detailed and rigorous study of KCW using a sample survey drawn from electoral registers, Bone made a distinction between those not registered because they did not wish to be and those not registered because they could not get on to doctors' lists. The latter were five per cent of the population; but when extrapolated over the London area as a whole this amounted to 50,000 people (Bone 1984).

This particular area of London has a highly mobile population, and while many people find it difficult to get on to doctors' lists, there are others who simply do not bother to register (Hanson and Wilks 1984). KCW CHC (1977), drew attention to this problem; and a working group of the local medical committee (LMC) and FPC members was set up. The group recommended the use of an advertising campaign. As a result, the number of enquiries about registration doubled (KCW FPC internal report 1981). More recently, an advertisement in the Yellow Pages telephone directory produced a response which, in the eyes of the FPC, fully justified the cost (Feinmann 1985e).

The FPC can provide the names and addresses of doctors who practise within a reasonable distance of the patient's home. If patients cannot find a doctor to take them, then the administrative staff of the FPC may discuss informally with a practice whether they will accept a patient. There is also another procedure. Each FPC has an allocation sub-committee which has the power to assign patients to doctors' lists (see Appendix II for membership). It must take certain factors into account: the size and location of the practice, for instance, and whether the patient has previously been removed from the list of another doctor in the area. Doctors may appeal against having a particular patient assigned to them, but unless there is a valid reason for this (such as the patient having been assigned to them in the fairly recent past) the committee's decision is final. Doctors may, however, apply to have a person's name removed from their list immediately following assignment. They may also claim exemption from having patients assigned to them at all, but they will lose financially by doing so.

In every FPC, there are some patients who have continual difficulties with registration. One administrator was particularly concerned that these patients, who are given no reason for their rejection, can get caught on what he referred to as a 'reallocation roundabout'. Their records never catch up with them; and their medical care can suffer. This can engender considerable frustration, and can sometimes lead to anti-social behaviour. In his area, the administrator told us, one angry husband had assaulted the receptionist at a health centre and a woman had tried to throw herself off the top of a multi-storey car park because she wanted to go back on a certain doctor's list. This administrator felt strongly that the vagueness of doctors' terms of service prevented the FPC from dealing with the problems of allocation effectively.*

Manchester FPC, working with the local CHCs, has now adopted what they call a doctor–patient liaison scheme to deal with this situation. They found that patients who were labelled as 'difficult', and passed on from practice to practice, usually fell into one of three broad categories: people with mental health problems, individuals suffering from alcoholism or drug addiction, or patients who were in the process of undergoing changes in their physical or mental health. The three CHC secretaries use counselling, together with their wide knowledge of the community and of doctors' special interests, to match up patients with a GP who can help with their particular problem (Feinmann 1985d). This scheme has, however, been sub-

* Interview

jected to some criticism; arguably, it is a manifestation of the FPC's failure to fulfill its own role in a satisfactory manner.

Complaints against family practitioners

In the words of Kenneth Clarke, when Minister of Health: 'The average member of the public does not know what a FPC is and does not know how to go about making a complaint ...' (Parliamentary debates 1984, col 286). Earlier in the same debate, Frank Dobson, the Labour Shadow Minister, had argued that any sensitive and intelligently-run organisation will use complaints as a method of identifying what is wrong, and a way of improving its services. He expressed his regret that no national standards or criteria were laid down in relation to the way in which FPCs dealt with complaints (Parliamentary debates 1984, cols 264–266).

For the individual member of the public, the procedure for making a complaint against a family practitioner is complex and can be daunting. Harrison and Gretton (1984) point out that, in general, NHS complaints procedures are weighted against the complaining consumer and in favour of the complained-against professional. Although the CHC can play a useful role as a 'patient's friend', ultimately patients must stand alone, with the onus entirely on them to present and to prove their case. By contrast, the contractors will have the full backing of their professional bodies at every stage. Honigsbaum (1969), in a memorandum prepared for Richard Crossman about the complaints procedure against GPs, traces the historical background and concludes that the process is heavily biased against the 'lonely and confused' patient. The basic pattern, he argues, is one of conciliation: for administrative purposes, the procedure is designed to deter litigation. He also adds: 'No medical service, no matter how good, could hope to produce so little dissatisfaction.' For while the overall number of complaints is rising, it is still, proportionally, low.

The FPC has a number of ways of dealing with complaints. These depend upon the nature of the complaint, its perceived seriousness and the degree to which the person or patient involved wishes to press their case. If complaints are of a fairly minor nature – 'grumbles', as Klein calls them – then they may be dealt with administratively (Klein 1973). Every family practitioner has a contract with the NHS. The contract lays down the way in which the professional is expected to go about the business of being a doctor, dentist, pharmacist or optician. Since Honigsbaum's memorandum was written, new guidelines have been introduced and, as Klein (1973) has indicated, different

FPCs handle complaints in different ways (see discussion in the previous chapter). Yet the NHS consumer still has an inadequate voice.

The informal complaints procedure

The informal complaints procedure is aimed at conciliating between doctor and patient in order to resolve disputes. These can be due to any matter which has caused friction between the doctor and the patient, including the doctor's manner. Not every FPC has chosen to adopt this mechanism. In 1966, the government and representatives of the medical profession agreed to the introduction of an informal procedure to deal with complaints against doctors (Ministry of Health 1968) but it is not obligatory, and difficulties have arisen in operating the system. It proceeds in the following way. A lay member of the FPC is appointed as a conciliator, with a medical member of the committee as a medical adviser. When any complaint is received in writing, the complainant is asked whether he or she wishes to pursue it formally or informally. If informally, the conciliator may visit the complainant and attempt to iron out the differences. It is intended that the informal procedure should normally be completed within two weeks. Complaints may revert to the formal procedure at any stage.

The following is a description of the system followed by Barnet FPC. The conciliator makes the initial decision about whether to intervene, and then contacts the complainant either by telephone or by post; visits the complainant at home to explain who she/he is; contacts the doctor involved; then meets the doctor at the surgery. 'These interviews often provide much information not disclosed in the complainant's letter.' Another interview is arranged with the complainant, who then decides whether or not to proceed further. Finally, written comments are made to both parties and to the chairman of the FPC (Barnet FPC 1980).

There have been problems with the informal procedure, and this perhaps explains why some FPCs have been reluctant to adopt it. It is often extremely difficult, if not impossible, to complete the process in two weeks. People may not be able to be contacted by telephone, or they may not respond promptly to letters. Complainants themselves often appear to consider the informal procedure a second best.

Formal complaints

Complaints against all four contractor professions may be dealt with under the formal procedure of a service committee (see Appendix II

for details of membership). The way in which the investigations take place, and the rules governing them, are broadly similar for each profession. Their purpose is to establish whether or not a complaint that the contractor has broken the terms of the contract can be sustained. The service committee, with lay members chosen by the FPC and professional members chosen by their local representative committees, must listen to the evidence, establish the facts of the case and, where necessary, subject the evidence to cross-examination before reaching a decision. Complaints have to be made within a certain time and they must be made in writing. (Some FPCs delegate officers to help complainants with this.) The chairperson of the service committee makes the final decision, on the basis of the written evidence, whether there should be a hearing (Statutory Instrument 455 NHS (Service Committees and Tribunal) Regulations 1974).

At a hearing, the onus is on the complainant to make the case that the contractor has broken his or her terms of service. The complainant may bring witnesses to back up a story. A 'friend' can assist in preparing the evidence, although that person will not be allowed to address the committee. Written evidence – hospital reports, ambulance reports and coroners' reports – may be produced. However, once again the onus is on the complainant to obtain this evidence, and the authorities involved may be reluctant to cooperate. The FPC should assist the complainant, if there is difficulty. It is not possible to subpoena witnesses at this level of the process. The aim is to make the proceedings relaxed and not intimidating but, nevertheless, the process is highly structured. This can be helpful in situations where emotions may run high. For the contractor involved, a professional reputation may be at stake. Service committee hearings can be the prelude to a civil case. Reports on all cases are sent to the DHSS, and there is a right of appeal. Where there is a serious breach of the terms of service, cases may be referred to the appropriate professional disciplinary body. Thus, service committee hearings exist within a wider system of control.

As already pointed out, the committee's task is to reach a judgement about whether there has been a breach of the terms of service. Doctors' terms of service are set out in a long and complicated document, but most cases are concerned with paragraph 13 of Statutory Instrument 160 NHS (General Medical and Pharmaceutical) Regulations 1974. This states that a doctor:

> ... shall render to his patients all necessary and appropriate medical services of the type usually provided by general medical

> practitioners. He shall do so at his practice premises or, if the condition of the patient so requires, elsewhere in his practice area. ... Such services include arrangements for referring patients as necessary to any other services provided under the Health Service Acts and advice to enable them to take advantage of the local authority social services.

The meaning of these obligations is subject to interpretation by the committee in the light of the particular circumstances of the case. Complaints against doctors must normally be made within eight weeks of the events which gave rise to them.

In the case of dentists, the terms of service are different. They are set out in Statutory Instrument 1468 NHS (General Dental Services) Regulations 1973. Dentists must 'employ a proper degree of skill and attention', and provide the treatment necessary to secure 'dental fitness'. The rules about complaints differ slightly as well. A complaint regarding a dentist should be received in writing within six months of the completion of treatment or within eight weeks of the matters which gave rise to the complaint. The dental officer from the DHSS may be asked by the Dental Estimates Board to examine a patient who has had NHS treatment, as a part of random and routine checks. In fact, part of the obligations of a patient who received NHS treatment is to agree to such an examination. On the basis of this, the Dental Estimates Board may then bring a complaint.

Complaints against dentists are usually about the appropriateness and quality of the work done, and the correctness of the amount charged for it. The service committee can actually look at the dentist's work, and this makes the character of dental hearings very different from those of the medical service committee.

Complaints against pharmacists are far fewer, and they typically concern the correct dispensing of prescriptions. Complaints against opticians are rare.

Whichever profession is involved, the procedures used at the service committee hearings are very similar. After the necessary paperwork has been assembled, the parties to the hearing meet at the FPC offices and are conducted to a room where the committee meets. There will be at least one lay member and one professional member, or up to three members of each, and a lay chairperson. The complainant presents the case with assistance, if necessary, from the chair of the committee, and is then subjected to cross-questioning. The respondent then puts his or her case with similar questioning; first from the complainant, then from the committee. After a summing up by both parties, the committee reaches a decision. If it finds the

contractor in breach of the terms of service it may then issue a warning or impose a fine.

Fines imposed on dentists tend to be much higher than those imposed on doctors. This is a reflection of the nature of dental work. Dentists may be further punished by a requirement to get the permission of the Dental Estimates Board before undertaking certain courses of treatment. All or part of the NHS charge paid by the patient for inadequate work may also have to be returned to the patient.

When the service committee has decided on its recommendations, these go forward to the full FPC. This may, on occasion, alter the recommendations. The report is then sent to the parties concerned, and to the DHSS. Either party may appeal against the decision. The DHSS may then decide whether to support the committee's findings or whether to set up a new hearing. An appeal can involve the subpoenaing of witnesses. Morgan Williams (1983) has described the process in relation to medical complaints.

Comment

In a number of ways, the NHS is at present undergoing a process of reappraisal. Client attitudes towards professionals are changing, however imperceptibly, as foreseen in the American experience (Betz and O'Connell 1983; Rothman 1984). Patients are becoming less passive: self-help groups, community projects, pressure groups are all playing an increasingly important part in the field of health care. The foundation of the College of Health is another milestone in public participation. But, as Maxwell and Weaver (1984) point out, public participation does not deny the need for professional participation. Some professionals are embracing a new philosophy of healing, seeing it as a process of cooperation between doctor and patient rather than a one-way flow where one partner is dominant, the other subservient. At a conference on Access to Personal Files, organised (7 November 1985) by the Campaign for Freedom of Information,* a Birmingham GP and a London consultant described how giving their patients total access to their medical files had increased mutual trust and strengthened the doctor–patient relationship.

Several of the administrators whom we visited deplored the fact that the number of complaints from the public was rising. The number of appeals to the Secretary of State is also increasing. We would prefer to argue, however, that this is a healthy phenomenon. Cartwright and Anderson's most recent study of general practice (1981)

* The Campaign for Freedom of Information, 3 Endsleigh Street, London, WC1H 0DD.

suggested that patients' expectations are rising. Patients expressed more dissatisfaction with the information they received than with any other aspect of medical care.

The latest DHSS report on The Health Service in England (1985b) contains a brief section entitled Patients and the Public. The first sentence reads: 'In the past the health service has tended to use complaints as a way of measuring patient satisfaction.' Few, if any, FPCs have looked at complaints in this way. Fewer still have attempted to use them as a way of improving their services.

The report goes on to argue that the Griffiths report has now shown that market research is a more positive way of measuring consumer opinion. The subsequent discussion refers in passing to hospital complaints, and to the work of the Health Services Commissioner. No mention at all is made of the family practitioner services, apart from an acknowledgement that complaints about the community services show a 30 per cent increase since 1982.

FPCs can no longer, as they frequently did in the past, remain aloof from the communities which they serve. Many of them might find that professional market research into public perceptions about family practitioners and the family practitioner services could prove to be a fruitful and rewarding exercise.

SECTION II

The Family Practitioner Committee and the Contractors

3
Family Practitioner Committees: GPs and medical services

Access to the general medical services provided by GPs is one of the cornerstones of the NHS. Virtually the whole population is registered with a GP (Ritchie, Jacoby and Bone 1981). This provides an opportunity both for continuity of care and for the building of a personal relationship between doctor and patient. The core of the GP's task is to give advice, diagnosis and treatment to those who are ill, or those who think they are ill. Patients should be referred to hospital, or to other health and social services when necessary and care should be provided after hospitalisation.

The GPs' contract with the FPC is in some respects so general as to be almost meaningless; yet in others, it is very specific. For example, GPs must provide for their patients '... all necessary and appropriate services of the type usually provided by general practitioners'. More concretely, they must be available for consultation at their practice premises at times agreed with the FPC. They must visit their patients, if necessary '... at the place where the patient was residing when accepted by the doctor', or elsewhere by agreement. They must make arrangements to be available to their patients at other times for emergencies, or make suitable alternative arrangements for message-handling and locum cover. Such arrangements must be agreed with the FPC (NHS (General Medical and Pharmaceutical Services) Regulations 1974 Statutory Instrument No. 160).

As well as caring for their patients when they are ill, GPs may offer services such as vaccination and immunisation, maternity care or contraceptive services to their well patients. Some GPs may also provide what the RCGP call 'anticipatory care': care which aims to prevent ill-health among particular groups within a practice population. Mother and baby clinics, child health surveillance and screening for particular diseases are examples. DHAs, with their responsibilities for community health services, may also be providing some or all of these services.

There has always been a variety of styles in GP practice, but differences between what practices provide appear to have been growing. There are also variations in standards of practice; most obviously and visibly in practice premises. This situation raises a number of issues for the profession, and for the FPC. The importance of making more information available to patients has already been discussed, but there are broader questions concerned with improving

standards of care for communities and thereby providing greater equality of access and availability. Here the FPC needs to work with local GPs, as well as with DHAs, in order to ensure an appropriate mix of services.

General medical services (GMS) dominate the work of the FPC. GPs are the only group of contractors who provide services for a list of patients. There is a major administrative role in the maintenance of the patient register, GP/patient registers, the medical list, the payment of GPs and support services for them. The regulatory role is also extensive. The FPC has a responsibility to uphold the contract; and surgery hours and the availability of GPs, deputising services and practice premises are particularly important. The planning and development role of the FPC is almost wholly concerned with general practice, and the 1985 regulations (DHSS 1985c) make these duties explicit.

In future, all FPCs will be involved in helping and encouraging GPs to improve standards in primary care. This is not an easy task, as it demands a high level of managerial as well as administrative skill. The FPCs' formal powers are limited: the GP's contract is vague and does not cover new areas of work such as anticipatory care; and as a group GPs are highly sensitive about their independent status. They tend to be committed first and foremost to their practice populations rather than to the needs of wider communities. FPCs need to know their practitioners well: their practice philosophy, their expectations, their problems, the services they provide and how they would like to develop these. This knowledge and information, together with a clear formulation of both policies and tactics, is essential for negotiating change.

In this chapter, and in the following chapter on practice premises, we aim to explain the powers which FPCs have in relation to GPs in more detail, and we illustrate how some FPCs have approached the task. We first describe general practice and recent changes.

General practitioners

In 1982, there were about 28,000 GPs in practice in England and Wales. The majority were unrestricted principals: that is, fully-qualified doctors providing the full range of services. One per cent were restricted principals, who had a small list or provided a limited number of services; one per cent were general practice assistants, who were paid a salary by the principal; and seven per cent were trainees (Dowson and Maynard 1985). The contracts of unrestricted and restricted principals are held by the FPC and the appointment of other doctors, assistants, locums and trainees, is agreed with them.

The number of unrestricted principals has increased by 11 per cent since 1978. This is a faster rate than the population increase: the ratio of GPs to the population has increased from 45 per 100,000 in 1975 to 50 per 100,000 by 1984 (DHSS 1985a). Britain has a larger number of general practitioners than many other countries where medical specialisation has gone further. This reflects a commitment to good quality frontline care, the gateway to specialist care in the NHS. As a consequence of their increase in numbers, the GPs' list sizes have on average fallen: from 2,384 in 1974 to 2,089 in 1984 (DHSS 1985b). Despite the activities of the Medical Practices Committee (MPC), a national body which aims to achieve an even distribution of GPs throughout England and Wales, there is still some variation in list sizes in different parts of the country. However, this is much less extreme than in other European countries (Maynard 1976). The work of the MPC is discussed below.

The cost of general medical services

In 1983–4 general medical services in England and Wales cost 29 per cent of the family practitioner services' budget (DHSS 1985b). This was paid to GPs through a system of fees and allowances. These allowances fall into four categories:

1) Capitation fees for each patient on the list are the major source of a GP's income. There are extra payments according to whether the patient is under 65, 65–74 or 75 and over.
2) A range of allowances is paid at a flat yearly rate. A basic practice allowance is paid to all GPs with over a thousand patients on their lists. Additional allowances are paid for seniority, group practice, practising in an under-doctored area, and for post-graduate training.
3) Payments are made for items of service such as vaccinations and immunisations, cervical cytology tests, night visits, the treatment of temporary residents, the provision of maternity services, contraceptive services and the supply of appliances in rural areas.
4) Certain practice expenses are also reimbursed, such as allowances on rent and rates; and there is a 70 per cent reimbursement on the salaries of practice staff. These are subject to certain conditions, which are described in more detail below.

A GP's income will vary according to the value of these different items. Using 1983/4 Review Body figures, and taking an 'average' list size and items of service performed, Bowles (1984) calculated that in 1983 a GP's average total gross income would be £29,960. This

included fees and allowances. Allowing for expenses, net income would be £20,670.*

GPs and patients

GPs treat nine out of ten of all episodes of illness themselves, or refer patients to services in the community. In about 10 per cent of cases they act as referral agents to the hospital (GMSC 1984). The General Household Survey collects figures on consultation rates between GPs and patients. On average, people consult their doctors between two and three times a year, although consultations do vary according to age, sex, and socio-economic group (OPCS 1984). Women consult the doctor more than men: five times a year compared with 3.5. This difference is consistent for every socio-economic group. In general, consultation rates were lower for the higher social classes. Within the age groups, the 0 to 4 year-olds had the highest rates, followed by the over 65 year-olds. These patterns of consultation will affect the GP's workload and therefore some practices are likely to be busier than others.

Cartwright and Anderson's second study of patients and their doctors, carried out in 1977, indicated that in general the level of satisfaction which patients have with their doctors has remained high (Cartwright and Anderson 1981). From the patient's point of view, there were two ways in which the GP service could be said to have deteriorated between 1964 and 1977. First, home-visiting had declined and criticism of this had increased four-fold. Second, practitioners were less inclined to be interested in, or think it appropriate to be consulted about, the problems of daily living experienced by their patients. However, as Hicks has remarked of satisfaction studies in general, '... when questioned directly, the vast majority of people say they are satisfied with the form of care they are receiving. Few are able to envisage the advantages and disadvantages of other systems' (Hicks 1976; see also Klein in Maxwell and Weaver 1984).

Changes in general practice

Since the establishment of the NHS in 1948, there have been important changes in the way GPs work. In 1952, 43 per cent were in single-handed practices; by 1983, only 12 per cent were single-handed. In 1976, seventy-six per cent of doctors were in group practice (that is,

* The average net income envisaged by the Review Body for 1985/6 was £23,440. Fees and allowances, plus practice expenses of £11,320, made an average gross income (net plus expenses) of £34,760. (Personal communication, the Editor, *Money Pulse*, 19 March 1986.)

three or more partners). There has also been a trend towards larger practices. In 1983, 29 per cent of GPs were working in practices of five or more partners (Dowson and Maynard 1985).

Over the years, the average age of GPs has been falling, as more new recruits are joining the profession and there has been a tendency towards earlier retirement. The modal age of GPs has fallen from 50–55 in 1977 to 30–34 in 1984. In the 1970s professional standards were strengthened by the introduction of three years' vocational training following registration. This became mandatory in 1981 and consists of two years in an academic department of general practice, followed by one year working with a trainer GP. There is currently considerable variation in the training GPs have received, and higher training on a voluntary basis is being proposed (RCGP 1985b).

The increase in the size of practices has been accompanied by a growth in the numbers of staff employed by GPs, or attached to practices by the health or local authority. In 1977, nine out of ten practices employed a secretary or a receptionist. Successive governments have attempted to encourage the development of larger groups of GPs working with community health staff and local authority social workers, providing services to patients through a primary health care team. This was defined by the Harding Committee as '... an interdependent group of general medical practitioners and secretaries and/or receptionists, health visitors, district nurses and midwives who share a common purpose and responsibility, each member clearly understanding his or her own function and those of the other members, so that they all pool skills and knowledge to provide an effective primary health care service' (DHSS 1981f). The primary health care team has been seen both as the best way of providing care and treatment for patients in the community and of developing programmes for health promotion and prevention. Many GPs, however, have not received any training for working in this way.

Recent government publications – *Health Care and its Costs* (DHSS 1983a), the annual report on the Health Service in England (DHSS 1985a) and the BMA publication, *General Practice: A British Success* (GMSC 1984) – have presented a bland picture of slow but progressive improvements in terms of group practice, expenditure on services, doctor–patient ratios and numbers of attached workers, and in the value for money provided by general practice. However, there are also indications, from within the profession and in policy-making circles, that there is a concern to raise standards. These are not evenly high. Some also believe that general practice is failing to adapt quickly enough to play a full part in providing comprehensive community services. In general, far too little is known of the scope,

process or content of GPs' work (Bosanquet 1986).

As a result of the very general terms in which the GP's contract with the NHS is framed, GPs are able to practise with a great deal of independence. The RCGP argues the positive side of the contract system: '... the right of the doctor to decide what he or she does, applying his or her own preferences and prejudices about the most effective way to administer patient care ... such individuality has the merit of creating an independent advocate for the patient, unfettered by hierarchical demands, and can provide a dynamism and flair within the practice' (RCGP 1985a). On the other hand, it is clear that the profession is also concerned about GPs who fail to provide an adequate service. The flexibility, and the absence of standards, yardsticks or minimum service requirements can lead to inadequate care. Metcalfe (1985) comments that '... there is ample evidence, anecdotal and from formal research, that a significant minority of GPs' behaviour can only be described as unmotivated, unprofessional and technically incompetent' (see also Acheson and Henley 1984).

Metcalfe and Wilkin's research in Manchester, where data was derived from a large and representative group of GPs, found great diversity in all aspects of practice. To pick out three measures: prescribing rates per 100 consultations varied from less than 60 per cent to more than 85 per cent; laboratory tests varied per 100 patients from less than one per cent to more than 10 per cent; referral rates ranged from less than 3 per cent to more than 15 per cent. 'It is quite clear', they remark, 'that patients registered with different GPs were receiving quite different patterns of care' (Wilkin and Metcalfe 1984).

At present there are few mechanisms for monitoring GPs. FPCs have limited powers in this direction, and there is no established system of peer review. The way in which GPs are paid does not encourage good practice; indeed rather the reverse. A lazy doctor is not financially worse off as a consequence.

Many argue that the failure of general practice to play a larger role in the area of preventive and community health care has led to the fragmentation of services and a clinical drift towards hospital care. It has been pointed out that rates of immunisation in this country are low compared to those in other countries. (This includes the USA, where there are fewer general practitioners.) The extent of anticipatory care – screening for disease and monitoring chronic illness could be much further developed. Tudor Hart claims that medical science is failing to apply available knowledge to combat disease: '... medical science and clinical medicine derived from it have not failed, they have simply not been applied rationally to the whole popula-

tion' (Tudor Hart, no date). Others have drawn attention to an increasing use of hospital A & E departments in inner cities for conditions which could be treated in general practice (see Farmer and Chambers 1982; Farmer 1984; Dennis 1984). The considerable variation in lengths of stay in hospital for certain conditions, for example, maternity cases and hernia operations, indicates that with sufficient community nursing support, time in hospital could be cut. In some areas, there has been a growth of hospital-based out-patient clinics, for among others, patients with diabetes or hypertension. This raises questions about appropriate location. They could be based in general practice or run in conjunction with GPs. Some minor surgery now undertaken in hospital could also be done in general practice (Honigsbaum 1985). In a small number of areas, community paediatricians support GP child health development clinics (Crouchman 1985).

Improving standards

The profession has made a number of responses to the above criticisms. The General Medical Services Committee (GMSC) of the BMA has argued that the number of GPs should be increased to deal with increased tasks and that item of service payments should be provided in order to encourage GPs to carry out further services (GMSC 1979; Wilson 1985). The problem with this approach is that costs would rise, with no necessary guarantee that services would be provided more consistently than at present.

Some put greater faith in extending and developing primary health care teams. St Yves (1984), for example, advocates the employment of nurse practitioners and other health workers and the delegation of some tasks from GPs to nurses (see also Honigsbaum 1985). Others have suggested an organisational change: the transfer of community nursing staff from the DHAs to the FPC (DHSS 1981f, page 30).

The Royal College of General Practitioners (RCGP) have recently undertaken an initiative to improve the quality of general practice. About one third of GPs belong to the RCGP and its main objective is to raise professional standards. While supporting a wide variety of practice arrangements and organisational structures, they argue for greater peer and collegial control through: 1) higher standards of training and systems of accreditation; 2) changes in the system of payment to reward good practice; 3) a greater emphasis on principles of good management: developing practice objectives; peer review within the practice; the employment of practice managers and the use of computers to aid record-keeping (RCGP 1985b).

There are also those who would turn to more market-oriented solutions, aiming to bring in greater competition in order to stimulate change and innovation. 'NHS practice is a relatively well-rewarded, non-competitive monopoly and its practitioners enjoy virtual life-long tenure' (Marinker 1984, page 12). Marinker proposes that communities should negotiate franchises with GPs with the aim of providing a package of health care for a fixed period of at least three years. It is not clear, however, what Marinker means by 'the community', and how it would be represented. He does not specify how such franchises would be negotiated, and from what knowledge base. The difficulties with such ideas relate to the problems of generating 'community action' and of formulating 'community objectives', particularly in areas without an appropriate structure and which contain very heterogeneous populations. Marinker suggests that the FPC could play the role of broker for the community. This would certainly add to the complications of their present role without bringing any clear advantages other than the winning of an ideological point: the establishment of fee-paying, competitive general practice.

Maynard (1985) flirts with the idea of bringing health maintenance organisations (HMOs) to Britain. HMOs consist of a group of health care producers who, in exchange for a patient's prepayment or subscription, contract to provide comprehensive health care services. These include regular health screening as well as treatment for acute illness and, argues Maynard, they encourage doctors to evaluate treatment decisions and to concern themselves with costs. Vouchers could be used to offset variations in the income of users. HMOs assume that subscribers are equally 'health conscious' and rational consumers. In the USA, HMOs may have resulted in some cost saving, but they have done little to reduce inequalities in health status between different social classes and ethnic groups (Anderson 1972). A fundamental principle of the NHS has been to ensure equity in distribution and access. Although it has not achieved this aim it is still an important objective, and it is not a goal which would be achieved by the introduction of HMOs.

The prime objectives envisaged by these solutions are better value for money and increasing consumer influence on the service. These goals can, and in our view should, be achieved within existing structures, probably at a lower overall cost. Radical organisational change carries its own costs and its effects can be unpredictable. More positively, the FPC is now seen to have a role in improving standards both through the use of regulatory powers and by providing support for GPs.

The role of the FPC: surgery hours and out-of-hours care

FPCs can influence the pattern of general medical services in their areas in three major ways: through interpreting the terms of service and then by monitoring them; second, by encouraging changes in practice structure and location in order to reflect local needs; and third, by informing and assisting GPs to improve their practice premises. (Practice premises are discussed separately in chapter 4).

To be eligible for a full basic practice allowance (in 1985, £7065 per annum) GPs must devote '... a substantial amount of time to general practice. ... This will be partly provided by surgery sessions and partly by home visiting. The conditions will normally be met where such services given by the doctor to his patients amount on average over the year to 20 hours per week at times which are reasonably spread over the normal working week' (DHSS 1981e).

The above paragraph is illustrative of the unspecific nature of the regulations governing the working arrangements for GPs, and the discretion which this gives to FPCs to set the parameters. Downey has indicated that FPCs interpret this regulation differently; and doctors may spend their time in different ways. Wilkin and Metcalfe's study in Manchester found, for instance, that 16 per cent of their sample of 397 GPs spent less than 12 hours in a week seeing patients (Wilkin and Metcalfe 1984). One administrator commented: 'It's quite simple. GPs sign a very short statement which says that they are spending a minimum of 20 hours a week in surgery sessions. Apart from sitting in on their surgery sessions, it's very difficult to check' (Downey 1985b).

Providing that they fit in with the minimum requirements, GPs may decide on the time of their surgery hours. However, many FPCs do attempt to review these to see that they meet the needs of patients. Manchester, for example, has rules, policies, and achievement marks concerning surgery times. Surgeries are not allowed to close before 18.00 hours. Patients must be allowed to see GPs between the last surgery on Friday and the first surgery on Monday, normally during a one-hour period. Another FPC, which does not yet have a policy on weekend surgeries, is concerned that there may be a need for these, and wishes to prevent a loss of service. Therefore, if a GP applies to stop running a Saturday morning surgery, this may only be for a trial period of six months in the first instance. This means, however, that the onus is put on patients to complain if they do not wish the service to be lost.*

Few, if any, FPCs have attempted to find out what patients in

* Interview.

particular areas want. This has been left to CHCs or to specially commissioned research studies (KCW CHC 1979; Leinster 1982). For example, one CHC member in Leeds who compared a previous FPC list with the current one found that there had been a 20 per cent reduction in surgeries open after 18.00 hours and a 40 per cent reduction in Saturday morning surgeries. Meanwhile, 24 per cent of patients questioned said that they lost pay if they took time off work to visit the doctor (May 1985). In London, a survey of the health care needs of Chinese people living and working in Bloomsbury found that 21 per cent of families had difficulties in getting to see a GP because surgery times clashed with their work hours (Bloomsbury Community Services Unit and Bloomsbury CHC 1984). However, we did find that some FPCs were beginning to discuss these issues. In Norfolk, where there are a number of long-distance commuters, the FPC has asked doctors to keep their surgeries open until 18.00 hours. It is also contemplating an extension of this if the demand can be demonstrated.* Greenwich and Bexley FPC is concerned by high attendance levels at the local A & E department, and intends to establish whether this is due to the non-availability of GPs at certain times.* Tameside and Glossop is planning a joint venture with the CHC to investigate consumer perceptions of primary care services as a whole.†

Doctors under contract to the NHS are responsible for providing care and attention for their patients every evening and night, and every weekend of the year. They may wish to opt out of the responsibility for their patients at night: this was an option negotiated by the Doctors' and Dentists' Review Body in 1966. However, few have in fact chosen this reduced contract, as it means a financial loss. It has been accepted that doctors are entitled to 'time-off and leisure time' provided that they make suitable arrangements for out-of-hours cover. This responsibility has two elements. The doctor must be available: that is, the arrangements for getting in touch with the doctor out-of-hours must be adequate. If the doctor chooses not to be available personally, then the deputy must be suitable.

The FPC has the responsibility for agreeing these arrangements and, by implication, for ensuring that they are working properly. This seemingly clear line of accountability, like much else relating to the operation of FPCs and their relationship with contractors, is cloaked in ambiguity. Apart from the new regulations for deputising services, discussed below, it is not known how FPCs monitor 'availability' and what information they collect.

Since the contractual arrangements were first introduced in 1948,

* Interview. † Questionnaire.

the way in which GPs practise has changed in a number of fundamental ways, many of which have been described above. The full impact of these changes in the GP's workload is not known, although one consequence is that GPs have increasingly made arrangements to rationalise their out-of-hours work. They may, for example, join with other practices to organise a duty rota. In inner city areas especially, doctors tend to live away from their practices, so they are more likely to make arrangements for deputising. Doctors' attitudes towards being available to their patients at night may well have changed. Webster *et al* (1965) comment: 'The telephone demanding attention during the night represents one of the most unwelcome and often unrewarding sides of a family doctor's life.' A further change in the general context of GPs' work has been the recent rapid growth of telecommunications technology. It is now accepted that GPs must be available via the telephone, although this is not explicitly stated in the terms of service. Most practices now have some method of handling calls and transferring them, and of passing on messages both in and out of surgery hours. We have dealt with this issue more fully elsewhere (Allsop and May 1985). The adequacy of these methods will depend on a number of factors, including the efficiency of the telecommunications system itself and the capability of the individuals handling the messages. These changes have created both the incentive and the technological means for doctors to arrange their out-of-hours cover in a way which suits themselves and uses their time in the most appropriate manner.*

A survey carried out in 1984 by MORI for the BMA found that 87 per cent of doctors are on call for their own patients at least once a week between 19.00 and 23.00 hours, while 27 per cent are on call three times a week. There was more likelihood of those doctors in single-handed or two-handed practices being on call than those in larger practices. Seventy-five per cent of doctors were on duty between 23.00 and 07.00 hours at least once a week; 21 per cent three times a week. In smaller practices, half the doctors were likely to be on duty three or more times a week. At weekends, 63 per cent of doctors as a whole were likely to be on call at least once a month. This was higher in small practices (MORI 1984). Looking at general practice as a whole, there is no doubt that these evening, night and weekend visits make up a small proportion (only one to three per cent) of general practice consultations. (Crowe, Hurwood and Taylor 1976; Cubitt and Tobias 1983).

* It should be noted that out-of-hours care can mean care outside surgery hours, or it can refer to the period between 19.00 hours in the evening to 07.00 hours in the morning. At weekends, the period runs from 13.00 hours on Saturday to 07.00 hours on Monday.

In some parts of the country, schemes have been developed which involve the FPC collaborating with other groups in providing more effective and efficient ways of message-handling for GPs. One example of such a joint enterprise is the Telephone Answering and Message Relay System in South Glamorgan (TAMERS). This is a sophisticated and highly-developed answering system based on the ambulance service. The South Glamorgan ambulance control operates a two-way VHF radio-communications system for all the county's ambulance services and for community nurses. The scheme began on an experimental basis, linking doctors in three practices in Cardiff who shared a common night-duty rota, using spare equipment owned by the health authority (Smail, Lloyd and Mann 1981). The experiment was evaluated after three months, and it was found that 94 per cent of the calls had been acknowledged by the doctors within 10 minutes. Subsequently, a working party was set up involving the health authority, the LMC, the FPC and the ambulance service to develop a proposal to open the service to other GPs in the area.

Deputising services

There has been an increase in the number of deputising services and in doctors' use of them. The first deputising service began in London in the mid-1950s. By 1984, there were 50 services operating in England and Wales (BMJ 1984). Accurate figures on the extent to which deputising services are used are hard to come by. Consents to use the service are high; in some areas as many as 98 per cent of doctors have consent to use them. The way in which these services are used depends on the structure and approach of the practice as well as on the type of area. In most rural areas there are no deputising services available. In metropolitan FPCs such as London and Birmingham there are a number of competing services.

The MORI (1984) survey of out-of-hours care in England found that 33 per cent of the GPs contacted used deputising services some of the time. Over half of the GPs over 60 years old used deputising services. Use was greater by single-handed and small practices, less by larger and group practices. Rather higher figures of use were found by Smith (1985) in a sample of a hundred practices in towns and cities in England and Wales. This survey found that 79 per cent of all practices approached used deputising services; 52 per cent of those with three or more partners. These findings, however, do not give an indication of how much of the out-of-hours work is carried out by these services. The Review Body of Doctors' and Dentists'

Remuneration (1982) found that over 40 per cent of night visits were carried out by deputies.

There are two ways in which doctors can be held accountable for their out-of-hours work. The first way is through the service committee procedure. If a doctor's arrangements for being available are found to be inadequate, or if the locum, deputising doctor or assistant is shown not to be of a good enough standard, then the complaints procedure can be used by the FPC or by a dissatisfied patient. The second avenue is through the FPC itself. Doctors must inform FPCs of their out-of-hours arrangements, and obtain agreement to locums taking over during periods of holiday or study leave. 'We must be satisfied that GPs can be contacted reasonably out-of-hours. We require the telephone number to be displayed in the surgery, with instructions. The situation must be made clear to patients', one administrator commented.*

Our 1985 report highlighted some of the factors which inhibited telephone access to doctors in London (Allsop and May 1985). We recommended that FPCs should collect information on systems used out of hours, and that they should be prepared to help GPs to improve their systems in the same way that they assist with practice premises. An FPC administration can be more, or less, pro-active in its approach. It can encourage and facilitate the development of rota arrangements; it can give advice about the advantages and disadvantages of different kinds of answering services. It can also attempt to develop particular standards, and then devise ways of seeing that they are adhered to. The use of deputising services continues to arouse strong feelings, although there is an absence of hard evidence that they are less adequate than other forms of out-of-hours cover. Patients are more likely to express dissatisfaction about a visit from a deputising doctor (Royal Commission on the NHS 1979; Sawyer and Arber 1982; Prudhoe 1984). Comments were made that deputising doctors appeared tired, or did not know the patient's personal history. Lack of linguistic competence was another cause for concern. However, it must be said that this level of dissatisfaction is not high. The allegations which appeared in the *Sunday Times* and other national newspapers in 1983 should be treated with caution.

Among doctors, there is general support for the existence of deputising services. The report of the working party on general medical services (DHSS 1974) commented in 1973:

> The pattern of life has altered significantly and few would demand that their doctor should always be available. Indeed, no such right

* Interview.

> exists ... any doctor in general practice, or indeed any other form of clinical practice, must have some deputising arrangement. The problem is not whether such arrangements should exist, but how they can be organised in the way least harmful to continuity of care.

There are, however, differences of opinion among doctors about how much commercial deputising services should be used. Cartwright and Anderson (1981) found that 52 per cent of doctors saw these as a disadvantage to patients. The MORI survey found that 82 per cent of those doctors who used deputising services were satisfied with them. It is generally agreed that deputising services should be of a high standard, well run, with good quality deputies. There is more controversy about whether there should be limits to use, and about how deputising services should be monitored. FPCs now have an important role in these areas, and following the circular of May 1984, they are in the process of devising strategies with the interested parties (DHSS 1984c).

FPCs have two main responsibilities in relation to monitoring deputising services. They have to ensure that the service is operating at a satisfactory level – a quality of care criterion – and they have to see that there are limits to the extent of use – a value for money criterion. Under their contract, GPs are not allowed to use a deputising service every night and weekend. There is evidence to indicate that the night visiting rate rises with the use of deputising services, a cost borne by the DHSS (Buxton, Klein and Sayers 1977; Sheldon and Harris 1984). The aim of the FPC should be to ensure that out-of-hours care is of no less a standard than that provided in hours. A doctor wishing to use a deputising service must obtain consent from the FPC to do so.

There are limits suggested in the new circular, but the deputising sub-committee of the FPC must make the decision depending on local circumstances. This committee includes members who represent lay and medical interests (see Appendix II). It appoints a local doctor as a liaison officer. He or she will act as its eyes and ears, making a regular check on the running of the service. The liaison officer can also check on the appropriateness of doctors' clinical responses to presented symptoms. The operational statistics of the service must be made available to the committee. These include numbers of subscribers, numbers of patients, the time taken to answer calls, the outcome of calls, the numbers of cases where complaints have been made and their outcome, the number of telephone lines, operators on duty and so on.

Besides the committee, there are other subtle checks on the deputising services which are worth highlighting. Deputising services are profit-making organisations, and therefore compete with each other. They fall into three categories. First, there are those run by BMA Air-Call, the biggest group. These operate according to a code of practice drawn up by the BMA. A proportion of the profits is returned to the BMA. This group tends to set the standards for the market. A second type is owner-controlled; doctors who subscribe to the service take a share of the profits. The third type is company-controlled and profit-making, but without the BMA link.

All three types of deputising service have a medical director, concerned with the maintenance of professional standards. Subscribers have an interest in seeing that standards are maintained, and they may vote with their feet by ceasing to use a particular service. The monitoring introduced in 1984 was not new, but had previously (since 1976) been carried out on behalf of the FPC by professional advisory committees. The onus is now clearly on FPCs, although the vagueness of the circular has created local difficulties.

The deputising sub-committees are now directly involved in interviewing potential deputising doctors, using a lay and a medical member. The circular lays down that all candidates must have had at least six months' experience of working in general practice within the last three years. The committee must also be satisfied about the applicant's linguistic competence. The market situation has changed, because there is now a much larger pool of vocationally-trained doctors available as general practice has become more popular. Many deputising services work only, or mainly, with deputies who are themselves GP principals. In Hampshire, 80 per cent of deputies are principals; in Portsmouth, all deputies must be principals. In Dorset, all GPs who use the service are required to work as deputies. The administrator says: 'My Committee took the view that the most important things they needed to satisfy themselves about were the adequacy of the service, its manning, the quality of its deputies and its ability to respond to the day-to-day commitments of those working in it' (Walker 1983).

FPCs would appear to have had some problems in determining limits to use. In 1985, a *Medeconomics* journalist carried out a survey of FPCs. Almost a quarter had not yet set any limits, or else had decided that they could not, or would not, do so. One view expressed was that if a deputising service was good enough to use one night of the week, or for a set number of calls a month, then it was good enough to use the whole time. If the doctor was prepared to sign a declaration, the committee was not going to impose a 'silly

numbers limit' (Kent 1985). This argument ignores the value for money aspect of FPC control.

Those FPCs which had set limits revealed wide differences: from five to 25 calls per thousand patients per month. Few FPCs have detailed information regarding the circumstances of particular practices and their registered patients available to them, so they have decided upon very broad criteria which cover the FPC area as a whole. Some FPCs have left the question of monitoring to the professional integrity of the doctor. Kensington, Chelsea and Westminster FPC have decided to do annual random checks of the use of deputising services, with their doctors' permission. Another FPC requires their doctors to inform the FPC whenever they use deputising services.

The monitoring of deputising services is an issue which continues to concern the DHSS, and it has featured as part of discussion in performance reviews of FPCs.

The structure and distribution of practices

Since the 1946 NHS Act, the distribution of practices in England and Wales has been determined nationally by the Medical Practices Committee (MPC). At local level, the FPC works within rules laid down by the MPC and FPC decisions about individual doctors and practices must be agreed by the higher body. GPs wishing to practise in an area must be accepted, and their premises and the location of them agreed. These cannot be changed without permission from the FPC. However, GPs do have considerable autonomy in how they organise their practices. Patients may be drawn from anywhere within a broad catchment area which may extend beyond the FPC boundaries. GPs may organise their work and employ staff as they wish. Once the pattern of practice has been established, the FPC's ability to change it is limited.

The FPC has a responsibility to see that general medical services are provided for patients and that they receive adequate personal care and attendance (see Appendix I). But sometimes this may be difficult to achieve, as they cannot *direct* GPs to change the structure, location or catchment area of their practices to suit changing needs and shifts of population. FPCs can only attempt to exert influence. They are more likely to be successful when the 'carrot' of money is involved. Possibilities will be hedged around by the variety of interests, often conflicting, referred to in the next chapter. The strongest constraint on the FPCs is the MPC.

The power to decide on the number of doctors permitted to prac-

tise in any particular area of the country is controlled by this central body. The MPC consists of a chairman, who is a doctor, six other doctors (five of whom must be in active practice) and two lay members. The committee was set up as part of the NHS, and it was designed to achieve a more equal national distribution so that the most favoured areas of the country would not continue to attract larger numbers of doctors.* The MPC has been successful in this as the number of GPs has gradually increased, and 80 per cent of practice areas are categorised as intermediate or restricted (Doyle 1984). In 1974, just under half of all GPs practised in either open or designated areas; by 1980 this had fallen to one third (Dowson and Maynard 1985). By 1982, the number of people living in under-doctored or 'designated' areas had fallen from 8 million to 0.5 million (OHE 1984). The latest MPC report, for the end of September 1984, indicates only one designated area: Durham (*The FPS* 1 January 1985, page 9). Many FPCs now argue, however, that the MPC's tight control over the numbers of doctors and their distribution is inhibiting FPCs from responding to local needs.

Each doctor has to apply for permission to start a practice, join a partnership, or replace a partner. Each application is judged on its merits and on the needs of the locality, first by the FPC and then by the MPC. The MPC has the right to refuse an application. Where a practitioner dies or resigns, the MPC must agree that there should be a replacement. It is for the remaining partners to select a successor. If the practice is single-handed, it falls to the FPC to advertise, to interview candidates and to make recommendations to the MPC, who then make the final decision. Doctors whose applications to practise in particular areas are refused, or who are unsuccessful in applications for vacancies, have a right of appeal to the Secreatry of State. This cumbersome device was presumably designed to protect the interests of contractors, but it is now little more than a bureaucratic ritual.

At FPC level, recommendations about practice vacancies or the expansion of a practice are made by a member-level committee:

* Areas are classified as follows:

Designated. The average list size over 2500; there must be sufficient excess patients to support additional doctors. In certain circumstances financial assistance can be given, to encourage new doctors to enter the area.

Open. Average list size 2101–2500. Applications to join the Medical List are normally approved.

Intermediate. Average list size 1701–2100. Normally regarded as adequately served, unless there are special circumstances.

Restricted. Average list size 0–1700. Applications are normally rejected unless there is a special case.

the standing joint committee or practice vacancies committee (see Appendix II). This committee also responds to requests from GPs for extra partners or to requests to set up new or branch surgeries. For example, if a new housing development takes place, a practice may ask for an additional partner to cope with the influx of patients. The practice will need to provide information to the FPC to support its case.

Some FPCs may take a more active approach. They may know enough about their area to anticipate changes and can suggest to GP practices that they should expand. They may themselves make a case to the MPC, particularly if the area is restricted. Ideally, the location and structure of practices should change as population shifts. Practice premises should be within 'pram pushing distance of those wishing to use their services' (Knox 1979). Potentially, due to the low capital investment involved, general practice should have this degree of flexibility, although this is not always the case. Many believe that FPCs should have greater powers to take initiatives without recourse to the MPC. Now that doctors are distributed more evenly, it has been argued that the MPC should play a lesser role. The GMSC has recently taken this view (BMJ 1985b).

We came across the following examples of ways in which FPCs can encourage practice change and development. People in the Meaden Vale area of Nottinghamshire were remote from medical services. The parish council approached the FPC and asked for a surgery or branch surgery, preferably with a dispensing facility or a chemist's shop. The FPC found a site, but it involved negotiating with the parish council, the county council, the local medical and pharmaceutical committees and the National Coal Board. Following a practice break-up in another area, a GP agreed to practise from a Portakabin as a temporary measure. The FPC helped to set in motion the building of a surgery under a Cost Rent scheme. After three to four years, the doctor has a list size of 1,600 and a chemist has also moved in.*

Due to the development of the new Selby coalfield in North Yorkshire, the town of Selby is an area of growing population. On the initiative of the FPC, a practice vacancy was created and a GP started a practice from a Portakabin. The FPC paid the doctor's removal expenses, supplied furniture and equipment for the surgery and reimbursed ancillary staff in full. In 1984, a second partner joined the practice. The FPC and York Health Authority identified a site for permanent surgery premises, and a public discussion meeting was held before this was made available. In anticipation of long-term

* Interview.

population demands, a four-GP unit was planned, with finance provided by the General Practice Finance Corporation (GPFC) under the purchase and lease-back scheme (North Yorkshire FPC 1983, 1984).

These FPCs have taken steps in order to meet particular needs, but we have also encountered instances of missed opportunities. In one part of London, 12 single-practice vacancies were replaced by 12 single-handed practitioners. This, of course, is partly due to the fact that GPs may resign or retire in different parts of the FPC area thus making it difficult to create new group practice units. It has often been suggested that in such cases the remaining very elderly GPs should be compulsorily retired in order to create vacancies in the same neighbourhood. At present, there is no retirement age for GPs; and the FPC has no such powers (see page 171).

Some FPCs have taken a very positive line towards single-handed practices. Manchester takes a special interest in enabling them to provide comprehensive services for their patients, by encouraging the employment or attachment of support staff. Norfolk talks to single-handed GPs nearing retirement in order to discuss ways of easing their workload. This enables the FPC to think ahead, anticipating future vacancies.

FPCs may bring in doctors to meet the needs of particular sections of their population. Kensington, Chelsea and Westminster secured the services of a Chinese-speaking doctor for a medical centre in Soho. Other FPCs have attempted to recruit Asian women doctors in locations with sizeable Asian populations.

There are, however, many difficulties for FPCs attempting to ensure that patients or particular groups have a choice of doctor which reflects their needs, wishes or culture. The relationship of type of GP to population is obviously a sensitive issue. A 'mismatch' can occur in a number of dimensions. For example, one interviewee commented upon a clash of expectations between three Asian GPs and the geographically isolated and close-knit white working-class community they served. Cartwright and Anderson (1981) comment that Asian GPs tend to see their clinical role as their main responsibility, and are frequently less interested in social conditions. The main criterion for acceptance on the medical list remains professional competence. The MPC maintains standards nationally, so the FPC's room for manoeuvre is small.

The employment of ancillary staff

The FPC is able to reimburse 70 per cent of the salary costs of ancillary staff. These staff fall into two broad categories: staff concerned with nursing and treatment; and staff concerned with secretarial and clerical work, and with receiving patients. FPCs can encourage the employment of ancillary staff by explaining to individual doctors and practices the opportunities open to them. This can be done in a reactive way, following an approach from a doctor. Alternatively, the FPC can take a pro-active approach as part of a planned programme of developing group practice. Norfolk, for example, has pursued a vigorous policy of encouraging the employment of ancillary staff at the level of 1.27 per 'responsible doctor' (Norfolk FPC 1984).

There are two main ways in which GPs and other health or social work staff can work together. GPs can employ staff directly, in which case reimbursement is limited to two full-time (or equivalent part-time) staff per doctor. Alternatively, staff employed by another agency, DHA, local authority or other, can be attached on a full- or part-time basis. Fullard, Fowler and Gray (1984) have estimated that only 15 per cent of GPs have employed the full complement of reimbursible staff. FPCs can use some discretion in deciding where staff reimbursement is appropriate. There are complex rules which operate in relation to the employment of relatives, for example. In the past, a doctor's wife might have carried out many tasks unpaid. Caretakers can be employed in practice premises and, as larger group practices have developed, there has been an increasing need for practice managers. Specialised tasks have increased, causing a division of labour, and GPs' expectations have changed. While expenses are met for employing some specialised staff, many GPs and FPCs feel that the rules are not yet sufficiently flexible. Some administrators argue that practice budgets would be a feasible alternative.*

An area which is currently expanding rapidly is the employment of staff concerned with nursing and treatment. Some GPs now wish to employ health workers such as physiotherapists, counsellors, or psychotherapists, as well as specialist nurses, including nurse practitioners, to support clinical developments. Nurses who specialise in the management of heart disease, diabetes and other chronic illnesses in the community are also being employed. The FPC administrator has to be skilled in interpreting, and sometimes in bending, the rules to facilitate these developments. Such staff can be attached to a number of practices within a geographical area, doing sessions in

* Interview.

each 'patch'. Alternatively, they may work with the patients on a practice list, wherever they live.

These questions are discussed more fully elsewhere (LHPC 1981; DHSS 1981f; Bowling 1985). From the FPCs' point of view, it is clear that if they are to play a part in enabling GPs to develop team working they must have good information on the type and location of ancillary staff employed and attached in their areas; and they must know GPs' opinions about existing arrangements. They will need to discuss future aims and objectives with those who control community care resources. Some FPCs are already engaged in this process. In future, this will be a necessary part of collaborative planning.

Working together: GPs and FPCs

The RCGP (1985b) in their policy statement on general practice state that 'In future family practitioner committees, working closely with district health authorities and the profession, should help general practice to become responsive to a community's particular needs. Together they should identify local standards for service ...'

As a consequence of the new requirements to produce annual programmes and a longer-term strategy statement, FPCs are now much more consciously and explicitly identifying policies for primary care, and also developing ways of working with individual GPs and LMCs. Where these relationships and networks are already well established, some FPCs are encouraging and supporting GPs to move into such new areas as local 'peer review'. The main contribution the FPC can currently make to this process is in providing information to GPs about their practices and their workload; together with the possibilities and opportunities for change. If such data were to be put together with the information held by other organisations, it could provide a basis from which the profession could identify its priorities and set standards in the local context. The FPC will then be able to argue the case for primary care, using this database, in the arenas where resources are allocated: with the DHAs, the regional health authorities, the MPC, and the DHSS. Computerised systems make the provision of such data a great deal easier. We discuss this further in chapter 8.

Barnsley is an example of an FPC which has been developing this approach (see Barnsley FPC 1986). As an FPC it has certain obvious advantages: it is coterminous with its DHA; it has a patient register which has been computerised for four years; and it is relatively small,

with a population of 230,000 and 108 unrestricted principals. Recently the Centre for Health Economics at the University of York has provided research support in producing practice profiles using recent socio-demographic census data. As few Barnsley doctors have their own practice computers, the FPC will provide them with this service. Doctors will have detailed breakdowns of their patient list by age and sex, and they will be able to compare their lists with the average for different types of practice, using a number of social indicators: for example, the numbers of elderly people, of children and young people, of patients who are unemployed, living alone, single parents, or patients of particular ethnic origin. This information should give the GP an indication of expected workload and provide a basis for planning practice developments – perhaps in choosing priorities for anticipatory care, in taking on a partner with particular skills, or in employing practice staff. The FPC is currently in the process of collating data on items of service payments for night visits, contraceptive services and so on. This will provide comparative data sets between practices. When improved information becomes available from the Prescription Pricing Authority on practice prescribing, it will also be possible for practitioners to look at their prescribing patterns and make comparisons.*

From the individual GP's point of view, the collection of such information can be double-edged. It could be interpreted as a threat, or as an unwarranted interference by the FPC. All new knowledge affects established patterns of interest, and FPCs have to walk a difficult tightrope between their regulatory and their planning and development roles. Barnsley, and other similar FPCs, are taking care to work with their local medical committees, establishing areas of mutual benefit, while at the same time identifying objectives which serve the community interest.

As far as FPCs as a whole are concerned, local medical politics is the crucial variable in achieving changes in primary care. Time and again in our discussions with administrators, they stressed the importance of 'good relationships'. Establishing these is, of course, part of good management but the variations in professional networks and in dominant values are clearly very great; and these can prove formidable obstacles. The LMC is the body which represents local doctors. It may genuinely reflect the views of a range of opinions, or it may be controlled by a particular group, leaving others isolated or uninterested. It can be either a reactionary or a progressive force. In

* Personal communication from the administrator, 26 November 1985.

one area which we visited, younger doctors were so dissatisfied with the LMC response to a DHA planning document on community care that they formed a splinter group. This group now meets regularly for discussion. It is circulated with consultation documents and makes its own response. Other areas have a GP forum, an informal group of local GPs which meets regularly and aims to stimulate good practice. Where there is a strong and positive link between the LMC and the FPC, and where both organisations can reach down to grass-roots practitioners, there is a clear potential for responding to community needs. In areas where there is hostility and antagonism, there are limitations to what the FPC can achieve.

4
Family Practitioner Committees and GPs: practice premises

Practice premises probably affect the way primary care is provided more than any other single factor. They form the space in which patients consult their doctor; and thus affect the way in which medicine is practised and its capacity for change and adaptation. Premises, whether they are owned or rented by GPs, also form a stock of capital assets which has accumulated over time, which both the public and the doctor have an interest in maintaining. This chapter aims to outline the way in which policies in relation to practice premises have changed; the incentives to improve premises which exist; the positive and negative role of FPCs; and the ways in which particular FPCs have approached this aspect of their task.

There are different views about the appropriateness, or otherwise, of state intervention in this aspect of medical practice. Those who emphasise the importance of the independent contractor status argue that if doctors are to bear the cost of providing premises, they can only be required to provide what they want to provide and not what anyone else thinks they should. The other side of this argument is that the GP's income is derived from the public purse. The community, therefore, has a right to receive its general medical care from adequate practice premises. Good medicine is more likely to be practised from good premises. The Royal Commission on the NHS had no doubts. They urged FPCs to use their powers to monitor the standards of doctors' surgery premises '... vigorously to ensure that patients are seen by their general practitioner in surgeries of an acceptable standard' (Royal Commission on the NHS 1979, page 82).

GPs' premises have received more attention than the practice premises of other contractors. This is partly because perceptions about the organisation of general practice have changed. This in turn, is the result of the increasing importance attributed to linkages between general practice, hospital, and community health care, and also to changing views about the best way of integrating what still remain, after a number of health service reorganisations, the three separate arms of the service. Premises are the most permanent and fixed asset in service provision. They reflect the choices and decisions made by doctors in the past. Armstrong (1985) identifies two archetypes in practice premises: the surgery in the front room of the doctor's home, the 'domestic setting'; and, in contrast, the purpose-

built health centre or group practice building. These 'specialised buildings' contain separate spaces for separate functions – for waiting, for consultation, for examination and for specialist attached staff. There are record systems and specialist diagnostic equipment; rota systems for out-of-hours cover, and telecommunications systems for getting in touch with the GP. He also notes a transitional type where the doctor's surgery occupies a separate space in a domestic building; but the trend over the last 50 years has been towards more purpose-built premises.

Policies for improving practice premises

In relation to primary health care, one of the aims of the 1946 NHS Act was to encourage the development of health centres. These were to be built by the local authorities, who were responsible for community health at the time. They provided the capital, designed the building, maintained the premises, managed them and paid for the ancillary and supporting staff. Doctors normally paid rent for their part of the premises. Over the next two decades, health centre development was slow, and limited to those local authorities with a clear commitment to health care. The main inhibiting factor was not lack of capital so much as an unwillingness on the part of doctors to join health centres. Many felt them to be a threat to their contractor status; they feared that they would lose their independence. GPs have also been concerned by lack of security of tenure, and often feel that they have insufficient control of staff employed by the local authorities. Although a circular recommended that doctors should employ their own staff or should be present at selection procedures for health authority staff, GPs still have to negotiate their position (DHSS 1977b).

The 1960s and early 1970s saw a change in attitudes among recruits into general practice. The number of health centres grew from 270 in 1971 to 1000 in 1978 (DHSS 1983a). The 'doctors' charter' of 1966, introduced a new system of payment for GPs to create parity with hospital consultants, and gave them greater self-esteem. Direct reimbursement of rent and rates on practice premises was introduced, and this, in the words of one doctor, was '... the turning point towards better practice premises' (Wilson 1983). Whether doctors rented or owned their premises, this became an allowable practice expense paid from central funds through the FPC.

When the NHS was reorganised in 1974, the AHAs took over the community health services from the local authorities. As part of their responsibility for planning primary care, they were expected to put

aside some capital monies for 'clinic' developments. In 1979, a DHSS circular (DHSS 1979b) aimed to encourage inner city health centre development by allowing premises to be built in anticipation of future need. Since the mid 1970s there has been a tailing-off of capital investment and a new reluctance on the part of GPs to join health centres, as there are now more financially attractive ways for GPs to improve their own practice premises through improvement grants.

FPCs have a number of negative powers in relation to practice premises. They must inspect, and agree to premises being '... proper and sufficient ... having regard to the circumstances of [the] practice', when a doctor joins the Medical List. They must agree to practice premises being suitable for the reimbursement of rent and rates when these are claimed; and they usually are. They must inspect practice premises when there is a complaint about their condition. They must inspect plans and premises if a Cost Rent or Improvement Grant is applied for. Since December 1984, following a DHSS circular on surgery premises, FPCs have been obliged to establish a system of routine visiting and inspection (DHSS 1984d). This must involve FPC members as well as officers. Some FPCs have visited premises regularly and have used their powers to develop phased programmes of practice improvement; drawing up local standards and ways of assessing adequacy, encouraging GPs to undertake improvements and advising them of finance. We describe some examples of this approach below. Not all FPCs have been active in this way, and the circular aims to establish a minimum level of involvement.

One of the reasons for the differences in approach between FPCs has been the absence of agreed minimum standards. Although, under the terms of contract, GPs must provide 'proper and sufficient' accommodation at their practice premises, this concept is nowhere precisely laid down. The nearest definition in terms of space and amenities appears in DHSS (1981f), the Statement of Fees and Allowances, paragraph 56, schedule 1, but this has only advisory status. Firmer guidelines are given in the 1984 circular: there should be ease of access for all, including those with special difficulties; a properly-equipped consulting room, allowing privacy; lavatory and washing facilities; an internal waiting room to meet normal requirements; and premises should be in good repair. Ultimately, however, the FPC has to develop locally agreed standards, and it should help doctors to meet these with a combination of encouragement and firmness.

The 1984 circular reiterates that an FPC can refuse the reimbursement of rent and rates if it is not satisfied. In fact, reimbursement has rarely been withheld (Noble 1984). Premises were agreed for

reimbursement when the doctor *joined* the Medical List and were not necessarily inspected at all thereafter. The London Health Planning Consortium's report (LHPC 1981) on primary health care in inner London found, for example, that only a quarter of premises were within the standards recommended in the Statement of Fees and Allowances. It is possible, in theory, for an FPC to bring a service case against a GP whose premises are unsatisfactory, but this too is rare.

The doctor's practice expenses of rent and rates are reimbursed irrespective of tenure type: whether owned, leased or rented from a public or private landlord. Practice expenses are the equivalent of tax relief, and they have a marked effect on income. Where doctors practise from a health centre, they are charged a certain sum by the authority for accommodation, rates and ancillary staff, all of which are reimbursed. Where doctors own their surgeries, a notional rent, equivalent to the current market rent, is paid to the practice. Where the surgery forms part of the doctor's home, the whole building is assessed and a proportion of it allowed. The district valuer may be involved in assessing the rent in cases where such a valuation is taken.

While rent and rate reimbursement were used mainly to cushion the rising cost of providing premises, other grants have become available to encourage GPs to undertake improvements and modernisation. We intend to argue however, that these grants remain a blunt instrument for bringing about a consistently higher standard of premises as part of a planned programme. The Cost Rent scheme was introduced by the Ministry of Health in the mid 1960s, a period of rapid inflation in property prices. Under the scheme, doctors can apply to the FPC to build new premises, to adapt existing premises or to buy a building for conversion. They receive what is, in effect, a very low interest rate loan. The responsibility for handling the development and the investment risks or benefits are taken by the practice, while the actual ongoing costs are defrayed wholly, or partly, by a notional rent reimbursement paid by the FPC.

The Cost Rent scheme gives FPCs a positive way of encouraging GPs to improve premises and influencing what they build. Before doctors can proceed with building, they have to obtain approval in principle from the FPC and provide sketch plans. This approval allows the doctor to proceed with the project, after receiving planning permission and a favourable report from the regional medical officer. (These officers, appointed by the DHSS, give advice on a range of professional matters.)

The General Practice Finance Corporation (GPFC) which was set

up in 1981, provides another source of loan capital. GPs can borrow money from the GPFC at a rate lower than the market rate, in order to acquire a share in a practice project, improve surgery accommodation or to build and adapt premises. The GPFC also buys purpose-built practice premises and leases them back to doctors. FPCs are involved in publicising and in processing these schemes. (More details are given in a series of articles in *The FPS*, 10, no 2, 1983, pages 35–46.) Until recently the GPFC budget has been unlimited, but in 1985 it was cash-limited by the DHSS. Sums paid out had risen dramatically, from £294,000 in 1975 to £1,920,000 in 1982; a six-fold increase (Dowson and Maynard 1985).

Improvement grants are also available through the FPC. These were introduced at the same time as the Cost Rent scheme, but they involve smaller amounts of money. When approval is given for an Improvement grant, the FPC will provide 30 per cent of the cost of improvement work. Higher grants are available for premises not previously used as practice premises. Ceilings on grants are based on the number of doctors involved, but there is a maximum limit of £18,500 per practice. The rate is higher in inner London. The scheme requires that the practice finds the rest of the capital to carry out the work, and also undertakes any necessary decorating and repairs.

In brief, the FPC has a number of functions in relation to Cost Rent and Improvement grants. They agree and advise upon the need for improvements; help identify options most appropriate to the particular practice concerned; advise on locations; explain the schemes; and offer general advice.

The schemes offer a set of positive incentives for doctors to improve their practice premises. However, the take-up has been patchy. Some FPCs have taken more interest than others. North Yorkshire, for example, had 27 substantial improvement schemes in 1982/3 (registered population 0.5 million). Cheshire, with 162 practice premises, has 116 which have been improved, extended or newly built in the last decade (Henshall 1983). There has been a much lower take-up in inner London, and this was commented on by the LHPC in 1981. But there are variations here too. Greenwich and Bexley (registered population 454,000) has had 15 schemes running per year for the last few years, while Islington had its first major scheme in 1983 (registered population 350,000). (Greenwich and Bexley FPC 1984; personal communication Camden and Islington FPC 1986.)

The DHSS has recently augmented existing grants by two further schemes designed to improve premises in inner cities. One (DHSS 1985g) was designed to encourage the development of group prac-

tices in the partnership authorities or programme authorities established by the Department of the Environment (DoE). For a period of two years, doctors who join together to practise in a group can receive an incentive payment of not more than £4,000 per doctor. There is also an additional incentive payment on top of the usual group practice allowance.

A second scheme made £9 million available for practice improvements over a three year period. In this case, the FPC decides on priorities and distributes the grant: up to 60 per cent of the cost. The sum allocated to each FPC is in fact very small. For example, Tower Hamlets (part of City and East London FPC) received £125,000 in 1984. The money has to be spent in one allocation (Timbs 1984).

Improving premises: the constraints

In general terms, these schemes for improving practice premises could all be described as 'top-down' policies. They were introduced by the DHSS, from the centre, but their ultimate success depends upon the responsiveness of a number of agencies at the periphery. Health authorities, local authorities and FPCs respond to DHSS circulars in different ways; as do LMCs and individual doctors. A diversity of local factors will create incentives and disincentives. Socio-demographic patterns, land values, the type of housing stock and tenure, industrial development and decline will all affect the property market in terms of prices and possibilities. Within this framework, it is useful to try and identify some of the problems.

The individual doctor must make the decision to undertake and carry through a major improvement to his or her premises. This will involve dealing with a variety of professionals – valuers, architects, surveyors – and taking a certain risk. It can be difficult to predict the financial impact on either a doctor or a practice of undertaking a major scheme. A practice may gain or lose financially due to factors beyond its control; such as the rate of inflation. If a practice embarks on an extensive scheme it is likely to involve considerable expense of time and energy. The process varies in complexity in different parts of the country. The cost and difficulty of acquiring property in inner London, for example, is particularly high. Evidence given to the LHPC suggested that this was a major reason for the poor standard of practice premises in London. At the end of the day, unless there is some positive incentive to change, GPs may well be better off financially by doing little to provide amenities or services for their patients. Patients are typically the passive recipients of the services

provided, their expectations being, on the whole, determined by what they are accustomed to.

The Cost Rent and Improvement schemes can be immensely complex for the FPC as well as for doctors (see Martin 1983). FPCs need to have guidelines for dealing with projects and sometimes they have neither the experience nor the expertise to do so. Some items, for example, are allowed under the grants, some are not. One FPC found that they were disallowing very large sums for various items. They have developed a system of sitting down with the practice, the architect and accountant right at the start, and obtaining a costed schedule. This FPC just happens to include a quantity surveyor and an architect as FPC members, which, according to the administrator, 'is useful'.* Unlike DHAs, FPCs do not have 'works departments'. Some committees may even be too small to allow staff specialisation, as suggested by the 1984 surgery premises circular (DHSS 1984d).

From the point of view of the public purse, another drawback of the Cost Rent and Improvement schemes is that they are not subject to value-for-money criteria. The FPC is not obliged to make judgements of this kind; and again it does not have the knowledge to do so. Furthermore, the schemes need not form part of an overall primary care development plan. Each project can be started in total isolation from the next. Noble (1984) argues that the current grants system is not a vehicle which can easily be used to plan and provide buildings for the future, nor to change patterns of practice. She claims that the DHSS is currently acquiring the indirect financial responsibility, in terms of rent and rate reimbursement, for a 'rag-bag' estate of primary health care buildings.

The success of new schemes and their rate of take-up, together with the possibilities for acquiring better premises generally, often depends on local authority planning policies. Some local councils have planning policies and regulations which curtail the change of use from a residential building to a doctor's surgery because this involves the loss of the residential unit. Other authorities own surgery premises, but have proved to be poor landlords showing little interest in, or understanding of, the GP's position. The examples discussed below indicate that change can be inhibited where local authorities do not have a forum where issues relating to health can be discussed.

District health authorities (and in the past AHAs) may also be landlords of GP premises, as in the case of health centres. There are many conflicting demands on the use of such premises, and GPs may not be given priority. Representation of GP and FPC interests has

* Interview.

typically been weak at all levels of the health authorities.

FPCs themselves are another variable in the policy implementation network. No systematic research has been done on how FPCs have developed their responsibility for practice premises but it is clear, both from the literature and on the basis of our interviews and questionnaires, that wide variations exist. As we have already suggested, the role of the FPC is an ambiguous one. FPCs are asked to ensure 'proper and sufficient standards' of premises; but until very recently there were few firm criteria. They have not been required to say what they were doing; nor have they been held accountable. Doctors remain responsible for premises; yet they receive public money to improve them, and if they own the property, they can make considerable financial gains. The FPC is asked to ensure that public money is correctly spent, yet as an organisation it lacks the professional expertise to carry out this role.

As far as setting local standards for practice premises is concerned, the role of the LMC in enabling or hindering the FPC is probably a crucial, but a hidden variable. The attitudes and influence of the LMC clearly differ from area to area, but the link between it and the medical members of the FPC is vitally important. One FPC chairman commented that his committee was moving into a planning stage for setting up criteria, inspecting premises, and preparing to use its powers to withhold rents and rates in the case of unsatisfactory premises. This was having an impact on GPs, but was not without costs: 'The LMC is very prickly about it all, and the majority resist practice inspections'.* After all, the traditional view referred to at the beginning of this chapter, perceives premises as private property where the GP runs a business. An FPC which overplays the regulatory role may lose the ability to facilitate change.

Ham and Hill comment:

> So-called implementation problems arise precisely because there is tension between the normative assumptions of government – what ought to be done and how it should happen – and the struggle and conflict between interests – the need to bargain and compromise – that represent the reality of the process by which power and influence is gained and held in order to pursue idealised goals. (Ham and Hill 1984, page 145).

Responsibility for seeing that practice premises are of a more even standard now rests more clearly with the FPCs, and their combination of carrots and sticks. Policies will need to be supplemented by a continuation of special funds (so far these have been pathetically

* Interview.

small) and perhaps by the appointment of staff who are specifically concerned with developing strategies to overcome local problems. A fundamental first step, however, is for all FPCs to collect good information on their local GP premises; on the problems their GPs face; and on their aspirations generally. Given the amount of public funding devoted to rent and rate reimbursement, as well as to more direct grants, it is indeed surprising that such data do not already exist.

We turn now to look at how the question of practice premises has been approached in three areas with 'inner city' problems: Manchester, Nottingham and Tower Hamlets and Hackney, both part of City and East London FPC. We wish to show that not all inner cities have low standard premises or a preponderance of more traditional practice structures. It is clear that problems vary considerably; and they are crucially affected by past policies.

Inner city practice premises: Manchester, Nottingham, Hackney and Tower Hamlets

The report by the LHPC (1981) documented serious deficiencies in primary care in inner London. It prompted this response from the *British Medical Journal* (1981): 'Britain's inner cities have some of the worst social and medical problems combined with some of the poorest primary care. This has been known for a long time.' However, recent work by Wood in Manchester has indicated that the pattern of general practice in inner Manchester does not follow the pattern in inner London (Wood 1983). In his study of inner cities, Bolden (1981) commented that 'Birmingham, Manchester, Glasgow, and Liverpool had primary health care problems significantly different from those of London.' In Manchester, he noted that although there were many features of social deprivation, '... many problems seemed to be well under control'. This is a consequence, we argue, of positive action over a decade by a number of agencies with responsibilities for health, including the FPC.

Wood's work, carried out in 1981, found differences between inner London and inner Manchester. She carried out a survey of 485 unrestricted principals who had surgery premises in the Manchester–Salford area and the adjacent area of inner Manchester. This covered five health authorities: Manchester North, Central, South, Salford and Trafford. It emerged that the age structure of practitioners was different from that of inner London. The percentage of GPs aged over 65 in inner London was 18 per cent in 1979, while in Manchester in 1981 it was 9 per cent. In terms of the number of

single-handed practitioners, inner Manchester had fewer than inner London: 27 per cent as compared to 34 per cent.

There is no clustering of doctors with small and unrestricted lists in inner Manchester; the level is a quarter that of London. This may reflect a lack of the concentration of private practice which occurs in parts of inner London such as Kensington, Chelsea and Westminster. In terms of the standard of premises, 52 per cent in inner Manchester are purpose-built, twice that of the outer area. The number of purpose-built premises in London was not calculated by the LHPC, but in view of the figures collected by the regional medical officers quoted earlier, and the findings of a study by Horton quoted in the LHPC report, it is likely to be low.

Comparisons on a number of other variables cannot be made with London, but on the basis of comparing inner Manchester with outer Manchester there are similar proportions with age/sex registers, employed practice staff, and with a range of specialist equipment generally associated with a good level of practice. The major difference between inner and outer Manchester seems to be that in inner Manchester there are more doctors who live away from their practice premises, and consequently a greater use of deputising services for out-of-hours calls. A similar pattern exists in London.

There are undoubtedly a number of factors which explain the parity of standards between inner and outer Manchester. Manchester City Council has had a determined policy of slum clearance and redevelopment over a number of decades. This has paralleled a health centre programme by the authorities responsible for health. Since 1974, Manchester FPC has had an administrator who has attempted to develop a positive strategy of improving the quality of general medical and other services.

Manchester FPC covers a population of half a million and has a boundary coterminous with Manchester City Council and the North, South and Central District Health Authorities. Looking back over the decade, the administrator picks out important landmarks on the road towards improving practice premises. On taking over, his first step was to develop contacts with the city hall, at both member and officer level. 'We let it be known in the early days that councillors had a responsibility for health, and that we should be working together in harmony.'* So, if the housing department was contemplating a demolition or re-housing development, the FPC was informed. They were also sent planning applications, and they

* Interview.

extracted those relevant to pharmacists, GPs, dentists and opticians. It was important, he argued, to make contacts with key people in the city estates valuation department – as a statutory body could, he felt, cope better with the city hall than individual doctors could. He also stresses the value of advising the council where, in the FPC view, planning applications by doctors, dentists, pharmacists or opticians should be turned down because they were in areas already well provided for.

Another important step was taken in 1977/8 when the FPC embarked on a systematic premises inspection programme. Criteria were drawn up for assessing quality in measurable terms, so that the same information was collected for each practice. On the basis of this, the FPC could get some idea of the scale of the task. With the help of the LMC, a symposium was arranged for all practising GPs in the area on the subject of quality in medical care.

The administrator spoke on 'quality in the eye of the administrator': that is, premises. The aim of the day was to publicise and launch the programme, and to gain goodwill. GPs were subsequently contacted by letter and given an outline of the quality initiative, the financial options and the help which could be given by the FPC. The FPC offered to provide age/sex registers as part of an improvement programme.* About three-quarters of the practitioners expressed an interest. A well-briefed FPC officer then visited the premises to discuss the potential for change. This interview provided an opportunity to discuss plans for the future of the practice and general organisational issues as well as the physical stock. The administrator feels that this 'took the sting out' of the pro-active role of the FPC.

Doctors who did not respond to the letter sent out by the FPC were then sent a follow-up. If this, too, elicited no response, the doctor was informed that a visiting party from the FPC would come and look at the premises. A lay and a medical member of the committte would then visit and give a second opinion. Finally, the doctor was given an ultimatum to improve the premises within three months or rent and rates would be withdrawn. This worked in every case. The supreme sanction – a medical service committee – was hinted at, but never used. At the same time, the FPC ran training days for doctors' receptionists. These always included a session from the CHC on the patient's viewpoint, so that a different perspective could be presented.

Other FPCs with inner city problems have now got practice improvement programmes, though few are of such long standing as Manchester's. Bolden (1981) does suggest that Manchester has been fortunate in the combination of a local authority concerned with health

* Seventy per cent of Manchester GPs now have age/sex registers. (Feinmann 1985e).

matters, an active FPC administrator and a progressive department of general practice.

In Nottingham, too, there has been considerable collaboration between authorities in planning general medical services. Nottingham has three health districts, and in Nottingham City in particular, there has been an active health centre programme, supported by Nottinghamshire County Council and its predecessors. The city also has a university with a department of general practice.

Nottingham City health authority has a health centre criteria group, which includes representatives from the FPC. Although the health centre programme is now virtually complete, this group has a standing brief to develop premises and to make sure that the number and distribution of practices is keeping pace with population change.

Ten years ago the FPC developed its own programme for the routine inspection and improvement of practice premises. The administrator explains: 'We wanted to get away from the concept that the health centre was the cure-all'. He believes that GPs should provide their own premises and maintain control over them. 'Two of our staff became very expert in the field of practice premises and they act as facilitators. This is an FPC job, and we don't need an outsider; [such as a specially appointed facilitator] we should be doing our own dirty work.'*

The administration of FPCs is more complex in London than in either Manchester or Nottingham. There are sixteen FPCs in the greater London area. Each FPC has a different configuration of problems. The socio-economic characteristics of the different areas have been described by Jarman in a survey of primary care in London (Jarman 1981); and the findings of the LHPC are well-known. In summary, these reports identified five major characteristics and problems in primary health care in inner London.

1) Large numbers of people – in some cases as many as 25 per cent - were not registered with a GP. It appeared that many people did not know about or understand the FPC's role in registration.
2) Many people in inner London felt that they had difficulty in getting in touch with their GP or their GP's representative, particularly by telephone.
3) Many practice premises were of a very low standard.
4) There were more single-handed practices, more doctors over 70 years old, and fewer practices with attached or employed nurses in inner London than elsewhere.
5) In district nursing and health visiting, there was a vicious circle of

* Interview.

high caseloads of a particularly demanding type; poor working conditions; high staff turnover and a high proportion of inexperienced personnel. The organisation of health visiting and district nursing was further complicated by the large number of small GP practices with wide catchment areas. These made nurse–doctor communication extremely difficult.

These problems are probably greater in Hackney and Tower Hamlets than elsewhere, and we review briefly what has taken place since the LHPC report. City and East London FPC relates to three DHAs: City and Hackney, Tower Hamlets and Newham. The London Borough of Hackney, in the East End, suffers from overcrowding, high unemployment and poor housing stock. It has a large number of ethnic minorities. Eighty-five per cent of the housing stock is owned by the borough or by the Greater London Council (GLC). Thousands of these units are unusable. The borough has a low rateable value, and has been called the poorest in England. There are currently 104 GPs in Hackney. In the early 1980s, one third were practising single-handed, one third were practising from health centres, and the remainder were in group practices. Fifteen per cent of GPs were over the age of 65, and 11 per cent over the age of 70. Following the LHPC report in 1981 and the reorganisation of the NHS into districts, the new City and Hackney DHA formed a high-level strategy planning group to give impetus to primary care. It included the district medical officer, community unit officers, three professors (including one of general practice), an A & E consultant, the FPC administrator, the CHC secretary and the district health education officer. In 1985 this was replaced by a smaller, less 'top-heavy', primary care planning group.

A health liaison officer was appointed in 1983, financed by DoE inner city partnership money (Hackney is a partnership authority). The liaison officer's salary was paid from these funds for two years. He worked to the strategy planning group but was independent from the main administrative stuctures of the health and local authority. Meanwhile, City and East London FPC was taking its own steps to begin the process of improving premises. The FPC sent Hackney Council a proposal, which was passed to the health sub-committee of the social services committee. Was it possible, the administrator asked, to launch an initiative for practice improvement with a policy statement from the council? An insider gave us an account of the sub-committee meeting, when the item came at the bottom of the agenda. One member, who also belonged to the DHA and the FPC, insisted on discussing the item that evening. As a consequence, a joint work-

ing party on practice premises was set up which included officers from the FPC, the DHA and the council, a GP and the director of the Medical Architecture Research Unit (MARU).* It produced a general planning policy statement which set out its aims of improving the distribution and standard of practice premises – with emphasis on equality of access.

The council's support for the initiative was a critical factor as it acknowledged its responsiblities as the major landlord, and its role as the planning authority. It was unaware, at that time, of the extent of the stockholding or of the condition of premises. The working party asked MARU to survey practice premises in Hackney: their condition, and who owned them. On the basis of the information provided, the working party meets every three weeks. It has a number of clear operational objectives:

a) to review all GLC/borough stock and bring it up to standard;
b)to plan for the projected residential population in 1990;
c) to process all applications for premises and improvements.

The legwork in building relationships with doctors is being carried out by FPC officers, with the help of MARU.

Any progress in improving premises can only be assessed over a long time-scale, but the existence of the working party and of the planning group for primary care provided a core of strategically-placed and powerful individuals who could commit the resources of their organisations. One further example illustrates their importance.

Collaboration between the academic department of general practice at St Bartholomew's Hospital, with its professorial staff, and the FPC has helped to bring about what one commentator characterised as '... a dramatic change in general practice, in relations with the health authority, and in the kind of GPs who want to work in Hackney'.† Inner City partnership money, channelled through the DHA, has also been used to employ clinical assistants who combine teaching responsibilities with practice sessions with GPs who are about to retire. A programme for attaching trainees to GPs has been initiated, with back-up from the department of general practice. This runs workshops and training courses which have been essential in providing support for doctors working under pressure in an area of great social stress. Some of these trainees have been appointed to practice vacancies locally. The planning group is currently develop-

* MARU is based at The Polytechnic of North London, Holloway Road, London N7 8DB. It has produced a useful series of information sheets on the acquisition and improvement of practice premises.
† Interview.

ing a policy of nurse attachment to all GP practices.

City and East London FPC also covers the London Borough of Tower Hamlets. This has a similar socio-demographic profile to Hackney. A large number of practice premises (two-thirds) are rented from either the GLC or from the borough. Some of the doctors have repairing leases (which means that they are responsible for repairs). In the past, the GLC has clearly lacked interest in the state of these premises. Many GPs have have had problems in getting maintenance carried out. Unfortunately, the consequences of treating doctors in the same way as small businessmen ('rather like greengrocers', as one GLC officer remarked) ultimately penalises their patients, who are forced to consult their doctors in poor and unsuitable premises.

As 85 per cent of land in the borough is council owned (London Borough of Tower Hamlets 1985) GPs have found it difficult to find alternative accommodation. In recent years, a great deal of data has been collected about practices in Tower Hamlets by the FPC, by researchers at the London Hospital, and at the Centre for the Study of Primary Care at Steel's Lane Health Centre (funded by the North East Thames Regional Health Authority), and by a primary care development worker also based at Steel's Lane (funded by the King's Fund).

A study carried out in 1980 by Heath and Sims commented that some of the surgeries were in a deplorable condition '... badly lit, undecorated, poorly heated and shabby, surgeries that were unlikely to inspire the confidence of patients' (Heath and Sims 1984). The reasons for this situation are complex. As in Hackney, there had been little change in the pattern of practice for many years. Heath and Sims found that about half of the practices were single-handed: out of 85 GPs there were only two practices which had four or more partners. Only fifteen practitioners were under 40 years old, while over one third (36 per cent) were over 60. Many practitioners lived away from their surgeries.*

This age structure suggests a lack of change; even stagnation. Hull, Livingstone and Dunford, using past executive council records, were able to plot the pattern of practices over time and to compare this with the pattern in England and Wales as a whole (Hull, Livingstone and Dunford 1984). They comment that in Tower Hamlets the

* In this respect, it is interesting to note that not every FPC is prepared to allow GPs to live where they wish. FPCs have the right to insist that a GP moves into his or her practice area when negotiating the area the doctor covers. The administrator of Nottingham FPC has said: 'We are quite strict about this. The only exceptions we make are for trainees, as their contractual obligations are so much less.' (Doyle 1984)

development of group practices lags behind the rest of the country by 15 years. Doctors renting premises with repairing leases may have had little incentive to improve them. Some surgeries are up flights of stairs; others are on the ground floors of tower blocks. We were told about one case where water was streaming down from the flats above, and the doctor concerned found it very difficult to get the public landlord responsible to deal with the matter.* Another doctor reported 25 incidents of major vandalism and five robberies in the previous three years at health centre premises which did not have a caretaker (Heath and Sims 1984).

Doctors in Tower Hamlets appear to work in a very isolated fashion. Heath and Sims found that in a sample of practices (71 per cent of the whole) 42 per cent employed no ancillary staff. The other practices employed nurses but did not use their clinical skills, tending to use them as receptionists. No practice in Tower Hamlets ran a routine screening programme for cervical cancer. Communications between the DHA, with its large teaching hospital, and the GPs were particularly poor.

Dennis, using FPC figures, indicates that the pattern of practice has changed since the early 1980s. Only 21 per cent of doctors now practise single-handed and the number of support staff employed is increasing. Dennis's figures, supplied by the FPC in 1983, show seven secretaries/receptionists, 58 receptionists, two nurses, seven practice managers and seven 'others' (Dennis and Salvage 1984). A planning group which involves the FPC and the DHA has now (1985) been established in Tower Hamlets. Their priority is practice premises.

The primary care development worker has already reviewed practice premises, and has produced maps which locate GP surgeries and indicate the size of practices. Sixteen are currently in touch with the FPC about major improvements. The GLC has made some new sites available. Until the FPC and the development worker took these initiatives, neither the GLC nor the council knew they were major landlords of GP premises. The flow of information from the DHA to the GPs – and vice versa – is improving, and a policy has been developed to improve the take-up of vaccination and immunisation among children. Difficulties do arise, due to the very high rates of mobility in the area. Seventeen per cent of the population reside in the borough for less than a year. In Spitalfields, for example, we were told that school rolls change by 30 per cent every term, making it difficult for the FPC to maintain accurate GP/patient registers. This in turn inhibits the realisation of preventive health policies.

* Interview.

Supporting changes in general practice: London

Since the LHPC's 1981 report, funds have been found from a number of sources to support changes in general practice in London. We have already described two development worker posts. Another variation can be the appointment of a senior doctor to upgrade the organisation of professional services. The assumption underlying such appointments was that a medical practitioner would prove less threatening, and thus more effective, than either a knowledgeable administrator or an expert on practice premises. One such facilitator in Islington commented in this context that he '... did not have disciplinary functions such as the FPC could exert under the doctor's terms of service' (Elliot 1984). He also found that standards were very low. He graded the premises he visited against the Statement of Fees and Allowances criteria, from 1 to 10 (high). He found that 20 out of the 45 practices were over the half-way mark. Only 45 per cent of them had employed practice nurses. Community nursing staff tended to work independently of GPs. There were times when telephones were not manned; and the means by which patients could contact their doctors were fairly primitive in technical terms. The general conclusion was that compiling profiles of general practices should be an important first step in the FPC's planning function. However, 'for reasons of confidentiality', the facilitator's data was not made available to Camden and Islington FPC!

General practice facilitators are now being appointed in other parts of London, and they are being given a wider brief to encourage changes in practice organisation as well as in premises. The job description for a general practice facilitator to assist in Kensington, Chelsea and Westminster (funded by the North West Thames RHA) specified that the post holder would be expected to '... develop primary health care teams, the movement to group practice, the relationship with other services, particularly psychiatry and geriatrics ... and the GP's role in prevention'. We hope that the information collected will in future be made more widely available.

MARU, or more specifically, the Inner London Practice Premises Unit of MARU, has been playing an important role in providing both professional design expertise and information regarding sources of financial help. Perhaps their most important contribution for doctors contemplating or undertaking improvements to inner London premises is support and enthusiasm. They specialise in particularly difficult design briefs or planning problems; they have themselves received both support and funding from the King's Fund (Valins 1983).

Comment

We suggested at the beginning of this chapter that the debate over practice premises and the role of the FPC conceals deeper issues: control over property and space. But while GP premises may have claims to be both public and private space, the FPC's responsibilities have been redefined. The balance has shifted. A variety of schemes can support GPs in physically improving their property, and FPCs are engaged in establishing guidelines for minimum standards.* Information about local practice premises should be an essential ingredient of the FPC's database. The review process will make FPCs more accountable to the DHSS for the progress they make.

Our examples show that effective communication between districts, local authorities and FPCs clearly yields results. All such initiatives will, however, need the continuing support of the DHSS and, ultimately, of the government. In order to maintain momentum, adequate resources for capital investment must be provided. Through policies on premises, FPCs can attempt a greater equality of provision and of access. Practice changes can be linked with the broader issues of primary care policy, such as working space for community nurses and other health workers. Finally, the patient's perspective cannot be ignored. In addition to setting basic standards for physical amenities, FPCs must be sensitive to the ways in which consumers experience these facilities. Patients' responses will influence both their perceptions and their use of NHS general practitioner services.

* *Primary Health Care, an agenda for discussion* indicates that £80m per annum is spent on improving practice premises in the UK as a whole. (1986, HMSO, Cmnd. 9771, page 12).

5
Family Practitioner Committees and the dental, ophthalmic and pharmaceutical services

Family Practitioner Committees and the Dental Services

Dental disease is the second most costly illness in the UK, surpassed only by mental disorders (Royal Commission on the NHS 1979). NHS dentistry is divided into three parts: the general dental services, with which most patients are familiar; the community dental service, which includes school services; and the hospital dental service, consisting mainly of specialists to whom patients are normally referred by a general dental practitioner (GDP).

Total spending on the general dental service is now running at approximately £600 million a year: some 4.5 per cent of the NHS as a whole, and about half the cost of the general medical services (Parkin and Yule 1985, to whom we are indebted for the statistics in this section unless stated otherwise).

FPCs have three functions in relation to dentists: they maintain a register of GDPs; they pay dentists their fees; and they ensure that GDPs comply with their terms of service. However, their responsibilities for dentists are very different from their responsibilities for doctors.

Distribution of dentists

The distribution of dentists is acknowledged to be a major problem. In 1982, there were 13,936 registered dentists carrying out NHS work in England and Wales. Unlike GPs, dentists may – in theory – set up practice wherever they wish. Neither health authorities nor FPCs have any formal controls over distribution; there is no equivalent committee to the doctors' MPC. According to the British Dental Association (BDA), this is because any system of open or closed lists would require some means of measuring local need for treatment '... and there is not at present enough consistent and regularly available epidemiological data to do this satisfactorily' (BDA 1984a). As a result, there are gross discrepancies between regions, in both manpower and financial expenditure (Lennon 1983). The Dental Strategy Review Group (DSRG) declared in their 1981 report that social class and geographical differences in dental health remained unacceptably wide (DHSS 1981b). In England, the Northern Region has 27 per cent below the average in terms of dentists to population ratio, while

North West Thames and South West Thames are 51 per cent and 37 per cent above respectively (1982 figures).

The BDA publishes a guide to practice location for dentists, but this is couched purely in terms of market forces. It does, however, point out that while in the past dentists tended to gravitate to 'cleaner and greener' parts of the country, in future, areas of deprivation and high unemployment could prove attractive for practical reasons: '... a higher proportion of potential patients will be eligible for help with NHS charges' (BDA 1984a).

Between 1974 and 1982, the number of dentists per 100,000 population grew overall from 23 to 28. Because of this increase in manpower, and following recommendations from the DSRG, in 1983 the government introduced a 10 per cent cut in the intake to dental schools. Henceforth, the number of students would be subject to annual review. In March 1985, the government announced an imminent change in the immigration rules. While overseas doctors and dentists had previously been allowed unrestricted entry, from 1 April doctors and dentists from overseas who wished to become general medical or dental practitioners would need to comply with the entry provision for the self-employed. Those seeking entry for the purpose of post-graduate training in hospitals would be admitted for up to four years. All other doctors and dentists would be subject to the usual work permit arrangements. These moves, according to the Secretary of State for Social Services, Norman Fowler, were intended to prepare the United Kingdom for self-sufficiency in medical and dental manpower (Parliamentary debates, House of Commons, vol 76, 26 March 1985, cols 228–230). These changes do not apply to doctors and dentists from the EEC.

Both these measures evade the growing problem. Recently, the Dental Health Service Unit at the University of Manchester conducted a study which aimed to identify the influences on the distribution of GDPs. They found that the most important factors were the dentist's home town and university. Their study of provincial universities revealed that 75 per cent of dentists recruited locally stayed on to practise in their local region, and among students recruited from outside the region 45 per cent remained to practise near where they qualified (Lennon 1983). These findings serve to support the DSRG's recommendation that student numbers should be maintained in dental schools in regions which are under-dentisted (DHSS 1981g). The unit also looked at the influence of existing practices on the location and distribution of new dentists. In a survey of 600 GDPs, it was found that a majority of the dentists (39 per cent) joined long-established practices, while only 5 per cent established

new practices. 'Yet if FPCs are to provide services to under-dentisted areas, then it is new practices that are required' (Lennon 1983).

Dental treatment and charges

Dental treatment has been available under the NHS since 1948. Responsibility for the school dental service and other community services was transferred from local authorities to the NHS in 1974. Unlike doctors, dentists do not keep lists of patients for whom they are responsible. A dentist's obligations – and contract with the NHS – start when a patient has been accepted for treatment; they – and it – end when that course of treatment is over. Before the patient signs a form on completion of treatment, the dentist must ensure that that patient is 'dentally fit'. 'Vague and limited though that definition of their obligation is, it remains all there is' (Parkin and Yule 1985, page 27). It can mean, however, that dentists can decline to carry out time-consuming work on NHS crowns or dentures without necessarily being in breach of their terms of service. FPCs could encourage good quality dental care in their local areas by defining and monitoring their own standards of 'dental fitness'.

Dental services are not free at the point of delivery, as medical services are. Dental patients have to pay for some part or nearly all dental treatment. In 1970 charges amounted to 18 per cent of the total cost of services; by 1982 this had risen to 26 per cent. According to a BDA spokesperson, patients are currently paying 60 per cent (personal communication, 22 October 1985). Forty-five per cent of chargeable dental treatment is free, as young people under 18, students under 19 in full-time education, expectant and nursing mothers and those receiving supplementary benefit or family income supplement are all exempt from charges. No charges are made for check-ups, repairs to dentures and some emergency services. If they are not eligible for free treatment, patients will have to pay the full cost up to £17, and 40 per cent of any cost over that amount. In addition, there are charges for dentures, bridges, crowns, inlays, pinlays, and gold fillings. The maximum cost for any course of NHS treatment is currently £115 (Leaflet D.11, 'NHS dental treatment', DHSS, April 1985). With this level of charges, some patients are understandably confused as to whether they are receiving NHS or private treatment.

It should also be noted that elderly people are not exempt from dental charges unless they qualify for free treatment on the grounds of low income. The fifth annual meeting of the society of FPCs (1979) was of the opinion that a large proportion of the elderly were

not taking up the general dental treatment they needed because of the high level of charges, and that recent rises would aggravate the situation. They requested the then Secretary of State urgently to consider the provision of such treatment free of charge to patients over 70. But, in reply to a similar request from Barnet FPC, the DHSS declared that it did not feel that the elderly were neglected in this matter: the government's view was that help for adults in meeting NHS charges should be related to patients' means rather than their age. The management committee of the Society of FPCs felt that this statement disregarded the fact that the elderly were much more likely to need dentures, and therefore likely to incur higher charges (*The FPS*, 7, no 3, 1980). One recent study of access to primary health care found that one quarter of people without teeth were deterred from going to the dentist by the cost of treatment, as compared to six per cent of those with natural teeth (Ritchie, Jacoby and Bone 1981).

In 1984, the BDA published a pamphlet which argued the case against still further rises in charges. By holding down the cost of treatment and constantly increasing charges to patients, the government, claimed the BDA, had substantially reduced its own financial commitment to the general dental services. It also pointed out that as unemployment levels have risen, remitted charges have also risen rapidly, amounting to almost £31 million in 1983. Dentists feared, too, that patients might be deterred from seeking necessary treatment, thus neglecting conditions which could then become more serious (BDA 1984b).

How dentists are paid

Dentists are paid on an item of service basis: that is, according to the amount of work they carry out. This means that the incentive is for quantity, rather than quality; there is no financial incentive at all to encourage prevention. The Dental Rates Study Group attempts to set the fee for each type of treatment in such a way that dentists are rewarded at the same rate for every minute they spend with a patient. Each fee contains an element for net income and an element for practice expenses; also, where appropriate, an element for the cost of materials and for any laboratory work necessary. In 1983, the Doctors' and Dentists' Review Body, on the basis of assumptions about the amount of work which the average dentist can carry out, determined a target net income of £17,890. Nevertheless, in 1983 67 per cent of dentists earned between £20,000 and £60,000; 1.6 per cent earned over £100,000. These figures will, however, include practice expenses; and some of the work may have been carried out by assistants.

It is not known with any precision how many dentists work wholly in the private sector, or indeed how much time registered NHS dentists devote to private practice. The Dental Rates Study Group estimated in 1982 that the latter figure was 11 per cent. There is no way of telling how this is distributed between practices. Dentists may not mix private and NHS work during a single course of treatment. They cannot, for example, accept a patient under the NHS and then refuse to provide necessary treatment unless the patient pays a fee.

Very little information exists concerning the practice structure of dentists: whether they work in group practices, employ ancillary staff, or how much they have invested in premises or equipment. This is partly due to the fact that FPCs do not reimburse practice rent and rates or make a financial contribution towards employing ancillary staff, as they do for doctors. Using figures from the BDA, Parkin and Yule estimate that most practices employ a surgery assistant and a secretary/receptionist, but that less than half employ a technician to make up crowns, dentures and bridges, and very few a dental hygienist. The employment of the latter would presumably imply group practice; in 1981 the BDA estimated that 53 per cent of dental practices were single-handed (DHSS 1981g).

Recently, there have been a number of experiments sponsored by the DHSS which entail the employment of salaried dentists. One pilot scheme, set up on 1st October 1984, aims to test the feasibility of paying dentists on a capitation basis for the treatment of children up to the age of 16. This study is limited to 50 dentists in 21 practices in four FPC areas in England and Wales: Gloucestershire, Manchester, Redbridge and Waltham Forest, and South Glamorgan. It will last for one year, and if considered successful will be expanded elsewhere (DHSS 1985g). This development reflects a change of approach towards dental work which may well be a foretaste of the future.

What can the FPC do?

As noted above, the FPC's formal role in relation to dental services is a limited one. However, we have encountered a considerable undercurrent of dissatisfaction towards FPCs in the dental profession. In their view, FPCs are frequently dominated by doctors. Too little attention they feel, is paid to dental matters, apart from the occasional sensational publicity given to high-earning dentists.

According to M A Lennon, Senior Lecturer in Community Dentistry at Manchester University's dental school, there is a great deal that FPCs and health authorities could do to improve the availability of services in their areas. First of all, he suggests, they could use their

'not inconsiderable influence' at national level to upgrade the debate. Secondly, they could improve the quality of local information in order to assist dentists setting up new practices. Lennon argues that FPCs, with the assistance of the Dental Estimates Board, should examine the distribution of dentists within their areas, and determine which sections of the population are not provided with services. West Sussex FPC found, when they conducted a survey, that they had two problem areas.* It would be possible, claims Lennon (1983), to provide prospective dentists with a very useful area profile. Both Somerset and Oxfordshire FPCs provide information for dentists regarding location.* The BDA advice sheet (BDA 1984a) recommended that intending practitioners should visit the area they have in mind and, among other personal research, talk to the local FPC administrator. Manchester FPC, which clearly derives great benefits from its contacts with the university's dental school, takes care to interview personally all the dentists coming into its area, and it follows up the applicant's interests in making salaried appointments. Dental disease is high in Manchester, and the dentist–patient ratio is low. The FPC is prepared to advertise for a dentist to fulfil the requirements of a particular locality.†

A dentist must provide a 'proper and sufficient' surgery and waiting room accommodation for patients, and he or she must possess suitable equipment and instruments. FPCs have no automatic right to enter a dentist's premises; these are normally inspected by the regional dental officer (RDO). FPCs may, however *ask* to visit, and they may do this either on a routine basis or as a result of a complaint by a member of the public. In the latter case, an officer/member visit can be arranged, and the FPC then has the right to insist that repairs should be carried out if necessary. If permission for such a visit is refused, the FPC may ask the regional dental officer to visit on their behalf; this is done in Avon (Avon FPC 1984).

Lennon (1983) observes that many dentists complain of difficulty in obtaining planning permission for premises. FPCs could assist them here, he suggests, by ensuring that the planning authority is aware of the positive benefits to the community of providing general dental services. The FPC can also help the dentists to guide their applications through the administrative system. Leinster (1984), in a review of primary care services which focused on Newcastle, mapped the accessibility of the general dental services in that city. Many dentists, she noted, practised from premises that they lived in or otherwise owned. Very few worked in NHS premises. Her survey

* Questionnaire.
† Interview.

revealed an uneven spread of dentists; working class areas had the lowest provision. One of the things which the health authorities could do to encourage more even distribution, claimed Leinster, would be to provide premises – and a salary.

The great majority of dentists, as we have already noted, are paid by the FPC on an item of service basis, following claims made to and approved by the Dental Estimates Board. These claims provide FPCs with an enormous amount of information. They also provide a means of checking whether dentists are adhering to their terms of service. Large claims for expensive items of treatment may be checked, and investigated through the Dental Service Committee.

It is the duty of the Dental Estimates Board to monitor for over-treatment and to check for fraud, but as Parkin and Yule (1985) point out, 'their monitoring and detection system is not sophisticated'. The DHSS has its own Dental Reference Service, whose inspectors do random checks, but these are few and far between. In 1984, in recognition of the problem of accountability, the DHSS set up an inquiry under the chairman of the Northampton Health Authority (*The Observer*, 7 July 1985). Among its recommendations, the report requests FPCs to compile practice profiles of the dentists in their area (DHSS 1986a; see also DHSS 1986c).

Although systems of payment are agreed nationally, Lennon urges FPCs to take more local initiatives and to exercise greater flexibility in this regard. We have already mentioned some schemes for employing salaried dentists; Lennon argues that more facilities for general dental services could be provided in health centres. In Greenwich and Bexley there are two dental units based at Lakeside and Galleons Reach health centres in Thamesmead, which provide general, community, and academic dentistry (Greenwich and Bexley FPC 1983). City and East London FPC employs four salaried dentists in health centres in areas where there are few local dentists. This arrangement dates back to the days of the Inner London Executive Council (prior to 1974). Salaries are paid by the DHSS. Lennon records that the General Dental Services Committee of the BDA changed its policy in 1982, after a detailed assessment. It expressed the view that health centres widened employment opportunities for dentists; that the terms of service were not unreasonable; and that availability of health centres made local initiatives more feasible.

FPCs may support and approve schemes for providing emergency dental services at weekends and on Bank Holidays. These services must be operated from premises under the control of the health authority; dentists are paid on a sessional basis. At present, there are 52 emergency dental schemes in operation in England, set up through

DHAs, FPCs and local dental committees (DHSS 1985a). Bradford FPC cut costs by organising its emergency service in conjunction with the district dental officer and a local hospital.*

One important aspect of the FPCs' role, which applies as much to dental services as to other areas of primary care, is the provision of information to the public. Kensington, Chelsea and Westminster FPC, whose inner city area is one of high population mobility, which encompasses a large number of tourist hotels, a wide variety of ethnic groups and also copes with a considerable daily influx of commuters, keeps a comprehensive list of the dentists in the area. It includes details of dentists with different language skills; those who will do domiciliary visits; those with surgeries on the ground floor, accessible to the disabled; and dentists who will undertake various types of treatment on the NHS.† Such details are not difficult to collect, but it was surprising to find several FPCs professing ignorance about their local dental services.

FPCs and the ophthalmic services

There are basically two types of optician, each with different training and areas of expertise. Ophthalmic opticians test sight, dispense lenses and fit and supply glasses. They are also qualified to detect diseases of the eye and will, if necessary, refer people to a medically qualified eye specialist. Their education lasts three years, with an additional supervised year in practice. Dispensing opticians make up lenses from prescriptions, and fit and supply glasses. They have a two-year training. In addition, a third group, ophthalmic medical practitioners (OMPs) carries out the same tasks as ophthalmic opticians. These are medically qualified people with optical qualifications who have chosen to specialise in this area of work. The hospital ophthalmic services carry out the 'acute' aspects of eye care; these are equivalent to about one fortieth of the work of the general service (Key 1986).

Opticians and the FPC

Since the 1946 Act, which established the supplementary ophthalmic service (after 1968, it became the general ophthalmic service) the administrative agency at local level has been the executive council and its successor, the FPC. The population is entitled to free eye tests, and until 1985, was also entitled to low-cost NHS lenses and frames. Following a course of treatment, opticians submit their claims for

* Questionnaire.
† Interview.

payment and the FPC pays authorised claims. Premises from which opticians practise may be inspected. These should contain sufficient room for consulting, a waiting room and suitable equipment. FPCs keep a list of registered practitioners and their addresses for information, but the public are free to go to whomsoever they choose for each sight test and appliance. There is no provision for controlling the number of opticians in any FPC area. They may practise where they choose, and as a consequence distribution is uneven. The ratio of opticians to population is greater in areas of higher population density and prosperity (Key 1986). Opticians must abide by their terms of service and, like other contractors, they are subject to the service committee procedures described in chapter 2. All three branches of the profession nominate members to the FPC and the relevant sub-committees.

At the end of 1983, there were 2,400 dispensing opticians, 4,900 ophthalmic opticians and 850 OMPs practising in England. Eighty-six per cent of sight tests were carried out by ophthalmic opticians, and 14 per cent by OMPs. The number of sight tests has been steadily growing. The increase in the year ending in 1983 was 500,000 (DHSS 1985a). Fifty-five per cent of men and 64 per cent of women in this country now wear glasses, while another one per cent of men and three per cent of women wear contact lenses (*The FPS* 1, no 12, 1985, pages 9–11). Key, however, in a recent review of the ophthalmic services, quotes evidence to suggest that '... a surprisingly large proportion of the population make do with defective sight'. It is particularly high amongst the elderly (Key 1986, page 40).

The costs of the ophthalmic services have been rising. Between 1978/9 and 1983/4, costs rose by 14 per cent in real terms. This has been largely due to the growing demand for sight testing, as the charges for NHS glasses have increased steadily. In 1983/4 the average difference between patients' charges and the full cost was around £5 (DHSS 1985a, page 22). It is also worth noting that 30 per cent of those who have their eyes tested do not need a new prescription.

The state and opticians

The relationship between the state, the FPC and the optical professions is an interesting one. It has changed following the 1984 Health and Social Security Act, but the consequences of this have yet to work themselves out. Under the NHS Act of 1946, sight testing was free, but charges for glasses were soon introduced. NHS lenses and frames of a basic kind were available, free of charge, for children and for certain categories of adults on low incomes. However, lenses

and frames can be purchased privately, or NHS lenses could be fitted to non-NHS frames. These were termed 'hybrids'. Alternatively the whole transaction, from sight-testing onwards, could be carried out privately. Opticians were able to provide private or NHS care from the same premises, during the same working hours. Their income is derived from both sources.

Most sight tests are carried out under the NHS, and it has been estimated that in 1975 two-thirds of appliances were dispensed on the NHS (*The FPS*, 1, no 12, 1985, pages 9–11). Recently this has been tending to rise (Key 1986). In 1983, 500,000 children had free lenses and one million adults were supplied with free or reduced-cost glasses (DHSS 1985a).

Out of all the contractor professions administered by the FPC, the ophthalmic opticians were the last group to obtain a state licence and a mandate to practise. They have also been the first to lose part of that monopoly. State registration of ophthalmic opticians was a consequence of the 1958 Opticians Act. This ratified a de facto situation which had existed since 1946 for, under the Act, ophthalmic opticians were acknowledged to have a special expertise in refraction, diagnosing sight deficiencies, and prescribing lenses to correct defective sight. Fielding and Portwood (1980) argue that the 1911 National Insurance Act first gave ophthalmic opticians a role in sight testing and, as a consequence, they gradually acquired the status and privileges of a profession while OMPs derived professional status from their medical qualification. Dispensing opticians have a narrower range of professional skills: to match prescription to lens; lenses to frame; frame to patient. Professional associations lay down the requirements for the education and training which bring registration. The NHS Act brought state-funded work for opticians and gave the public access to free sight testing and subsidised glasses. It was concerned with welfare; not with the cosmetic aspect of eye care.

Opticians may work as solo practitioners, as partners in a group, or they may be employed by a corporate body. Increasingly, as the demand for fashionable frames and contact lenses has grown, solo practice has declined. Forty-five per cent of opticians now work for corporate groups (*The FPS*, 1, no 12, 1985, pages 9–11). The profit margin on the sale of glasses, excluding NHS appliances, is alleged to be high. In 1976 the Price Commission expressed concern that the public were paying too much, commenting: 'It is quite clear that dispensing private spectacles is a very profitable activity' (Price Commission 1976, para 5.12). They found that there was considerable variation in prices; when they had an identical prescription

dispensed by a number of opticians, the price charged ranged from £23 to £64. The Price Commission, like the 1970 Monopolies Commission report, saw the restriction on advertising (a consequence of the professional licence to practise granted under the 1958 Opticians Act) as the cause of high prices.

In 1981, the Director General of Fair Trading was asked to investigate the issue. His report (Department of Trade 1982) also criticised the bar on advertising and the consequent lack of information available to the public about relative prices and the options open to them. The report (para 12.12) commented that paragraph 11 of the NHS terms of service '... has the effect of preventing individual opticians from informing patients and potential patients of the facilities which they are able to offer through the general ophthalmic service'. It recommended that the provision of glasses should be open to greater competition: that unregistered (unqualified) sellers should be allowed to enter the market. This, it claimed, would make the industry more efficient by encouraging innovation, and it would also be in the interests of the consumer. He or she would be able to choose glasses knowing the costs involved. Prices would fall overall, as they had been kept artificially high by the opticians' monopoly position. The report did not find that as a whole opticians' profits had been 'excessively high', but profit margins varied. Governments had been (and still are) involved in acrimonious discussions with the profession over payments. Payments due to opticians under the regulations were stopped in 1985 but the optician's associations have recently won two cases in the High Court, which judged such action illegal.

The deregulation and privatisation of the ophthalmic services

In the 1984 Social Security Act, the government began to withdraw from a commitment to a primary eye care service. The Act, while retaining public access to free sight testing, has 'relaxed the restrictions on who could sell glasses'. A prescription can now be taken to an unqualified person to be dispensed. The supply of NHS glasses will be terminated to all except children, those on low incomes or those needing very complex lenses. The Act allows for the establishment of a system of grants to these groups to replace the present arrangements '... so as to be able to extend to them the advantages of buying privately' (DHSS 1985a, page 23). From 1 July 1986, a system of vouchers will replace the present arrangements (DHSS 1986b; DHSS 1986c). The vouchers will have a range of values, according to the type of prescription, and a claim form will be issued by the prescribing practitioners. Thus, dispensing opticians will cease

to be in contract with FPCs.

The changes in legislation have been opposed by the opticians' professional associations, and others. One of the issues involved is the importance of professional judgment in making up glasses. Can these be safely sold across the counter? Are customers able to judge what they need themselves and, if they make a mistake, is it likely to do them harm? The opponents of the change call it an 'ill-advised' measure. They argue that a number of decisions have to be made about appropriateness and fit for each individual, and that this ought to be done by a qualified person (Gray 1984). The Office of Fair Trading report (Department of Trade 1982) estimated that unregistered practitioners would probably take from three to five per cent of the dispensing market, or 250,000 to 300,000 pairs of spectacles.

Under the 1984 Act unregistered sellers are not allowed to dispense glasses to children under the age of 16, and they are not allowed to fit contact lenses. They must only dispense glasses on the presentation of a recent prescription from an ophthalmic optician or an OMP. However, Gray, a practising ophthalmic optician, argues: 'What is to stop the unscrupulous trader from copying an existing pair of spectacles and "adding a bit for luck?" ... this will mean that the health care role of an eye examination will be lost' (Gray 1984).

It is certainly assumed in the Act that adults should be free to choose where to go to have their glasses dispensed. The Office of Fair Trading (para 14.13) had argued that the main question was whether customers (here the terminology is significant) are reasonably able to judge their needs for themselves, and whether mistakes were likely to do them harm. It was concluded that: 'There was almost unanimous agreement among those giving evidence that inaccurate spectacles could not cause permanent damage to the eyes, but there exists the possibility of minor discomfort.' This point was reiterated by Kenneth Clarke in the committee stage of the bill (Parliamentary debates 1984, col 143). In the light of this opinion the advantage lay in removing the need for qualified dispensing and the restriction on advertising.

It is not known what effect the lack of availability of low-cost NHS glasses will have on demand, nor the consequence of deregulation on the price of glasses. The opticians' associations have consistently emphasised the 'service' or health and welfare aspects of their work, and stressed their role in maintaining a good standard of eye care in the country at a relatively low cost (Fielding and Portwood 1980). They fear that any rise in price will be a deterrent. Many opticians have in the past carried out work for which there is no special

renumeration. Some have undertaken domiciliary visiting of the housebound, for example, for which they receive travelling expenses only.* This is a service which is not commercially viable, while failing sight among the elderly is a major cause of a reduction in the quality of life and a loss of personal independence.

Opticians are also concerned that the voucher, when it is introduced, will not be sufficient to cover the actual costs of new glasses for vulnerable groups. For example, a survey of 150 opticians carried out for the Royal National Institute for the Blind by the Consumers' Association found that a pair of glasses commonly prescribed after a cataract operation cost £11.75 on the NHS, but were priced privately, in similar frames, at around £55 (*Self Health*, 7, June 1985).† Furthermore, both children and the elderly may need frequent eye testing and changes of glasses. Any voucher system will need to allow for this, or we shall risk a deterioration in standards of eye care. Opticians would like to extend their work into the supply of low-vision aids to the visually handicapped, arguing that this could be more cheaply and more adequately provided at the primary level. This has been resisted by governments. Recent developments suggest that the primary purpose of the 1984 Act is to withdraw from state involvement in general ophthalmic services.

Both FPCs and professional groups have voiced concern about the implications of the new legislation, particularly about the standard of practice premises and their obligations in relation to them. The FPC will have no jurisdiction over the premises of unregistered dispensers. One Midlands FPC which had a regular programme of inspection of all premises mentioned the difficulty of inspecting opticians in department stores where there was often little privacy.‡ Another FPC commented in its annual report that if members of the public were able to go to unregistered persons to have their glasses made up, this removed an area of health care from the FPC. They were therefore concerned that there would be no right of complaint to the FPC in cases of dissatisfaction (North Yorkshire FPC 1984, page 27).

Family Practitioner Committees and pharmaceutical services

Some FPCs appear almost indifferent to their pharmacist contractors, although good quality pharmaceutical services play an important part in the provision of primary care. The gross cost of these

* In Scotland, the NHS does offer some reimbursement to encourage domiciliary visiting in remote rural areas.

† *Self Health* is published by the College of Health, 18 Victoria Square, London E2 9PF.

‡ Questionnaire.

services represents 47 per cent of the total cost of the FPS; according to the DHSS annual report (DHSS 1985a), about eight out of ten patients consulting their GPs can expect to be given at least one prescription as part of their treatment, although it is not made clear whether this refers to one consultation or to one illness episode. In 1983, over 315 million prescriptions were dispensed in England alone. Seventy-eight per cent of these prescriptions were dispensed to patients who were exempt from charges (this figure includes the six per cent who have bought 'season tickets'). The 1984 figures, this time for both England and Wales, show an increase of one and a half per cent on the number, while the cost had increased by seven per cent to £1504 million (*Pharmaceutical Journal* (PJ) 1985d).

Registered pharmacists and registered premises

In order to qualify as a pharmacist, it has been necessary since 1970 to take a three-year degree course at one of the 16 schools of pharmacy in the UK. This must be followed by one year of preregistration experience, working in an establishment approved by the Council of the Pharmaceutical Society of Great Britain (PSGB). The student then becomes a registered pharmacist by paying a registration fee and subsequent annual subscription to the society. The statutory committee of the PSGB can discipline pharmacists who are guilty of either professional misconduct or criminal offences by removing their names from the register, and thus forbidding them to practise. On 1 January 1983, there were 33,411 registered pharmacists. Of these, 74 per cent were working in the community, 15.3 per cent in hospitals, 5.2 per cent in industry and one per cent as academics (1984/5 figures from the PSGB).

The 1933 Pharmacy and Poisons Act requires the PSGB to maintain a register of premises, and to inspect them. The council of the society appoints inspectors for this purpose: at the time of writing, 20 travel around the country while four are based in the society's offices. New pharmacies must apply to the PSGB, which will not register them until they have been inspected. The premises must meet the definition of a 'retail pharmacy business' as set out in the Medicines Act 1968, that is, they must be capable of operating as a pharmacy, and they must be supplying items not on the General Sales List (see below). PSGB inspectors may call at premises where they have reason to believe that offences may be committed against the sale, supply or storage of medicines or poisons.

Drug licensing

Until the early 1960s, drug manufacturers could market their products without having to satisfy any independent body as to their efficacy or safety. After the thalidomide scandal, the 1968 Medicines Act brought together much previous legislation on drug dispensing and set up a regulatory drug licensing system which affected all products registered after September 1971. The DHSS is the licensing authority, and it is advised on drug safety by independent committees such as the Committee on Safety of Medicines. The licensing process is carried out in secret, the evidence for giving or refusing a licence is not made public, and it is not clear what standards the law requires (Medawar 1984). According to Medawar, the Medicines Act gives the authorities great discretion, so that their decisions can in effect only be questioned by the drug companies concerned.

At the time of the Act, there were already thousands of named products, together with thousands of dispensing ingredients, on the market. These were granted what were known as 'licences of right', although they were liable to review by the 1975 Committee on the Review of Medicines. It was originally estimated that the process would take 'about eight years', but now EEC directive 75/319 requires them to complete the review within 15 years, that is in 1990. Gretton and Harrison (1985, page 106) describe the weakness of national government in the face of the powerful multinational drug industry: '... an industry that can, to take the UK example, effectively dictate the terms on which it agrees to bolster the country's export effort, and thus promote one policy objective, as long as it remains free to undermine at will Departmental efforts to reduce the drugs bill to the national health service, and so nullify another ...'.

The Medicines Act established three categories of drugs: Prescription Only Medicines (POMs); Pharmacy only drugs (Ps); and General Sales List drugs (GSLs). POMs are available only on either NHS or private prescriptions, issued by a doctor. They can be dispensed only by pharmacists or by dispensing doctors. The pharmacist is responsible for checking that the prescription details are correct, and for checking with the doctor if necessary. Pharmacy only drugs (Ps) may only be dispensed when there is a pharmacist present to supervise. While he or she does not have to make the actual sale, they must be aware that it is taking place. GSLs are the simple medicines for everyday illnesses. They may be sold over the counter in shops and supermarkets, but analgesics (such as aspirin) can only be sold outside pharmacies in small quantities.

The limited list

Greenfield (1983) looked at effective prescribing, and considered the possibility of a limited list. The report noted that 6,500 products were available for prescribing at NHS expense, and that 4,500 of these were listed in the British National Formulary. The average prescriber was said to use a range of 200–300 drugs. The WHO has identified a list of only 250 essential drugs (quoted in Medawar 1984, pages 92–3). Generic substitution has been practised in NHS hospitals for some years, and the growth of hospital formularies has had a beneficial effect on GP prescribing.

When, towards the end of 1984, the government first announced that it wished to introduce some form of limited list prescribing into the FPS, it faced massive opposition from the Association of the British Pharmaceutical Industry (ABPI). One general manager of a pharmaceutical company was heard to claim that some companies would lose 60 per cent of their business; the ABPI, he went on to declare, 'had mounted the biggest campaign it had ever organised' (PJ 1985a). The government was forced to retreat, and to rethink its policy. When it introduced its limited list early in 1985, it was in a modified form which only achieved three-quarters of the original targets. However, even this was still resisted by the pharmaceutical companies, who conducted an acrimonious advertising campaign, and by the BMA, who opposed it on the grounds that it would interfere with doctors' clinical freedom.

Nevertheless, after 1 April 1985 a number of drugs in the following categories were no longer made available under the NHS: cough and cold remedies, antacids, laxatives, analgesics for 'mild or moderate' pain, vitamins, tonics and bitters, and benzodiazepine tranquillisers and sedatives. A 'black list' of named products was prepared (see The National Health Service (General Medical and Pharmaceutical Services) Amendment Regulations 1985, SI 1985 No 290). Many of the drugs on the list are over-the-counter preparations; some are described in the British National Formulary as either ineffective or unsuitable for prescribing; others have cheaper generic equivalents. Sixty-eight additional products, ranging from Nivea cream to Flora margarine, were considered by an Advisory Committee on Borderline Substances, declared not to be medicines, and therefore not prescribable by GPs. Pharmacists could no longer claim reimbursement for dispensing any of these items. A 'white list' was subsequently produced, in order to help doctors and pharmacists know what was currently available on the NHS. This list was prepared by the DHSS for administrative and advisory purposes only; it

has no legal significance. An advisory body has been established, with the remit of monitoring the 'black list', dealing with appeals from the companies and from doctors, and considering the designation of new drugs. A useful summary of the new regulations, together with copies of both lists, appears in the *Pharmaceutical Journal* for 30 March 1985 (PJ 1985b).

The Pharmaceutical Services Negotiating Committee (PSNC), FPCs and remuneration

The PSGB is not involved in negotiating payment or terms of service of the NHS dispensing contract. The contract with the FPC is held by the owner of the pharmacy. The PSNC represents all pharmacies in contract with the NHS. It also negotiates the drugs tariff with the DHSS; drug prices are updated monthly. The committee is constituted of 25 registered pharmacists engaged in the NHS pharmaceutical services. Its members are chosen as follows: 14 contractors elected from each NHS region in England; one elected from Wales; five nominated by the National Pharmaceutical Association; four pharmacists nominated by the Company Chemists' Association; and one pharmacist nominated by the Cooperative Wholesale Society.

The PSNC negotiates pharmacists' remuneration annually with the DHSS. Since 1980, all pharmacists who open a chemist's shop more than one kilometre from another pharmacist can claim a basic practice allowance from the FPC; in 1985, this was £3,000 per annum. For purposes of remuneration review, pharmacies are divided into six groups, according to the number of prescriptions dispensed. Group 1 is from 1–15,999, while Group 6 is from 85,000 and over. Additional fees are payable for dispensing certain appliances and dressings, bulk prescriptions, controlled drugs, oxygen cylinders, and for out-of-hours rota duties. There is also a container allowance.

The FPC's hours of service committee agrees the opening hours for the chemists' shops in its area. It also establishes whether there is a need for an out-of-hours rota, and makes arrangements with the Local Pharmaceutical Committee (LPC) to provide a service (see Appendix II). In order to make sure that the quality and quantity of drugs dispensed are in accordance with the prescriber's instructions, the FPC operates a drugs testing scheme, in conjunction with a local inspector from the PSGB. Any discrepancies will be referred to the LPC, for investigation and action. The LPC is elected by both contractors and pharmacists. The FPC keeps a list of names and addresses of registered pharmacies and has reponsibility for seeing that this is circulated and available. It has no explicit power to

inspect premises.

Prescriptions are examined, checked and priced by the Prescription Pricing Authority (PPA), a special health authority created under the 1977 Health Service Act. Its members are appointed by the Secretary of State, and it has offices in London, Birmingham, Durham, Liverpool, Manchester, Newcastle, Preston, Sheffield, Wakefield and Bolton. Wales has its own pricing committee. The PPA provides information and statistical services to FPCs, the DHSS, GPs and pharmacists. It is hoped that computerisation will further facilitate the monitoring of prescribing habits and drug costs.

Location and distribution: the proposed new contract

The Royal Commission (1979) noted that the number of pharmacies was diminishing, particularly in rural areas. They were concerned that the growth of group practice and health centres was causing what they referred to as 'leapfrogging' by pharmacists, who were constantly moving in, nearer to doctors' surgeries. However, the commission did not believe that the public was experiencing sufficient difficulty in getting prescriptions dispensed to warrant the introduction of a national system of controlled location. Since 1979, the situation has changed and the number of pharmacies dispensing NHS prescriptions has once again begun to grow: at the end of February 1985 there were 11,106 compared with 10,935 at the same time in 1984 (PJ 1985c). The DHSS acknowledged that distribution is uneven, with some areas over- and some under-provided (DHSS 1985). In urban areas there is no body which controls distribution. As Glorney (an FPC administrator) remarks, the number and location of chemists' shops in most FPC areas depends to an increasing extent on decisions made in the boardrooms of a handful of multiples based in London or in Nottingham (Glorney 1985). In rural areas, distribution is controlled by the Rural Dispensing Committee. This is described in the following chapter.

In May 1985, it was announced that a new contract for community pharmacists had been negotiated between the PSNC and the DHSS. Its most important feature was an attempt to limit the numbers of pharmacies on a local, rather than a national, basis. New pharmacies would only be able to open where they were 'necessary and desirable', and this decision would henceforth be made by a specially constituted committee of the FPC: the pharmacy practice sub-committee. This committee would be expected to follow national guidelines, but the appeals machinery would be local. In addition, existing contractors handling less than 16,000 prescription

items a year would be offered incentives to relinquish their contracts, although 'essential small pharmacies' would not be affected.

In a Lords' debate on 19 June 1985, Baroness Trumpington (Under Secretary for Health and Social Security) dismissed the argument that market forces could be left to take care of the number of pharmacies. As patients either paid a standard prescription fee, or nothing, she stated, in this situation market forces were conspicuous by their absence: 'The public as taxpayers are left to underwrite whatever cost is incurred by however many pharmacies choose to set up in business'. In one part of London, she claimed, there were 21 pharmacies within one square mile; in another FPC area, an average of one pharmacy every 200 yards. This was a wasteful use of public money, she declared, and one of the government's main objectives in negotiating with the PSNC was to remedy that situation (PJ 1985e). In short, the new contract was basically a cost-cutting exercise, by which the same size of cake would be distributed in larger slices; it would have no effect on the distribution of services in rural areas.*

As the income from the NHS contract amounts to approximately 70 per cent of a pharmacy's turnover (PSGB figure, 1985), these proposals unleashed a storm of controversy and ended by splitting the profession. While LPC members from England and Wales voted overwhelmingly at their delegate conference to accept the package, the new contract was bitterly opposed by the Company Chemists' Association and by a breakaway alliance of independent small contractors who called themselves the British Pharmacists' Association (UK). The opposition claimed that 1200–1300 small chemists would be put out of business. The announcement of the new proposals brought a spate of applications, from both multiples and independent contractors, asking the PSGB to register new premises. By June 1985, 342 has been received, more than the total number of premises registered in 1984 (150) (PJ 1985e). By October, over 700 applications were pending (PJ 1985g).

All sides assumed that the new contract would be going ahead until, on 30 September, Barney Hayhoe, the newly-appointed Minister of Health, suddenly declared that on legal advice he was unable to proceed. His powers under the NHS Act, he claimed, were insufficient for introducing the new contract and, in particular, for making provision for the FPCs to grant new contracts only where it was necessary or desirable in patients' interests. This part of the contract would have to be deferred 'until suitable powers were available'. His letter to the chairman of the PSNC is reproduced on the

* It was suggested to us by one informed source that this contract was offered as a quid pro quo for PSNC acceptance of the limited list.

cover of the PJ for 5 October 1985.

The PSGB expressed its incredulity in a statement issued on 1 October. It found it difficult to understand, it said, how the DHSS could have proceeded with negotiations over an extended period of 14 months or more '... without making sure that the action it proposed was either within existing law, or that new primary legislation would be laid to make what was proposed possible'. It appeared unlikely that the proposed legislation would be seen for some time, if at all (PJ 1985h). The editorial in the same issue of the PJ referred to the situation as a 'disaster', and 'leapfroggers' charter'. The only new economic pharmacies, it claimed, were likely to be situated near doctors' surgeries (PJ 1985g). A government attempt to introduce a similar contract in Scotland was defeated in the Lords on 22 October 1985. Negotiations are continuing, however, and new legislation is now expected in the current (1986) parliamentary session (DHSS 1986c).

The role of the community pharmacist

The advent of the NHS, with easier access to doctors' surgeries, meant the decline of much 'counter-prescribing' in pharmacies. The Royal Commission saw the pharmacist's role as traditionally one of dispensing medicines prescribed by doctors. However, as most medicines no longer need to be made up, it acknowledged that the community pharmacist was looking for a new role (page 95). The pharmacist's responsibilities, it claims, include: dispensing and monitoring prescriptions; providing advice to the public by means of non-prescription medicines, and relating this service to patients known to be receiving treatment from their doctors; supplying dietary aids, particularly for invalids and infants; supplying family planning requisites, together with surgical dressings, equipment and appliances and baby care products. The pharmacist should also be available to give advice on health topics, where necessary recommending the inquirer to seek medical attention. Pharmacists should also co-operate with government and other health education campaigns, mainly by displaying and distributing publicity material.

Recently, *Which?* magazine set out to test these claims. Their investigators made over 400 visits to dispensing chemists' shops, where they described various symptoms, some 'mild', some 'serious', and asked for advice (Consumers' Association 1985). When mild symptoms were given, assistants handled most of the queries. On all visits, the inquirers were sold medicines; usually without being asked whether other drugs were being taken. Most remedies did, however,

cost less than the £2 prescription item price. Investigators who described the serious symptoms asked for the pharmacists themselves, and measured their responses against the PSGB guidelines. They found that while pharmacists were readily available, often they simply sold the customer medicine without stressing the need to see a doctor. *Which?* magazine's conclusion was that not all pharmacists were following their society's guidelines, as expressed in the PSGB's 'Response to symptoms in general practice pharmacy'. Pharmacists, they thought, should take more responsibility for what went on in their shops, taking decisions as to which queries assistants could handle and when. They also drew attention to the lack of privacy for consultations. If facilities for privacy were available, they suggested, there should be signs saying so. This was one finding with which the PSGB did agree. They commented: 'If the pharmacist is seriously to pursue an advisory role, such a facility is essential' (PJ 1985f).

In October 1983, the trustees of the Nuffield Foundation set up an enquiry into the present and future role of community pharmacies. Pharmacists, as the Royal Commission stated, can play an important role in reducing costs in other parts of the NHS. The Nuffield inquiry examined their role in health care, and reviewed their education and training in the light of the current situation.*

Comment

This section has only touched briefly on some of the issues which are currently affecting the pharmaceutical services. Others – such as the aftermath of the Griffiths report (DHSS 1983b), the effects of high prescription charges, the debates over parallel importing and patient package inserts (for the latter, see Collier 1985) – have had to be ignored here largely for reasons of space, but they will assume increasing importance in the future when FPCs set out their own objectives and priorities for the community services. Computers, for instance, can be a vital source of coordination and cooperation between the hospital, the GP and the community pharmacist; their use could rationalise prescribing and facilitate the monitoring of adverse reactions to drugs. There will be much that FPCs can do in this area.

* *Pharmacy*: The report of a committee of inquiry appointed by the Nuffield Foundation, was published in March 1986 (The Nuffield Foundation, Nuffield Lodge, Regent's Park, London NW1 4RS).

6
The Family Practitioner Committee in rural areas

Rural areas present particular problems to both consumers and providers of primary health care. As Pheby (1984) points out, these problems cannot be divorced from the wider economic and social changes which have affected the rural community as a whole. Woollett (1981) highlights depopulation, lack of employment opportunities, lack of suitable housing (to rent or to buy), and the social and age imbalance of village communities. Over the past 20 years, government policies have resulted in drastic cutbacks in rural public transport. Acute medical facilities have become increasingly centralised, with resources concentrated in district general hospitals. As noted elsewhere, the number of health centres has grown and it has been DHSS policy to encourage doctors to form group practices. In rural Cambridgeshire, we were told of one health centre which served 25 outlying villages where public transport was 'non-existent' and voluntary transport 'very patchy'.* Elsewhere, in Oxfordshire, local people were not consulted at the planning stage when a health centre replaced seven local clinics. The parish had to provide a transport service; one patient with a heart condition was obliged to hire an ambulance himself in order to get to a London hospital (Price 1983).

Although such developments have transformed the rural environment, the basic problems of health care remain depressingly familiar. Paul Jennings compiled a picture of village life in 1965 using 2,600 scrapbooks put together by members of the Women's Institute. In rural Cumberland (as it was then), villagers were concerned about their lack of a dispensing chemist – there had not been one in the village for 60 years – and worried about the difficulty of collecting and delivering prescriptions. In a village in Wales, the district nurse, whose work there was mostly with the elderly or the very young, found herself acting as surrogate doctor, pharmacist and counsellor all in one (Jennings 1968). Recently, Exeter CHC conducted a wide-ranging survey of services in rural Devon and found similar preoccupations (Exeter CHC 1983). For the professionals, the 'confused elderly' were a particular cause for concern. In 1978, the Association of Community Health Councils for England and Wales (ACHCEW) regarded the closure and non-availability of pharmacies to be 'highly disturbing' (*The FPS*, 5, no 5, 1978, page 106).

* Interview.

FPCs tend to be seen as urban-focused, in both their location and membership. They are criticised accordingly for their apparent lack of understanding of rural areas. Norfolk FPC, aware of past bias towards Norwich, has consciously attempted to base new initiatives in other districts.* According to one spokesman from the National Council of Voluntary Organisations (NCVO), past relations between FPCs and Rural Community Councils (RCCs) have been poor. Hitherto, he claimed, they have had no need to develop a relationship.* In 1985, the Standing Conference of RCCs together with the NCVO formed an alliance known as Rural Voice. Rural Voice has set up a rural health group, which aims to focus on health issues of concern to rural communities, to provide a channel of communication, and to promote and publicise good practices. In future, planning rural health services will increasingly involve cooperation and collaboration.

Doctors in rural areas

Doctors' perceptions of their role have altered, together with the rural environment. According to Dr Farrow (Chairman of the Rural Practices Sub-Committee of the GMSC, and a member of the Rural Dispensing Committee – see below), when he entered practice in the 1960s, doctors had loved to come into rural medicine, with its cottage hospitals and attractive environment: '... the rewards were the lifestyle as much as the money.' Nowadays, he lamented, young doctors were more hard-headed. They wanted to work in partnerships of at least three or four, to have more time off, to be near urban amenities – and they did not want their wives involved in the practice. The last criterion, observed Dr Farrow, was especially difficult to fulfil (BMJ 1985f).

In the countryside, patterns of practice still differ from those in urban areas. Doctors working in designated rural practice areas are eligible for payments from the Rural Practice Fund, a system of Byzantine complexity which is administered by the Central Advisory Committee on Rural Practice Payments. Doctors are awarded rural practice units on the basis of at least 10 per cent of their patients living at least three miles distant from the main surgery 'by the normal route'. Additional units may be credited for 'difficult walking' (if visiting the patient involves negotiating a route that is very steep, rough or boggy), or for a 'blocked route' (if the normal route from the main surgery to the patient's residence is liable to flooding or other severe weather conditions). Further payments may be

* Interview.

claimed if the doctor has to incur ferry charges, hire a boat or pay tolls in order to visit an isolated patient. In North Yorkshire, for instance, the FPC noted that the closure of a river bridge had generated increased rural practice payments to one GP in their area (North Yorkshire FPC 1984). Somewhat surprisingly, Greenwich and Bexley FPC spent £16,000 in rural practice payments during 1983/4 (DHSS 1985d).

Rural doctors may have smaller lists than their urban colleagues, but list size is no indication of workload, as country doctors will need to provide a wider range of services to their patients (Pheby 1984). While this may be more satisfying in terms of the traditional 'family doctor' role, it can also involve a degree of frustration. Rural doctors are constantly dealing with problems that are more social than medical (Horobin and McIntosh 1983). Horobin and McIntosh also describe the added mental strain on GPs when they are isolated from professional support in areas where specialist services may not be immediately accessible. In an emergency, for example, there may be no easy access to secondary care.

Horobin and McIntosh (1977) recorded that rural doctors experienced considerable problems in their social relationships. If they became too involved with their patients' lives, they feared that they would never be off duty. Pheby, who conducted a survey of every single-handed rural GP in Britain, also found that time off was 'the major problem which caused disruption in the services': 15.5 per cent of his respondents had no regular time off at all (Pheby 1984). Norfolk FPC has attempted to assist its single-handed rural GPs in organising cooperative deputising arrangements – in spite of encountering problems of personality, geography and finance.* This FPC also circulates a list of available locums, which is constantly updated.

Availability is an area where patients' demands may conflict with professional needs. Exeter CHC, whose comprehensive survey of local rural medical services was referred to above, felt that good community relationships with doctors were more marked in villages closer to a main surgery where, the CHC believed, doctors were more deeply socially involved with their patients, both as neighbours and fellow villagers (Exeter CHC 1983).

Access to services

For patients in rural areas, the health issue of overriding importance is access to services (Dobson 1984; Fearn *et al* 1984). The Exeter report found that 75 per cent of parishes reported problems with

* Interview.

transport to hospital, while 51 per cent had difficulty in getting to the doctor. The population is likely, as in Devon, to contain a higher than average proportion of elderly retired people. Apart from commuters to the larger local towns, rural areas frequently depend on agriculture and on seasonal holiday trade; both low wage occupations (Exeter CHC 1983). Lancashire FPC covers a county that is highly diverse, containing major urban areas, new towns, rural areas, dormitory villages, resorts and retirement areas. In the health district that includes Blackpool, the population is inflated by an estimated 16 million visitor days per year. Doctors working in popular tourist areas will need to plan their services to match the special needs of holiday visitors (Maskrey *et al* 1985). An influx of summer visitors can impose considerable burdens on the NHS (Exeter CHC 1983). In the county as a whole, rural areas are tending to gain population and there has been a considerable increase in pensioners living alone. The county planning department estimated recently that one in eight of all Lancashire households consisted of women pensioners living on their own (Lancashire FPC 1984).

During 1984, Derbyshire RCC embarked on a rural health services project, designed to investigate the level of health services in rural Derbyshire and to identify problems related to access. A paper contributed to this project by the WI claimed that within rural communities, women had much poorer access to all types of facilities than economically active men; lower income groups had considerable problems; while the elderly population had the greatest problem of all (Derbyshire Rural Community Council 1984).

Horobin and McIntosh's sample of rural GPs came from Scotland, which is, according to Dowson and Maynard (1985), the best doctored country in the UK; some had been in their practices for 20 or even 30 years. Pheby's study (1984) found that single-handed GPs in isolated communities were leaving in large numbers. According to him, the average stay in single-handed Highland practices was only 8.4 years. Farrow also notes that turnover in rural practices is rising (BMJ 1985f).

When doctors either retire or move away, rural communities are frequently threatened with losing their surgeries as facilities can be centralised and practice premises lost. A number of studies confirm that surgeries in rural areas have been closing at a substantial rate. Woollett (1981) records 19 per cent closures in Cornwall between 1967 and 1976 and 14 per cent in Devon from 1967 to 1975. In Norfolk, a recent search through the FPC files revealed that a total of 189 surgeries of all types had closed between 1966 and 1984; this figure included 55 branch surgeries. Out of this total, 41 (22 per cent) had

closed without being replaced by another surgery (Norfolk FPC 1984a).

Fearn *et al* (1984), in a study of branch surgeries in rural Norfolk, argued that while many had poor facilities and primitive conditions, they were providing patients with a valuable service. While their chief benefit was undoubtedly their accessibility, 84 per cent of patients who attended them did not need to be referred to a main surgery. Branch surgeries, Fearn claimed, were largely used by disadvantaged sections of the community: the elderly, manual workers and their families, and those without cars – people too young, or too old and infirm to drive, or those whose financial or family circumstances prevented them from using private transport. These people are already socially vulnerable, and are likely to have a greater than average need for health care. Fearn's study did not discriminate, however, between branch surgeries and 'outlying consultation facilities' (OCFs). Branch surgeries are subject to FPC jurisdiction, while OCFs (which may only consist of a room in a private house) are not (DHSS 1981e, paragraphs 51.4, 51.10, and 51.11).

At a conference concerned with access to health care in Oxfordshire villages, Dr Muir Gray of the Oxfordshire DHA stressed that rural health services should not be developed in isolation; there must be joint planning. There was a distinct possibility, he feared, that those people not able to contact services directly would fall through the net. He went on to cite the particular example of those who, because of speech or hearing impediments, might have difficulty using a telephone (Price 1984). Some local authorities are now cutting back in their provision of telephones to the disabled and elderly, in spite of the Chronically Sick and Disabled Persons Act 1970. Many low income families cannot afford their own telephones. And in Oxfordshire, according to a CHC representative speaking at the same conference, 27 per cent of people in the county had no car: 'this represents 21,000 families' (Price 1984). While FPCs cannot themselves organise transport, they can and should make themselves aware of rural needs; consult their rural consumers, and recognise the importance of communications in rural areas.

Rural pharmacies

As mentioned earlier, the closure – or non-existence – of pharmacies in rural areas has been a subject of concern for a number of years. ACHCEW, in its evidence to the Royal Commission on the NHS (*The FPS*, 5, no 5, 1978), indicated disquiet about the pressure exercised on small pharmacies by supermarkets, health centres and group practices. In a National Federation of Women's Institutes (NFWI) survey conducted in 1977, only 25 per cent of the sample

of settlements surveyed had a chemist (quoted in Woollett 1981). Woollett went on to speculate that a population of 7,000 to 8,000 people was necessary in order to support a pharmacy. Since the 1970s, the DHSS has operated the Essential Small Pharmacy Scheme, whereby pharmacies providing an essential service in either rural or urban areas are given financial support because their income from NHS prescriptions is small. In order to qualify, such pharmacies must handle more than 6,000 and less than 24,000 NHS prescriptions a year, and they should be situated at least 2 kilometres from any other pharmacy. In 1983, 404 pharmacies received a total of £375,000 under this scheme (*Rural Viewpoint* 8/9, October 1984).* The whole system of the location of pharmacies has recently come under review, with the attempted introduction of a new contract (see pages 101–103).

Farrow was convinced that rural patients preferred doctors to dispense for them: 'Once they've experienced dispensing by doctors, they want to continue it. There is a psychological advantage in the doctor's handing over drugs he has prescribed' (BMJ 1985f). But as several of the FPC administrators we interviewed pointed out, chemists can provide a source of informal advice that may obviate the need for a visit to a doctor or hospital. In addition, pharmacists are able to buy in a far wider range of products, including drugs, than a doctor can.

Rural dispensing

The question of who should dispense drugs in rural areas has been a constant source of friction between doctors and pharmacists. As David Clark of the NCVO puts it: 'Should it be the chemist working from a village pharmacy where he or she can provide further advice, and can act as a frontline adviser in preventative medicine? Or should it be the doctor who may have the ability to deliver prescriptions from branch surgeries or on visits to remote homes?' (*Rural Viewpoint*, 8/9, October 1984). According to one pharmacist and FPC member, this was a dispute which had been 'festering' ever since the National Insurance Act of 1911 (James 1984). Certainly, one FPC administrator told us that in his rural area '... doctors and pharmacists were at each other's throats'.†

When the NHS started in 1948, it was intended that pharmacists, with their specialised training, should dispense drugs. According to the General Medical and Pharmaceutical Services Regulations 1974,

* *Rural Viewpoint* is published by the NCVO, 26 Bedford Square, London, WC1B 3HU.
† Interview.

doctors were only allowed to dispense for patients when the patient lived in a rural area more than one mile from a pharmacy as the crow flies, or when a patient would have serious difficulty in obtaining any drugs or appliances from a chemist. This was at the discretion of the FPC. However, it was acknowledged that when changes occurred – pharmacies opening or closing, or a practice starting or stopping dispensing services – patients could frequently suffer in consequence.

For both professions, dispensing income was the significant factor. Rural pharmacies could become uneconomic, or rural practices might be threatened if permission to dispense was to be withdrawn. As Farrow succinctly remarked, the limited rural dispensing cake had to be fairly distributed (BMJ 1985f). In 1975, the two professions set up a joint committee. After a considerable period when neither profession would accept the other's proposals, the committee finally reported in 1977 (DHSS 1977a).

Its main recommendation was that 'significant changes' in rural dispensing arrangements should be regulated by an independent statutory body consisting of three doctors, three pharmacists, three lay members and a lay chairman, all appointed by the Secretary of State. In 1980, the government announced that it was prepared to enact these recommendations but it was 1983 before the DHSS and the professions could agree on the necessary statutory framework. Between 1975 and 1983, there had been a 'rural dispensing standstill' with no changes allowed, and, according to James, considerable confusion all round, particularly in FPCs (James 1984). The Health Minister eventually announced the establishment of the Rural Dispensing Committee (RDC) in 1983. It was agreed, in addition, that both professions should set up a voluntary fund based on contributions from their local LMCs and LPCs, to compensate doctors or pharmacists adversely affected by RDC decisions.

The RDC, chaired by Sir Alan Marre, produced its first annual report in September 1984 (DHSS 1984f). The highly complex new regulations, it declared, ran to 17 printed A5 pages and needed to be read in conjunction with the NHS (General Medical and Pharmaceutical Services) Regulations 1974 as amended – which they in turn amend still further. Evidently anticipating some confusion, both the DHSS and the Welsh Office issued a 20-page memorandum of guidance, while the RDC itself produced a still briefer, simpler guide which was issued as an appendix to its report.

Briefly, the new arrangements apply in what is called a controlled area – an area which is 'rural in character'. This designation is decided by the relevant FPC but, as the report points out, there are no guidelines on this; each FPC adopts its own approach. Although the

RDC does not rule out the possibility of producing guidelines in the future, it is still too early, it claims, to detect any pattern of underlying principles which it might recommend to FPCs. While recognising that judgments will need to depend on local knowledge, nevertheless the committee expects the FPCs to take into consideration such factors as 'the size of the community, distance between settlements and overall population density, as well as spread and frequency of public transport in the area'. The committee recognised that rural areas were frequently characterised by a 'relatively limited range of local services'. It did not, however, consider that a rural area was necessarily one with high employment in agriculture; many residents might be commuters to jobs in towns. The committee also stressed that assessments of rurality should be made according to the actual circumstances of the day, and not be dependent on possible future development.

The RDC is, therefore, '... the body of first instance for deciding an application from doctors or pharmacists to dispense prescribed medicines in rural areas' and '... the appellate body in relation to FPC decisions on whether particular areas are or are not rural in character' (DHSS 1984f). The RDC must also judge whether any change would 'prejudice the proper provision' of existing services.

In its first year of operation, the committee received 20 applications from pharmacists and 54 from general medical practices. The RDC also considered three cases where the opening or relocation of a pharmacy within an urban area affected dispensing patients within one mile of the prospective pharmacy. During the same period, 21 FPCs notified the RDC of 37 decisions on rurality, some of which were subsequently contested.

The FPC dispensing sub-committee

Decisions as to whether an area is a 'controlled locality' (a designation, incidentally, which is only applicable in the context of NHS dispensing) are made by an FPC sub-committee set up for the purpose: the dispensing sub-committee (DSC). The DSC has 10 members: three appointed by the LPC, three by the LMC, and three lay FPC members who must be neither doctors nor pharmacists, nor relatives or employees of doctors or pharmacists – plus a lay chairman. The DSC has unconditional delegated powers to deal with dispensing matters.

When an FPC notifies the RDC, its local professional committees, individual contractors and others of an application, a period of 30 days is allowed for comments to be submitted to the FPC, for sub-

sequent transmission to the RDC. When considering applications to dispense within designated 'controlled localities', the DSC is expected to take into consideration the views of the local professions affected, and also to gauge the opinions of such community representatives as parish councils, RCCs, WIs and CHCs. This evidence will then be passed on, together with the FPC's own views, to the RDC, which makes the final decision.

In January 1984, 29 of the county FPCs in England replied to an NCVO questionnaire about the implementation of the new regulations. Twenty-eight had already established a DSC, but out of these, only eight had decided to conduct a county-wide review in order to define their rural areas. In 20 counties, the DSC was using the designation 'rural' which had been adopted by the pre-1974 health authorities, ignoring any changes that had taken place over the last decade. Very few FPCs had chosen to consult outside bodies such as RCCs (NCVO 1984).

The DSC's decision on rurality is final, unless either the LPC or the LMC wishes to appeal – again within 30 days – to the RDC. The RDC may decide to visit the area in question and hold a local hearing. However, once the RDC has decided such an appeal, the question of rurality cannot be reconsidered for five years – a provision which, according to one FPC administrator, is the only good thing about this highly complex new legislation.*

The North Yorkshire FPC records (1984) that these new regulations had '... generated a considerable additional administrative and secretarial workload in the processing of applications... The Dispensing Sub-committee has needed to meet very frequently. ...' Norfolk FPC (1984) also refers to the 'long deliberations' about proposals for change in dispensing arrangements, where the DSC had to attempt to reconcile the frequent conflict of opinions between the medical and pharmaceutical professions and face the 'common accusations' by the public that change was being thrust upon them without their consent. This FPC has now adopted a policy of holding public meetings to explain the reasons for impending change.

Dispensing patients

Patients may apply to their local FPC to become 'dispensing patients' – that is, to have their medicines dispensed by a doctor – under either the 'serious difficulty provision' or the 'one-mile rule', described above. To apply, each member of a family over the age of 16 will have to fill in the appropriate form. Dorset FPC attempted to simplify

* Interview.

this procedure by ruling that only the head of the household need sign, but they were promptly taken to the Ombudsman by the pharmaceutical profession, who won their case.*

It was 'a disturbing revelation' to Dr Farrow of the RDC to discover the inadequacy of some FPCs' records on rural dispensing. Many, apparently, had no dispensing lists, and it had been a 'major administrative exercise' for them to bring their lists of dispensing patients up to date (BMJ 1985f). Some FPCs now list the numbers of their dispensing patients in their reports. Avon records approximately 46,000 or 4.9 per cent of its population (Avon FPC 1984); Nottingham had 53,879 in 1984 (Nottingham FPC 1984). Cheshire, in reply to a request on our questionnaire for innovations or good practices, felt it worth noting that it kept a register of dispensing patients.

'Odd souls' and the neighbourhood net

The independence and self-reliance of country people is a recurrent theme in the literature of rural life (see Exeter CHC 1983). Doctors in Horobin and McIntosh's sample of rural GPs confided that they were 'less troubled by trivia' than in their previous experience of urban practice, and explained this as being due to a more stoical and considerate attitude on the part of rural patients (Horobin and McIntosh 1977). The statement is possibly more revealing of doctors' attitudes than of anything else. From the patient's viewpoint, such apparent stoicism could well be an expression of low expectations in the face of inadequate provision.

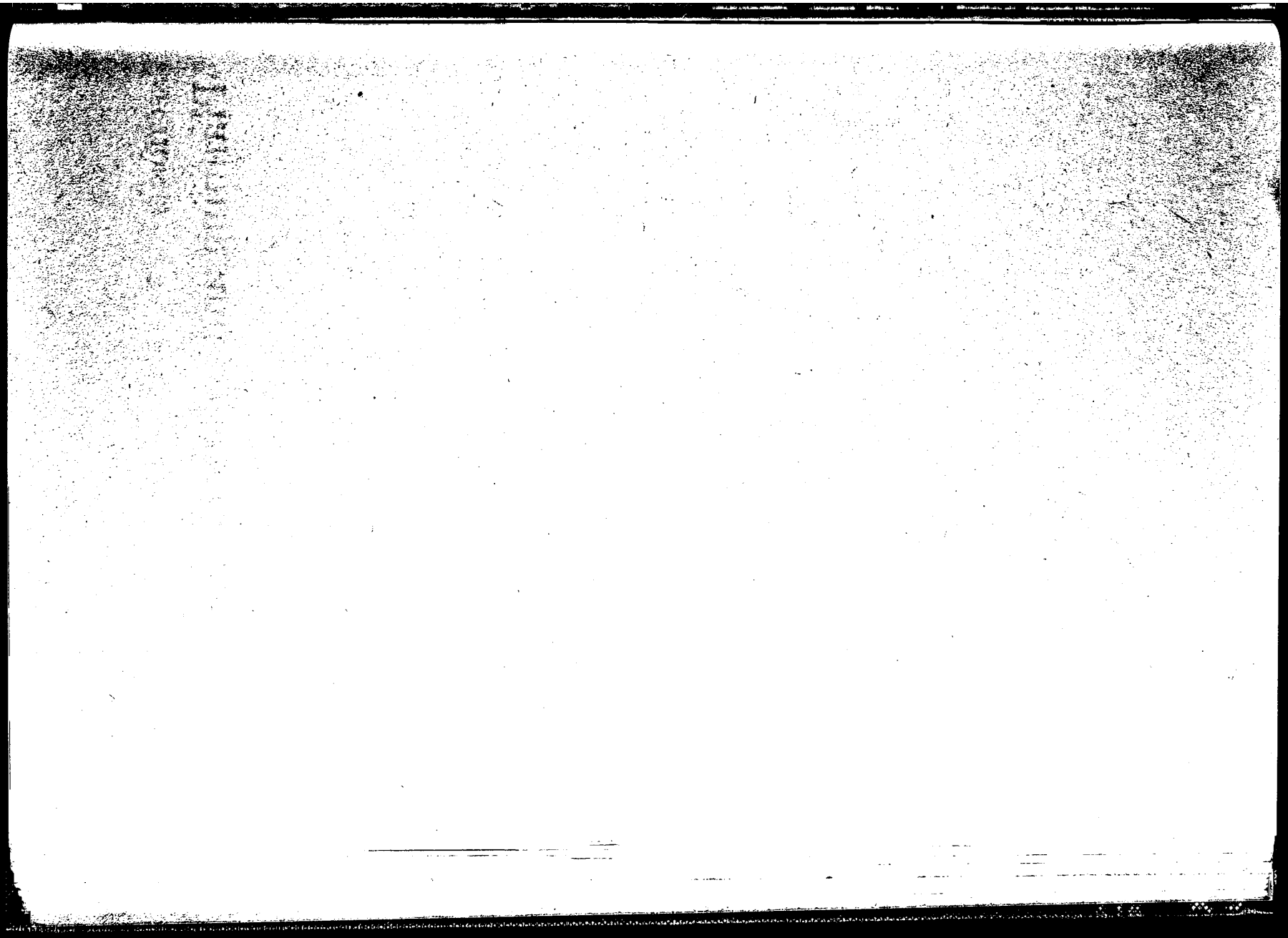
The Exeter report (1983, pages 10–11) found that the parish councils and parish clerks who responded to the CHC questionnaire about rural health problems were often defensive in their self-sufficiency. 'We do not have problems in our village ...', and 'we're all right, thank you' were frequent responses. But in their analysis of this attitude (which the researchers soon christened the 'not-here syndrome') the report questions whether such isolationism, and the persistent determination to 'make the best of things' can be taken to extremes and eventually lead to apathy. Did the net of neighbourliness indeed reach out to everybody, they wondered, or were there some hidden 'odd souls' whose attitudes and ailments might not commend them to the sympathy of their neighbours? Exeter CHC felt sure that there *were* such people in rural communities, and feared that they might be suffering unnecessarily, because of the lack of either state or voluntary support.

* Interview.

In a study of several community self-help schemes, Abrams argues that the 'neighbouring' relationship is the weak link in any chain of social care: '... its prominence in some epochs and communities reflects the lack of alternative sources of care rather than its own intrinsic strength ... even within the informal sector, the neighbour relationship has feet of clay; pitted against the formal sector, it is a broken reed' (Abrams 1984, pages 413–414). FPCs in rural areas will need to be more active in seeking out their own 'odd souls', and more creative in providing for their health needs.

SECTION III

Planning and collaboration



7
Family Practitioner Committees and district health authorities: sharing services, joint provision and planning

The importance of collaboration between the separate arms of the health service and the authorities providing welfare services has been a persistent theme of DHSS reports, circulars and White Papers. The 1984 Health and Social Security Act aimed to provide:

> ... arrangements for the efficient administration of family practitioner services which [were] most likely to promote collaboration between those services, the primary and secondary health care services to be administered by the new district health authorities and the local authority services.*

Collaboration, or as we have defined it here, working together, is perceived as the means for promoting a high degree of integration, at a planning, operational and service delivery level, between a range of interdependent but separately administered services; services whose pattern of provision is shaped by their administrative structures and the skills of providers rather than by the needs of clients. There may be gaps in provision, as well as wasteful overlap. But the creativity and imagination needed to achieve collaboration should not be under-estimated. And there are powerful systemic pressures which militate against working together. To use an analogy from physics these could be compared with centrifugal forces. Those directing agencies which provide health and welfare services have their own specific goals and priorities. These goals mirror professional and managerial values, and they may create conflict both within and between organisations. Organisational structures, budgetary constraints and the time-scales for decision-making all affect organisational behaviour, and may be a source of misunderstanding between agencies. They may render the cost of collaboration too high. These factors can often make it easier to ignore the wider objective: meeting the needs of patients, clients and populations.

Conversely there are centripetal forces which increase the pressure to collaborate. These come from central government which, through a deluge of reports and circulars, continues to urge organisations to work together in the interests of efficiency and effectiveness. As the infinite nature of demand has been recognised, and as measures to

* Extract from a letter from then Minister of Health, Dr Gerard Vaughan, to the secretary of the Society of FPCs, Mr John Knighton, 17 November 1981 (quoted in Williams 1985).

restrict the growth of public expenditure have taken effect, so the necessity of choosing between competing demands and obtaining value for money has been emphasised. Effective services are perceived as those which fulfill the requirements of service users and which are sensitive and appropriate to the local context. While governments have stressed collaboration at the local level, where the decisions are taken, their exhortations have frequently gone unheeded. Organisational studies suggest that where organisations have similar perceptions of goals and priorities and access to similar information, this increases the possibility of exchange; and interagency collaboration can occur (see Ham and Hill 1984).

The DHSS and collaboration

The raison d'être of the 1974 reorganisation of the NHS in England and Wales was to secure a greater integration of hospital and community services under the umbrella of the Area Health Authorities (AHAs). Joint Consultative Committees (JCCs) were established as a mechanism for encouraging planning and collaboration between health and social services. An elaborate planning system was developed to ensure integrated forward planning of primary, secondary and tertiary care. The AHA control of the administrative element of FPCs was intended to ensure that this aspect of primary care was included in the planning process. However, as Purser has commented: '... this was sound in theory, but seldom took place in practice: there was little really effective working together' (Purser 1984).

The theme was reiterated in the 1982 NHS reorganisation. In *Patients First* (DHSS 1979a), it was argued that smaller, more locally based district health authorities (DHAs) would encourage greater collaboration. *Care in Action* (DHSS 1981b), the Conservative government's policy statement, underlined the importance of the coordinated development of community services for elderly, mentally ill and physically or mentally handicapped people. Although there were no target resource allocation figures as in the earlier priorities document (DHSS 1976), it stressed the importance of a resource shift from acute to community care. The introduction of an annual review process for both regions and districts, was intended to encourage progress.

> During 1980 and 1981 there grew a firm conviction that autonomous FPCs stood a better chance of achieving collaboration ... without any fears of being threatened and neither side smarting from the apparent indifference of the other; with insufficient re-

sources or inadequate standard of service being blamed on the other (Purser 1984).

A DHSS spokesperson put it more succinctly: '... quite a lot of divorced people get on better than when they were married' (Halpern 1984). Meanwhile a joint working group on collaboration was set up to explore two issues: the contribution which FPCs should make to health services planning; and the scope for information exchange between DHAs and FPCs.

The joint working group reported in 1984, and put forward four 'precepts' for collaboration:

1) A mutual understanding and respect for each other's roles and responsibilities.
2) An identification of areas of common interest and concern and the establishment and pursuit of common goals, policies and programmes.
3) Agreements concerned with sharing information.
4) The creation of formal arrangements and informal links to secure cooperation between the organisations by the simplest means and at the level appropriate to the functions concerned (DHSS 1984e).

Since the report, not only have FPCs been given a statutory duty to collaborate but formal mechanisms have been introduced, such as FPC membership of JCCs. The joint working group recommended that there should be regular contact between the DHA and FPC chairmen and officer membership of joint planning teams. Further guidance is given on collaboration and planning in the DHSS circular on management arrangements for FPCs (DHSS 1985c).

Our purpose here is to focus on collaboration between FPCs and DHAs, as this, together with the FPC/family practitioner relationship, is the most crucial area for future planning and service development. We recognise this is only part of a wider network which would include the local authority social service, planning and housing departments; as well as CHCs and voluntary organisations. Some of the networks of communication have been discussed in previous chapters. In this, and in the following chapter we concentrate on discussing zones and purposes of collaboration between DHAs an FPCs. We examine the way they may share each other's administrative services, provide services jointly for particular groups, plan service development and cooperate in the area of preventive health care. We shall discuss these issues largely from the FPC perspective.

Collaboration is a difficult topic either to chart conceptually or to inquire into systematically. FPCs and DHAs not only work together

for particular purposes, but they may use a variety of mechanisms, involving sets of participants who are drawn from different levels within the organisations and from different disciplines. The flow of communication involved may be uni- or multi-directional and it can occur with varying strength and frequency. Collaborative structures evolve as organisational structures change. The implementation of the Griffiths enquiry recommendations, for example, has changed the way in which some DHAs have organised their community services. We could not attempt to cover all these aspects of collaboration.

In our discussion we draw on our data from interviews in DHAs and FPCs and on the responses to a questionnaire which was sent to all FPCs asking for examples of good practices (see Appendix IV). This data was collected in the early part of 1985, before the change in FPC status. We have used the material to illustrate ways of working together within the various zones of activity – we found that most FPCs and DHAs were working together in one way or another. Over half of the FPCs who replied to our questionnaire (55 per cent) mentioned as an example of good practice some mechanism for collaboration with the DHA. This was also the case in all the FPCs where we carried out interviews. However, four out of the eight community unit administrators we interviewed commented that they had great difficulties in establishing purposive links with their FPC, and in some cases they had abandoned the attempt. As we have already indicated, it was not possible to draw any firm conclusions from our data about structures. The arrangements which exist are too various. Patterns of collaboration are local and idiosyncratic; and they are influenced by the history of past relationships, and by personalities. Williams (1985), in a study of collaboration in ten FPCs undertaken for the DHSS, came to similar conclusions.

Our discussion of planning in the last section of this chapter is organised rather differently. We present 'snapshots' of three types of approach to planning, based on interview data. At the time our interviews were conducted FPCs were not obliged to plan their service development, and some did not. It is not possible to generalise from our findings; the numbers were too small.

Sharing services

Sharing services can be of great importance in building relationships between organisations. It can provide a reason for discussing issues and a basis for reciprocity and exchange. Until April 1985, DHAs were responsible for the administrative aspect of FPCs so some degree of service sharing should have been normal practice. However

some FPC administrators expressed the view that cooperation was inhibited rather than encouraged by this arrangement; in many cases DHAs were uninterested in FPCs, and failed to understand their functions. This may have been due to the fact that on the whole the flow of services, including information, has been from DHAs to FPCs rather than in the other direction. This will be a development area for the future as the application of computer technology will make it easier for FPCs to process the data they already hold: data which could be of value to DHAs. We discuss this issue in more detail in the following chapter. Here we describe the services which our interview and questionnaire data suggest are currently being shared. We give some examples; but we have no way of knowing how widespread such practices are.

In general, DHAs control and manage a much greater span of services than FPCs. They employ more people, including a range of specialists with whom they have a direct managerial relationship. DHAs have larger budgets and a greater flexibility in managing them than any FPC. Most DHAs have provided managerial support services such as O and M and personnel advice for FPCs. Other districts have extended access to certain specialist facilities. Victoria (now Riverside) health district works department, for example, provided advice on practice premises and had a telephone advisory service for GPs.

DHAs may provide a range of information services to contractors through the FPC; for GPs in particular. They can supply up-to-date lists of consultants, together with details about outpatient and specialist clinics. DHAs can also circulate information about the waiting times for particular specialties, for both inpatient care and outpatient appointments. This is a basic service, but in some areas we were told that the information system was 'quite appalling' and not kept up-to-date at all.* It is particularly important that GPs and other health workers understand the organisation of community services. In one area, for example, a primary care development worker is putting together a guide to the community child health services, and providing information on DHA community services for GPs new to the area.

Open access to hospital diagnostic facilities is equally important, as a GP can then refer a patient straight to an x-ray or pathology department. The FPC can play a part in negotiating such access. Data on how individual GPs use these facilities, and on their referral patterns in general, is valuable to both the DHAs and FPCs as a monitoring tool for service managers. The extent to which DHAs

* Interview.

and FPCs exchange this information is not known.

DHAs can also support practitioners by providing them, through the FPC, with items in constant use, thus achieving savings through bulk buying. Doctors use quantities of clinical consumables such as hypodermic syringes, and this can cause problems of disposal. South Glamorgan FPC has drawn up a list of 90 to 95 common items, and the community health unit has agreed to supply them free to GPs.

The London Health Planning Consortium (1981, recommendation 30) recommends that inner London DHAs should assist GPs in purchasing furniture and equipment at cost through their own supplies departments. In Hackney, a working group has been set up to rationalise the purchase and use of diagnostic equipment by all community health staff. The group suggested that every practice in Hackney should be given an order book, together with a code through which to order. This is a cheaper source of supply than commercial channels, and it includes a delivery service. Community nursing staff benefit from the use of standardised equipment, rather than having to cope with a wide variety bought by GPs from different sources.

Some DHAs provide a specimen collection service for GPs, in order to speed the processing of diagnostic tests. Others run a clinical waste disposal service. The efficient delivery of internal mail is also seen as important in many areas, particularly those with high patient mobility. From their relatively isolated position in the field, GPs can be incorporated into the health system via a mail service which rapidly transfers patient records and hospital letters. The new electronic mailbox technology could also link GPs into health authority communications systems.

In summary, there are a large number of services which the DHAs can, and in some areas do, provide. Some districts see this provision as part of the process of building up goodwill with their practitioners. LMCs can have traditional and somewhat defensive attitudes, and they may mistrust these approaches. Perhaps they fear a loss of independence if the relationship with the health authority becomes too close. In one case, we were told ruefully, when the DHA offered a service, the LMC in question 'behaved like an ungrateful bunch of louts!'* Management and decision-making structures are fundamental to success.

Where attempts to share services are rebuffed or ignored by either the FPC or the LMC, community unit officers may attempt to work directly with GPs. DHAs have helped GPs to equip rooms for nurses at practice premises, for example, have paid for domestic staff, or have offered to bear the costs of telephones. One authority provided a programme for a microcomputer in a GP's surgery from the com-

* Interview.

munity unit budget. DHAs have also provided age-sex registers where FPCs have not developed a policy of assisting GPs in this way.

Nursing services in the community

One of the most important areas in which the FPC and the DHA need to work together is in developing policies for the deployment of nursing staff in the community. Such policies will need to be acceptable to GPs. Since the policy shift towards care in the community, GPs' ability to care for more dependent people on their practice lists will depend upon the way in which they can work with, and use, the skills of nurses, health visitors, and district and specialist nurses who are employed by the DHA. Such staff have an independent role, but they may be 'attached' to a GP practice. GPs may also have their own practice nurses. Ideally all these staff should work together as a team; possibly with the addition of social workers and counsellors.

The Harding report on the primary health care team (DHSS 1981f) discussed the question of the relationship of nursing staff in the community to GPs and their methods of working together; as did the London Health Planning Consortium (1981). Both reports gave strong support to the concept of primary health care teams: that is, groups of health workers – GPs, nursing and other staff – working together to provide integrated and coordinated care.

The DHSS annual report for 1984 gives government backing for this policy: '... to exploit fully the scope for managing more illness in the community than hitherto' (DHSS 1985a, page 17). It claims that 80 per cent of health visitors and district nurses are now working in close cooperation with family doctors; and that their numbers are increasing. Collaboration is extending to other health workers such as midwives, school nurses and community psychiatric nurses. There is also a treatment, support and a health prevention and promotion aspect to this work. However, the report's sanguine comments on the benefits of team working ignore some very real organisational difficulties and challenges.

The two reports quoted above (Harding and LHPC) both draw attention to the particular problems in inner London where, because of the large number of small practices and overlapping practice areas, it has been more difficult to attach nurses to GP practices. This may also be true of other inner cities. A nurse attached to one GP with a scattered, often rapidly changing patient list, has been seen by those making resource allocation decisions as an inefficient use of scarce nursing manpower. Too much time is spent in travelling; and there is a lack of identification with one particular community, its culture

and problems. In many city areas there has been a preference for 'patch' working; that is, nurses are attached to a number of practices with a fixed geographical area. They do not necessarily provide care for patients in those practices who live outside their 'patch'.

From a GP's point of view he or she will wish to have nursing care for practice patients, and the more closely a nurse is attached to, and identified with, the practice the more control the GP is likely to have. On the other hand, the managers of nursing services in the community must aim to use nurses' time in the most efficient way and also to provide nursing care for those who have been identified as having priority within the district. Thus there is a conflict of interest: GPs are likely to favour practice attachment; while nurse managers will prefer geographical patch working. At field level, district nurses may have conflicting obligations: to the district nursing service, which employs and organises them, to the GPs with whom they work, and to the patients whom they serve. Health visitors and other specialist nursing staff tend to work more autonomously. In the case of the former, they have a statutory role to fulfill. It is frequently suggested that the role of the health visitor is not understood by GPs.

In all the areas which we visited it was recognised that the GP/nurse relationship was an important issue for both the DHA and the FPC. One administrator articulated the problems. This issue, he said, was extremely frustrating: '... the doctors are not happy with the way the so-called primary health care teams are working. The district nursing service has different objectives and interests to the GPs, and we do not have a forum in which these problems can be discussed'.* No area had a policy which had been fully developed and implemented, although some solutions were being discussed. Here the mechanisms for an exchange of views and information were important. In Nottingham, for example, the issue had been considered by the Unit Management Team (UMT) and the FPC. A policy of 'loose' zoning arrangements was adopted. The level of district nurses was set for particular areas on a population ratio, weighted for social deprivation. Nurses were then attached to practices in order to cover patients within a specific area. The GP member of the city UMT is also a member of the county-wide FPC and of the LMC. He undertook to explain the policy in those arenas.

Calderdale FPC approached the issue in another way.† The LMC, the FPC and nursing management have agreed on the policy of encouraging GPs only to accept patients within certain geographical areas. This means zoning their lists. The success of such an approach

* Interview.
† Questionnaire.

will be dependent on goodwill and good relationships, as there are no statutory powers to enforce such proposals.

Two other more sophisticated ways have been developed to determine nurse attachment. One rests on locality planning. This is discussed in greater detail below. Briefly, the health district is divided into areas which are then evaluated on the basis of a range of social indicators: nurses can then be concentrated in areas of high social deprivation. An alternative approach is to collect information on the basis of GP practice lists.

In Hackney, for example, the strategy planning group for primary care (see page 78), has initiated such an approach. Information has been collected on workload, so that nurses could be attached on this criterion rather than by a simple population ratio. This policy was supported by the GPs, and there has been a phased programme of looking at existing nurse workloads on a practice-by-practice basis. It was possible to get an accurate idea of the average daily workload, and of tasks which could be delegated to auxiliary nurses. The practices are then grouped, and nurses matched to practices on the basis of personality, degree of mobility and skills. The plan is to encourage the GPs to employ practice nurses directly with 70 per cent reimbursement. The remaining 30 per cent of the nurses' salary would be met by the district, and part of the nurses' time would be used to develop preventive health programmes organised by the district.

Here, the answer is seen to lie in the direct employment of practice nurses. On the basis of this, one district is aiming to negotiate contracts individually with GPs on the basis of duties to be carried out and the work to be done in the practice. This type of solution, which can tailor nurses' workload to GPs, will need considerable investment of management time.*

In 1985 the DHSS set up a review team, chaired by Mrs Julia Cumberlege, to advise on ways in which the community nursing services could be improved to meet the needs of different groups of patients within the community. Announcing the appointment, the then Minister of Health, Kenneth Clarke, declared: 'We are concerned about the extent to which different services may overlap, whether there are gaps, whether the training provided is well matched to the tasks community nursing staff now face, and whether the services are cost effective' (*NAHA News*, June 1985†). The Cumberlege recommendations will have considerable significance for FPCs and the organisation of nursing services.††

* Interview.

† *NAHA News* is published by the National Association of Health Authorities, Garth House, 47 Edgbaston Park Road, Birmingham B15 2RS.

†† Neighbourhood Nursing – a focus for care (1986) DHSS, London, HMSO.

FPCs not only have a role to play in helping to represent the GP's views in discussions with DHAs – but also in attempting to establish policies which are appropriate to their particular communities. This may also mean that they will have to act more politically, as active champions of primary care. The administrator of Greenwich and Bexley FPC for example, sees nursing services as the most important issue which he will have to confront in the near future. In his area, the ratio of health visitors to population is half the regional norm. He hopes that the FPC will act as a pressure group for improving the situation.*

Homeless people

In many cases FPCs and DHAs have worked together to provide special facilities for people whose access to primary care through the normal channels may be difficult. This can be because they are mobile and stay only a short time at any one address, or because they have no fixed address at all. Others may be unaware of the services that are available. They may include homeless and rootless people, single mothers with young children who have sought refuge in hostels for battered wives, or people staying in hostel accommodation. Some, because of language or cultural norms and values, will not find their way to facilities unaided, yet their need for primary care is often high.

A number of FPCs have made special arrangements for homeless people. People with no fixed address are not entitled to general medical services except in an emergency. Emergency services can be provided in a situation of acute illness or accident, but there may be difficulty in contacting a GP and there can be no continuity of care nor reference to medical records. The number of homeless people living in any one FPC area will vary, with a concentration much more likely in inner cities. Failure to reach this population at primary care level can lead to more serious and acute illness. Treating acute illness episodically may well be expensive, and useless.

FPCs have approached the problem in a variety of ways. In Norwich there is a night shelter which can accommodate about fifty people. Due to the growing reluctance of GPs to accept its inmates as patients, the FPC has set up a rota scheme and arranges the transfer of medical records. Doctors from six or seven practices take it in turns to treat the occupants of the shelter. Nottingham FPC tackled the situation differently. They arranged for GPs to visit a 'down-and-out' centre

* Interview.

regularly and paid them on an emergency fee basis; the cost amounted to about £3,000 a year. However, the district auditor ruled that this was outside the discretion of the FPC and another scheme had to be devised. Clinical assistantship posts were established in collaboration with the DHA, who provided the finance to pay the GPs. This, too, meant bending the existing rules.

Manchester FPC recognises that the single homeless are a major problem. The city is the regional capital, and it is on what the administrator referred to as 'the Glasgow to London vagrancy route'. Here the question has been tackled in a systematic way, providing an example of the entrepreneurship necessary to develop a service. The initiative started with a joint FPC/AHA decision to employ a salaried GP on the staff of the then area medical officer, to treat people in selected hostels. On the basis of this experience, it became clear that the issue needed to be tackled on a broader front. It was necessary to identify the size of the problem, and to research the medical and health care needs of the single homeless. Extra funding was needed. Under the aegis of a joint steering group involving the FPC and two health districts, three years' funding was made available from inner city partnership funds.

A project was set up, involving a number of agencies, which pooled their thoughts and ideas. The local authority was particularly important because it could offer the single homeless an avenue to permanent housing. The department of epidemiology at Manchester University provided expert advice. A variety of voluntary organisations were brought into the discussions. It was agreed to include the health needs of travelling families and of battered wives. A health promotion team, GPs and nursing staff, worked to identify the needs in specific sites, and subsequently assessed and treated the patients. The aim was to register each patient with a GP, and to find them housing. This type of innovative scheme needs to be evaluated.

In Tyneside, a similar project involved voluntary organisations and the local authority. Again, the aim was to try to provide homeless people with an entry to existing services. The project coordinator, funded by the local authority, defined and investigated the problem and referred individuals to appropriate sources of help. GPs carry out clinics on a sessional basis, with part-time nursing support provided by the community unit. The FPC provided information about registration, and subsequently about 28 practices agreed to register patients from this centre.

The numbers of homeless people and of people living in temporary accommodation are probably greater in London than elsewhere. The Campaign for the Homeless and Rootless (CHAR) stated in its

evidence to the DoE in 1984 that 14,000 single people in London were staying temporarily in hostels, night shelters and DHSS settlement units (Victoria CHC 1984). Many more were housed in bed and breakfast hotels, were squatting, staying with friends and relatives or sleeping in the streets. The number of hostel places in central London has been decreasing; the GLC/London Boroughs Association report on hostels for the homeless predicted a further loss of 3,750 beds in the next five years (quoted in Victoria CHC 1984).

In central London, a number of imaginative projects have effectively circumvented the normal channels. One example is the Great Chapel Street clinic in Soho, which was developed jointly by the FPC, CHAR and the then AHA (see El Kabir 1982). This was originally funded by the DHSS, after premises had been found and costed by a planning group. A salaried doctor was recruited, plus a clinical assistant. Subsequently, the district and the FPC took over and the clinic became a branch surgery. The doctor was paid fees; a nurse was attached, and the equipment provided by the district. The centre is a walk-in facility, open all day. The doctor does a clinic session every afternoon from 14.00 to 16.00. There is chiropody and family planning; a community psychiatric nurse is attached and a psychiatric registrar attends once a week. The original intention was to provide a facility for under-25-year-olds, but it has now been extended to all homeless people. If patients have an address for more than three months, they are registered.

A number of satellite surgeries have also been established. Most of these have been set up in day centres, where nurses are in attendance during the day and a doctor is available once a week for a surgery. The day centre premises are provided by a variety of charitable trusts. The FPC recruits doctors 'by persuasion'; they are paid emergency fees. A research study to assess the needs of the homeless in the area has now been completed. There is a plan to set up another centre similar to Great Chapel Street, although this will depend on the availability of resources.

Looking at the schemes outlined above, it is clear that considerable effort is involved in getting such projects to work, and that they work best where there are shared goals and objectives. These may emerge because the structures for collaboration are already in existence, or may be formed in response to one agency's perceptions and initiative. However, there are undoubtedly situations where neither the DHA, the FPC nor the LMC see any advantage in working together. We found one such example in an inner London borough with a high level of non-registration, and where there are a large number of homeless families living in bed and breakfast accommodation. The

death of a single-handed GP created a vacancy, but once more there was a conflict of interest. Two single-handed practitioners already in the area covered the homeless population, although they did not provide a comprehensive service but treated emergencies and collected item of service payments on a temporary residence basis. The DHA and the FPC could not agree on a strategy. The DHA wished to bring in a doctor with special responsibility for the homeless. The FPC did not want to advertise the post on these terms. A DHA paper, explaining the issues, generated an acrimonious debate in the public part of an FPC meeting. Eventually, another local GP was appointed to practise from a mobile clinic and provide an immunisation and family planning service.* This example illustrates some of the constraints on the planning powers of an FPC.

FPCs and planning

> FPCs have always planned the family practitioner element of primary care services.
>
> FPCs cannot plan; they have no executive power over contractors and no control over budgets. They can only react to requests made by family practitioners.

These comments, from the same conference, reveal the wide range of perceptions about the task of FPCs and about what is understood by planning. Over the last decade, the DHSS approach to NHS planning has been both mechanistic and hierarchical (Haywood and Alaszewski 1980). Attitudes to planning have been 'top-down', with central government laying out strict timetables and procedures. Recently, guidelines have become more flexible, but there is still considerable debate about concepts and processes.

The planning system, as it developed after the 1974 reorganisation of the NHS, was designed to provide a stable framework for shifting the allocation of resources from richer to poorer regions and from acute to community care. The assumptions were that planning could bring about the conditions of its own success and that it was a key instrument in the internal management of the health authorities. It rested on the twin concepts of guidelines and plans. Guidelines on resources, policies and priorities would flow down from the DHSS to regions, from regions to areas, and then from areas to districts. Plans would flow up from below; and the cycle would be repeated. A rational consensus over goals was assumed to exist. The planning

* Interview.

system had been conceived in a period of optimism about increasing public expenditure. However, the low levels of economic growth brought increasing uncertainty, and in the absence of linkages between planning and resource availability the system could not deliver.

It also proved to be rigid and inappropriate, failing to bring about the kinds of changes envisaged by its architects. Following the well-orchestrated criticism of the Royal Commission on the NHS, a simpler planning system was outlined in the DHSS guidelines which followed the 1982 reorganisation (DHSS 1982). This circular made a distinction between strategy plans to be prepared by DHAs and RHAs, and annual programmes. Strategy plans were to take a comprehensive look at services over a period of ten years in the light of national policies and priorities, long-term resource assumptions and local circumstances. On the basis of these, annual programmes were to be prepared, looking two years ahead.

Since April 1985, the planning role of FPCs has been clarified (DHSS 1985c). FPCs are now seen to have a dual planning function: to initiate and pursue proposals for family practitioner services; and to react to health authorities' proposals for hospital and community services, where these affect areas of mutual interest. The DHA is to have the responsibility for pulling both parts together into an *overall* plan, based on information on the distribution and level of FPS provided by the FPC.

FPCs are expected to compile profiles and strategy statements every five years. These are intended to '... identify Committees' policies or proposals for family practitioner services against a background of local and national priorities, financial, manpower and other constraints and community aspirations and local opportunities' (Barnard and Wood 1985, paragraphs 51–62). They are also asked to prepare annual programmes within the agreed strategic framework, looking up to two years ahead.

There has been much scepticism about the ability of FPCs to 'plan'. It has been pointed out that FPCs do not have cash-limited resources relating to the payment of contractors or items of service. They do not therefore have the ability to use resource allocation to change either the structure or pattern of service. Looking at the question from another point of view, the FPC can do little to direct GPs, still less other contractors, to practise in a particular way or in a particular place. Nevertheless, it is argued in the NHSTA members' guide that

> ... the themes of planning apply equally to FPS as to other ser-

> vices: establishing baseline provision; identifying local needs, opportunities and constraints; determining aims and policies and deciding in consultation with other bodies how these might be achieved; introducing and implementing proposals and periodically reviewing progress (Barnard and Wood 1985, page 24, paragraph 53).

Like those of DHAs, the FPC planning proposals are to be subject to review, but the DHSS will undertake the review process. This will be less frequent than the DHA's annual review by region. The assumption by the DHSS that the FPC and the DHA have similar powers in relation to planning seems seriously to misunderstand the FPC's relationship to its contractors.

Approaches to planning

Best and Evans (1983) argue that there are two models of planning. One model perceives it as a means of control over the future. Planning is seen as a tool of management in seeking to reach a predetermined goal. This is very much the model which emerges from the DHSS planning documents which we have just discussed. The second model acknowledges that the context in which decisions must be made about resource allocation, and the direction of future action is uncertain and complex. They involve a number of actors whose values are different, and can be conflicting. Planning, here, is about establishing a general strategic view about future goals, gathering as much knowledge as possible about resources, the population to be served, the local context and relevant external factors. Within this framework it is necessary to adapt and cope with change, to resolve conflict and possibly to change in direction. This is called a learning model, as it aims to encourage concentration on process, influence and adaptation. Although the 1985 circular (DHSS 1985c) is nearer to this model, it does tie FPCs into a highly structured process. Our interviews revealed several different approaches.

Issue-based planning

A number of FPCs have used the improvement of practice premises as a vehicle for encouraging other changes in their general medical services. We described in chapter 4 how Manchester FPC used positive and negative pressures to improve premises, to provide age-sex registers and to support practitioners. While the FPC built up a network of relationships on a largely informal basis, these also take

more formal shape in order to deal with such specific issues as primary care for the homeless. Nottingham has also used this approach. Nottingham City Health District and the FPC have collaborated on planning practice premises for many years. The health district has a population of 600,000; the FPC has one million. The forum for collaboration was the health centre criteria group (HCCG), as in the past health centre development was the dominant issue. This programme has now come to an end, and it is unlikely that more centres will be built. The HCCG is now concentrating on improving GP premises and on rationalising the delivery of DHA services. There are good informal relationships between the FPC, the unit management team (UMT) for community services and the LMC. One GP, as we mentioned above, is a member of all three bodies. The community unit administrator believes that this cross-membership helps to legitimate decisions and thus makes it easier to promote change. The UMT would like to rationalise the use of clinic premises and of community nurses. One recent HCCG agenda reflects this priority. They discussed the health needs of small communities; extension schemes for older health centres; and they set up three working groups to look at the needs of particularly deprived areas. They decided to put capital into GP premises with a view to using them for clinics, and they reviewed plans for new housing development from the point of view of health facilities.

This focus on premises is also apparent in the FPC's approach to its other health districts; it now has officer planning groups for each one. These groups look at population projections, at the age of GPs and the geography of the area, including transport and education facilities. Information from the county and city planning departments is essential to this process.

An FPC-based strategic approach

In Norfolk, an attempt has been made to develop a strategic approach to planning within the FPC. This has not yet involved the DHAs. Norfolk is a large FPC, with a population of approximately 750,000. The population has been growing rapidly, particularly in areas where new industries have developed. During the last ten years it has increased by about 100,000. There are three health districts involved: West Norfolk and Wisbech, Great Yarmouth and Waveney, and Norwich. The two former districts are largely rural in character, with some areas of very sparse population. Along the coast, there are a large number of new nursing homes for elderly people.

Soon after taking over, the new administrator decided to build up a planning group. The administrator, assistant administrator and registrar, later joined by a planning and liaison officer, became the planning and development group (PDG). The PDG is a 'thinking group', which looks at ways of tackling such problems as helping unregistered patients, providing services for the homeless, funding computer projects, and so on. The administrator saw his first task as creating a strong middle-management structure, bringing in 'creative, innovative people' in order to prepare for computerisation and more sophisticated information-gathering.

The planning and liaison officer will be expected to prepare detailed profiles of the general medical services on a small area basis – with the number of surgeries, the number of GPs, and the number of single-handed practices. These will eventually be made available to the health authorities. The same information will be collected for dental and pharmaceutical services. The FPC hopes to ensure a better 'spread' of services through these means.

Norfolk FPC (1984, page 11) describes its planning and development role as follows:

> The essence of the Family Practitioner Committee's planning role is the gathering of information about existing services and resources; identifying the needs and aspirations of consumers, practitioners, health authorities, the Department and other interests, and any governing constraints; obtaining the views and advice of the local professional committees and formulating proposals for the distribution and development of family practitioner services.

The report, which is clear and informative, sets out a list of objectives for each of the contractor services for the following year. For example, the eight objectives listed for general medical services include anticipating single-handed GPs nearing retirement age and the working out of a mutually acceptable plan to ease their workload, and the full operation of a cervical cytology recall scheme for women over 35 by building up collaborative arrangements with the health districts.

The administrator stresses the importance of collecting information before starting to plan; and the time-consuming nature of this process. He found, for instance, that new surgeries in Norfolk were being built to current population levels, without taking the future into account. The FPC now uses the county structure plan, which breaks down information to ward or parish level, and then tries to assess the degree of development taking place in each doctor's area. Even apparently minor developments can be cumulative, and may

have an impact on family practitioner services. Continuing close contact between the FPC and GPs is necessary in order to monitor the impact on workload.

The administrator gave us an example of the kind of issue which arises. He believed that North Wootton, a suburb of Kings Lynn, needed another doctor; complaints had come in to the FPC that there was difficulty in registering. There was a small community of 350 people, and the area was classified by the MPC as open. Access to GPs was difficult, as services had remained at the town centre. The FPC set up a meeting, and discussed the future with all practices. It was agreed that one practice could expand, with one or two partners. But the individual GP was very dilatory in implementing his promise, 'in spite of urging'. Then an ex-trainee came in, and suggested expanding in the other direction, north of the town. While the FPC was negotiating with developers and planners, the GP himself found a cottage. The FPC gave him every support. 'Without the PDG, this would probably never have come to fruition.' The DHA have also helped, as half the building was not used. A child health clinic was moved out of the village hall and incorporated into the practice. The FPC negotiated with the DMO, and with the community services administration.*

There is currently no shared strategic view about the direction of the development of primary care services between the separate health districts, although the publication of a radical document by the Norwich Health Authority, *The Organisation of Community Services*, was seen as an excellent base from which to start. The authority has developed the concept of community support groups: a form of locality planning. The aim is to base health workers such as speech therapists, chiropodists and psychiatric nurses in the community rather than in the hospital. Discussion is going on between the LMC, individual doctors and the DHA about finding suitable accommodation or extending premises.

Surprisingly, the FPC has been left out of this discussion so far, possibly because the DHA has failed to appreciate its relationship with the contractors. The DMO from each district has been invited to discuss a number of other issues with the PDG. In one district, maximum use is being made of GP premises by using them for clinics planned and run by the health authority. In the case of new premises, the aim will be to develop these jointly with Cost Rent schemes and DHA funding.

* Interview.

Joint strategy planning: FPC and DHA

An example of joint strategy planning is the approach taken by the Kensington, Chelsea and Westminster (KCW) FPC and the former Victoria DHA. The FPC covers two and a half inner London health districts and boroughs. The population is not large (425,091), but the problems of the FPC have been well documented (KCW CHC 1977; LHPC 1981; Bolden 1981). The intensively urban nature of the area, the contrast between the extremes of social deprivation and affluence, the high population mobility rate and pockets of high morbidity have all had an influence on the structure and pattern of primary care.

In the early 1980s, for example, there were a large number of single-handed practitioners, many of them elderly and practising with restricted lists. The MPC classification of the area is restricted: KCW has the highest ratio of doctors to registered patients in the country. The level of private practice is high, and mixed NHS/private practice is common. The quality of premises, claims the FPC administrator, is on the whole good: '75 per cent good and 25 per cent satisfactory'.* The commercial value of land is extremely high, and this limits the possibilities for changing the pattern of practice. The socio-demographic characteristics of the population have led to a high level of non-registration, particularly in areas such as Earl's Court.

As a consequence of the various research studies done in KCW, a good deal was known about the characteristics of primary care when the Victoria DHA was established in 1982. A joint approach to planning priorities was developed at officer level. The administrator of KCW FPC was a member of the DHA unit management team (UMT) for the community services, and went regularly to its fortnightly meetings. Objectives for primary care were jointly identified and they form part of the current DHA strategic plan (Victoria District Health Authority 1983). The aims are, firstly, to replace unsatisfactory premises; secondly, to bring together members of the primary health care team under one roof; thirdly, to facilitate the development of new primary health care teams by attaching staff, including local authority social workers, to groups of doctors, possibly on a sessional basis; finally, all practices should be encouraged to develop age-sex registers to enable prevention and screening programmes to be carried out. In relation to these objectives, the approach is pragmatic rather than planned, in the strictest sense of the word. When opportunities arise, maximum advantage is

* Interview.

taken. The community administrator built up good relationships with the borough planning department, going every six months to see the planners on an informal basis to find out what sites were becoming available. The opportunity arose to discuss the 'social use' of part of the development of a former department store site in Kensington High Street. The possibility of this being used for a small group practice was discussed with the FPC administrator, and his views were sought on which doctors might be interested. Finance for the development was found from regional 'slippage money', which had to be spent within the year. Plans were drawn up, and agreed with the interested doctors. The local authority rents the accommodation from a property developer; it then lets the premises to the practice, which is in turn reimbursed by the FPC. Through careful collaboration, good premises have been acquired in a high property value area for a very reasonable cost.

Not all exercises go as smoothly as this. A great deal of time has been spent attempting to set up a health centre in Earl's Court, with particular emphasis on care for the transient population of young, single people. Three practices were interested; a good site was found, and a bid put in. When negotiations were well under way, the property was suddenly taken off the market. Temporary premises are now being brought into service, while the search for a well-placed site goes on.

In this district, great importance was placed on building up shared knowledge and an information base among the various agencies concerned with health and welfare services. This activity was co-ordinated by a community research liaison group within the community unit. It aimed to use commissioned research in order to pinpoint more specific objectives within the broad strategy of developing primary health care teams and improving access to better quality services. The group included senior managers from the health authorities and social services, familiar with the information held by their organisations, together with representatives from nursing, DHA planning, health education, social services from the two boroughs and the FPC. Five different localities or 'villages' within the district were agreed for planning and service provision purposes. One project aimed to identify gaps in services as perceived by service providers: GPs, dentists, pharmacists, voluntary groups, community nurses and other community health workers. The group used the basic socio-demographic data on morbidity and mortality in order to identify priorities. Both boroughs produce social indicators of need on a ward-by-ward basis. There has also been a study of the health status of households using the Nottingham health profile.

Collaboration between the community unit and the FPC has contributed to the overall strategic planning framework adopted by Victoria. This was drawn up during 1983–4 and follows a planning model developed by the King's Fund College (Victoria District Health Authority 1983, 1984).

The model involves a three-stage process.

1) An inventory of what exists now: current resources; needs of the catchment population; perceived inadequacies; needs for teaching and research.
2) Expected changes: service development and improvements; reduction of available resources; impact of technology; expectations and demands; changes in social environment.
3) The changes which need to be made: distribution of acute services; balance of institutional and community care; realisation of defined health objectives.

The philosophy of this approach involves wide consultation with both providers and users of the NHS, and it aims to develop a flexible strategic framework within which decisions can be made, but which also allows for considerable uncertainty about the direction or scale of the likely changes.

The plan for health care in the community devised by Victoria DHA was drawn up jointly by the community unit and the FPC administrator, and discussed by both authorities. The plan defined the community in four ways: the resident population; a sub-set of the population in need of health intervention; the population which uses primary care services in the district (there are a large number of commuters and tourists in the area) and the patients registered with family practitioners.

Both the DHA and the FPC aimed to manage a comprehensive health care service in association with the local authorities and in consultation with a variety of other interests, including the CHC and the local representative committees. 'Locality planning' in the five villages can enable managers to put more resources into areas of particular need.

The plan envisaged that the FPC would be able to provide information on practice premises and on projected changes in practice structure. The DHA strategy plan and the collaborative relationships have benefited the FPC. It has been able to move from 'a fairly ad hoc, opportunistic approach, grabbing opportunities as they arose, reacting rather than planning',* to a more positive role. The FPC has used its resources flexibly. It has a planning and information officer.

* Interview.

A general practice facilitator has been appointed, a doctor, who will be working with GPs to encourage them to provide a more community-based service.

Kensington, Chelsea and Westminster FPC's relationship with its other two DHAs, Paddington and Bloomsbury, had not (at the time of interview) developed on the same close collaborative basis. This could be due to a number of factors: perhaps the lack of coterminosity in the case of Bloomsbury, or the complex management problems facing both districts, which have small populations and relatively large numbers of hospital beds. There may simply have been different priorities in community service development. As a consequence, the FPC has concentrated on working with individual GPs and on particular projects. For example, in Bloomsbury the redevelopment of Covent Garden displaced doctors, so a medical centre and a health clinic have now been set up in new premises. In addition to the Chinese-speaking doctor mentioned earlier, efforts are being made to recruit a variety of other Chinese-speaking staff in order to meet the needs of the local community.

In one of the districts, the main link has proved to be the department of general practice at St Mary's Hospital, Paddington. The department and the FPC work together to provide statistical services for local GPs. For example, quarterly statements compare doctors' workloads: their numbers of night visits, their vaccination and immunisation rates, and their claims for family planning. Work has also been carried out on patterns of prescribing. The FPC hopes to use these data in future planning, attempting to compensate for the current lack of a computer.

Planning and collaboration: some obstacles

We have identified three approaches among FPCs who had begun to plan their service development prior to 1985. These serve as alternative models to building purposive collaborative relationships between FPCs and DHAs. In the case of issue-based planning, the FPC's programme of improving practice premises is the core activity around which interaction can develop. Mechanisms have been set up, ranging from the formal to the informal; a knowledge base has been developed, with shared information; and further issues identified. A second model is FPC-based planning. FPCs can develop their own databases, and using information on population from other sources, project trends, identify resources and establish priorities. These can then be used as a resource for collaboration. A third model, joint strategy planning, can develop from collaborative links. Information

may be shared, policies jointly identified and a plan constructed which reflects the priorities of both authorities.

All three models are based on the premise that the FPC has a clear view of its own goals and priorities. The first stage in any planning process must be a good information and database. A second stage can be collaboration with DHA and an exchange of views, an exchange of data, an identification of areas of mutual concern, the establishing of appropriate mechanisms for policy formulation. Joint planning may be a third stage which can only arise out of established patterns of working together.

All FPCs are now obliged to present plans so that they can begin to identify what they do, and do not know about their areas. They can also compare their approach with that of other FPCs, as their plans must be presented in a written form. A methodology for FPC planning could now be constructed; both the DHSS and the training authorities could assist this process. The establishment of collaborative links will depend on the management skills of FPC administrators, as well as on the particular circumstances which they face locally. There are a number of obstacles, not only the systemic forces mentioned at the beginning of the chapter, but factors which are specific to the FPC/DHA relationship.

First, FPCs and DHAs have difficulties understanding each other's roles and responsibilities. DHAs are organisationally very complex. The way in which the community services in particular are organised varies considerably from district to district and has been subject to frequent change. DHAs have different kinds of joint planning arrangements with their local authorities. These collaborative links may currently take precedence as an attempt is made to develop priority services. Although DHAs are obliged to produce an annual costed operational plan, this does not necessarily provide a guide to services for those outside the organisation. FPCs will have to develop this knowledge. Equally DHAs, with their more clearly defined responsibilities and their broader span of managerial control, may misunderstand the FPCs' relationship with their contractors.

As we have already mentioned, some DHAs may bypass the FPC and work directly with individual GPs or through the LMC. This can be due to frustration with an FPC's lack of response to requests to discuss issues of mutual concern. However, in the long run it can be counterproductive as it undermines the authority of the FPC.

Secondly, problems of collaboration arise due to the differing salary, adminstrative, and management structures of FPCs and DHAs. Some FPC administrators saw their staffing structure as a problem. Under DHSS regulations, FPCs have typically consisted of

large numbers of clerical staff, with only a few officers in higher grades. Administrators complained of having to send junior officers to meet more senior DHA staff. Quite often FPC administrators saw themselves as the only persons in their organisation with the skills to undertake a negotiating role: a clear indication of the need for a management development programme.

This leads on to a third obstacle to collaboration: the concern amongst most FPCs at the lack of staff and resources with which to fulfill their new roles. In the past, major emphasis was placed on the FPC's administrative functions, but they are now being asked to develop in new ways; and this will mean restructuring as well as retraining. The introduction of computers is perceived as a vital step. Almost all the FPC administrators we interviewed and those who returned our questionnaires mentioned their lack of resources as a major obstacle to fulfilling their new planning role. While this could simply be the stock response of organisations which are resisting change, it could be argued that it reflects unrealistic expectations on the part of the DHSS. But FPCs are developing ways of coping. In one area an evaluation and development officer has been appointed using joint finance money: others are establishing links with institutions of higher education and using their research capacity. Both the DHSS and regions are being approached for extra funding. Some FPCs hope that by training members they can achieve fruitful inter-agency links on planning groups and JCCs. This seems to us to underestimate the kind of continuing professional commitment that is necessary to achieve collaboration and planning.

Lastly, all these obstacles are compounded by the lack of co-terminosity between DHAs and FPCs. When boundaries overlap, and where FPCs have to collaborate with a number of DHAs, the demands made on them become extreme. Administrators in such situations have commented that it is difficult to give equal attention to each DHA. Yet one third of FPCs need to work with three or more DHAs. Lancashire and Surrey each cover seven DHAs and the task of developing collaboration, let alone joint planning, is a formidable one. In Surrey, an area covering the affluent home counties and with pockets of rapidly growing population, the current strategy for building a collaborative network is threefold.* Firstly, the FPC is making a range of informal contacts with key officers in social services departments and health districts, and linking them with named officers in the FPC. The message is: we're here, and we want to start doing things. At present, this is very much a public relations exercise,

* Interview.

following an FPC press release on new membership which was sent out in April 1985. Yet, some key issues have already emerged from this initiative. There is a shared concern about residential homes for elderly people, many of which are being expanded without arrangements being made for GP cover. In addition, questions have arisen about local authorities' planning policies for GP surgeries. Guildford, for example, has a policy of siting GP premises in industrial units.

A second approach aims to use FPC members to make an effective contribution to the joint consultative committees (JCCs). All the current JCC/FPC members are doctors. The third area of the strategy involves setting up meetings with all the local representative committees in order to discover what information or resources family practitioners want, and how they would like to see the services developed. Some priorities have already been identified: dentists for example, would like better access to an anaesthetic and sedation service. Despite some progress in identifying such issues and in developing an FPC database there are obstacles to the joint identification of priorities and to developing policies for working together.

8
Collaboration and the prevention of ill-health

Introduction

The prevention of ill health and the promotion of health should be dominant objectives of the NHS; they should influence the organisation of services and the flow of resources. The fact that this is not the case is well documented and needs no elaboration here (DHSS 1980). Collaboration between the community units of DHAs, FPCs and the local representative committees in developing strategies for prevention provides many opportunities for dealing with avoidable illnesses and for promoting changes in behaviour.

Prevention can be divided into three categories. Each of these can be represented by a number of specific programmes. First, there is health surveillance, which is concerned with the early detection of disease in conditions that might otherwise develop into serious illness. This includes screening for specific conditions, or the identification of need: for example the developmental assessment of preschool children; screening for hypertension in adults; anticipatory care for the elderly; programmes for cervical cytology; and breast cancer screening. A second area of prevention is intervening to provide immunity; immunisation and vaccination programmes, or preventive dental care through fluoridation to stop the onset of dental caries. Lastly, there is health education and health promotion. This aims to provide information, professional advice and support, thus changing individual behaviour. We include family planning in this category.

These services are currently provided by DHAs in a variety of settings. Health workers are organised in a number of different hierarchies: health education, community medicine, the community and child health service, the school health service, the family planning service, and others. GPs may also provide these services, either at their practice premises or on a sessional basis in DHA clinics. There is a great deal of evidence to suggest that there is duplication and overlap; the full potential of such services cannot be fully realised without imaginative collaborative planning.

In this chapter we aim to discuss three areas of preventive health care, family planning services, cervical cytology and child health surveillance, where both the FPCs and/or family practitioners are involved in providing services as well as the DHAs. We also discuss

anticipatory care in general practice, where support can be given by the FPC. In both, the key to collaboration is shared information. The flow of information can be improved by FPCs fostering their links with family practitioners and fully exploiting the opportunities provided by computer technology. There have been a number of recent reports on this subject; we therefore discuss these in the final section of the chapter. We have drawn on our interview and questionnaire material to illustrate particular points, but local arrangements are so varied that it has been impossible to reach firm conclusions about good practices. More detailed research is needed on each of the areas which we briefly describe here.

Family planning

Since 1975, women have been able to register with their GP to obtain family planning advice, although GPs are not obliged to provide this service. Doctors who do may choose to restrict this aspect of care to their own patients; or they may offer it to any female patient, including those registered with other doctors. Fees for contraceptive services are claimed by doctors annually, but payment is made by the FPC on a quarterly basis. There are two levels: the ordinary fee for giving advice and/or the prescribing of a contraceptive pill, and a higher fee for fitting an inter-uterine device. The service is free of charge, as are supplies to the user. However, GPs have refused to provide NHS (that is, free) contraceptives to men as this service is not deemed to be a 'medical' one.

DHAs also run family planning services in the community, or as part of outpatient clinics in departments of obstetrics and gynaecology. The former are run by doctors and community nurses on a sessional basis. These clinics – and indeed those run by GPs – are often open at hours which suit women, and may either be convenient to work, or home. Some GPs and DHAs provide this service from Well Woman clinics.

Leathard (1985) has recently completed a study of family planning services in DHAs in England and Wales for the Family Planning Association. She found highly complex patterns of responsibility. Furthermore, almost three quarters of the DHAs surveyed (73 per cent) had no proposals for coordination between clinic services and local general practice arrangements. This confirms our own discussions with community unit administrators. There were some exceptions. In North Derbyshire, an assessment had been made of the overall need. It was noted, on the basis of a local survey, that an increasing number of women were going to their GPs for contraceptive

services. (North Derbyshire HA 1984a). A proposal is being developed to cease to run DHA funded clinics where the average attendance had been decreasing; where these are not used by 'high risk groups' and where the level of provision by GPs is high.* By contrast, in one Manchester district, the demand for DHA family planning services has recently increased by 14 per cent. It is not known why this has occurred; and whether there has been any corresponding fall in the use of GP services. The community unit would like more information about the services provided by GPs; and what they provide. They do not know, for example, how many women are fitted with the coil.*

Some community administrators admitted that they had not come to grips with issues of coordination and declared that it was 'a mess'. However, they argued that there are advantages for women in having a choice. Administratively, it is more difficult to rationalise services in areas where there is a high demand from women who are not registered with local GPs. In some districts, there are a large number of commuters and a highly mobile population.

Family planning is an area where there are advantages to be gained by FPCs and DHAs pooling the information they hold on services and how they are being used. FPCs have data on the claims made by GPs, and their type. They could gain further information from their GPs about the services which they provide, and about what they would like to provide. This would provide a basis for developing policies sensitive to the needs of particular communities; avoiding duplication but allowing an element of choice. It is of fundamental importance that FPC record systems are accurately kept. Two committees have recently found that they have been paying large sums to GPs for giving 'ghost patients' contraceptive advice. Doctors, paid an annual fee in quarterly instalments, had been overpaid for patients who had moved (*The Guardian* 2 November 1985, page 3).

Cervical cytology

Cervical cytology screening is an area where the science and technology are available to reduce mortality, and where both GPs and DHAs may provide screening. We discuss this in some detail because it illustrates policy failure at several different levels.

Cytology consultants are reported to be distressed by the present situation, likened by one to 'a cervical cancer epidemic' (*Lancet* 1985a). An editorial in *The Lancet* branded the UK screening programme as a failure but claimed that the blocks to effective action were purely administrative (*Lancet* 1985d). In Finland, Denmark,

* Interview.

Iceland, Sweden and the north-east of Scotland, with similar resources and expenditure, mortality had been reduced and was continuing to fall.

There is now ample evidence to show that screening can significantly reduce both morbidity and mortality (Ellman and Chamberlain 1984; ICRF 1984). It is also acknowledged to be a highly cost-effective procedure, as the cost of a screening programme is considerably less than the cost of treating either pre-malignant lesions – the pre-cancer state – or invasive carcinoma (Elwood *et al* 1984). But although some form of screening has been in existence since 1966, in 1980, 2,068 women in the UK died of cervical cancer, more than half of those who contracted the disease (Kingham 1985). Ninety per cent of these women had never had a smear test (Doyle 1983).

The national screening programme introduced in 1966 was intended to concentrate on women aged 35 or over. The names of women who had requested an initial smear test in hospital, general practice or family planning clinic were put on a central register at Southport, and they were recalled at five-year intervals. The system operated manually. In 1973, the scheme was extended to include women under 35 who had had three or more pregnancies. GPs were paid on an item of service basis for carrying out tests on these two groups. Studies showed that this manual system was not satisfactory. It did not include women who had never had a smear at all; and there was no means of monitoring whether those who were recalled actually attended for a test. Ninety-five per cent of the women who died of cervical cancer in 1980 were over 35 (Kingman 1985). The majority of tests were in fact performed on younger women when they approached doctors for either contraceptive or obstetric care.

In 1981, the Southport scheme was abandoned, on the advice of the Committee on Gynaecological Cytology (CGC). It was acknowledged to have been a failure. The CGC recommended that it should be replaced by local schemes of repeated call and recall, using population registers and based on computer systems. National guidelines and technical standards should be laid down. Subsequently the government asked health authorities to introduce local schemes (DHSS 1981b), but again only for recall, thus placing the onus on the individual woman to take the initiative and ask for a test.

Downey (1983a) has graphically described the chaos which ensued when the central register at Southport finally stopped taking forms at the end of 1982. The names and addresses held by Southport were returned to FPCs as they had patient registers for their areas. Between January 1983 and April 1984, FPC administrators had to cope

with five years' backlog of cervical cytology forms, without the benefit of extra staff or financial resources. Very few FPCs at this time had computerised patient registers and DHAs were reluctant to fund the necessary FPC computerisation. Where one FPC served several DHAs they were not always able to agree on the type of recall system. A *Medeconomics* survey at the beginning of 1983 showed that less than half of the FPCs had any formal arrangements to take over from the central national scheme. In February 1985, a further survey by *Medeconomics* found that there were still many areas where no recall system was in operation (Kingman 1985).

In November 1984, the Labour shadow Minister of Health, Frank Dobson, wrote to every DHA, FPC and CHC in the country asking about their arrangements for cervical cytology. In the report of his findings (MacGarvin 1985) he claimed that only three per cent of the 201 health authorities in England and Wales had a full cervical screening scheme. Thirty-eight per cent had no scheme at all. Only five districts – Chichester, Worthing, Mid-Downs, Gwynedd and Northumberland – had the full call and recall scheme that the CGC had recommended to the government in 1981. Stockport and Rochdale had full recall, but limited call. Out of the 77 DHAs which had no scheme in their areas, 70 stated in reply to Dobson's questionnaire that they could not actively prepare for one. The report called for urgent implementation of the CGC's recommendations.

The local schemes recommended by the CGC can only be achieved by agencies working together. Policies need to be established as to which women should be called and recalled. If a recall only system exists, then data from a number of sources needs to be centralised. The FPC register offers a good basis for developing systems as it includes all women registered with GPs. Special efforts need to be made to involve women who rarely visit their GP, or who are not registered at all.

Our interviews and questionnaires revealed differences in current practice, together with some of the problems. In North Derbyshire, the FPC is fortunate enough to have a computerised register, and an early recall system has been established. The DHA and the FPC are in the process of evaluating and monitoring the current situation: assessing the response to the five-yearly recall; investigating the policies of local general practices and clinics, and looking at their call and recall systems; also evaluating the follow-up for women found to have abnormal smears (North Derbyshire HA 1984).

Even those FPCs with computers may find they have difficulties. Norfolk, with its increasing population, finds itself with an unsuitable computer system because of financial constraints imposed by the

DHA. They are in the formative stages of recall, with the prospect of call still in the future. The FPC would like to buy a considerably enhanced system. South Glamorgan has had similar problems, with a 'grossly undersized' computer. They have also discovered that their database is inaccurate, due to misunderstandings over the sex of Welsh names. The administrator estimates that the average GP's list of around 2,000 patients has yielded 600–800 queries.

Another difficulty is insufficient financial and staffing resources. Research conducted in London and Nottingham (Chamberlain 1984) came up with the disturbing finding that fewer than two-thirds of women who had been screened received the recommended follow-up: '... deficiencies in communication among different sectors of the health service and between doctor and patient accounted for a much higher proportion of failed follow-up than patient default'. As a result of this study, a working party was set up in the district involving the DHA and the FPC. It made several recommendations: improved data systems, including computers; a better reporting system to GPs, and direct notification of abnormal results to the patient; the use of community nurses to ensure follow-up; improved education about early cervical cancer and its treatment; a structured management system with continuing evaluation. It was estimated that 90 per cent follow-up would be achieved by these changes. However, the required financial and staffing resources have not yet been made available within the NHS (paper given by Professor J M Elwood at Marie Curie Memorial Foundation conference, 9 October 1985).

Another weak link can be the GPs who do not inform the FPC or DHA whether they are doing their own recall systems, so duplication occurs. One GP, quoted in *Medeconomics*, remarked bluntly that the greatest obstacle to screening for cervical cancer rested in general practitioners' attitudes to practice organisation, record keeping and preventive medicine (Kingman 1985).

The whole process requires a great deal of work from the GP, as one medical assistant in cytology points out: 'The actual mechanics of organising a cervical screening programme are quite daunting. ... The GP requires an age/sex register and a lot of organisation. The daily nitty-gritty is difficult and time-consuming' (Doyle 1983). It has been argued that GPs can play an important role where the service is not provided by other agencies. Dobson stresses the role of the GP as a 'fail-safe mechanism', although he also makes clear that this does not mean that GPs have necessarily to be involved in the process of taking a smear. The Imperial Cancer Research Fund (ICRF) emphasises the importance of making arrangements that are acceptable to

women, and advises that there should be an element of choice (ICRF 1984). Many women would prefer to see a nurse, or to go to a Well Woman clinic.

The GP however is in a position to ensure that all women on the list in a given age group are called and recalled, and if they do not come, he or she could persuade them to do so. Back-up data can be provided by the FPC, in order to ease the administrative burden on the doctor. Experience in Aberdeen (where the mortality rate from cervical cancer is falling) has been that an effective strategy is for a central coordinator to work with each practice in turn introducing and explaining systems.

One DMO argues that the FPC's role should relate entirely to providing a database; there was no need for it to become involved in discussion of policy, as that is the province of the health authority. It was up to the LMC and the DMO to work out a suitable call system for women who were not coming forward. This might well involve the provision of health authority clinics with female staff. The FPC would then play a key facilitatory role in providing lists for GPs, as well as anonymous data for the DMO (Pledger 1984).

An alternative is the system in operation in West Berkshire where the DHA has recently set up a computerised screening centre in Reading. This links the electoral register to the computerised cytology system in the Royal Berkshire Hospital. The RHA's computer unit is also developing software to link FPC computer systems to local hospitals. This will presumably feed in information on services provided by GPs. The Reading centre will invite all eligible women in the area to attend for tests, and results will be coordinated through an operational group which includes six consultants from the Royal Berkshire (Davies 1985a).

Brough (1985) gives useful details of a computer recall scheme in Gateshead. The system here is run by the cytology laboratory in conjunction with the FPC: 'It would be very difficult for either to run the scheme on its own.' In the light of recent research, Gateshead has implemented a three-yearly recall rather than the five-year interval recommended by the DHSS.

The most successful programmes, claimed *The Lancet*, had the following points in common:

1. They are organised as public-health cancer-control programmes, specifically directed towards a reduction of mortality; that is their explicit objective. They are not simply laboratory services for providing a clinical investigation.

2. They call the age-groups at greatest and most immediate risk (30+) and they keep on trying. They concentrate first upon women who have never had a smear at all. They use population registers.
3. Someone is in charge: he/she has a name and a telephone number, and can be held to account.

Even if DHAs can collaborate with FPCs, the editorial concludes, it will be a triumph of local accommodation rather than of central planning. The basic failure, it implies, has been one of political will (*Lancet* 1985d). This political will can only develop through purposeful collaboration between DHA and FPC using what local resources there are at their disposal. FPCs which collaborate with a number of DHAs, and which are not computerised, will clearly have a more difficult task. Ultimately the responsibility for ensuring that screening programmes are organised lies with the DHSS.

Child health surveillance

Oversight of the health and development progress of babies and preschool children, together with the provision of a vaccination and immunisation programme, are major parts of a national policy for child health surveillance. Britain's record in the area of child health did not impress the Court committee on child health services in 1976: 'There is still a substantial amount of acute illness in childhood. Diseases, injury, stillbirth and death occur more often than is justified with present knowledge, and we are coping with them less successfully than most other countries' (*Fit for the future* 1976). *Care in Action*, the 1979 Conservative government's consultative document on priorities in the health and social services, emphasised the need to improve the uptake of community-based child health services (DHSS 1981b). In 1983, only 45 per cent of children aged five and under were attending clinics; an improvement of three per cent on 1978. This figure does not give any clue as to how many young children are given developmental and health checks by their GP (DHSS 1985a).

The take-up of vaccination and immunisation is not as high as it could be. In 1983, although the take-up for diphtheria, tetanus and polio was 84 per cent at the second birthday – the same for rubella taken at the fourteenth birthday – the rates for measles and whooping cough were 59 per cent and 60 per cent respectively (DHSS 1985a). These are average figures and the rate in some areas is far lower. This contrasts with the USA where, because children cannot enter school without it, measles vaccination is almost universal.

There has been controversy about the efficacy, costs and benefits of some immunisation programmes, and this has affected take-up rates; but the medical view is that the benefits of immunisation far outweigh the small risk of adverse reactions. It is predicted that the lack of protection from the 1983 measles epidemic, when 100,000 cases were notified to the authorities, will have resulted in 15–20 deaths and five cases of permanent brain damage (Office of Health Economics 1984).

In 1985, a DHSS health notice suggested that the incidence of whooping cough was also expected to rise again, and could reach the levels of 1982 when there were 66,000 cases and 13 deaths in England and Wales (DHSS 1985d). The notice asked DHAs to take action to increase immunisation rates, but stated that the government would not provide any extra cash or manpower resources. In 1976 the committee on child health services reported that there were still too many children whose health was not monitored. It suggested that there should be a means of defining the child population, and that services should be territorially planned and organised (*Fit for the future* 1976). The situation has not improved over the past decade. Wadsworth, of the Medical Research Council's national survey of health and development, comments on the continuing need for better information on child morbidity and makes a number of specific recommendations (Wadsworth 1985).

The operational responsibility for services remains diffused. The principal authority responsible, the DHA, has problems in ensuring that programmes are carried through effectively. GPs may carry out developmental checks on the babies and pre-school children registered with them, but they do not get paid extra for doing this. They do get paid for vaccination and immunisation, however, and should inform the DHA when these are carried out. Some GPs may run clinics for the DHA, paid for on a sessional basis. Alternatively, the DHA may run its own child health clinics. These services are usually the responsibility of the specialist community physician in child health, or alternatively the consultant in community paediatrics.

A major problem is ensuring that the whole child population is covered. Well over half the districts in England and Wales use the national child health computer system to register all children from birth until school-leaving age, so that routine checks can be carried out and children called in for vaccination and immunisation. Others rely on manual systems. Whatever system is used, it is only as good as the information which is put into it. Some GPs, for example, carry out procedures but fail to inform the DHA or to claim payment. Scrivens (1984) argues that there are also weaknesses due to poor

management of computerised systems. Among the districts she studied, there were many instances of low take-up and an 'apparent haphazardness' in the distribution of full courses of immunisation. She attributed this either to poor data collection or to ineffective service delivery.

In the districts we visited, we found a number of different methods of providing the service. In Tower Hamlets, for example, most child health surveillance was carried out in clinics. In North Derbyshire, GPs carried out the majority of checks. In Victoria, there was a mixture of both systems with the authority aiming to provide a service where GPs did not.

Over the next decade, child health surveillance is likely to undergo considerable change. Proposals from the Royal College of General Practitioners (1982) suggested that in future GPs should take over developmental screening: '... this should be seen as part of the continuum of general care, and an opportunity for review and re-appraisal of the total professional input to the child and the family'. Even if this does eventually occur, and there is considerable controversy about the issue, the DHA will still bear the final responsibility for child health surveillance (Macfarlane and Pillay 1984). The FPC can contribute to this area by giving administrative assistance to GPs through providing age/sex registers and information on claims made for payment.

Some FPCs have contributed to child health promotion. In Lambeth and Southwark, vaccination and immunisation claim forms are sent from the FPC to the community unit so that they can be checked against a master list. The unit supplies GPs with target figures for age-groups, and relates this to numbers on practice lists supplied by the FPC. On this basis, GPs can assess their levels of achievement. There are other examples of small steps in collaboration in child health promotion. In Kensington, Chelsea and Westminster, the FPC does a mailing to every female patient over the age of 15 with her medical card, explaining the benefits of rubella immunisation and where it can be obtained. Similar mailings are sent to the appropriate age-groups for measles and cervical cytology. The community unit in another area laid on a 'measles day' for primary health care staff.

Screening and health promotion in general practice

There are many in the profession who argue that general practice has a central role to play in preventive health care. GPs have greater access to populations than any other group of health workers. About two-thirds of those registered with GPs see their doctor at least once

a year (Tudor Hart 1982). Contacts are patient-initiated: people do not have to be especially called. Every consultation offers educational opportunities; GPs may have a continuing relationship with their patients and they are perceived as being credible and trusted. There is evidence to show that prevention in the primary care setting can be effective (Fullard, Fowler and Gray 1984). Tudor Hart, however, suggests that there are many lost opportunities. He quotes studies which indicate that only 50 per cent of patients with high blood pressure are known to their doctors, and that half of those treated are not adequately controlled. If these patients were followed up, he claims, the number of strokes could probably be reduced by 50 per cent. 'The GP should not only be a symptom responder but also an active and informed guide through the risks, possibilities, probabilities and remaining impossibilities of medical science' (Tudor Hart 1982).

The extent to which GPs are able to develop their services in the direction of anticipatory care depends on two factors: the skill with which they are able to manage their practices and the employment of specialised staff. The FPC can provide support in both these respects.

It is clear from the professional literature that practice nurses can be used effectively for screening and research. Two accounts appeared in the *British Medical Journal* in June 1985. One described how a questionnaire was administered by nurses to diabetic patients in a practice of 8,000. The aim was to evaluate the health information given, the extent to which it was followed, and how the condition was monitored by the doctor. The results indicated that patients did not follow advice given sufficiently, and that better means of follow-up could be devised (Baily 1985). The other example explains how a part-time 'screening nurse' is employed in a general practice in Bedford to screen patients visiting the surgery during a specific period. This resulted in a number of gaps being identified (Carson, Martin and Shepherd 1985).

Fullard, Fowler and Gray (1984) employed a practice facilitator. She was a trained and experienced health visitor, who initiated a health prevention project in which she trained practice nurses to measure blood pressure and then evaluated the results. This benefited the practice by helping members to re-orientate their activities, and it heightened consciousness of the preventive role. The cost to GPs, the authors argue, can be low, as the salary of such a practice nurse can be largely reimbursed by the FPC. In addition, tax relief and fees from item of service payments can be claimed.

The age/sex register can be a vital tool in undertaking health surveillance and for managing work in a doctor's practice. The

information it provides is also valuable to health authorities. We have already described how a number of DHAs and FPCs have assisted GPs in converting their records to this form. Wiltshire FPC helped GPs to convert their registers by employing ex-members of staff under the ancillary staff scheme. Gateshead employed young people under the local community services programme to help GPs in this way. Age/sex registers can improve the accuracy of record-keeping in general practice, although there are still great problems in keeping them up to date, particularly in areas of high population mobility (Bussey 1984). Hannay and Maddox (1977) reported address error rates of 40 per cent in an inner city Glasgow health centre. On further investigation, it was found that one third had moved, one third had never been heard of at that address, and in the remaining third, the address did not exist. FPCs have an important role to play in assisting GPs to maintain the accuracy of their patient registers. Information technology facilitates this process.

Some FPCs have worked with local representative committees, individual GPs and other family practitioners to mount screening programmes. For example, in Powys, mid-Wales, with a small population of 109,690 and a staff of fifteen, there are two ongoing health prevention programmes. One is concerned with reducing the mortality rate from cardiovascular disease; the other with screening for diabetes. The rate of cardiovascular disease in Wales is very high – the male death rate is 63 per cent higher than in England and Wales – and a programme called 'Heartbeat Wales' has been funded by the Health Education Council and the Welsh Office. All doctors in Powys have age/sex registers, and high-risk patients and high-risk families are identified within the practice. Ancillary staff are to be employed, with the encouragement of the FPC, to monitor those at risk by taking blood pressure, checking weight, testing urine and advising on diet.* Studies abroad have shown that treating symptoms such as hypertension, which may be precursors of cardiovascular disease, are more likely to be effective if done in special clinics by doctor-nurse teams than by doctors alone. Compliance increased when there was supervision by nurses (Fullard, Fowler and Gray 1984). There is, however, continuing debate about the efficacy of 'symptom screening'.

The second programme in Powys – developed by the DHA, the FPC and the local representative committees – is concerned with the early detection of diabetes through testing for diabetic retinopathy. Screening is carried out by an ophthalmic medical clinical assistant employed by the DHA. All practices are visited every six months. In

* Personal communication from Powys FPC 1985.

Kensington, Chelsea and Westminster FPC, a similar scheme was set up by the local ophthalmic committee. These are specific examples of local initiatives, but it is now being recognised that much more could be done by family practitioners, by FPCs, and nationally, to develop the potential for preventive health care.

A prerequisite, however, will be the careful and thoughtful collection of data and information. The Royal College of General Practitioners comment in their discussion paper, *Towards quality in general practice* (RCGP 1985, page 10):

> A major deficit ... is the lack of systematic operational data on the work of individual general practices. Little is known about the progress and effectiveness of care in individual general practices. This gap is replicated at FPC level and nationally. The lack of data stems partly from doctors themselves who have not seen the need for it in managing their practices, partly from some health authorities who also have not fully recognised that data from general practice is essential for comprehensive health care planning, and partly because there are no resources and skills to collect and use it.

There is clearly much that could be done by FPCs to support GPs in looking more systematically at what they do and helping them to develop anticipatory care. Equally, there needs to be collaboration between DHAs and FPCs in anticipating and monitoring the impact on GPs of ward and hospital closures, particularly where these involve the care of very dependent groups. Such decisions could have a dramatic effect on GP workload.

It is also important for FPCs to be active in helping to develop strategies for preventive dental care. We suggested in chapter 5 that there is an increasing emphasis on prevention in dentistry. Collaboration between the community dental services run by the DHA, the FPC and the local dental committee could result in the identification of policies and priorities. Barnsley FPC is involved in such discussions. They aim to provide an analysis of the take-up of dental services in the district, using data from the Dental Estimates Board as a basis for consultation. It is anticipated that the initial emphasis will be on improving take-up and access among and for particular target groups: young people who are no longer seen by the school dental service, but have not acquired the habit of visiting the dentist regularly; also elderly, handicapped and disabled people who may need a domiciliary service.

Collaboration and information

Over the last few years, a number of technical innovations have drawn attention to the potential benefits for preventive health screening in using information which is already in existence but which is currently difficult to access and use. Computer technology can be used for age/sex registers, and for administrative purposes such as registration and financial accounting. Policies to promote the use of computers have followed three DHSS reports (DHSS 1984h; DHSS 1984e; Andersen 1984).

The Körner report (DHSS 1984h) on the collection and use of information about services for, and in, the community aims to identify minimum sets of data with which managers can assess the efficacy and efficiency with which services are being provided. They need to judge how facilities are being used, and how money is being distributed between specialities, skill groups and programmes. The report aims to enable managers to answer such questions as: why is the service being provided? who should be receiving it? what is actually being achieved? how much is it costing?

Both the definition of objectives and information gathering are vital if priorities and policies in community health care are to be clarified. They are essential if health and welfare services are to be linked in a way which reflects local circumstances.

The Körner committee used two definitions of community services. The first is those services provided to the population living in a defined locality. The second is those services provided to a sub-set of the population of a defined locality, not in hospital, but in receipt of either short-term, long-term, or terminal care. Körner recommends a structured approach to each service or programme, which would include a statement of local policy and objectives, and target level of coverage; estimated target population; projected expenditure; the level of service provided; coverage achieved; and estimated actual expenditure.

In terms of the first definition of community services, it is recommended that data should be collected for the major programmes of vaccination, immunisation, health surveillance and screening, and for health education. Körner points out that the best source of much of this information is the FPC, as it has a register of patients and addresses. When registers are computerised by age and sex, community health programmes can be planned. The report comments: '... a place of residence code will be essential for detailed geographical analysis', and suggests that the aggregation of data will provide safeguards to the privacy of particular individuals.

With regard to the second definition of community services, those provided by health workers to particular patient groups, Körner makes an important recommendation for change. It suggests that the data-set on community nurses should be collected according to the services provided to a particular client group. The report also comments that it will be essential to know what GPs are doing and to get information from them.

> General medical practice is central to the provision of many of the services which we have considered in this report. We are very conscious of the fact that, without data about certain aspects of the work of general medical practitioners, district health authorities will have available only very incomplete information about the extent to which services are reaching the population for whom they are planned, and will find it difficult to assess whether their own provision is excessive or sufficient. This cannot but inhibit authorities' ability to plan, evaluate and account for the services they provide (DHSS 1984h, page 6).

The joint working party group on collaboration (DHSS 1984e) has already been discussed in relation to joint planning between DHAs and FPCs. It is clear from the report that the extent of collaboration and planning will depend to a large extent on the ability of the two organisations to exchange information. To match the improved DHA data from the community health side, the report recommends that data should be available on family practitioner services, so that a proper balance of care can be provided in the community. FPCs now need to produce a profile of their services, with a strategy statement every five years and an annual statement of intent. A detailed pro forma for such a statement is provided at the back of the report. The working party also recommends a regular exchange of information between community nurse managers and the FPC on changes in practices and on the deployment of nursing staff; also between community physicians, community dentists and FPCs.

The collaboration group were more cautious about the possibility of releasing data of a personal or commercial nature, and argue that policies will have to be drawn up to protect confidentiality. It is possible to aggregate data on patients in small areas for planning purposes, but still keep anonymity. Data can be released for particular projects, with special permission being sought from patients or doctors. Clearly this is an area where there will need to be continuing dialogue.

There is currently discussion in the profession on the structure of

medical records. Both the form and the content need improvement. One study which was concerned with evaluating the quality of records concluded: 'The quality of contents of existing general practice records is unsatisfactory for medico-legal, educational, epidemiological and research purposes' (Jachuck *et al* 1984).

Both the Körner report and the collaboration report have to be seen against the background of the opportunities presented by computers. This new technology can process large amounts of data, and make it available quickly and easily. Computers are increasingly used at many levels of the NHS. Pharmacists can use micros to control their stocks of drugs, and to label medicines. GPs may have age/sex registers with postcodes, and both doctors and dentists can use micros for dealing with the business side of their practices. Stoddard recently surveyed 400 GPs, and found that 33 per cent had access to practice computers. Sixty-one per cent of these had their practice registers broken down into age/sex form (Davies 1985b). He estimated that in the country as a whole 500 GPs were now using computers in general practice. The Royal College of General Practitioners' policy statement (RCGP 1985b, page 11) is unequivocal in its support: 'Failure to install and use computers in general practice within the next five years could result in its increasing isolation from the rest of the health service' (RCGP 1985a, page 11). A recent study by Ritchie (1984) describes the application of computers in more detail.

The FPC use of computers was investigated by Arthur Andersen and Company, a firm of management consultants (Andersen 1984). Their report sees substantial benefits in terms of efficiency. Data can be processed more quickly, and be less expensive in staff-time. It can also be more accessible for planning purposes. It is argued, for example, that postcoded registration data can help the planning and distribution of GPs overall and in relation to specific localities. Any screening programme which depends on targeting particular groups in the population will be made much easier to access. Information could also be made available for GPs to programme their work. They suggest, for instance, planning routine visits to elderly patients on the basis of postcoded data.

The report also sees FPC computerisation as providing useful feedback to practitioners to help them improve the quality of care. It suggests sending data to GPs, such as comparative figures for claims on items of service. Comparisons would also be possible on a variety of payments: contraceptive services, night visits or prescription forms. This information can be valuable as far as an individual doctor is concerned. Such statistics can equally allow the FPC to

monitor the patterns of a particular contractor more closely, and then to take action if necessary. The collaboration working group, sensitive to this point, rejected the suggestion that clinical information might be released for administrative purposes. A specific example which they are at pains to exclude for cross-checking is the names of those registered for contraceptive services against DHA lists. This reflects the interests of the medical members of the working party.

Some FPCs are already benefiting from computerisation; we have already cited Barnsley as an example. In some areas DHAs have contributed financially to FPC computerisation. DHAs in the Manchester area have all contributed to the purchase of a computer for Manchester FPC to develop an age/sex register. They see the main benefit of this to be the possibility of carrying out a range of preventive health programmes and targeting provision more accurately. For example, one district already has a chiropody screening programme for the over 65s. All the elderly people were contacted via a letter from their GP and asked to come for screening at the health clinic. Twenty-five per cent did not come; 25 per cent were already being seen; 25 per cent did not need the service; but 25 per cent were in need of attention. The service is now being rearranged, and where domiciliary services are necessary, the use of postcodes makes it easier to arrange visits. The district now wishes to develop other screening programmes such as audio-visual tests for people over 65, vitamin D deficiency tests for elderly women (the early detection of which can prevent osteo-myelosis) and screening for hypertension and breast cancer. They would like to obtain more clinical information from GPs, but agree that this would have to be negotiated with the FPC and the LMC.*

Bussey (1984) suggests that despite its inaccuracies the age/sex register has no good substitute, and argues that it is important to get the linkages between GP and DHA systems correct. If these sources are to be used in the future for naturally based epidemiological research, agreements have to be obtained about coding and consistency.

In the future, family practitioners ought to be in a position to feed information needed by the FPC straight into micros for processing. John Yates, of the Health Services Management Centre in Birmingham, has already begun to develop guidelines setting out the areas to be covered. He suggests that these could be set against assumed resources, services to be provided, with target levels, and care groups of patients to which the FPC wished to give priority (Yates 1985).

* Interview.

A software package is being developed along these lines. Greater accountability in resource use could also be achieved in this way.

By January 1985, only a small minority of FPCs had a computerised age/sex register. However, by 1986, the total should be 31 (*The FPS* 12, no 12, 1985, page 32). It is clear from our questionnaire material that where computerisation has been introduced it is bringing about a redefinition of roles and organisational development. Some FPCs have restructured their organisations following computerisation, to create new posts for computer managers, with an input into planning. It is also helping to build stronger links with practitioners. Northamptonshire is planning to use post-coded age/sex registers to obtain epidemiological information for GPs. Hampshire has a sufficient number of GPs with micros to have direct information input from GP surgeries. North Tyneside FPC has set up a computer consortium together with family practitioners, in order to consider the most appropriate ways of using the new technology in service developing and planning. They plan to buy standardised computers for GP surgeries, funded by a voluntary levy on all GPs. This will bring the twin advantages of cost savings and compatibility.

It is once again clear from our questionnaires that authorities without computers or with only limited facilities feel that this is acting as a brake. Almost a quarter of the FPCs who returned the questionnaire mentioned the lack of plans to finance a computer as the major obstacle to meeting the government's objectives.

Those FPCs with computers have not been without problems. Computerisation of patient registers has brought error rates of 10 per cent. This can sour relationships with the public; and it takes administrative time to set right. Financial savings may not follow either, as staff with different skills and expertise are needed. There needs to be substantial investment in education and training. Collaboration with other organisations is also necessary to identify how the resource can be fully exploited. This demands considerable management effort. A management input is also necessary at the level of GP practices if computers are to be used here. Data needs to be collected accurately, and ways of using information developed.

Finally, ethical and moral issues are raised by the use of computerised patient health data, particularly at the level of the FPC. It will soon be possible to follow through groups of patients with particular identified characteristics; to trace patients with particular blood groups, for example, or with particular diseases. The Data Protection Act of 1984 is aimed at protecting access to personal data by establishing and enforcing standards in data processing. This will be another issue which will need to be discussed between health

authorities.

We have only touched upon issues deriving from the introduction of computers into FPCs. The implications and effects cannot be judged at this early stage, although some FPCs are using the facility to good effect. It is important that experience in this area is shared through ongoing research.

What makes collaboration work?

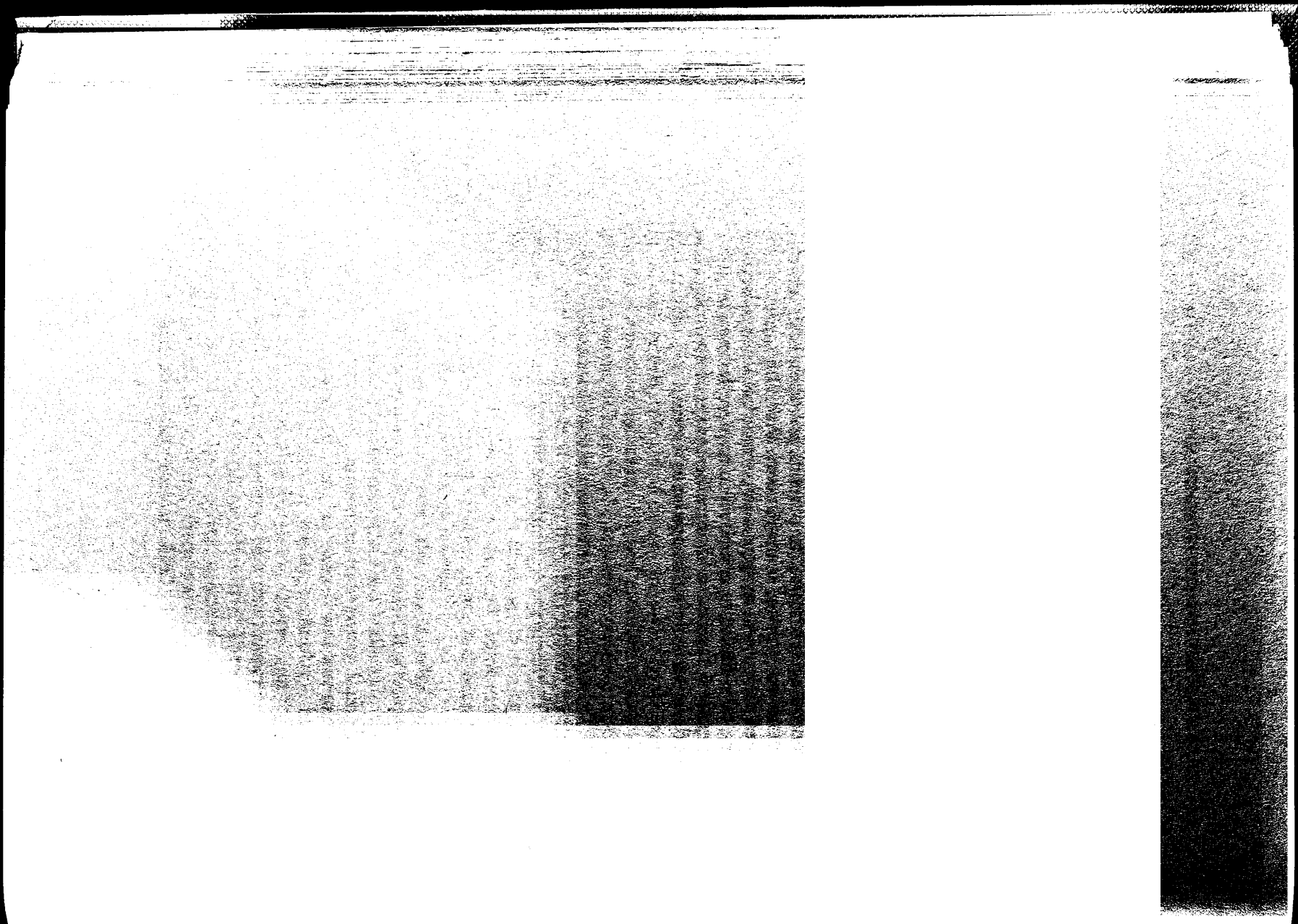
Virtually all the activities undertaken by FPCs which are concerned with change and development involve working together with either family practitioners or DHAs. This has been a recurring theme of the discussion in this and other sections of the book. Yet we have found varying degrees of commitment to collaborate in this way. At one end of the spectrum, there are FPCs which are only known to a minority of their practitioners, and almost unknown to their DHAs. At the other, there are those who are actively involved. Some have programmes for developing practice premises; others have developed an information base, or policies for the attachment of ancillary staff; many are aware of the concerns and worries of practitioners, GPs and attached community nursing staff, and of the need for expertise in practice management; still others are aware of the part they could play in supporting community-based preventive health programmes of various kinds, be it cervical cytology or community dentistry. This point is illustrated by our interview material. We asked community unit administrators how often they had spoken to the FPC in the previous week, either by telephone or personally. This ranged from two or three times, including a meeting, in the case of one DHA where there were close links, to not at all. Some unit administrators said that it was so long ago since contact had been made that they could not even remember when it was.

We can only speculate about the reasons why collaboration has developed in some places and not in others. It is tempting to attribute this to particular personalities and their leadership style. One influential British study of innovation in industry found that the most important determining factor in success was not individual personalities, industrial relations or specific technology, but the management and decision-making structures (Burns and Stalker 1961). To this we would add the existence of a management culture: a culture which puts emphasis on setting objectives. Turning to our examples, these two factors – appropriate structures and attitudes – were present in those FPCs where there was collaboration. A forum for regular discussion between the FPC and the local representative

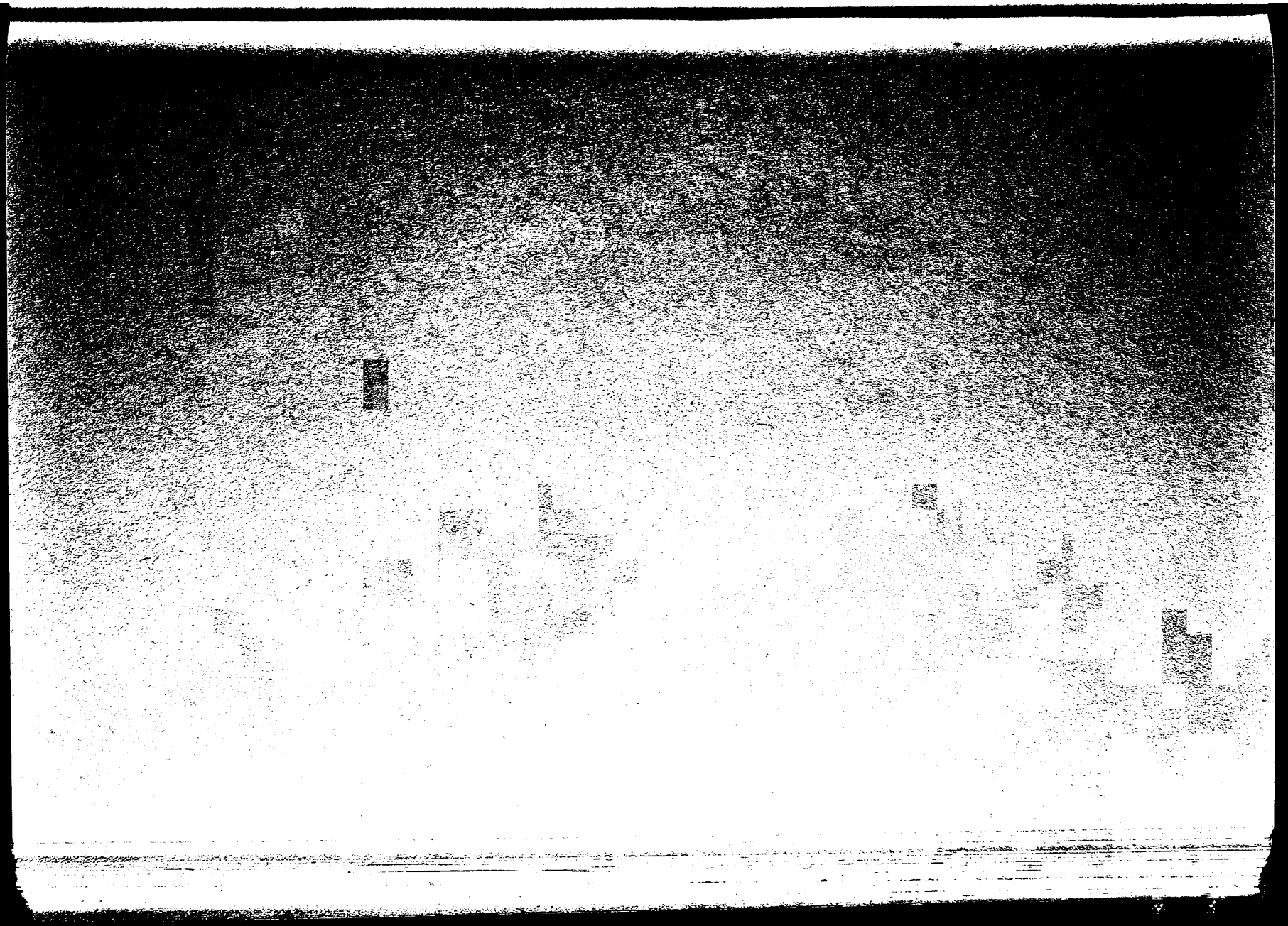
committees and the FPC and DHAs is important. It can create an opportunity for the emergence of a shared view on important issues; and it can set out a business agenda. This must be underpinned by a clear view from the FPC of what issues should be on that agenda, and of what it is possible to achieve within existing resources.

Our examples do suggest other factors external to the FPC which can facilitate collaboration. In a number of places we visited there was a local commitment to primary care which embraced the family practitioner element: local authorities who were interested or had been bullied into commitment; university departments concerned with quality of primary care; DHAs which were prepared to look outside hospital to care in the community. FPCs which do not have local facilitating factors of this kind have to find ways of bringing in expertise and will need to raise the funding to do so.

Collaboration is also made easier if the FPC has something to offer. This can occur in relation to practice premises, staff attachments and advice on practice management. With DHAs, access to information and the patient register is important but so is assistance in approaching GPs. FPCs are in a position to provide knowledge of the culture of general practice, and of the best ways of involving GPs in policies, both on an individual basis or as a group.



Conclusion



9
Family Practitioner Committees in the future: some genuine new clothes?

In this final chapter we attempt to highlight some of the major points which have emerged from our findings. We also discuss some of the factors which could enable FPCs to play a more positive role in promoting improvements in primary care. We summarise first some of the criticisms which have been made of FPCs and the family practitioner services, and outline the new statutory requirements. We then review the structural difficulties which may impede policy implementation, and speculate on future developments. To extend the metaphor we have chosen – we discuss the possibilities for giving the emperor some genuine new clothes.

Kenneth Clarke, the former Health Minister, in the debate on the committee stage of the Health and Social Security Bill, alluded to the change in FPC status as '... the preferred structure of the bureaucracy which would raise standards of performance and improve accountability' (Parliamentary debates 1984, col 305). This can be understood as referring both to the internal organisation and work of the FPCs, and to the activity of family practitioners who provide services for patients. If only the former is intended, then the change in FPC status is simply an exercise to curtail public expenditure. If the latter, it is the beginning of a process which should bring a transfer of resources to primary care. For unless this is the case, raised standards of organisation and greater accountability will bring little advantage to patients.

The defects of FPCs and family practitioner services

The major weakness of FPCs is that, on the whole, they have tended to develop their policies around the interests of practitioners. They have not been concerned with the wider issues which affect the level of health care in the community: with access, availability, standards and equity. Liaison with DHAs has been poor, and limited in its effectiveness.

In chapter 2 we concluded that FPCs had failed to 'market' either themselves or their services. We found that there was often an astonishing lack of information available about practitioners or FPCs, even for committee members, DHAs or local authorities; let alone for CHCs and members of the public. The FPC's role is not

well understood. This can sometimes contribute to a waste of public resources.*

People, as patients, are in a weak position in relation to health care. They find it difficult to judge what is 'good' or 'poor', both clinically and with regard to the services offered. Moreover patients are often bound to practitioners, particularly GPs, in a close and dependent relationship which makes it hard to offer criticism and use what Hirschman calls 'voice' to improve the service. It can be equally hard to use the alternative strategy, 'exit', and move to another practitioner, if both knowledge and information are lacking (Klein 1980). The FPC, therefore, has an obligation to act on behalf of patients and populations. Yet FPCs have a poor reputation with respect to involving such representative groups as CHCs. Complaints systems are a totally inefficient means of sampling consumer opinion, as Maxwell and Weaver (1984) point out. They are also an inadequate measure of consumer satisfaction. FPCs must not be complacent about their populations. Inevitably, the majority will remain silent.

In chapters 3 and 4 we discussed certain aspects of general practice and the powers which FPCs have to determine hours of work, deputising, the structure of practices and the standards of premises. As we stated, these powers have not, on the whole, been fully used. General medical services dominate the work of FPCs; and an FPC's ability to improve standards of primary care will depend on its relationships with LMCs and GPs. We gave examples of the way in which some committees have developed these contacts in more, or less, structured ways. General practice in this country has been slowly but steadily changing to meet the demands made by socio-demographic change, the growing potential for the prevention of ill health, and the demand for care in the community. But one feature of general practice, in the UK as elsewhere, is the gap between the satisfactory, the good, and the very poor standard of practice (Blishen 1969). From the point of view of those administering the services, this variability is compounded by a lack of knowledge about what GPs do: their actual workload and the content of their work. Maynard (1985) claims that 'Most procedures carried out in most hospitals, health centres and GP surgeries have not been evaluated

* A good example comes from Birmingham FPC's annual report, in a case involving the local authority. Residents in Winson Green petitioned the city council for a new pharmacy in their area. The council proceeded to discuss this request in apparent ignorance of the FPC's role in the matter. It only came to the notice of the FPC when a councillor who was also an FPC member drew their attention to it. The FPC then wrote to the council regretting that they (the council) had wasted their time, as the proposed new pharmacy would be too near existing provision to attract a basic practice allowance (Birmingham FPC 1982).

even crudely.'

The responsibilities of the FPC in relation to the practitioners providing dental, pharmaceutical and ophthalmic services are more limited. This is due to a number of factors. Most significantly, the contractual obligations are restricted; much of the administrative work in checking claims and calculating payment is carried out by national bodies, such as the Dental Estimates Board and the Prescription Pricing Authority. FPCs themselves have also tended to define their responsibilities narrowly. As a consequence, market forces have had more freedom to operate. This has had two effects. Firstly, the distribution of dentists, opticians and pharmacists is uneven. There are more practitioners in areas of high population density and prosperity. Secondly, in the case of the dental and ophthalmic services, there is evidence that the preventive aspect of care has been poorly developed.

New policies for FPCs

The circulars issued during 1985 suggest a clear intention to increase the FPCs' responsibilities to plan for improvements in primary care. They also encourage FPCs to collaborate with DHAs and practitioners in the process. A sense of purpose has been emanating from the DHSS. As early as 1983, a spokesperson introducing the proposed changes to an audience of FPC members and administrators warned that '... these simple sounding measures do not mark a return to the former Executive Councils ... the intention is that FPCs should be equal partners with DHAs' (opening address to the London and South Eastern Division of the Society of FPCs: King's Fund Centre 16 March 1983). A new mission has been spelt out for FPCs, and it has a new rhetoric. FPCs must concern themselves with seeing that the primary services for which they are responsible are available, comprehensive, evenly distributed and of good quality. In future, FPCs must be prepared to anticipate and respond to expressed needs for care in the community and to develop policies for the prevention of ill-health. One FPC administrator described the new-style FPC as being the 'front man for the GP' (Feinmann 1985e); on the other hand, Moran (1985), suggests that they should represent an alternative view of medicine. He asserts: 'FPCs should identify as a major task the restoration of the health care perspective ... to do anything less is to abdicate responsibility for which their front line role in health care uniquely fits them.'

In the new guidelines FPCs have been given clear instructions to 'collaborate'. The 1984 working group saw this as developing a

'... greater mutual understanding and respect for each others' (health and local authorities') roles and responsibilities, recognising community links as a particular point of contact, the creation of formal and informal liaison arrangements, ensuring joint reviews by DHAs and FPCs and the definition of common goals and purposes' (DHSS 1984e, page 5).* Such collaboration, we argued, also involves the FPC in working closely with its family practitioners; acting as their spokesperson with the DHA, representing their interests, if necessary, and supporting them in improving the service they wish to provide. Some FPCs have been working in this way for some time. But for others, it is a major new task. They should now be managing primary care services in liaison with DHAs, providers and consumers of services. Information exchange and collaboration are seen to be the keys to achievement. Accepting that a new role for FPCs is intended, what are the possible constraints?

FPCs: responsibilities without power

At various points throughout the book, we have argued that FPCs operate in a political environment in which the main means of achieving objectives is through negotiation, bargaining, persuasion and advocacy. These skills are necessary for all health services managers, as they have to deal with strongly entrenched professional groups. In the past, the main weakness of the FPC has stemmed from a lack of clear policy objectives, a lack of accountability, an absence of incentives; from an administrative, rather than a managerial culture. The new regulations will encourage change in these areas. However FPCs still lack the power to use sanctions. DHAs possess, as their ultimate weapon, the ability to withhold resources.

The sanctions which FPCs have are small by comparison: withholding reimbursement of rent and rates; refusal to attach staff; the service case; and, ultimately, a tribunal hearing to remove a practitioner from the list. These are rarely used. Arguably, they could be used more often. However, there are difficulties in two respects. Firstly, practitioners' contracts are based on legal requirements, and the DHSS has an appellate role. There have been cases where practitioners have appealed against a decision by the FPC, and won.† Such incidents can weaken the FPC's resolve to take a tough line. Secondly, to some extent there is a conflict between the FPC's

* The choice of the word 'collaboration' has been the subject of some speculation. The Concise Oxford Dictionary defines the verb 'to collaborate' as: 'work in combination with, especially at literary or artistic production; co-operate treacherously with the enemy'. Was 'cooperation' rejected for its socialist undertones?

† For example, in Dorset, a group of GPs appealed to the Secretary of State over an FPC

monitoring and policing role and its service development role. An FPC which monitors too vigorously and is constantly applying sanctions under its regulatory functions may find it less easy to encourage and to persuade.

While the DHSS has increased managerial control of FPCs, it has not laid down standards which should be achieved or targets for the services which practitioners provide. The DHSS has also been reluctant to alter the contract of practitioners in relation to their pay and conditions of service. The contract reflects the past rather than the present. One example of this is the thorny issue of a retirement age for doctors. Doctors are not obliged to retire at 60 or 65; indeed there are some who practise well on into their 80s. They also have the option of 'retiring' for 24 hours after the age of 60, when they can then receive both a pension and the full allowances and capitation fees. The FPC may refuse to renew their licence; this line is now being taken by Humberside.* However, the basic problem – the absence of the power to retire very elderly practitioners – remains.

FPCs have also been asked to plan their services. It is suggested in the NHSTA members' guide that the themes laid down for DHAs apply equally to FPCs (Barnard and Wood 1985). However the absence of sanctions, coupled with the contractual rights of practitioners, do mean that there are fundamental differences between FPCs and DHAs. Furthermore, FPCs cannot produce costed operational plans. Those who suspect the government's motives in establishing self-employing FPCs have characterised the recent changes as cosmetic, 'an elaborate confidence trick' which does nothing to alter the ability of practitioners to do or not do as they wish (*The Health Summary* 1985). We have argued that while FPCs are able to set a strategic framework for planning, the realisation of their programmes will depend on a number of local factors. These may defeat the most eloquent persuader.

Many are pessimistic about the future prospects. These pessimists, including the opponents of the 1985 change in status, argue that there is no incentive for DHAs and FPCs to collaborate. Why should DHAs attempt to achieve inter-organisation cooperation, with all its difficulties, when there are so many issues within their own organisations demanding management attention and while most

* Personal communication, Humberside FPC.

decision to refuse them permission to open a branch surgery (interview). In Birmingham, when the FPC withdrew consent from what it considered to be an unsatisfactory deputising service, the doctors involved immediately appealed to the department, while the owners of the service took out a High Court injunction against the FPC. However, in the latter case, the committee's original decision – to impose conditions on the service – was upheld (Birmingham FPC 1985).

authorities are already struggling with reductions in real resources? And FPCs are being asked to develop on a number of fronts simultaneously. They must monitor and regulate their practitioners' contracts more assiduously, set higher standards for premises, visit them, enforce requirements, plan their services, restructure their management, inform the public, adjudicate conflicts fairly and quickly, as well as collaborate. All this must be contained within existing resources.

One FPC administrator with a management background commented to us: 'The trouble is that FPCs are at present a one-horse, or rather a one-man band; therefore the Minister's hopes for the future are somewhat optimistic.'* A number of FPCs have extremely small staffs. Many have to cope with incredibly complex collaborative arrangements. Few officers currently working in the organisation possess the necessary skills to negotiate with GPs, community physicians or health authority general managers.

FPCs, family practitioners and improving standards of care

Despite the relevance of some of the comments there is room for cautious optimism. There are signs that the family practitioners themselves are concerned to improve standards. Our findings did suggest that despite the difficulties, FPCs were collaborating with practitioners to raise standards and with DHAs to plan services. The new responsibilities can only aid in this process. 'The time is ripe for progress' claims another administrator. 'With districts in the middle of Griffiths restructuring and the FPCs learning to walk on their newly found feet, both sides will want to be seen achieving, to be making new successes. It was never a better time for collaboration between the two sides' (Feinmann 1985e).

The quality initiative launched by the Royal College of GPs (RCGP) is one example of a professional concern to provide a more comprehensive, evenly distributed, good quality primary care service. GPs are now under pressure from a number of directions. First, there is increasing emphasis on giving good quality GP care for those who are ill. The RCGP has suggested a number of methods of peer review and, although it represents only a minority of the profession, it is the standard bearer and its thinking has an echo in government attempts to evaluate professional practice. Second, they are under pressure from patients whose expectations are rising and who are likely to be more critical. This is a trend which will continue, as GPs are encouraged to give more information about what they provide in their

* Interview.

practices and comparisons can be made.*

Third, GPs are now also expected to concern themselves with anticipatory care and health surveillance. This is because they are the providers of front-line care to individuals and families and because they are the group which, collectively, covers whole populations. Tudor Hart, an advocate for general practice, argues that GPs have '... relatively stable registered populations, with names and addresses; they are in a position to measure what is done and what needs to be done. GPs can plan work, evaluate its result and audit' (Tudor Hart 1982). New computer technology is making anticipatory care increasingly feasible, as is the employment of numbers of specialist health workers within practices. Both factors however increase the importance of good resource management. The organisation of improvement schemes is a further responsibility falling on some practices. These three factors have together increased the management task for general practice. They raise questions about the appropriate response. Some practices employ managers; in others a senior partner will take a leading role. The FPC can make a contribution to resolving such problems.

We have referred to a number of ways in which FPCs have assisted GPs: by training practice managers, advising on Cost Rent and Improvement schemes (although in chapter 4 we did express reservations about the ability of the FPC to apply value for money criteria in such a technically specific area), advising on the attachment of staff, and providing information on the use of computers. Lincolnshire FPC (1985) makes special reference to supporting GPs in this area in its current strategic plan. It states: 'The Committee will encourage practitioners to use computers and modern technology in general practice, and will assist in ensuring that adequate training, support and remuneration for the increased skills required by practitioners' staff are made available.' This kind of support is going to be vital if general practice is to develop on a broader front. An FPC contribution to the training and education of younger practitioners is also important. Many trainees and new recruits do not sufficiently understand the FPC's role. The administrator can give advice on partnership arrangements. For example, he or she can refuse to accept arrangements which appear to exploit some parties to the agreement. This applies to other practitioners as well as to GPs.

FPCs are working with the DHA community dental service to identify local gaps in the general dental services. There is particular

* The General Medical Services Committee (GMSC) is now supporting the provision of information on practices to both prospective and existing patients. One doctor arguing for the proposal suggested that the GMSC should be seen to be 'leading the profession' (BMJ 1985c).

concern to encourage young people to visit the dentist, and to provide a service for the housebound. There are also experiments with a capitation form of payment in order to encourage preventive dentistry. Pharmacists too are beginning to stress the advice and information service they provide to patients. Some keep lists of their regular patients, together with the medication they are receiving. Many pharmacists would like this service to be allowed for in the calculation of the basic practice allowance. The extent to which the planning role of the FPC can expand in relation to the community dental and pharmaceutical services will depend very much on the approach and influence of the local representative committees.

FPCs and collaboration

At the end of chapter 8 we suggested some of the factors which had aided collaboration. These included a clear view of the FPCs' objectives and priorities, and a structure within which to set objectives. The decision-making structure within the FPC itself, we would argue, is as important as inter-agency structures. FPCs where collaboration was working well could offer knowledge of the services provided by practitioners, as well as having an awareness of their perceptions and expectations. The FPC can act as a channel of communication to practitioners, and it should have a detailed knowledge of what is feasible. Moreover, it is quite possible for FPCs to work effectively with DHAs without computerisation. Measurable progress had been made over the development of cervical cytology policies and in planning the attachment of nursing staff in some areas we visited. However FPCs with computerised registers are beginning to build up a database for joint planning, and they can offer a very positive service to their practitioners and to the DHA. Frequently, organisations are faced simultaneously with incentives to collaborate and to compete. A good database will provide the FPC with a basis for exchange. But there is no doubt that the experience of collaboration can be difficult and frustrating, and FPCs will have to develop their own strategies at local level.

Elmore (1980), commenting on the findings of implementation research, emphasises the importance of local coalitions: '... unless the initiators of policy (and these are the local actors) can galvanise the energy, attention and skills of those affected by it (the policy), thereby bringing these resources into a loosely-structured bargaining arena, the effects of a policy are unlikely to be anything but weak and diffuse'. He goes on to argue that bargaining needs real stakes, flexibility in the use of resources and, if behaviour is to be changed,

then the closest point of contact with it should be chosen for intervention; '... the connection between the problem and the point of contact is the most critical point of the analysis'.

This would suggest that from the DHSS point of view the critical area for intervention is the individual FPC. For the FPC, it is the individual family practitioner or groups of practitioners. Traditionally family practitioners have been resistant to 'administrative' interference. However we have found that GPs, for example, do not necessarily form part of cohesive groups insulated from the health system around them. In many areas there were those who wished to provide better community and preventive services for their patients. There were also those who had been frustrated in their endeavours by unhelpful and bossy DHA unit administrators, uncooperative nurse managers and uninterested FPC administrators. Elsewhere, groups of younger GPs felt constrained by their more traditionally-minded elders who were dominating the LMC, and hence blocking access to channels of communication with the DHA. In some instances these GPs had formed alternative groups which made their own responses to consultation documents and provided an alternative source of representatives for DHA planning teams. They acted as a focus for those who wished to alter local policy. Essentially, such local developments represent a shift in the structured interest groups we referred to in the Introduction – a coalition of 'corporate rationalisers' (which includes both the FPC and professional leaders) with groups representing the community interest against a narrowly-defined and ultimately self-concerned professional lobby. By allowing interests to coalesce around a common task at the lowest organisational level, they are fulfilling some of Elmore's criteria.

Future prospects for FPCs

At the present time, the future development of FPCs is uncertain. This is due to two major factors. First, the direction of government policy in relation to primary care is not clear. Second, it is not known how far FPCs will be able to strengthen their various roles. To some extent, we have argued, this will depend on local circumstances.

During the 1980s, the Conservative government has been particularly concerned to contain expenditure on the NHS, to increase efficiency, to improve standards and to promote consumer influence and choice. We have shown that as far as FPCs are concerned the capacity to achieve these objectives is limited by the contractual obligations and concerns of family practitioners. But, as a *Guardian* leader commented (12 January 1985), there is a tide of change:

'... [the NHS] cannot be allowed to be simply a structure within which professionals are allowed to do as they like, spend as they like and generally behave like blocks of hermetically-sealed professionalism'. There are two further possibilities for radical change: an increased use of the price mechanism linked with managerial control to create incentives; or further deregulation and privatisation.

Enthoven (1985) advocates the use of financial incentives to encourage groups of doctors to provide services which, he argues on the basis of experience in US health maintenance organisations, can not only lead to an efficient use of resources but can 'even motivate doctors to expel poor performers from their group'. Bosanquet (1986) has taken up this proposal, suggesting that groups or 'firms' of doctors could be offered 'contracts' by DHAs to provide health screening services. Both the FPC and DHA could be involved in negotiating such contracts. These would involve tight management control (unlike the present system where GPs are paid for extra services on an item for service basis and there is no check on whether particular populations are being reached). Barnsley FPC has proposed the introduction of budgets for individual practices (Barnsley FPC 1985). The BMA, meanwhile, continues to press for an increased number of item of service payments. It rejects any attempt at managerial control which would apply value for money criteria (Wilson 1985).

Some deregulation and privatisation has already occurred in the dental, pharmaceutical and ophthalmic services. Successive governments, by imposing higher charges, have continued to increase the level of financial contributions made by patients. The scope of the services has also narrowed: the limited list, for example, reduced the numbers of medicines able to be prescribed under the NHS; the monopoly for dispensing glasses has been removed from dispensing opticians; the supply of subsidised glasses has been abolished and the present exemption system will be replaced by vouchers for children and adults with low incomes. The latter policy has been justified in terms of giving greater freedom of choice to the consumer. These measures were opposed by the professional associations. It is uncertain how far this 'customer knows best' reasoning will be extended to the pharmaceutical and dental services; if it is, the role of the FPC could be reduced.

Such changes are more likely if FPCs, DHAs and family practitioners do not build local coalitions which strengthen their roles in primary care. In our view, it is preferable that management control should remain with the statutory bodies as this is more likely to promote equity in both the standards and availability of services.

Assistance for FPCs

FPCs need to seize their opportunity while it is there. But they will need assistance, both from the DHSS and from the professions. Their capacity to achieve change will depend not only on skills at local level, but also on the extent to which they can gain – and maintain – support. We outline some areas where we believe that action should be taken.

Management education and training

All levels of FPC staff will need increased management training if they are to develop the necessary skills to undertake their new role effectively. Senior officers will need opportunities to share experiences with their peers, and to develop their own managerial capacity. FPC officers should be brought into the ambit of NHS training, attending courses alongside other health service managers. Training will be needed in the specific skills necessary to handle computer technology; and also in developing planning techniques and ways of measuring standards of service within the FPC context. Such support is already being provided by the FPS computer unit in Exeter, and the NHSTA is developing training programmes. Preparation for the change in FPC status has, however, been woefully inadequate. FPC administrators have constantly stressed the importance of training for their staff. However, they have not been well-informed about the opportunities available, and they often do not have sufficient budgets even to begin a training programme.

Members, too, need training. Little has been said about members directly, but their role in the FPC can be very influential. They have always played an important decision-making role on FPC sub-committees, particularly in dealing with practice vacancies and complaints. Members could play a very positive part in creating a sense of purpose and in defining objectives, although they will need to overcome internal conflicts of interest. They are unpaid, as are chairpersons, and this limits the time available; but the potential does exist. In many respects the role of FPC members is more powerful than that of their DHA cousins, particularly following the introduction of general management.

Resources

The question of resources is a major concern. FPCs are being asked to carry out new tasks, as well as fulfilling their existing responsi-

bilities more effectively. Budgets have never been drawn up for the discharge of these responsibilities. Although the Arthur Andersen report anticipated savings from computerisation, these were not offset by the new demands which could arise in relation to collaboration and planning (Andersen 1984). Once new information is available, it will generate new questions and new demands. The costs of informing the public have never been worked out. FPCs may well find themselves unable to meet the demands which are made upon them. Where there is a defined statutory obligation, duties such as hearing complaints or processing grants for practitioners may, perforce, take precedence over the broader objective of meeting the primary care needs of their communities. The DHSS must be prepared to provide the necessary resources. The review process will provide an opportunity for negotiation. There is a clear case for speeding up the FPC computerisation programme, and only the DHSS can provide the necessary funding.* The department should also be prepared to allow greater flexibility in the criteria for determining the reimbursement for ancillary staff, and in the appointment of clinicians to meet special needs. Equally, FPCs will have to be prepared to state their case vigorously. The DHSS should encourage innovation and experiment, and then evaluate it. There is no reason, in principle, why FPCs could not be budget holders for the discharge of particular functions.

Changing the contract

We referred earlier to the FPCs' lack of power to enforce standards relating to premises, and to their difficulties in ensuring that particular services are available. It is possible to agree standards by negotiation; but there is also a case to be made for renegotiating the contract of service. This can only be done by the DHSS in consultation with the professional organisations. Could not a retirement age be agreed for GPs? And could some agreement be reached for GPs to carry out specific preventive health care programmes, under collaborative arrangements?

Clarification of roles and setting objectives

We have suggested that FPCs could now be seen as managing primary care services for their communities in liaison with DHAs, the providers of services, and consumers. But if this is to be achieved there will need to be a clarification of roles. The following relation-

* A 1986 circular recommends an increase in the rate of computerisation, although this will be dependent on the cost savings in FPCs and on contributions from DHAs (DHSS 1986c).

ships within the FPC will need to be considered: FPC administrator/chairperson; chairperson/members; officers/members. The relationships which the FPC establishes with practitioners, DHAs, CHCs and local authorities are also important. These are all actors who have a stake in defining the local objectives for primary care. The roles and responsibilities need to be thought through, and appropriate mechanisms set up. Once objectives and priorities begin to develop, there will need to be a process of consultation. These processes will be essential in establishing political support and the vital 'local coalitions'.

Information

We have stressed the overwhelming importance of a good database from which to develop objectives. This needs to include both socio-demographic data and information on practitioners: the services they provide, their staff and premises; their aims, difficulties and expectations. When this is available, it will then be more possible to determine baseline provision and standards. This information should be made available to other agencies concerned with planning health care.

Funding research

Some areas of FPC work need to be investigated more fully through sponsored research. We can only suggest a few possible directions here. The impact of computer technology on the FPC as an organisation, the way in which this is being used by committees, the gaps in software programmes, the problems and costs of introducing computers, are all areas worthy of exploration. We believe it would be useful to investigate collaboration in relation to particular areas of provision, rather than collaboration over a broad spectrum. Thus, how DHAs and FPCs are dealing with the GP/attached nurse issue could be explored further; or joint working in the area of cervical cytology screening. It would also be of value to know more about the parameters of the FPC/LMC/GP relationship within FPCs. We are not aware of any work done in this area.

Developing a positive public image

FPCs have to find ways of making a greater public impact. This will not only mean more effective communication, as we suggested earlier. It means that FPCs will have to develop more entrepreneurial

skills – increasing their knowledge of other health organisations, using their own databases and resources, and actively seeking out sources of further funding – in order to bring about a fundamental shift of resources to primary care. It may well be their last chance.

Postscript

Since the completion of our study the consultative paper, *Primary Health Care – an agenda for discussion* * and the Cumberlege report on community nursing have been published.† Their publication should herald a period of lively debate, not least because on some more crucial issues their recommendations are diametrically opposed to each other. For example, the consultative paper declares that the independent contractor status of family doctors has brought benefits and should continue (p. 48) while Cumberlege recommends that in due course FPCs should be amalgamated with DHAs, thus bringing all primary care services under the control of one body (p. 49). The next decade will be an important one for primary care. It could bring shifts in the division of labour and new forms of control by both national and local agencies. Decisions about the role of the FPC will be central.

* (1986) Cmnd 9771. London, HMSO.
† Neighbourhood Nursing – a focus for care (1986). Report (Chairman Mrs Julia Cumberlege). DHSS. London, HMSO.

Appendix I

The functions of Family Practitioner Committees (1981)

Family Practitioner Committees are responsible for administering the arrangements for the provision of general medical, dental, ophthalmic and pharmaceutical services. The specific tasks which they carry out in undertaking that function include:

a) Arranging with general medical and dental practitioners, pharmacists, appliance contractors, ophthalmic medical practitioners and opticians (hereinafter referred to as 'contractors') for the provision, within the FPC's area, of the services which patients who wish to take advantage of those arrangements are entitled to receive. Ensuring, through the application of the appropriate regulations, that such persons receive adequate personal care and attendance. On request, assigning a person to a general medical practitioner in those cases where the person has previously been refused acceptance.
b) Maintaining the lists of contractors who have undertaken to provide family practitioner services in the area.
c) Dealing with applications for inclusion in those lists and the implications arising therefrom. Those from medical practitioners may only be granted by the Medical Practices Committee who also deal with medical practice vacancies. In the matter of applications to succeed to a practice vacancy, the FPC will advertise the vacancy and then consider all applications, draw up and interview a short list of candidates, and obtain references before sending all applications to the MPC with the FPC's recommendation as to the doctor or doctors to be appointed.
d) Administering the terms of service under which independent contractors provide services. FPCs are responsible for ensuring that obligations under those terms of service are met.
e) Providing advice and guidance to both contractors and patients. FPCs are responsible for establishing service committees under relevant regulations to investigate any complaints which allege that a contractor might be in breach of his terms of service. Service committees also investigate complaints and references from the Dental Estimates Board which involve allegations of breaches of the terms of service for dentists, and references about alleged irregular certification from local Social Security offices, and other matters, relating to the administration of the Family Practitioner Services. They also establish dental conciliation committees.
f) Calculating the fees, allowances and reimbursements to which contractors are entitled and ensuring their prompt payment; dealing with claims for travelling and subsistence allowances by doctors who attend approved educational activities. Monitoring claims to detect irregularities;

operating checks on remission of charges and refunding charges to patients in certain circumstances.

g) Approving where so required under the terms of service specific arrangements concerning the provision of services. For example, in the case of general medical practitioners, consent to the use of deputising services; approval of surgery premises and the time at which the doctor is available for consultation; consent to the employment of an assistant for more than three months in any twelve, and so on. Inspecting medical practice premises and assisting doctors to improve such premises by telling them of, and guiding them through, the improvement grant and cost rent schemes.

h) Maintaining lists of patients registered with general medical practitioners in the form of a nominal index, doctor's register of patients by doctor, and doctor's ledger showing numbers at the beginning of a quarter, additions, cancellations and number at the end. Notifying movements of patients from other areas to the FPCs concerned and the NHS central register; issuing medical cards to patients; checking doctors' lists to eliminate duplicate registrations ('inflation').

i) Arranging for the transfer of medical records between doctors and FPCs when a patient changes his doctor.

j) Ordering, storing and supplying to general medical practitioners sterile single-use syringes and needles and the various items of stationery and forms required for use by contractors. Issuing to doctors the Statement of Fees and Allowances and amendments, National Insurance Medical Certificate (doctor's statement) forms and prescription forms.

k) Administering the arrangements made for i) general practitioner maternity medical services and contraceptive services and ii) the supply of drugs and appliances by doctors.

l) Provision to health authorities of data on immunisation.

m) Assisting in the local operation of the cervical cytology recall system.

n) The receipt and monitoring of prescription charges from dispensing doctors and the checking arrangements concerning claims for exemption from prescription charges. Returns to the Secretary of State on these matters. Maintaining, for renewal purposes, records of holders of prepayment certificates for prescriptions.

o) The Drug Testing Scheme – preparing and administering the scheme for testing the quality and checking the amounts of drugs and appliances supplied by pharmacists.

p) Administering the domiciliary oxygen therapy scheme, maintaining lists of voluntary contractors (pharmacists, general medical practitioners and appliance contractors) and controlling holdings of approved equipment.

q) Organising rotas of duty pharmacists. Preparing and maintaining lists of pharmacists available to dispense urgent prescriptions outside normal and rota hours.

r) Consulting, funding and involving as required the local professional committees representing contractors.

s) Providing as necessary secretariat services to serve the lay and pro-

fessional members of FPCs to enable it and its associated sub-committees to function efficiently.

t) General planning of services including planning of family practitioner services in, for example, new town developments. Liaison with health authorities and, where necessary, any other relevant bodies on service planning including for example the planning of health centres.

u) Keeping accounts of receipts and expenditure and forwarding these to the Secretary of State.

v) Channel of communications for conveying the Secretary of State's policy guidance and advice to the contractor professions.

w) Liaison with DHSS as appropriate on matters relating to practitioner services; the provision of statistics and returns to DHSS.

Source: DHSS 1981a.

Appendix II

*FPC joint and sub-committees**

Sub-committee	Main function	Membership†
Allocation joint	To assign patients to a doctor's list who are unable to gain acceptance by any doctor	Chairperson 3 members 3 family doctors
Deputising services	To advise the FPC on the adequacy of deputising arrangements for general medical practice	Medical chairperson 1 experienced hospital doctor 4 family doctors 6 lay members
Dispensing	To deal with dispensing arrangements in rural areas	Lay chairperson 3 lay members 3 family doctors 3 pharmacists
Hours of service	To consider and recommend to the FPC pharmacists hours of opening and the adequacy of out-of-hours provision	Lay chairperson 3 lay members 3 pharmacists
Standing Joint or Practice Vacancies Committee (name variable)	To deal with matters relating to medical practices (interviewing for single-handed vacancies, reviewing Cost Rent and Improvement schemes, preparing material for the MPC, and so on)	Medical chairperson 3 lay members 3 medical members

* FPCs may have additional sub-committees to enable them to conduct their business: for example, for finance and general purposes, or for planning. These vary between FPCs.
† Lay members, including the chairperson, are appointed by, and usually from, the FPC. All professional members are appointed by the appropriate LRC; some will be members of the FPC.

FPC service committees

Sub-committee	Main function	Membership*
Medical service	To investigate complaints about alleged breaches of terms of service	Lay chairperson 3 lay members 3 family doctors
Dental service	To investigate complaints about alleged breaches of terms of service	Lay chairperson 3 lay members 3 dentists
Pharmaceutical service	To investigate complaints about alleged breaches of terms of service	Lay chairperson 3 lay members 3 pharmacists
Ophthalmic service	To investigate complaints about alleged breaches of terms of service	Lay chairperson 4 lay members 2 ophthalmic medical practitioners 2 ophthalmic opticians 2 dispensing opticians
Joint services	To investigate complaints about alleged breaches in terms of service where more than one profession is involved	2 lay members and potentially 8 professional members (2 from each service committee concerned)
Denture conciliation	To investigate complaints about the supply of dentures	Lay chairperson 2 dentists from a panel nominated by the FPC

* Lay members are appointed by, and usually from, the FPC. Professional members are appointed by the appropriate LRC. All members, including the chairperson, must have deputies.

Appendix III

Summary of the Alma-Ata declaration

The international conference on primary health care, held in September 1978 in Alma-Ata, the capital of the Soviet Republic of Kazakstan, expressed the need for urgent action by all governments, all health and development workers, and the world community to protect and promote the health of all the people of the world. The declaration reads as follows:

1) The conference strongly reaffirms that health, which is a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity, is a fundamental human right and that the attainment of the highest possible level of health is a most important worldwide social goal whose realisation requires the action of many other social and economic sectors in addition to the health sector.
2) The existing gross inequality in the health status of the people particularly between developed and developing countries as well as within countries is politically, socially and economically unacceptable and is, therefore, of common concern to all countries.
3) Economic and social development, based on a new international economic order, is of basic importance to the fullest attainment of health for all and to the reduction of the gap between the health status of the developing and developed countries. The promotion and protection of the health of the people is essential to sustained economic and social development and contributes to a better quality of life and to world peace.
4) The people have the right and duty to participate individually and collectively in the planning and implementation of their health care.
5) Governments have a responsibility for the health of their people which can be fulfilled only by the provision of adequate health and social measures. A main social target of governments, international organisations, and the whole world community in the coming decades should be the attainment of all peoples of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life. Primary health care is the key to attaining this target as part of development in the spirit of social justice.
6) Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology, made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain, at every stage of their development, in the spirit of self-reliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the

community. It is the first level of contact of individuals, the family, and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process.

7) Primary health care:

a) reflects and evolves from the economic conditions and socio-cultural and political characteristics of the country and its communities and is based on the application of the relevant results of social, biomedical, and health services research and public health experience.

b) addresses the main health problems in the community, providing promotive, preventive, curative, and rehabilitative services accordingly.

c) includes at least: education concerning prevailing health problems and the methods of preventing and controlling them; promotion of food supply and proper nutrition, an adequate supply of safe water and basic sanitation; maternal and child health care, including family planning; immunisation against the major infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries; and provision of essential drugs;

d) involves, in addition to the health sector, all related sectors and aspects of national and community development, in particular agriculture, animal husbandry, food, industry, education, housing, public works, communications and other sectors; and demands the co-ordinated efforts of all those sectors;

e) requires and promotes maximum community and individual self-reliance and participation in the planning, organisation, operation and control of primary health care, making fullest use of local, national and other available resources; and to this end develops through appropriate education the ability of communities to participate;

f) should be sustained by integrated, functional, and mutually supportive referral systems, leading to the progressive improvement of comprehensive health care for all, and giving priority to those most in need;

g) relies, at local and referral levels, on health workers, including physicians, nurses, midwives, auxiliaries, and community workers as applicable, as well as traditional practitioners as needed, suitably trained socially and technically to work as a health team and to respond to the expressed health needs of the community.

8) All governments should formulate national policies, strategies, and plans of action to launch and sustain primary health care as part of a comprehensive national health system and in co-ordination with other sectors. To this end, it will be necessary to exercise political will, to mobilise the country's resources and to use available external resources rationally.

9) All countries should co-operate in a spirit of partnership and service to ensure primary health care for all people since the attainment of health by people in any one country directly concerns and benefits every other country. In this context the joint WHO/UNICEF report on primary health care constitutes a solid basis for the further development and operation of primary health care throughout the world.

10) An acceptable level of health for all the people of the world by the year 2000 can be attained through a fuller and better use of the world's resources, a considerable part of which is now spent on armaments and military conflicts. A genuine policy of independence, peace, détente, and disarmament could and should release additional resources that could well be devoted to peaceful aims and in particular to the acceleration of social and economic development of which primary health care, as an essential part, should be allotted its proper share.

Source: Blair 1983.

Appendix IV

Methods: interviews and questionnaires

During the first half of 1985, we carried out a number of semi-structured interviews: with ten FPC administrators, seven community unit administrators, a community physician and two primary health care development workers. (The latter had been specially appointed on short-term contracts to facilitate the development of primary care in their areas. There are a number of such posts in different parts of the country.)

The FPCs were not strictly sampled in the technical sense. Our original brief had been to look for good practices in FPCs, so initially we decided to visit four FPCs which our informal network indicated had taken a positive approach towards developing primary care. We also decided to interview community unit administrators in these areas. This was possible in three cases.

Our second decision was to attempt to get a geographical spread of FPCs in terms of those with substantial rural, inner city and urban populations and to choose areas where the FPC had to relate to three or more DHAs. The final selection, including the initial four, consisted of two FPCs with rural populations, six covering inner city areas, and two urban areas; of these, nine related to three or more DHAs.

The interviews covered a number of topics: the characteristics of the FPC in terms of social demography, numbers of contractors, the organisation of local and health authorities, and collaborative mechanisms. We also asked administrators how they had approached their role, what they were aiming to achieve, what their objectives were and what were the obstacles to change. We asked them how they worked with different groups of practitioners and how they dealt with specific issues such as practice premises, the employment of ancillary staff, and complaints. We discussed areas of collaboration, if any, with the DHA: cervical cytology, helping homeless families, family planning, child health surveillance. We aimed to explore how policies had developed, and what administrators' perceptions were regarding the important strategies. The interview material was subsequently transcribed and a content analysis carried out under particular headings, generating further categories in the process.

The interviews with community unit administrators and others had a rather different purpose. We wished, firstly, to get their views about the problems of primary care; to find out how they were collaborating with FPCs and for what purposes. The interview data was also transcribed and analysed. This group, where they did not have a connection to a particular FPC, were suggested to us by the King's Fund Centre. They were widely spread geographically, and covered inner city, urban and rural areas.

Following our initial interviews, we sent a brief questionnaire to all the

FPCs which we had not visited, informing them about the project. We asked them to give us some basic factual information, and to tell us of any recent innovations and good practices, using their own subjective judgments to determine the criterion for a 'good practice'. We also asked them about any obstacles they anticipated in developing their role in the future. Fifty-five per cent replied. With some of these, we had further discussion and correspondence. The data was analysed in a matrix under subject headings similar to those developed from the interview data. Where possible this was quantified, although there were limitations to what could be done. Many of the examples given needed considerable elaboration of the context in which they occurred in order to give them meaning.

References

Abrams P (1984) Realities of neighbourhood care: the interactions between statutory and informal social care. Policy and Politics 12, 4: 413–429.

Acheson HWK and Henley MH (1984) Clinical knowledge and education for general practice. Royal College of General Practitioners.

Adam S and Mitchell J (1985) Commitment or camouflage? Health and Social Service Journal, 30 May. Centre Eight: consumerism in the NHS: 5–6.

Adam Smith Institute (1984) The omega file: health and social services policy. London, The Adam Smith Institute.

Alford R (1975) Health care politics. Chicago, University of Chicago.

Allsop J and Lovell A (1984) Patients without doctors. Health and Social Service Journal, 19 April: 463.

Allsop J and May A (1985) Telephone access to GPs: a study of London. London, King's Fund Centre, Project Paper No 53.

Anderson OW (1972) Can there be equity? The United States, Sweden and England. New York, John Wiley.

Anderson R (1984) Measuring blood pressure: reports from patients. Community Medicine 6: 109–114.

Arthur Andersen and Co (1984) Report of a study of family practitioner services, administration and the use of computers. DHSS.

Armstrong D (1984) The patient's view. Social Science and Medicine 18, 9: 737–744.

Armstrong D (1985) Space and time in British general practice. Social Science and Medicine 20, 7: 659–666.

Avon Family Practitioner Committee (1984) Report on the administration of the family practitioner services, 1983–4.

Bachrach P and Baratz MS (1970) Power and poverty, theory and practice. Oxford, Oxford University Press.

Bailey S (1985) Assessment of the records of care of patients with diabetes. British Medical Journal 290: 1792.

Bain DJG (1984) Deputising services: the Portsmouth experience. British Medical Journal 289: 471–473.

Barnard K and Wood J (1985) Family Practitioner Committees – a guide for members. Bristol, National Health Service Training Authority.

Barnet Family Practitioner Committee (1980) Informal procedure for dealing with complaints: the role of the conciliator. Unpublished paper.

Barnsley Family Practitioner Committee (1985) Strategy statement 1986–89.

Barrett S and Hill M (1984) Policy bargaining and structure in implementation theory: towards an integrated perspective. Policy and Politics 12, 3: 219–240.

Beale N and Nethercott S (1985) Job-loss and family morbidity: study of a factory closure. Journal of the Royal College of General Practitioners 35, 280: 510–514.

Beaumont B (1982) Evaluating the quality of primary medical care. Community Medicine 4, 2: 113–118.

Best G and Evans T (1983) Planning. In: Wickens I (ed) Effective unit management. London, King Edward's Hospital Fund for London.

Betz M and O'Connell L (1983) Changing doctor-patient relationships and the rise in concern for accountability. Social Problems 31, 1: 84–95.

Beveridge C (1983) Against centrism: planning and development in the NHS. Hospital and Health Services Review. September: 210–213.

Birmingham Family Practitioner Committee (1982) Report of the committee for the period 1 April 1980 to 31 March 1982.

Birmingham Family Practitioner Committee (1985) Report of the committee for the period 1 April 1982 to 31 March 1985.

Blair P (1983) Conference report on planning for primary health care. King's Fund Centre.

Blishen BR (1969) Doctors and doctrines. Toronto, University of Toronto Press.

Bloomsbury Community Services Unit and Bloomsbury Community Health Council (1984) The health care needs of Chinese people in Bloomsbury health district: the report of a survey.

Bolden KJ (1981) Inner cities. Journal of the Royal College of General Practitioners, Occasional Paper 19.

Bone M (1984) Registration with general medical practitioners in inner London. London, HMSO.

Booth TA (1981) Collaboration between the health and social services. Part 1: A case study of joint planning. Part 2: A case study of joint finance. Policy and Politics 9, 1: 23–49 and 9, 2: 205–226.

Bosanquet N (1986) GPs as firms: creating an internal market for primary care. In: Harrison A and Gretton J (eds) Health care UK 1986. Policy Journals.

Bowles B (1984) The expenses myth that is eroding your target pay. Pulse, 31 March: 27.

Bowling A (1985) Doctors and nurses: delegation and substitution. In: Harrison A and Gretton J (eds) Health care UK 1985 – an economic, social and policy audit. London, CIPFA.

Bowling A and Betts G (1984) The scope for preventive medicine in general practice in the East End. Health Education Journal 43, 4: 96–99.

British Dental Association (1984a) Advice sheet no 22. Where to work? A guide to practice location for the general dental practitioner.

British Dental Association (1984b) NHS dental treatment – what it costs and how the cost has risen.

British Medical Journal (1981) Primary care in inner London: inadequate and exposed. 282: 1739–1740.

British Medical Journal (1982) GMSC discusses reduction in average list size. 285: 1675.

British Medical Journal (1984a) Deputising services: a serious blunder. 288: 172.
British Medical Journal (1984b) Confidentiality of personal health information. 289: 1559–1560.
British Medical Journal (1985a) More stringent standards for GPs' surgeries. 290: 186.
British Medical Journal (1985b) The working of the MPC. 290: 654.
British Medical Journal (1985c) GMSC worried about membership of new FPCs. 290: 801.
British Medical Journal (1985d). Community care. 290: 806.
British Medical Journal (1985e) Family practitioner committees: a price for independence. 290: 953–954.
British Medical Journal (1985f) Rural practice: an interview with the chairman of the Rural Practices Sub-Committee. 290: 1089–1092.
British Medical Journal (1985g) Cervical screening survey. 290: 1083.
British Medical Journal (1985h) From the GMSC. 291: 1591.
Brough AK (1985). Local recall scheme for cervical cytology. Letter in The Lancet, 11 May: 1102.
Burns T and Stalker GM (1961) The management of innovation. London, Tavistock Publications.
Busk N (1985) The unachievable balance. NAHA News, June.
Bussey AL (1984) Family practitioner committees, computers and community medicine. Community Medicine 6: 47–49.
Butler JR and Vaile MSB (1984) Health and health services. London, Routledge and Kegan Paul.
Buxton MJ, Klein R and Sayers J (1977) Variations in GP night visiting rates: medical organisation and consumer demand. British Medical Journal I: 827–830.
Carson I, Martin E and Shepherd P (1985) Health screening by a nurse in general practice. British Medical Journal 290: 1792.
Cartwright A and Anderson R (1981) General practice revisited: a second study of patients and their doctors. London, Tavistock Publications.
Chamberlain J (1984) Failures of the cervical cytology screening programme. British Medical Journal 289: 853–854.
Charles C (1983) Keep doctors on their toes. The Sunday Times, 26 June.
Charlton JRH and Lakhani A (1985) Is the Jarman underprivileged area score valid? British Medical Journal 290: 1714–1716.
Collier J (1985) What the doctor ordered. The Times, 16 October.
Consumers' Association (1978) Treating medical complaints: a report on NHS complaints procedures. London, Consumers' Association.
Consumers' Association (1979) Registering with a doctor. Evidence submitted to the Royal Commission on the NHS. London, Consumers' Association.
Consumers' Association (1980) Discussion paper: the rights and responsibilities of doctors and patients. London, Consumers' Association.
Consumers' Association (1983) Access to GPs. A report examining problems associated with surgery hours, appointment systems and deputising services. London, Consumers' Association.

Consumers' Association (1985) Advice across the chemist's counter. Which? Magazine, 1 August: 351–354.
Crouchman MR (1985) The first year of a joint child health clinic within an inner London general practice. Unpublished. Department of Child Health, St George's Hospital, London, SW17.
Croydon Family Practitioner Committee (1984) Tenth Annual Report of Croydon Family Practitioner Committee.
Crowe HGF, Hurwood DS and Taylor RW (1976) Out of hours calls in a Leicestershire practice. British Medical Journal I: 1582–1584.
Cubitt T and Tobias G (1983) Out of hours calls in general practice: does the doctor's attitude alter patient demands? British Medical Journal, 287: 28–30.
Davidson N (1985) Championing minority groups. Health and Social Service Journal, 2 May: 550–551.
Davies P (1985a) Cervical screening. Health and Social Service Journal, 23 May: 648.
Davies P (1985b) Computer file: computers in general practice. Health and Social Service Journal, 27 June: 813.
Davies LM and Bretman MD (1985) What do community health doctors do? A survey of their work in the child health service in Nottinghamshire. British Medical Journal, 290: 1604–6.
Deitch R (1983) Family practitioner committees get a direct line. The Lancet, 19 February: 427.
Deitch R (1984) The government's intentions for primary care. The Lancet, 10 March: 580.
Deitch R (1985) The future of the NHS family practitioner service. The Lancet, 31 August: 511–512.
Dennis N (1984) Voting with their feet. Health and Social Service Journal, 19 April: 465.
Dennis N and Salvage A (1984) Information on GP services in Tower Hamlets. Steel's Lane Health Centre, 384 Commercial Road, London E1.
Department of Health and Social Security (1971) The organisation of group practice. London, HMSO.
Department of Health and Social Security (1974) Report of the joint working party on general medical services 1973 (Chairman Sir George Godber). London, HMSO.
Department of Health and Social Security (1976) Priorities for health and social services in England. London, HMSO.
Department of Health and Social Security (1977a) Report of National Joint Committee of the Medical and Pharmaceutical Professions on the dispensing of NHS prescriptions in rural areas. (Chairman CM Clothier).
Department of Health and Social Security (1977b) Health centres. HC (77)8.
Department of Health and Social Security (1977c) Observers from CHCs at family practitioner committee meetings. HC(FP) (77)2.
Department of Health and Social Security (1979a) Patients first. A consultative paper. London, HMSO.

Department of Health and Social Security (1979b) Primary health care: health centres and other premises. HC (79)8.

Department of Health and Social Security (1980) Inequalities in health: report of a research working group (Chairman Sir Douglas Black). London, DHSS.

Department of Health and Social Security (1981a) Arrangements for the administration of family practitioner services: a consultative paper. HN(FP) (81)12.

Department of Health and Social Security (1981b) Care in action. A handbook of policies and priorities for health and personal social services in England. London, HMSO.

Department of Health and Social Secutity (1981c) Care in the community. A consultative document on moving resources for care in England.

Department of Health and Social Security (1981d) Health services development. Review of the NHS planning system. HN (81)4.

Department of Health and Social Security (1981e) NHS general medical services. Statement of fees and allowances payable to general medical practitioners in England and Wales (The Red Book).

Department of Health and Social Security (1981f) The primary health care team. Report by a joint working group of the Standing Medical Advisory Committee and the Standing Nursing and Midwifery Advisory Committee (Chairman Dr W Harding).

Department of Health and Social Security (1981g) Towards better dental health – guidelines for the future. The report of the Dental Strategy Review Group.

Department of Health and Social Security (1981h) Cervical cytological recall scheme. HN (81)14.

Department of Health and Social Security (1982) Health services development: the NHS planning system HC(FP) (82)3.

Department of Health and Social Security (1983a) Health care and its costs. The development of the National Health Service in England. London, HMSO.

Department of Health and Social Security (1983b) NHS management inquiry (Leader Roy Griffiths).

Department of Health and Social Security (1983c) The health and social services and social security adjudications Act 1983: FPCs. HC(FP) (83)2.

Department of Health and Social Security (1984a) FPCs: accountability arrangements. HN(FP) (84)37.

Department of Health and Social Security (1984b) Complaints about dentists, chemists, opticians and family doctors.

Department of Health and Social Security (1984c) General practitioner deputising services. HC(FP) (84)2.

Department of Health and Social Security (1984d) Family practitioner services. General medical services – surgery premises. HN(FP) (84)42.

Department of Health and Social Security (1984e) Report of the joint working group on collaboration between family practitioner committees and district health authorities.

Department of Health and Social Security (1984f) The Rural Dispensing Committee. First annual report.
Department of Health and Social Security (1984g) Temporary scheme for incentives to group practice in inner city areas. Statement of fees and allowances. HN(FP) (84)14.
Department of Health and Social Security (1984h) Fifth report of the Steering Group on Health Services Information (Chairman Mrs E Körner) London, HMSO.
Department of Health and Social Security (1985a) The Health Service in England: annual report 1984. London, HMSO.
Department of Health and Social Security (1985b) The Health Service in England: annual report 1985. London, HMSO.
Department of Health and Social Security (1985c) Management arrangements for family practitioner committees. HC(FP) (85)10.
Department of Health and Social Security (1985d) Family practitioner committees, performance indicators: 1984 exercise. (Unpublished)
Department of Health and Social Security (1985e) Childhood immunisation programme. HN (85)19.
Department of Health and Social Security (1986a) Report of the committee of enquiry into unnecessary dental treatment. London, HMSO.
Department of Health and Social Security (1986b) Voucher system for glasses: consultation letter, 13 January.
Department of Health and Social Security (1986c) Management arrangements for family practitioner committees: operational requirements and guidelines 1986–87. HC(FP) (86)2.
Department of Trade (1982) Opticians and competition – a report by the Director General of Fair Trading on Sections 21 and 25 of the Opticians Act 1958. London, HMSO.
Derbyshire Rural Community Council (1984) Rural health services project: access to rural health services.
Dixon RA and Williams BT (1977) Twelve months of deputising: 100,000 patient contacts with 18 services. British Medical Journal 1: 560–563.
Dobson F (1984) Rural health services. Medicine in Society 10, 3: 11–12.
Downey M (1983a) Cytology: still no action. Medeconomics, October: 25–27.
Downey M (1983b) Deputising standards need closer surveillance. Medeconomics, December: 44–47.
Downey M (1985) GPs face FPC crackdown on work hours. Medeconomics, February: 25.
Dowson S and Maynard A (1985) General practice. In: Harrison A and Gretton J (eds) Health care UK 1985: an economic, social and policy audit: 15–26. London, CIPFA.
Doyle L (1983) Do it yourself cytology recall for the over 45s. Medeconomics, August: 45–47.
Doyle L (1984) Limit the practice area. Medeconomics, March: 22–23.
Dunsire A (1978) Implementation in a bureaucracy. London, Martin Robertson.

Edwardson S (1983) An outline of service committee procedure. Society of FPCs, London and South Eastern division. Conference paper. King's Fund Centre.

Elcock H and Haywood SC (1980) The buck stops where? Accountability and control in the NHS. Hull, University of Hull, Institute of Health Studies.

El Kabir DJ (1982) Great Chapel Street medical centre. British Medical Journal 284: 480–481.

Elliot A (1984) General practice facilitator – a personal view. Health Trends 16: 74–79.

Ellis N (1985) Family practitioner committee independence: what will it mean? British Medical Journal 290: 607–611.

Ellman R and Chamberlain J (1984) Improving the effectiveness of cervical cancer screening. Journal of the Royal College of General Practitioners 34, 267: 537–542.

Elmore RF (1980) Backward mapping: implementation research and policy decisions. Political Science Quarterly 94, 4: 601–616.

Elwood JM, Cotton RE, Johnson J, Jones GH, Curnow J and Beaver MW (1984) Are patients with abnormal cervical smears adequately managed? British Medical Journal 289: 891–894.

Enthoven A (1985) Reflections on the management of the NHS. Oxford, Nuffield Provincial Hospitals Trust.

Exeter and District Community Health Council (1983) Medical services in rural areas. Exeter Community Health Council.

Fairey MJ (1983) The Körner report and its implementation. Hospital and Health Services Review 79: 180–182.

Farmer RDT (1984) Patients like to be 'an emergency'. Health and Social Service Journal, 19 April: 466.

Farmer RDT and Chambers JS (1982) The relationship between the use of accident and emergency departments and the availability of general practitioner services – a study in six London hospitals. Department of Community Medicine, Westminster Medical School, London SW1.

Fearn RMG, Haynes RM and Bentham CG (1984) The role of branch surgeries in a rural area. Journal of the Royal College of General Practitioners 34: 488–491.

Feinmann J (1985a) Ripples first, followed by a tidal wave. Health and Social Service Journal, April: 412–413.

Feinmann J (1985b) Profits in primary care. Health and Social Service Journal, 30 May: 672–673.

Feinmann J (1985c) Who will monitor GP deputies. Health and Social Service Journal, 13 June: 732.

Feinmann J (1985d) Square pegs into round holes. Health and Social Service Journal, 11 July: 876.

Feinmann J (1985e) Let your FPC start to do the talking. Health and Social Service Journal, 7 November: 1402–1403.

Fielding AG and Portwood D (1980) Professions and the state – towards a typology of bureaucratic professions. Sociological Review 28, 1: 23–53.

Fit for The Future (1976) Report of the Committee on Child Health Services (Chairman Professor SDM Court). I. Cmnd. 6684. London, HMSO.
Frazer RC (1984) Age-sex registers as a screening tool for general practice: the sign of the wrong address problem. British Medical Journal 289: 923.
Fullard E, Fowler G and Gray M (1984) Facilitating prevention in primary care. British Medical Journal 289: 1585–1587.
Gelbier S (1982) Denuispr« ajd management of the National Health Service: 1974–1982. Public Administration 60, Summer: 163–176.
General Medical Services Committee (1979) Report of the new charter working group. British Medical Association.
General Medical Services Committee (1983) The cost effectiveness of general practice. British Medical Association.
General Medical Services Committee (1984) General practice: a British success. British Medical Association.
General Practitioner (1978) The GP's guide to the work of an FPC. 6 October.
Glorney M (1984) Closer encounters for health care. Health and Social Service Journal, 12 July: 821–822.
Gray M (1984) The case against change. The Family Practitioner Services 11, 3: 65–66.
Greenfield PR (1983) Report to the Secretary of State for Social Services of an informal working group on effective prescribing. London, DHSS.
Greenwich and Bexley Family Practitioner Committee (1984) Annual report for 1983–4.
Grove Health Centre, London W12. Patient information leaflet.
Halpern S (1984) Divorced – but still on good terms. Health and Social Service Journal, 31 May: 640.
Halpern S (1985) Caring in the community ... myths, messages and money. Health and Social Service Journal, 7 March: 276.
Halpern S (1985) What the public thinks of the NHS. Health and Social Service Journal, 6 June: 702–704.
Ham C and Buchanan R (1985) HAs ill-prepared to make life and death judgements. Health and Social Service Journal, 21 March: 353.
Ham C and Hill M (1984) The policy process in the modern capitalist state. Brighton, Wheatsheaf.
Hamid Husain M (1983) Pay GPs for teamwork. Medeconomics, September: 67.
Hamid Husain M (1985) The case for small practices. British Medical Journal 290: 1553–1554.
Hambleton R (1983) Health planning – a second chance? Policy and Politics 11, 2: 189–201.
Hannay DR and Maddox EJ (1977) Missing patients in a health centre. Community Health 8: 210–216.
Hanson F and Wilks M (1984) Mobile patients in an inner London practice. British Medical Journal 288: 1579–1582.
Harrison A and Gretton J (eds) (1984) Health care UK 1984: an economic, social and policy audit. London CIPFA.

Harrison A and Gretton J (eds) (1985) Health care UK 1985: an economic, social and policy audit. London, CIPFA.
Harrison A and Gretton J (eds) (1986) Health care UK 1986: an economic, social and policy audit. Policy Journals.
Haywood SC (1983) The politics of management in health care: a British perspective. Journal of Health Politics, Policy and Law 8, 3: 424–442.
Haywood SC (1985) An essay in the government of health: Griffiths or status quo. Social Policy and Administration 19, 1: 59–70.
Haywood SC and Alaszewski A (1980) Crisis in the Health Service. London, Croom Helm.
The Health Summary (1985) Delivering the FPC goods. II, VI: 5.
Heath MCD and Sims PA (1984) The general practitioner in the inner city: a survey of a London health district. Journal of the Royal College of General Practitioners 34, 261: 199–204.
Heeralall D (1984) How to set up a deputy co-op. Medeconomics, March: 24–26.
Heller R and Rose G (1977) Current measurement of hypertension in general practice. British Medical Journal 1: 1442.
Henshall E (1983) The role of the FPC member. Conference organised by the Society of FPCs, London and South Eastern Division. Conference Paper: King's Fund Centre (unpublished).
Hicks D (1976) Primary health care: a review. London, HMSO.
Honigsbaum F (1969) Complaint procedure in the GP service. Memorandum to the Rt Hon Richard Crossman MP (unpublished).
Honigsbaum F (1979) The division in British medicine: a history of the separation of general practice from hospital care, 1911–1968. London, Kogan Page.
Honigsbaum F (1985) Reconstruction of general practice: failure of reform. British Medical Journal 290: 823–826.
Horder J (1982) First care first. The Times Health Supplement, 26 March: 19.
Horobin G and McIntosh J (1977) Responsibility in general practice. In: Stacey M, Reid ME, Heath C and Dingwall R (eds) Health and the division of labour: 88–114. London, Croom Helm.
Horobin G and McIntosh J (1983) Time, risk and routine in general practice. Sociology of Health and Illness 5, 3: 312–331.
Hull S, Livingstone A and Dunford A (1984) The general practitioner in the inner city. Letter in Journal of the Royal College of General Practitioners 34, 265: 469.
Hunter D (1979) Coping with uncertainty: decisions and resources within health authorities. Sociology of Health and Illness I, 1: 40–68.
Imperial Cancer Research Fund (ICRF) (1984) Co-ordinating committee on cervical screening. Organisation of a programme for cervical cancer screening. British Medical Journal 289: 894–895.
Jachuck SJ, Price P and Bound CL (1984) Evaluation of quality of contents of general practice records. British Medical Journal 289: 26–28.
James ME (1984) The rural dispensing standstill: an investigation and some conclusions. The Family Practitioner Services 11, 2: 34–38.

Jarman B (1981) A survey of primary care in London: report prepared for the Royal College of General Practitioners. Occasional Paper 16.
Jarman B (1983) Identification of underprivileged areas. British Medical Journal, 286: 1705–1708.
Jarman B (1984) Underprivileged areas: validation and distribution of scores. British Medical Journal, 289: 1587–1592.
Jennings P (1968) The living village: a picture of rural life drawn from village scrapbooks. London, Hodder and Stoughton.
Jones AE (1983) Implementation of the rubella vaccine programme in Manchester. Community Medicine 5: 287–294.
Journal of the Royal College of General Practitioners (1983) Patients' views of general practice. January: 5–7.
Journal of the Royal College of General Practitioners (1985) Job loss and the use of medical services. November: 507.
Kensington, Chelsea and Westminster Community Health Council (1977) The family doctor in central London. Kensington, Chelsea and Westminster Community Health Council.
Kent Voluntary Service Council (1983) Is there a Doctor in the hall?
Kent A (1985) FPC deputy rules vary. Medeconomics, March: 29–35.
Key I (1985) Recruiting new principals in general practice. British Medical Journal, 291: 451–455.
Key I (1986) General ophthalmic services. In: Harrison A and Gretton J (eds) Health Care UK 1986, Policy Journals.
Kingmann S (1985) Cytology recall is still patchy. Medeconomics, February: 67–69.
Klein R (1973) Complaints against doctors: a study of professional accountability. Croydon, Charles Knight.
Klein R (1980) Models of man and models of policy: reflections on exit, voice and loyalty ten years later. Milbank Memorial Fund Quarterly 58, 3: 416–429.
Klein R (1982) Performance evaluation and the NHS: a case study in conceptual perplexity and organisational complexity. Public Administration 60, Winter: 385–407.
Klein R (1982a) Reflections of an ex-AHA member. British Medical Journal, 284: 992–994.
Klein R (1983) The politics of the National Health Service. London, Longman.
Klein R (1984) Who makes the decisions in the NHS? British Medical Journal 288: 1706–1708.
Knox PL (1979) Medical deprivation, area deprivation and public policy. Social Science and Medicine 13D: 111–121.
Kogan M (ed) Johnson D, Packwood T and Whitaker T (1985) School governing bodies. London, Heinemann.
Körner E (1984) Improved information for the NHS. British Medical Journal 289: 1653–1656.
Lancashire Family Practitioner Committee (1984) Lancashire Strategy Statement and Profile.

The Lancet (1985a) Serious deficiencies in cervical screening. 30 March: 766.
The Lancet (1985b) Screening for breast cancer. 13 April: 851–852.
The Lancet (1985c) Slipping through the net. 11 May: 1115.
The Lancet (1985d) Cancer of the cervix: death by incompetence. 17 August: 363–364.
Law J (1983) Look forward to FPC visits. Medeconomics, January: 15–16.
Law J (1984) Deputising Co-ops mark the way ahead. Medeconomics, January: 40–5.
Law J (1984a) Keep medical records under your control. Medeconomics, November: 34–37.
Leathard A (1985) Planning the families of the future. Health and Social Service Journal, 14 February: 190–191.
Leavey R and Wood J (1985) Does the underprivileged area index work? British Medical Journal 291: 709–711.
Leinster C (1984) Planning primary care: a review of services focussing on Newcastle. Medicine in Society 10, 3: 13–24.
Lennon MA (1983) A view of the general dental services. The Family Practitioner Services 10, 11: 252–253.
Lincolnshire Family Practitioner Committee (1985) A strategic plan for the improvement of primary care services in Lincolnshire 1985–1990.
London Borough of Tower Hamlets (1985) Primary care in Tower Hamlets: future policy and liaison in provision of general medical practitioner premises. Unpublished internal paper.
London Health Planning Consortium (1981) Primary health care in inner London: report of a study group (Chairman Professor ED Acheson) London, DHSS.
Macfarlane JA and Pillay U (1984) Who does what and how much in the pre-school child health service in England. British Medical Journal, 289: 851–852.
MacGarvin M (1985) Cervical cancer screening – what's going on? A report prepared for Frank Dobson MP, Shadow Minister for Health.
McPherson K (1985) The political argument on health costs. British Medical Journal, 290: 1679.
Marinker M (1984) Developments in primary health care. In: Teeling-Smith G (ed) A new NHS Act for 1996. London, Office of Health Economics: 17–22.
Martin D (1983) Cost rent and improvement grants. The Family Practitioner Services 10, I: 15–19.
Maskrey N, Poppleton JF, Knoweldon DJ and Graham LC (1985) Illness among holidaymakers and the effects on a seaside practice. British Medical Journal 290: 1551–1553.
Maxwell R and Weaver RN (eds) (1984) Public participation in health – towards a clearer view. London, King Edward's Hospital Fund for London.
May A (1985) CHCs and FPCs: towards a closer co-operation. The report of a conference held at the King's Fund Centre on 19 February 1985.

Maynard A (1985) HMOs in the NHS? The Health Summary II, 2: 5.
Medawar C (1984) The wrong kind of medicine? London, Consumers' Association and Hodder and Stoughton.
Medical Architecture Research Unit (MARU) (1985) Improvement of practice premises. Information sheets 1–3. London, the Polytechnic of North London.
Metcalfe D (1983) Trends in the utilisation of the NHS. Journal of the Royal College of General Practitioners 33: 615–616.
Metcalfe D (1985) Not the Green Paper. The Health Summary II, 2: 3.
Ministry of Health (1944) A National Health Service. Cmnd 6502. London, HMSO: 9.
Ministry of Health (1968) Informal handling of complaints about general medical services. ECL 4/68.
Minogue M (1983) Theory and practice in public policy and administration. Policy and Politics II, 1: 66–85.
Mishra R (1977) Society and social policy. London, Macmillan.
Moran G (1985) Opportunity knocks – seize it. Health and Social Service Journal, 13 June: 740.
Morgan-Williams D (1983) Anatomy of a medical complaint. Health and Social Service Journal, 28 April: 500–501.
Morgan-Williams D (1983) Hearings with hearsay. Health and Social Service Journal, 5 May: 536–537.
Morgan-Williams D (1983) Appeals behind closed doors. Health and Social Service Journal, 12 May: 568–570.
MORI (Market and Opinion Research International Ltd) (1984) Attitudes of GPs towards out-of-hours patient care. MORI/British Medical Association.
National Council for Voluntary Organisations (NCVO) (1984) Progress on rural dispensing. Paper for the standing Conference of Rural Community Councils.
Newcastle Inner City Forum and Newcastle Community Health Council (1983) Women, health and the health service in Newcastle-upon-Tyne. Primary Health Care Project 1981–83.
Noble A (1984) General practice premises and the provision of primary health care facilities in inner London. London, Polytechnic of North London Medical Architecture Research Unit.
Norfolk Family Practitioner Committee (1984) Report on the administration of the family practitioner services in Norfolk 1983–84.
Norfolk Family Practitioner Committee (1984a) Fearn report. Draft internal paper 9 November.
North Derbyshire Health Authority (1984) Evaluation of cervical cytology services. 24 August. Unpublished paper.
North Derbyshire Health Authority (1984a) Review of family planning services in North Derbyshire. Unpublished paper.
North Yorkshire Family Practitioner Committee (1983) Report by the administrator FPS, 1982–3.
North Yorkshire Family Practitioner Committee (1984) Report by the administrator FPS 1983–4.

Nottingham Family Practitioner Committee (1984) Report of the chairman 1984.

O'Donnell M (1984) One man's burden. British Medical Journal, 289: 1632.

Office of Health Economics (1984) Childhood vaccination: current controversies. London, Office of Health Economics.

Office of Population Censuses and Surveys (OPCS) (1984) The general household survey, 1982. London, Social Survey Division, HMSO.

Pamphilon J (1985) Report for the assistant administrator's group (Greater London) on FPCs and planning. Unpublished. London, King's Fund Centre.

Parkin D and Yule B (1985) General dental services. In: Harrison A and Gretton J (eds) Health care UK 1985: an economic, social and policy audit. London, CIPFA: 27–34.

Parliamentary Debates House of Commons (1984) Official report of Standing Committee A: Health and Social Security Bill. 24 January–20 March. London, HMSO.

Parr CW and Williams JP (eds) (1984) Family practitioner services and their administration. 2nd edition. London, Institute of Health Service Administrators.

Pater JE (1981) The making of the National Health Service. London, King Edward's Hospital Fund for London.

Patients' Liaison Group (1984) Availability of information for patients. Journal of the Royal College of General Practitioners: 672–673.

Paton A, Potter JF and Saunders JB (1981) ABC of alcohol: detection in hospital. British Medical Journal 283: 1594.

Pearson M (1984) Consumers and the NHS. In: Harrison A and Gretton J (eds) Health care UK 1984: an economic, social and policy audit. London, CIPFA: 115–124.

Pharmaceutical Journal (1985a) Pharmaceutical industry under threat. 234, 6332: 709.

Pharmaceutical Journal (1985b) The limited list: a special guide. 234, 6322: 405–418.

Pharmaceutical Journal (1985c) Pharmacy numbers rise. 234, 6322: 402.

Pharmaceutical Journal (1985d) Scripts up in number and value in 1984. 234, 6332: 709.

Pharmaceutical Journal (1985e) Anti-leapfrogging move. 234, 6335: 818.

Pharmaceutical Journal (1985f) Screening and prescribing in the pharmacy. 235, 6340: 133–134.

Pharmaceutical Journal (1985g) More than slightly appalled and surprised. 235, 6349: 423–424.

Pharmaceutical Journal (1985h) Suspension of new contract: Pharmaceutical Society incredulous. 235, 6349: 432.

Pheby DFH (1984) General practice in isolated rural communities. Rural health conference, 30 May. Unpublished paper.

Pledger G (1984) Planning roles. Health and Social Service Journal, 12 July: 823.

Pollitt C (1984) The quality and the width (PIs). Health and Social Service Journal, 29 November: 1415.
Pollitt C (1985) Can practice be made perfect? Health and Social Service Journal, 6 June: 706–707.
Pollitt C (1985) Measuring performance: a new system for the NHS. Policy and Politics 13, 1: 1–15.
Price Commission (1976) Prices of private spectacles and contact lenses. Price Commission report no 20. London, HMSO.
Price N (1984) Health provision for villages – access to health services and self-help groups in Oxfordshire. Conference report, 6 December. Oxfordshire Rural Community Council.
Prudoe RH (1984) Deputising services. Letter in British Medical Journal 288: 718.
Purser RH (1984) Future relationships between DHAs and FPCs. Hospital and Health Services Review, July: 167–170.
Review Body on Doctors' and Dentists' Remuneration (1982) Twelfth report. Cmnd 8550. London, HMSO.
Ritchie J, Jacoby A and Bone M (1981) Access to primary health care. London, OPCS, Social Survey Division, HMSO.
Ritchie LD (1984) Computers in primary care. London, Heinemann Medical Books Ltd.
Roland M (1984) Deputising services. British Medical Journal 289: 451–452.
Rothman RA (1984) Deprofessionalisation: the law in America. Work and Occupations 11, 2: 183–206.
Royal College of General Practitioners (1982) Healthier children – thinking prevention. Report from General Practice 22.
Royal College of General Practitioners (1985a) Towards quality in general practice. A council consultation document.
Royal College of General Practitioners (1985b) Quality in general practice. Policy statement 2.
Royal Commission on the National Health Service (1979) Report (Chairman Sir Alec Merrison). Cmnd 7615. London, HMSO.
Russell W (1985) That ever more elusive green paper. British Medical Journal, 290: 1914.
Sacks O (1984) A leg to stand on. London, Duckworth.
St-Yves IFM (1981) At the crossroads of primary health care. Royal Society of Health Journal, 101, I: 33–36.
Sawyer L and Arber S (1982) Changes in home visiting and night and weekend cover: the patient's view. British Medical Journal, 284: 1531–1534.
Scrivens E (1984) Management information in the National Health Service: the use of the child health computer system. Community Medicine 6: 299–305.
Shaw CD (1982) Monitoring and standards in the NHS. (1) Monitoring. British Medical Journal 284: 217–219.

Shaw CD (1982) Monitoring and standards in the NHS. (2) Standards. British Medical Journal 284: 288–289.
Sheldon ME and Harris SJ (1984) Use of deputising services and night visiting rates in general practice. British Medical Journal, 289: 474–476.
Simpson R (1979) Access to primary care. Research paper no 6. Royal Commission on the NHS. London, HMSO.
Smail SA, Lloyd RHG and Mann PG (1981) New communication service for primary care. British Medical Journal 282: 365–8.
Smith H (1984) Stand up for independence. Medeconomics, February: 15–19.
Smith H (1985) Your life in their hands. Medeconomics, June: 13–15.
Stevenson JSK (1982) The advantages of deputising services: a personal view. British Medical Journal 284: 945–948.
Stevenson JSK (1984) Deputising services. Letter to British Medical Journal 288: 570.
Stott NCH and Davis RH (1979) The exceptional potential in each primary care consultation. Journal of the Royal College of General Practitioners 29: 201–205.
Strong PM (1979) The ceremonial order of the clinic. London, Routledge and Kegan Paul.
Taylor D (1983) The consumer movement, health and the pharmaceutical industry. London, Office of Health Economics.
Taylor D (1984) The family practitioner services. In: Understanding the NHS in the 1980s. London, Office of Health Economics: 30–36.
Taylor M (1983) The NHS and the consumer. Hospital and Health Services Review 79, 4: 176–180.
Teeling Smith G (1983) The future for pharmaceuticals: the potential, the patterns and the problems. London, Office of Health Economics.
Thorne S (1983) Vox Pop. The Health Services 61: 190.
Timbs O (1983) Keep your list up with the FPC number. Medeconomics, April: 89–91.
Timbs O (1984) Hurry for inner city cash. Medeconomics, January: 25.
Timbs O (1985) Scots show how to avoid cancer testing scandal. The Observer, 24 March.
Tudor Hart J (1982) Measurement of omission. British Medical Journal 284: 1686–1689.
Tudor Hart J. The liberal critique of medicine. Medicine in Society 8 (3): 23–28.
Valins M (1983) The design of general practice premises: a suitable case for treatment. The Family Practitioner Services 10, 1: 12–13.
Varnam MA (1982) Should general practitioners be planners? British Medical Journal 285: 479–480.
Victoria Community Health Council (1984) Falling through the net.
Victoria District Health Authority (1983) Evaluation of health services in Victoria: a strategic framework for the future. I.
Victoria District Health Authority (1984) A strategic framework for the future. II.

Wadsworth M (1985) Measuring socio-demographic change. British Society for Population Studies, Occasional Paper 34. London, OPCS.
Walker I (1983) Do FPCs know how often GPs use deputies? Medeconomics, August: 12–17.
Walsh K, Hinings B, Greenwood R and Ramson S (1981) Power and advantage in organisations. Organisation Studies 2, 2: 131–152.
Watson E (1982) Issues for London DHAs: policies for child health. London, King's Fund Centre.
Webster GL, Ritchie AF, Morrell JAL and Scaife B (1965) Night calls in general practice. British Medical Journal I: 1369–1371.
WHO and UNICEF (1978) International conference on primary health care. Alma-Ata, USSR 6–12 September 1978. Geneva, WHO and UNICEF.
Wilkin D and Metcalfe D (1984) List size and patient contact in general medical practice. British Medical Journal 289: 1501–1505.
Willcocks JA (1967) The creation of the National Health Service. London, Routledge and Kegan Paul.
Wilcox R (1984) Improving the FPC's planning and development role. The Family Practitioner Services 11, 15: 101–102.
Williams S (1985) Case studies in collaboration. A report on collaboration between FPCs, DHAs and other bodies. Report for the Department of Health and Social Security.
Wilkin D (1985) Myth and reality in general practice. The Health Summary II, 3: 5.
Wilson MA (1983) Towards better practice premises – the doctor's view. The Family Practitioner Services 10, 2; 35–38.
Wilson MA (1985) Letter from the chairman of the GMSC of the BMA to the Rt Hon Barney Hayhoe MP, Minister for Health, 11 December.
Wistow G (1982) Collaboration between health and local authorities: why is it necessary? Social Policy and Administration 16, 1: 44–62.
Wood J (1983) Are the problems of primary health care in inner cities fact or fiction? British Medical Journal 286: 1109–1112.
Wood J (1983) Are general practitioners in inner Manchester worse off than those in adjacent areas? British Medical Journal 286: 1249–1252.
Woollett S (1981) Alternative rural services: a community initiatives manual. London, Bedford Square Press for NCVO.
Yates J (1985) A ten year blueprint for primary health care. General Practitioner 18 January.

Index

The abbreviations used in this index are listed in the Glossary on pages xi–xii.

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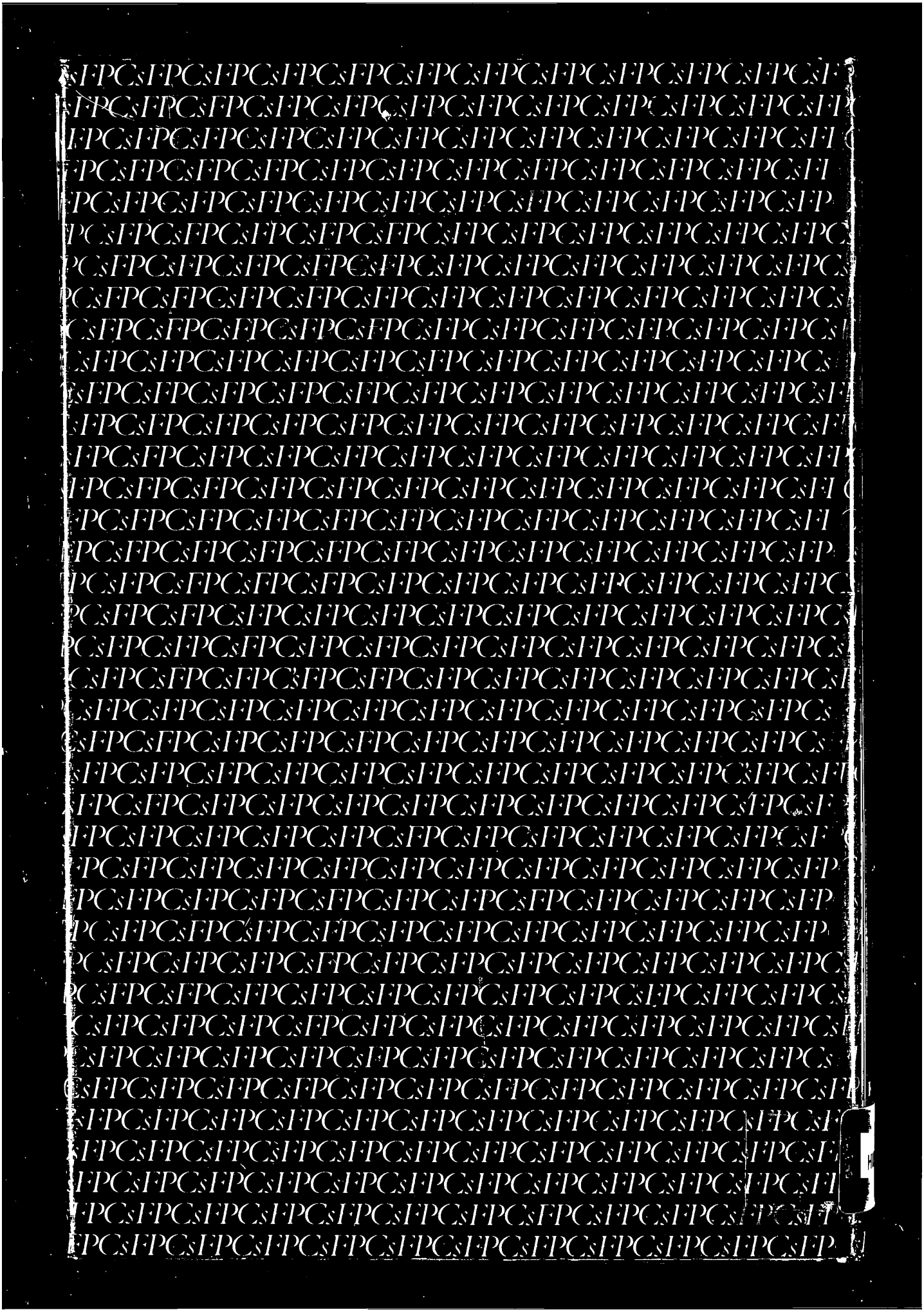
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