Primary Health Care: An Agenda for Discussion

A response from the King's Fund London Programme

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SECTION A: BACKGROUND

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1. INTRODUCTION

The publication of "Primary Health Care: An Agenda for Discussion" was welcomed by the London Project Executive Committee of the King's Fund as an opportunity to contribute to the debate on the future of primary health care. In order to prepare a response which would contain practical recommendations for improving inner London primary care, it was decided to hold a series of six workshops reflecting some of the major themes in the Green Paper (APPENDIX 1). While this response reflects the often animated discussions that took place, it is not a record of them.

One disadvantage of focussing on the six workshop themes is that a number of other issues are not given full attention. "Neighbourhood Nursing - a focus for care" is not separately discussed; and comment on the family practitioner services is largely confined to general medical practitioners. This reflects the Green Paper's emphasis on general practice but should not be interpreted as an endorsement of its reduction of primary health care to primary medical care.

2. A NOTE ON THE INNER CITY

This response is informed by the practical experience of workshop participants - all of whom are involved in primary health care in inner London. Many of the difficulties of primary health care in the inner city were documented in the Acheson report, and are well-known: social and economic deprivation, a large proportion of elderly GPs, poor premises, violence, difficulties in retaining staff, high workloads, and the need to provide services for groups with special needs such as homeless people, drug users and frail elderly people. Many people from black and ethnic minority communities live in inner city areas and services are slow to meet their needs. Compounding these demands on primary care is the scale of change in the acute and long-term care sectors.

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The multiple deprivation associated with inner city areas can be found in many other areas such as outer city estates, mining towns, and areas of high unemployment. The recommendations contained in this paper are relevant not only to inner cities but are likely to be of interest to all concerned with improving the quality of primary health care.

3. STRUCTURE OF THIS RESPONSE

The Green Paper is a tantalising mix of proposals, questions, suggestions and firm intentions. This has prompted a range of responses from 'alternative' green papers to detailed comments on the few firm proposals. This response steers a middle course, and takes as its structure the six objectives outlined on page 49 of the document: raising standards of care; making services more responsive to consumers; promoting health and preventing illness; giving patients the widest range of choice in obtaining high quality primary health care services; improving value for money; and enabling clearer priorities to be set for family practitioners in relation to the rest of the health service. Under each heading we discuss the effect the Green Paper proposals might have on inner city primary health care.

SECTION B: DETAILED RESPONSE

1. RAISING STANDARDS OF CARE

While most of the proposals contained in the Green Paper could be subsumed under this heading, three separate areas will be addressed in this section: changes in the contract (1.1) (the Good Practice Allowance, capitation fees, retirement at 70 and end of '24 hour retirement'); experiments in short-term contracts and salaried GPs (1.2); and the part that FPCs can play in quality control (1.3). The bulk of the Green Paper proposals focus on professional contracts and their relationship to performance: (1.4) outlines some alternative approaches to raising standards.

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1.1 Changing the contract

1.1.1 The Good Practice Allowance (GPA)

The 115 recommendations of the Acheson report are about increases in resources, improvements in practice premises, equipment (including computers), and staffing, as well as ways of encouraging team work, group practice and links with secondary care. Basic changes of this kind have yet to be achieved in many inner city practices. This means that the criteria for receiving the GPA are unlikely to be met by many inner London practices. In addition, there is little evidence that financial incentives - in the form of 'item of service' payments - have been successful in transforming inner city health care. We would therefore argue that this proposal would act as a reward for those practices already providing primary care of a high quality and would serve to lower the esteem (as well as the income) of practices falling outside this category.

A further argument against the proposal for a GPA is that it is firmly targeted towards the GP pocket, although some of the criteria reflect successful team work and efficient practice organisation. As it stands this proposal divides team members at a time when a team approach is essential for effective prevention and care in the community.

Rather than putting resources into a GPA to reward the high standards of a few GPs, we recommend that resources are directed towards ensuring that all practices provide an agreed minimum standard of service.

Specific local projects could do much to help inner city practitioners overcome obstacles to raising standards of care. Some FPCs have already started to do this, for example by helping to set up age-sex registers or arranging collection and delivery services; but to allow this 'enabling' function to be developed, FPCs need access to a flexible budget which they can use in an entrepreneurial way.

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1.1.2 Capitation fees

The proposal to encourage doctors "to practice in ways that will encourage patients to join their lists" by increasing the proportion of practice income made up of capitation fees is based on two assumptions. First, that consumers are the best judges of the quality of care they receive; and second, that large lists do not militate against the provision of high quality services.

The literature on the relationship between list size and quality of care is inconclusive. However, evidence from some inner city practices suggests that increased workload, as reflected in high consultation rates, high turnover of patients, more night visits and higher proportions of patients with multiple problems, has led to a deliberate limitation of list size in order to provide adequate standards of care. This suggests that manageable list size varies with the location and nature of the practice.

It seems clear that making practice income more dependent on list size would be detrimental to the quality of care provided by those practitioners with 'demanding' lists. Heavier workloads are associated with underprivileged areas, and it has been suggested that taking this into account in devising a system of financial reward for general practitioners would be more equitable than the present system or than one more dependent on list size.

The relationship between composition of list and workload needs more thorough investigation before changes are made to the way GPs are paid. Part of any such investigation would be to look at how the work generated by the practice list could be shared among members of the primary care team. Flexible ways of utilising staff such as nurses, health visitors, psychologists, social workers, advocates and interpreters should be explored by GPs, FPCs, DHAs and LAs. Longitudinal studies should be undertaken to monitor ways in which workload is affected by size and composition of lists; and by the division of labour in primary care.

1.1.3 Retirement at 70 and abolition of 24-hour retirement

These proposals are heartily supported.

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In Greater London there are more than 240 GPs over the age of 70 (approximately 6%) and a further 500 are over the age of 60. The proportion of elderly GPs in the inner city is even higher. When these GPs retire, the number of vacancies is unlikely to match the number of retirements, because many elderly GPs have small and declining lists. However, the combination of retirement at 70 and of the abolition of 24-hour retirement could, as the Acheson report pointed out, provide an opportunity to transform inner city general practice.

How far this potential will be exploited depends on the ability of FPCs to develop - and on their power to implement - medical manpower policies. FPCs must match the distribution and skills of GPs to the needs of localities. This will involve FPCs working with CHCs, DHAs, ILEA, social services, voluntary organisations and others to compile local information and supply it to prospective applicants for vacancies. Currently GPs have to give only three months notice of their intention to retire. This is clearly inadequate to allow FPCs time to gather the information needed to advertise and fill the vacancy appropriately.

Some FPCs are beginning to develop equal opportunities policies and we welcome the adoption of recruitment policies which take into account the needs of black and ethnic minority populations.

If FPCs are to take a stronger role in manpower planning, their relationship with the MPC needs to be reviewed. We recommend that FPCs be given more autonomy in decisions about medical manpower. As a minimum the MPC should make known to FPCs the criteria on which its decisions are based. MPC practice area boundaries should also be renegotiated in the interest of a more equitable distribution of doctors in inner city areas.

Most vacancies for GPs, however, arise because of changes in partnerships rather than from retirements of singlehanded GPs, but this is an area where FPCs have little influence. If manpower planning is to provide a real opportunity for change, FPCs must play a bigger part in partnership arrangements. They should require certain categories of information from

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practices applying for a new partner, to include details of workload, case mix, ethnic groups in the population and plans for expansion in services. FPCs should also promote a standard contract for incoming partners.

1.2 **Inner city proposals: financial incentives and short-term contracts**

A large number of vocationally-trained doctors apply for every vacancy in inner London - which suggests that financial incentives to attract applicants are not necessary. However, some inner city doctors begin their careers in single-handed practices, which can present them with severe difficulties, especially in the early years when they are building up the practice. FPCs should be given sufficient flexibility in their budgets to help young doctors setting up in single-handed practice achieve more quickly the high standard of care to which they aspire. For example, additional ancillary staff allowances could be made available for a specified period.

Job-sharing schemes might also be introduced. Where the list size is adequate, two doctors who wish to form a partnership should be able to set up as separate principals but share a basic practice allowance for a predetermined period. This would enable a practice to be built up and might serve to reduce subsequent partnership problems.

We welcome the proposal to implement a cost-rent scheme which is more sensitive to costs in inner cities. However, difficulties in finding suitable sites and premises in inner cities remain. FPCs should take some responsibility for finding premises when they do not accompany a practice vacancy. If FPCs are to succeed in planning primary care services in inner cities, they must have a strategy and resources for acquiring land and/or premises where they are needed, and be able to sell, let or lease land and premises to GPs.

The shortcomings of a system of primary health care based on independent contractors are nowhere more evident than in the services - or lack of them - provided for groups with special needs such as homeless people, Travellers and hostel dwellers. The employment of salaried GPs for a limited period meets specific needs but is only a short-term solution. If

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adopted in the long term, and limited to the care of certain people, this further stigmatises them and reduces their choice of primary care. Short-term solutions of this kind must be accompanied by longer-term strategies for providing integrated health care for disadvantaged groups.

1.3 **FPCs and quality control**

We welcome the proposal in the Green Paper that FPCs "develop more systematic means for measuring quality and detecting shortfalls in the provision of services".

FPCs already have a remit to monitor certain aspects of service delivery where criteria are clear, such as standards of premises, hours of availability and telephone answering arrangements. They should be required to carry this out and be provided with adequate resources and manpower to do so. Withholding of rent and rates is not always an effective deterrent where minimum standards are not met, and we recommend that sanctions available to FPCs be strengthened. FPCs also have the potential to monitor all 'item of service' payments. Complaints provide a further indication of service quality. A number of FPCs provide their practitioners with practice profiles and comparative information, which enable aspects of quality to be assessed.

We envisage an expanded role for FPCs in monitoring standards. At a local level, standards of clinical care as well as standards of service delivery should be developed by the LMC, FPC, local RCGP members and in conjunction with the DHA, CHC and other bodies.

While the setting and monitoring of minimum standards of clinical performance is fraught with difficulty, and is not discussed in the Green Paper, this area is of particular importance as it is one where patients are least likely to be aware of shortcomings. It would be helpful to have guidelines on setting standards for acute, chronic and anticipatory care; which bodies (consumer, professional, statutory) are to be involved and how audit can effectively be carried out. We recommend that, in conjunction with the professional bodies, minimum standards of clinical care are developed and monitoring procedures established.

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Before GPs are able to fulfil an expanded role in preventive, continuing and community care, effective monitoring systems need to be established. This implies computerised information systems at practice level which will need to be linked to a computerised register at the FPC. This would also provide a resource for joint planning at district level. Where audit takes place within individual practices in accordance with agreed objectives, information relevant to primary health care planning should be transmitted to the FPC. Annual practice reports would be one way of providing this information.

We recommend that FPC and DHA staff jointly devise ways of monitoring the effects of DHA policies, such as early discharge and day surgery, on the provision of primary care services, on patients in the community and on their carers; and that, in conjunction with Departments of Community Medicine, outcome variables (such as avoidable deaths and infections, take-up of preventive services, preventable handicap) are developed and used as a tool to assess quality of primary health care services.

1.4 Further recommendations for improving service quality

First, we recommend that every district should have a multi-disciplinary and multi-agency planning forum , involving providers, managers and users of services, that will set objectives and operationalise local targets for primary health care. A useful context in which to frame objectives for primary health care can be found in the 38 'Health for All' targets developed by the European Region of WHO. They reflect a broad definition of primary health care, and the emphasis on reduction of inequalities, community participation and collaboration make them of particular relevance to inner city health care. We regret that WHO's 'Health for All' initiative is not mentioned in the Green Paper, despite having been endorsed by the government. Much information about health needs already exists at a local level - not just with FPCs, CHCs and DHAs but also in voluntary organisations and from community health project initiatives. Forums for exchange of this kind of information should be established at District and local ('patch') level, and GPs encouraged to participate. To encourage information exchange relevant for joint planning, we recommend

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that the laws relating to the confidentiality of data be reviewed, so that, for example, information held by the FPC may be made available - with appropriate safeguards - for planning purposes.

Second, Academic Departments of General Practice and Departments of Community Medicine have an important role to play in assisting FPCs and local GPs to improve quality of care. Some Departments of General Practice are working with their local 'constituencies' of primary health care professionals and are forming links between primary and secondary care by, for example, the creation of protocols for outpatient follow-up and by putting GPs and consultants in touch with each other. An educational base can be used to reduce isolation, raise professional standards, provide information profiles and carry out epidemiological studies.

Third, despite increasing numbers of local 'GP forums' many GPs in the inner cities are isolated from their colleagues, other professionals, the activities of district health authorities, and the communities they serve. They may be unaware of basic help and information that can be provided by FPCs. Remedies to overcome this isolation are difficult to implement due to the independent contractor status of GPs. One way of overcoming this has been through the employment of GP facilitators who visit GPs, identify their needs and provide relevant local information. We recommend that resources are provided to FPCs to reduce the isolation of GPs and to encourage their involvement in planning.

2. MAKING SERVICES MORE RESPONSIVE TO CONSUMERS

Consumer choice is a second major plank in the Green Paper's strategy for improving the quality of primary health care services.

2.1 Dissemination of information

We support the suggestion that the FPC and individual practitioners should disseminate a broad range of information about standards and targets as well as about services provided. The production of annual reports is one way for

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practitioners to provide detailed practice-based information which could meet the twin aims of professional and public accountability. There are examples, particularly in the field of maternity care, where information related to standards of care has been produced by consumer groups. We believe this can and should be extended to other areas of care. Widespread advertising by individual GPs, without first ensuring minimum standards of clinical care will not necessarily be in the interests of consumers.

2.2 Choosing and changing doctors

The theoretical right to change doctor is a practical impossibility for many living in the inner cities. Doctors close their lists, restrict their catchment areas or refuse individual patients; some users cannot travel easily due to constraints of geography or mobility. The extent to which ease in changing doctors will influence overall quality of care largely depends not only on the existence of an informed, mobile and critical clientele, but also on the availability of practices of a high standard. This is not the case in many parts of the inner city.

However, we support the proposal that consumers be more easily able to change doctors without first contacting the FPC or the doctor whom they wish to leave. The system which currently operates for people changing address could be usefully extended to cover all those wishing to change their doctor.

2.3 Capitation fees

We do not agree that increasing the proportion of practice income from capitation fees would improve quality of care for reasons outlined in 1.1.2.

2.4 Complaints procedures

This section incorporates views on the consultative document "Family Practitioner Services: Complaints Investigation Procedures". We welcome the proposals to extend the time limits within which complaints may be

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lodged; to accept oral complaints; and to encourage all FPCs to operate informal conciliation procedures. The latter proposal is important if the many problems which do not constitute a breach of contract and which are not appropriate for service committees are to be addressed. In addition, as more FPCs offer informal negotiating procedures, this puts great responsibility on lay members, to whom appropriate support should be provided if the system is to work well.

We support the suggestion that greater use should be made of patient advocates in informal negotiations and service committee hearings: the choice of advocate should rest with the patient.

FPCs may receive information about poor quality care which may amount to a breach of contract although no formal complaint will be made. Some FPCs have argued that they should be able to initiate complaints in such cases and we would support this.

2.5 Patient participation groups

Patient participation groups are just one of the ways users may participate in primary health care. It appears that groups are most successful where communication with GPs is already good and it is not clear how they would succeed in improving the quality of some inner city practices. In addition, the concerns of those who do not, or are not able to, participate in these groups are unlikely to be addressed. Patient audit of general practice should be further developed; views could be channelled through FPCs or CHCs.

Patient participation groups should be encouraged as one of a range of approaches to involvement and participation of the community in primary health care. Likewise, local health care associations recommended in the Community Nursing Review could be part of the spectrum of community participation, and an extension of CHC-based activities. Their constitution, membership and accountability arrangements would need to be clarified. Patient participation groups, local health care associations or any other forum for community involvement, need to be properly resourced and

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have clear relationships to planning structures and community health councils. CHCs will need additional funds if they are to develop their role as a specialised resource for community groups.

We would like to draw attention to the work being done to encourage local communities to participate in primary health care. This takes a variety of forms - district-wide, locality-based or focussed on particular groups or health facilities.

Some DHAs are incorporating views of community groups and users of services in planning and management through 'user groups' and 'local advisory groups' based on health facilities. Community health workers and community development workers are also being employed to help identify needs of particular groups. Likewise, a small number of general practices are working closely with community health workers. Users (through CHCs or voluntary organisations) are also involved in district-wide planning on a care group basis. As more districts decentralise services, user involvement on a locality basis is likely to increase. Consideration needs to be given to which kinds of participation are appropriate at district, local, care group or other levels.

Existing mechanisms for user participation have not always been successful in involving black people and other minority groups. We emphasise that those groups least successful in making their voices heard do not fare well in a market model. Some CHCs have shown that minority groups can participate more fully once the right structures are established. For example, advocacy schemes help patients negotiate directly with health professionals and 'user representatives' on committees need to be supported by a group to which they report back. Professional time spent in identifying user views is essential if the objectives of primary health care are to be achieved. All training courses should encourage professionals to value the views of users.

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3. PROMOTING HEALTH AND PREVENTING ILLNESS

GPs are undertaking an increasing proportion of population-based preventive services, such as immunisation and vaccination. Before practices engage in preventive work of this kind, policies should be agreed between practices and the DHA, and should include arrangements for monitoring and follow-up of patients. The practice agreements suggested in the Cumberlege report could help primary health care teams set objectives and annual targets for prevention.

High mobility rates in inner city populations make preventive and screening services which depend on call and recall of patients difficult to administer. Different ways of delivering preventive services for inner city populations should be explored, and GPs encouraged to monitor the take-up of preventive services on an opportunistic basis.

The provision of screening services for at risk populations is only part of what is required to promote health and prevent illness. If healthy lifestyles are to be encouraged and healthy environments created, the community will need to participate fully in setting local targets for prevention. Collaboration across statutory and voluntary agencies will be required to effect change. Team work for primary prevention therefore needs to involve local people and community workers as well as professionals from health and local authorities. We recommend that DHAs, local authorities and FPCs find ways of involving local communities in jointly developing targets for primary prevention.

4. GIVING PATIENTS THE WIDEST RANGE OF CHOICE IN OBTAINING HIGH QUALITY PRIMARY CARE SERVICES

See Section 2.

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5. VALUE FOR MONEY IN PRIMARY HEALTH CARE: THE CASE OF HMOS

In the USA, HMOs are praised for delivering cost-effective health care with minimum federal intervention. While the Green Paper does not clarify whether such organisations might produce similar effects in a UK setting, we would make the following observations.

Much of the success of HMOs derives from management and financial integration of primary and secondary care. Most of the savings compared with traditional fee-for-service systems accrue from reduced hospital admission rates. Primary health care workers perform an effective 'gatekeeping' function and their performance is monitored through, extensive feedback and audit procedures across primary and secondary sectors. Physicians and other primary care staff work from protocols and guidelines designed to ensure efficient use of expensive secondary care facilities.

The HMO model shows what may be achieved through integration of primary and secondary care and we would recommend that stronger links continue to be forged in the UK. We see potential in the development of protocols for follow-up and continuing care, and for information on referral and utilisation rates to be made available to primary care workers. We emphasise that the success of HMOs depends on management audit of clinical activities as well as of service delivery.

HMOs compete for customers and provide a 'user friendly' service. Patients' views on the quality of care received are regularly canvassed and waiting times are monitored. We consider that management arrangements of this kind play an important part in ensuring user accountability in primary health care workers.

While supporting certain management and monitoring aspects of HMOs, we do not consider that integrated funding across primary and secondary care on a piecemeal basis is a viable option. Indeed, the NHS already provides a framework for management and there is great potential in developing stronger management and planning of primary health care services.

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Criticisms levelled against HMOs include lack of equity (in population terms) and variable comprehensiveness of coverage and in services offered. Some HMOs are attempting to achieve monopoly status in order to underwrite more 'expensive' clients - in other words, creating a mini-NHS.

In the UK context the question of devising incentives which will improve standards remains. We consider that the development of minimum standards, educational support, improved management, quality control, and a more informed and participating public will go further than financial incentives to increasing 'value for money' in primary health care.

6. ENABLING CLEARER POLICIES TO BE SET FOR FPS IN RELATION TO THE REST OF THE HEALTH SERVICE

DHAs have overall responsibility for ensuring that public health and preventive services are available for populations. Thus health authorities continue to provide preventive and screening services and first stage diagnostic services (for example, through accident & emergency departments). In inner cities, where primary medical care lags behind, they provide a greater proportion of these services. New patterns of care are developing and the scale of change is dramatic. This has implications for the content and style of delivery of GP services.

First, it is increasingly recognised that much of the work of outpatient departments could be carried out by GPs. Initiatives to extend the boundaries of general practice include agreements on follow-up care, attachments to general practice of a wide range of DHA staff, consultant visits and access to hospital beds. The impact of these changes on the quality of patient care needs careful monitoring.

Second, the rationalisation and centralisation of acute services involving increases in day cases and patient throughput affects community health

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services and primary care, but this is rarely quantified. GPs and community nursing services should collect as part of their routine information gathering, data that will show the effects of policies in the acute sector.

Third, with increasing numbers of mentally ill, mentally handicapped and elderly people living in a range of community settings, GPs are now providing primary medical care for these groups. In order to promote a policy of normalisation, services should be delivered through multi-disciplinary teams including community psychiatric nurses and psychologists, which are part of primary care services. FPCs need to liaise with DHAs and local authorities over plans for developing care in a community setting. FPCs should communicate with GPs likely to be affected. GPs must be involved at an early stage in arranging primary medical care for those leaving institutions.

Fourth, the expansion of privately or local authority funded residential care and sheltered housing often occurs without consideration of the implications for primary care. FPCs and primary care workers should be consulted at an early stage.

We would urge that joint planning between FPCs and DHAs is promoted so that the two extremes of assuming availability of GP care - or alternatively of providing parallel primary care services - be avoided.

A number of organisations have suggested the creation of new primary care authorities. We recognise a further reorganisation is not imminent. However, the potential for improved planning and management and for setting up systems of quality control already exists and should be strengthened. This would provide a solid base for any possible future reintegration of services.

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SECTION C: CONCLUSION - QUALITY IN PRIMARY HEALTH CARE

Many of the recommendations included in this response are based on the following:

- that minimum standards for clinical activities and service delivery in primary medical care need to be established, implemented and monitored;

- that independent contractor status sits uncomfortably with the promotion of management and accountability in primary health care;

- that fragmented responsibility for primary care has resulted in a policy vacuum;

- that the principles spelled out in the Declaration of Alma Ata and operationalised in the European Regional Strategy of WHO demonstrate that far more is involved in primary health care than the performance of professionals;

- that the market model of care espoused in the Green Paper and based on choice for consumers and increased financial incentives for doctors, will do little to improve care for disadvantaged groups;

- that the scale of change in acute and long-term care sectors is not matched by developments in primary care;

- that primary health care continues to be underresourced and that FPCs will need additional resources if they are to fulfil their new management and planning roles.

APPENDIX 1

Green Paper Workshops

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

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

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

4. Health Maintenance Organisations: inspiration or illusion?

5. Consumers and primary care: beyond market research

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

Each of the workshops was chaired by a member of the London Project Executive Committee; and participants included chairs and administrators of FPCs, development workers, community unit managers, representatives from Departments of Community Medicine and General Practice, CHC secretaries, GPs and representatives of Social Services Departments.

APPENDIX 2

London Project Executive Committee

Chairman: Peter Westland, Under Secretary (Social Services), Association of Metropolitan Authorities

Berry Beaumont, General Practitioner, North London

Graham Cannon, Director, King's Fund Centre

Robert Davies, Chairman, Kensington & Chelsea & Westminster FPC

Denise Dennehy, Nursing Officer, DHSS

Christine Farrell, Member, Haringey HA

Ed Glucksman, Consultant, Accident & Emergency Department, King's College Hospital

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