Some of these deficits relate to service provision but for most the remedy lies with the health professionals. The challenge for educators is to stimulate and motivate colleagues to practise patient centred medicine in this difficult and demanding field.

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The Future of FHSAs

Commissioning for quality

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This is the fourth in a series of articles on the future of family health services authorities

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Primary health care is now high on the health agenda. The decision, taken immediately after the general election, not to move quickly to merge family health services authorities with district health authorities reflected a feeling at the centre that the development of primary care, and in particular general practice, is a major task that requires the undivided attention of one agency.

The general acceptance of the need to transfer resources from the acute sector to primary health care masks the real problems that exist in primary care and in general practice. Primary health care is the least organised part of the NHS, relying as it does on an outmoded system of organisation that has changed little since the inception of the NHS in 1948. While the rest of the NHS moves towards a contracting system based on the health needs of local population, family health services remain wedded to the blunderbuss of national contracts.

The inflexibility of this approach is being highlighted in many ways. The Tomlinson report into London's health services was critical of the current contract. "Many of the problems we have identified stem from this. In particular we see little direct local management accountability for services delivered and for resources consumed in the General Medical Services."[1]

Another issue identified by Tomlinson as a constraint on the development of general medical services by family health services authorities is the fact that they "have no management control over the allocation within their areas of the most important resource: skilled manpower, in the form of GPs." Tomlinson questions the role of the medical practices committee and recommends that within the London primary care development zones the medical practices committee should devolve to authorities the responsibility for deciding how the general practitioner staffing might best be organised. Such a recommendation might equally apply to the rest of the country.

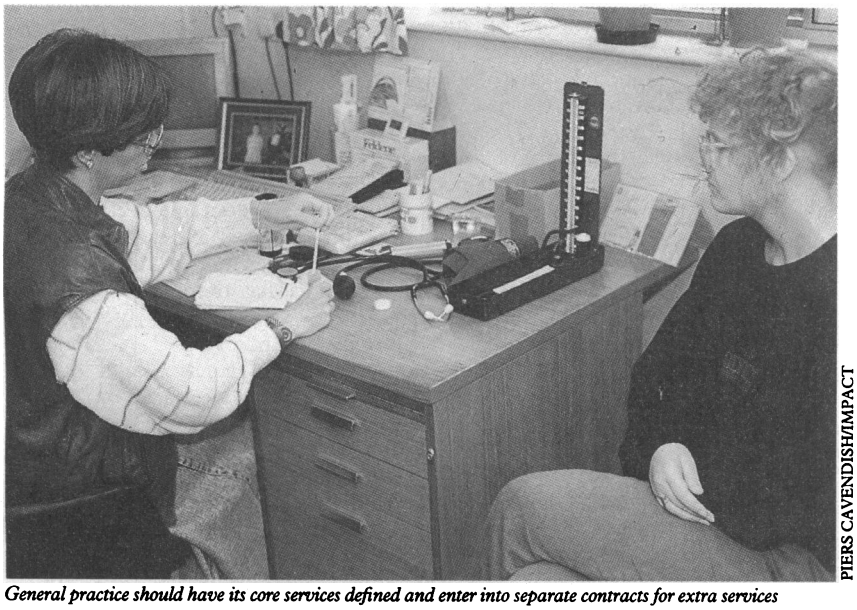
Similarly, the introduction of a patient's charter for primary care has run into difficulties where the desires of its authors confront the regulatory minefield surrounding family health services. The complaints procedure is an excellent example of the way in which the current bureaucratic system is incompatible with the concept of a patient's charter.

Primary health care teams

If family health services authorities are to be able to adapt a truly consumer oriented approach to services there must be a radical change in the current method of contracting, and also in the way in which general practice is organised. The current situation of contracts with individual doctors must be replaced at the very least by contracts with practices but in the longer term by contracts with multidisciplinary primary health care teams.

The concept of primary health care teams has been with us for many years, but in reality there are precious few examples of them effectively existing in practice. The fragmentation of services must be addressed if primary health care is to play a more important part in the future. The rethink that is taking place about the desirability of incorporating community services in whole district NHS trusts is to be welcomed.

The fact that the present general practitioner contract does not specify in detail what services are covered by it makes planning the delivery of primary health care services difficult. Just as there are core services specified in contracts with hospitals, so general practice should have its core services defined. These would be services that all practices in contract with the NHS would be expected to deliver. This would enable practices wishing to offer services in excess of the



PIERS CAVENDISH/IMPACT

General practice should have its core services defined and enter into separate contracts for extra services

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core specifications to enter into separate contracts with purchasers for these services. The effect of such a system would be to move additional resources into primary health care.

Quality standards in the contracting process

A major weakness in the existing contract for general practice is the total lack of any quality standards in the contracting system. Within the rest of the NHS quality has become a key element in the contracting process, with both purchasers and providers actively engaged in determining and monitoring standards. There is no equivalent in the general practice contract. Family health services authorities working locally with the profession have a central role in establishing quality standards for general practice.

A few family health services authorities have recognised that this is an essential role that they must perform. Essex Family Health Services Authority, after lengthy consultation with both the profession and community health councils, published its *Quality Goals for General Practice.* The authority distinguished between clinical standards and standards for the process and structure of general practice: "The FHSA will not set any explicit minimum clinical standards, the setting of clinical standards should be the job of the professions delivering the health care. The authority will seek to promote and facilitate the process of standard setting by the professions in any way that it can. Because standard setting is an essential preliminary to medical audit, the involvement of practices in this process will be crucial.... The FHSA will set standards for the structure and process of primary care, thus ensuring that in all general practices there is a framework within which the practitioners and their team members can develop appropriate standards of care."[2]

The setting of standards, however, should not be seen as an isolated event. It must form part of a coordinated approach to the management of services. Standard setting must be linked to committed support for developing and extending the role of general practice. There must be resources made available for medical audit and education. The vast discrepancy in this area between general practice and the rest of the medical profession has to be addressed as a priority.

Developing audit and management

Further clarity is needed on the potential conflict between confidential education driven medical audit and the need for family health services authorities to commission audit to address their purchasing agenda, which reflects national priorities and the local health needs of the population. It is a challenge for the medical profession to develop processes of audit, evaluation, and research that address the needs of patients, providers, and purchasers for quality assurance. Similarly the current system of postgraduate education for general practitioners must be reviewed. Educational programmes must bear some relevance to the nation's health priorities. In audit and education, as in many other areas, general practices and family health services authorities must learn to be able clearly to show value for money.

Another area where family health services authorities should be assisting general practice is that of management and business planning. The rapid and extensive changes of the past few years have highlighted the difficulties that many practices face in managing change. General practice consumes, directly or indirectly, a considerable proportion of the total NHS resource yet very little support or guidance has been given to general practice to cope with what is a major managerial challenge.

Summary

- Health services, and general practice in particular, remain wedded to an outmoded system of organisation. This is no longer appropriate to the modern NHS and is a block to development
- There is an urgent need to define more specifically the term general medical services and to set quality standards for their delivery
- Medical audit and postgraduate education must be linked to health priority
- Considerable support must be given to general practice to enable it to develop.

Far too many practices have no strategic plan for their development and decision making, and managerial responsibility in many is haphazard and uncoordinated. This is not the fault of general practices, most of which have been cushioned from such activity by the dependency culture surrounding them. The success of the profession's negotiators in securing a fee for every activity and a grant for every development has produced a situation where many practices have been protected and shielded from the reality of being independent contractors. It has also led to innovative and progresssive practices in effect being financially penalised for setting examples.

Accreditation

The continued existence of a small but significant number of practices delivering poor quality services is an indictment of the existing system and weakens the credibility of general practice. The principle of a "contract for life" must be questioned. If the idea of local contracts related to the health needs of local populations is accepted there must be a right for the purchaser to seek alternative providers in the event of continual poor quality service. The existence of such a right would probably concentrate the minds of that minority of practices to such an extent that the actual need to enforce it would diminish considerably.

If the move towards local fixed term contracts is considered too radical thought must be given to a system for the accreditation and reaccreditation of practices. The combination of greater accountability and the demand for higher quality standards will inevitability lead to pressure for introducing such a system, possibly along the lines of that used for training practices. A key issue, however, will be the extent, if any, of management involvement in the accreditation process. The public shows an increasing degree of unease with systems in the public sector that allow monitoring to be done exclusively by peer review.

The increasing influence of management in family health services may not be welcomed by many general practitioners accustomed to their independent contractor status. The development of an effective system of primary care is, however, too important to be left entirely to the whims of independent individual practitioners. General practice has tremendous skills and talents which must be used more effectively in and as a coordinated part of the health service.

There is a challenge for family health services authorities and general practitioners alike to adapt to the new demands that will undoubtedly be placed on them if the move towards a better and more effective primary health care system is to be achieved.

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