PRACTICE OBSERVED

Reflections on Primary Care

Thirst for new wine: responses to "Agenda for Discussion"

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Whatever else the government's consultative document on primary health care may achieve it has disclosed the diversity of opinion and the depth of feeling that exists within and beyond the medical profession about the current state of primary care and about the directions in which it should be developing.¹ If the government had hoped to confine the debate to a limited number of specific issues it will have been dismayed by the opportunity that the publication of the document has offered to the various interest groups to restate their global blueprints for the future of primary care. Prominent among these groups are, of course, the General Medical Services Committee (GMSC)² and the Royal College of General Practitioners (RCGP),³ but others who have weighed in include the King's Fund Centre,⁴ the College of Health,⁵ the National Association of Health Authorities,⁶ the Trades Union Congress,⁷ the Royal College of Nursing,⁸ the Association of Community Health Councils of England and Wales,⁹ the Society of Administrators of Family Practitioner Services,¹⁰ the Pharmaceutical Society,¹¹ and the British Dental Association.¹² Presiding over these and other assorted contributions has been the House of Commons social services committee assessing the degree of consensus on different issues and advising the government about appropriate ways of responding.¹³

Disappointed expectations

Various impressions emerge from a perusal of these responses to the consultative document. The first is that it has pleased nobody. Many of the responses go almost out of their way to express dissatisfaction not merely with specific proposals or suggestions but with the shallow cast of the entire document. "Our expectations

were high that far-reaching proposals for change were on their way," observes the Society of Administrators of Family Practitioner Services, "but those expectations were disappointed. The document fails to address the broader issues we consider fundamental to a debate on primary care." Many of the other interested parties would endorse that judgment, and there is also a surprising degree of consensus about the major reasons for their dissatisfaction—the narrow approach to primary care adopted in the document and the absence of any indication of the availability of additional resources.

The impact of the former complaint is somewhat blunted by the variety of meanings attached to the notion of primary care. But it is a common criticism that the consultative document concerned itself too narrowly with organisational and financial issues in the administration of the family practitioner services and took an insufficiently catholic overview of the total spectrum of first line care. Thus the Royal College of Nursing, emphasising that primary health care was far wider than just primary medical care, complains that "the government's narrow definition has excluded discussion of such essential components as mental health services, occupational health services, health education, community hospitals, services for people in nursing and residential homes, and the care of handicapped and disabled people and people suffering from chronic or degenerative conditions." In similar vein the National Association of Health Authorities is disappointed that "there is no reference to the UK's commitment to the Declaration of Alma Ata, and no mention of the objectives set by the WHO European Region." Laudable though such pleas for vision might be, they are of uncertain utility. Governments, no less than anyone else, have a limited capacity for comprehensive thought and action, and given the difficulties that will be encountered in pushing through even modest reforms in the family practitioner services the pleas for panoramic vision seem a little fanciful.

The complaint about the absence of any mention of additional resources is likely to trouble the government rather more for it inferred in the consultative document (without actually saying so) that its proposals could be implemented within the planned financial allocations to the family practitioner services. The complaint, moreover, is not always one of special pleading in one's

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own cause. It is scarcely surprising to find the GMSC arguing that "the whole purpose of the government's initiative will be lost if more resources are not forthcoming," but the charge of special pleading cannot generally be levelled against, say, the College of Health, the King's Fund, and the Trades Union Congress in drawing attention to the new money that is still needed to implement the Acheson report on primary care in the inner cities.¹⁴

Unkind cut from RCGP

The National Association of Health Authorities goes even further, making the point that existing levels of resources are insufficient to meet even the modest changes proposed in the consultative document, much less any more ambitious ones that may emerge through the consultation process. Ministers may perhaps see the unkindest cut of all as that of the Royal College of General Practitioners' plea for the establishment of a national development fund for primary care of "no less than £100 million per annum at 1986 prices" for much of the early drafting of the document was widely assumed to have been done in Princes Gate.¹⁵

The second general impression is that of the predictability of many of the responses as they derive from—and seek to enhance—the particular interests of those advancing them. Thus, the Royal College of Nursing is eloquently in favour of the Cumberlege report's concept of the neighbourhood nursing service¹⁶ (although it is at pains to point out that "the starting point for services should be people's needs rather than professional aspirations"); the Society of Administrators of Family Practitioner Services wishes to see the eventual creation of new primary health care authorities (to be created, no doubt, by upgrading the existing family practitioner committees); the RCGP believes that "within the next five years general practice should receive at least the same resources for postgraduate institutes and departments as is accorded to the other main branches of medicine"; the Association of Community Health Councils supports the proposals for more information about practices to be available, for the complaints procedures to be simplified, and for patients to have access to their medical records; the Pharmaceutical Society wants the sale of medicines to be restricted to pharmacies, and so on.

None of this is either surprising or alarming for that is how the world is. Yet these declarations of interest may eventually enable some useful hypotheses to be tested about the relative power of the different groups in influencing the decisions of ministers. One such hypothesis (admittedly controversial) might be that matters on which both the GMSC and the RCGP concur will eventually carry the day.

The third general impression is of the bewildering variety—even confusion—in the concepts invoked in the debate and the language through which they are expressed. In some cases the confusion may be relatively unimportant at this stage of the debate, though a degree of order would not come amiss. In discussing the community child health services, for example, the responses refer to "preventive paediatrics," "child health surveillance," "paediatric surveillance," "monitoring the under 5s," and "developmental surveillance." Such diversity of language is not only irritating, there is also the suspicion that the different concepts that may be lurking beneath these captions will remain obscured until the point at which they could obstruct agreement about a policy.

Other confusions may be more serious. The consultative document's failure to distinguish between the proposed good practice allowance as a reward for past excellence and as an incentive to the future maintenance of minimum standards underlies much of the confusion in the responses to it. Some argue against the allowance on the principled grounds that professional pride should be the sole motivator of proper conduct (reflecting a view of the allowance as an incentive to competence), while others insist that any such payment should not disadvantage those whose practice circumstances have involuntarily limited the quality of care that they can provide (reflecting a view of the allowance as a reward for past excellence).

Confusion over health care shops

The debate about the so called health care shops shows even more clearly the dangers and difficulties of conceptual and linguistic confusion. In this case the origins lie in the consultative document's conflation into two brief paragraphs of several separate issues that are not necessarily linked. At its simplest the notion of the shop may mean no more than the gathering together under one roof of a wider variety of primary care services than is presently found even in health centres—a sort of out of town hyperhealth centre. The House of Commons social services committee is clearly of the view that this is the limit of ministers' interpretations, at least in the short term. It is plain from many of the responses, however, that more is being read into it than this. For some the shop is equated with the health maintenance organisation (HMO), although that terminology was not mentioned at all in the consultative document.

From this perspective the shop is more than simply an assembly of services in one place; it is a trading organisation that offers comprehensive care either from its own resources or by buying in from outside organisations in return for an annual premium. Standards of clinical quality and operating efficiency are maintained by competition for custom against other HMOs, by commitment to the levels of service that are set out in the organisation's prospectus and by the possibility of profit sharing among the providers. Although the HMO shop need not necessarily imply the privatisation of care (the premiums could, for example, be paid by the family practitioner committee rather than directly by patients), several responses to the consultative document clearly regard the discussion about health care shops as the thin end of the wedge of privatisation. The Royal College of Nursing, for example, rejects what it sees as an attempt by the government to create "a service delivered by independent contractors acting as small businessmen" and the Trades Union Congress is "opposed to the suggestion that private primary care services should be encouraged." It seems essential that the different images evoked by the notion of health care shops should be carefully delineated and treated on their own merits. To eschew discussion of the notion of the shop as a hyperhealth centre or even as an HMO on the grounds of an ideological opposition to the privatisation of primary care is unfortunate for there may be merit in the former even though the latter is unacceptable.

Conflicting understandings on community nursing

A final example of the threat that is posed to clear discourse by a confusion over concepts is found in the handling of the issue of community nursing services. The consultative document commended for discussion the recommendation in the Cumberlege report of the establishment of a neighbourhood nursing service for communities of between 10 000 and 25 000 people headed by a professional manager and coordinating the work of district nurses, health visitors, and school nurses. Already, however, there are signs that the hoped for discussion is faltering in the face of conflicting understandings about the way in which a neighbourhood nursing service would actually coordinate its work with the existing primary health care teams. On the one hand the Royal College of Nursing confidently asserts that there is "no conflict between this concept and the fostering of primary health care teams within the neighbourhood"; on the other hand the GMSC believes that "the neighbourhood nursing scheme would undermine the cohesion of the primary health care team." Both views cannot be right, and a more careful exploration of the likely impact of neighbourhood nursing on the primary health care team would seem to be a necessary precursor to any judgments about its acceptability. The observation of the Commons social services committee that "there appears to be a surprising inability on both sides to understand the other's position" is helpful if it prompts a dialogue to resolve the mutual misunderstandings.

The fourth general impression from this set of responses to the consultative document is that of a widespread consensus on several specific issues raised in the document. If agreement among interest groups is a major determinant of policy decisions it is possible to predict with some confidence what will (and will not) be done in due course. On the negative side the good practice allowance will not be introduced (at least in the format in which it was outlined in the consultative document), the proportion of a doctor's remuneration represented by capitation fees will not be increased, and wholesale (or even experimental) privatisation will not be allowed.

Many and varied are the arguments against these innovations and few if any are those in favour. On the positive side better and more comprehensive information will be available to patients about practices and the services they offer, ways will be found of making it easier for patients to change their doctors, the complaints' procedures will become more user friendly, more resources will be made available for primary care in inner cities, the prevention of disease and the promotion of health will be encouraged, and general practitioners will become responsible for a comprehensive paediatric

surveillance service. Many and varied are the arguments in favour of these changes and few if any are those against.

The interesting issues, of course, are those on which opinion is divided, especially those in which the minority opinion is held by the group with the greatest apparent power. Two such examples are the proposals in the consultative document to introduce compulsory retirement for general practitioners at 70 and to end the 24 hour retirement system. There is widespread support for government action on both these issues, with the notable exception of the GMSC. Action on these issues may be a sensitive indicator of the profession's political influence in the face of what seems to be a unified opposition. The desirability of some form of merger between family practitioner committees and district health authorities to create new primary care authorities is also the subject of a similarly divided opinion. The benefits of such a merger were commended in the Cumberlege report and are supported by the Society of Administrators of Family Practitioner Services, the Trades Union Congress, and the National Association of Health Authorities.

The opposition is again led by the GMSC, which declares itself to be firmly opposed to any such amalgamation. But in this case the balance of political power is somewhat clearer since the government itself indicated in the consultative document that "it is too soon to contemplate changes, which would in any case need to be based on a close analysis of the likely benefits." In this particular instance the Commons social services committee offers a way forward in recommending an immediate start to such an analysis because "in the long run we can see no logical reason for their separation."

Lastly, there is a clear impression from these responses of a willingness to grasp the (now mature) nettle of the quality of care but widespread disagreement about a sting free way of doing it. It is worth emphasising the implications of the willingness to grasp the nettle: there is no serious challenge to the government's view about the variable quality of the general medical services or to its objective of raising the general quality of these services nearer to that of the best. The problem is that of finding ways of doing so that will be both effective and acceptable. There is virtually unanimous opposition to the introduction of a good practice allowance and to an increase in the capitation element as motors of change, but there the consensus ends.

Degree of radicalism

One way of categorising the responses is by their degree of radicalism. At the conservative end of the spectrum is the package of measures that have been advocated for some time by the GMSC. The basic elements of the general practitioner's contract would remain unchanged but list sizes would be further reduced to create time for the development of cervical cytology, paediatric surveillance, and minor surgery, and doctors would be encouraged to take on these extra functions through the extension of direct reimbursements and items of service payments. The ancillary staff scheme would be developed, increased funding would be available for surgery premises, general practitioners would have open access to diagnostic facilities and other support services, and community hospitals would be encouraged. The package is conservative in the sense that it seeks to extend what is believed to be good in the existing scheme of things while leaving undisturbed the deeper structures.

At the radical end of the spectrum are those who argue that only a wholesale renegotiation of the general practitioner's contract will ensure a significant improvement in standards of care. The model, interestingly, is that of the HMO. As in the HMO the new contract would specify, in much greater detail than at present, the range and level of services to be provided, and the performance of individual practices would be monitored against the agreed elements of the contract. Those that fell short might be exposed to a range of sanctions, including (in the most radical version) the non-renewal of the contract at the expiry date. In most formulations of this radical argument the family practitioner committees would have the key role in negotiating contracts and monitoring the performance of practices, but the College of Health goes somewhat further, arguing the case for the creation of an independent inspectorate, similar to the HM Inspectorate of Schools, to assess such features of the practice as accessibility, record keeping, the use of call and recall systems, immunisation rates, and procedures for issuing repeat prescriptions.

Representative of the middle ground is the Royal College of General Practitioners, which accepts in principle the need to

renegotiate the contract in ways that will enable remuneration to be linked more closely to performance, but insists that control should remain within the hands of the profession. An independent inspectorate of the kind advocated by the College of Health would be anathema to the RCGP as it would to the GMSC. The key motors of change in the royal college's scheme are education, training, and peer review, all of which have a much higher profile than in the GMSC's response.

Strong rhetoric but vague objectives

While there is no shortage of opinion about the methods of achieving higher standards the responses are notably vague about the objectives. It is almost as though the means of transport is more important than the destination. At best the objectives are intermediate ones, concerned with the resources that ought to be available and the services that ought to be produced from them. Thus, a good practice would be one that had a greater number and variety of ancillary staff than at present (including nurse practitioners), that produced a detailed prospectus of its services and published an annual report of its activities, that offered systematic screening and other health promotional services, that paid proper attention to the education and training of its staff, that was prepared to submit to critical evaluation by colleagues, that utilised computer based practice registers and repeat prescription systems, and so on.

What is unclear to the disinterested observer is how, and to what extent, such changes would improve the health of patients—for example, by reducing death rates from preventable causes, reducing days of sickness absence, increasing people's mobility and capacity for self care, easing pain and anxiety, and generally helping them to cope better with the demands of the daily round. The links between the intermediate objectives (better services) and the final objectives (better health) may be so well established that they no longer need rehearsing, but that is probably not the case. To take for granted a set of causal links that are actually complex and imperfectly understood may, in the long run, be less productive than knuckling down to the difficult task of dissecting them.

These, then, are some random reflections on the bulky responses of the major interest groups to the government's consultative document. The rhetoric is one of vision and of willingness to change. There is a thirst for new wine, rich in the heady ingredients of consumerism, quality assurance, and multiprofessional collaboration. Whether the skins can be freshened sufficiently to take it remains to be seen.

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(Accepted 31 March 1987)