

lors, which suggests that general practitioners view bereavement as a problem which responds to the non-directive forms of counselling associated with these professionals.

As in previous studies,^{6,14} our findings showed also that each type of counsellor was referred a wide variety of problems ranging from family and relationship difficulties to substance misuse and psychiatric illness. While many counsellors may be skilled in a range of therapeutic approaches, any one type of counsellor is unlikely to be qualified to deal with such a broad range of illness. Many must have been called on to treat patient problems outside their knowledge. General practitioners will need to become more discriminating in their referral policies if they are to maximise the benefits of their counselling services. They must be helped in this task by better research into which types of patient problems are best treated by which types of psychological intervention. We plan further studies into the work of selected counsellors and their impact on referral rates and psychotropic drug use.

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The Future of FHSAs

From FPC to FHSA to . . . health commission?

June Huntington

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

By 1986 I had worked with general medical practitioners for 16 years, in both the United Kingdom and Australia, but knew nothing of family practitioner committees. While working with a London district health authority in 1986 I met my first family practitioner committee administrator who, when asked whether patients ever came to the office, replied that he was not running a public complaints service.

A week later I attended a meeting of the neighbouring family practitioner committee at which one of the agenda items was the Royal College of General Practitioners' policy document on quality in general

practice.¹ A general practitioner member of the committee, who also sat on the district management team of the district health authority, saw fit to remind the chairman, himself a retired pharmacist, that the quality of the general medical services was not within the purview of the family practitioner committee.

Later in 1986 I began to direct a study of the management development needs of family practitioner committees for the NHS training authority, and found that certain of the committees' features uncannily reflected those of general practices. Both were relatively isolated organisations, with few means of exchanging

Summary

- The transformation from family practitioner committee to FHSA signalled a shift towards serving the public and servicing rather than serving independent contractors
- FHSAs were charged with improving the range, quality, cost effectiveness, and consumer responsiveness of the family practitioner services component of primary care
- FHSAs were given increased discretion over funding of premises and staff developments in the general medical services, but few sanctions. Impediments to their attempts to procure local improvements, such as the continued powers of the medical practices committee and their own lack of discretion over allocation of Jarman payments, remain
- Nevertheless, most FHSAs have far deeper and more comprehensive knowledge about practice activity than previously, and are increasingly "trading" allocation of resource and development to practices in return for greater practice accountability

- Their closer relationships with GPs have illustrated the difficulties of achieving improved primary health care without greater integration of general medical services with community health services, leading some FHSAs to engage in joint commissioning of primary care with district health authorities
- Fundholding has developed differentially across the country and in some places will soon cover the whole population. Because of the regional health authorities' lead role in establishing fundholding, some FHSAs have remained marginal to this development
- The complexity of services fundholding practices will purchase by April 1993 makes it imperative that they be held accountable, as locally as possible, for their performance as both purchaser and provider. This task will require commissioning authorities that contain members and managers experienced and competent in commissioning both primary and secondary care

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good practice with others of their kind. They both employed long serving staff who were wedded to the local area, while "new blood" staff were often misused, demotivated, and poorly managed. Both were relatively unmanaged organisations: the managerial distance between practices and the family practitioner committee was matched by that between the committees and the Department of Health. Both were typically headed by a small group of men, but staffed by a large group of low status, deferential women.

I recount my own early experience of family practitioner committees in order to establish at the outset of this series of articles on family health services authorities the transformation that has been achieved in these organisations in the past six years. Most family health services authorities of today would be unrecognisable by that administrator and general practitioner in 1986 who challenged the idea that family practitioner committees should be anything other than the servants of their contractors. Family health services authorities, thanks to the changes wrought by the provisions of *Working for Patients* and the 1990 general practitioner contract, are now well advanced in the work outlined in the three documents that expressly addressed their particular responsibilities.^{3,4} This work is best summarised as delivering continuing improvements in the range, quality, cost effectiveness, and consumer responsiveness of the family practitioner services, including the general medical services, which are responsible for over 90% of all patient contacts with the NHS each year.

The FHSA agenda

The full extent of this agenda goes widely unrecognised in the rest of the NHS, as do the rigours of wringing improvement from services provided by independent contractors, whose contract continues to be negotiated nationally between the General Medical Services Council and the secretary of state. Few NHS managers outside family practitioner services are aware of the legal, financial, and psychological complexities of the independent contractor status and the constraints these exert on, for example, family health services authorities' own financial management arrangements.

While district health authorities are free to put the whole of their resources behind their purchaser function, family health services authorities have but a tenth of the leverage with which to shift the pattern of the general medical services in their patch. If they abide by the letter of their financial management arrangements they cannot veer between the "admin" part of their budgets (allocated to cover their own running costs) and the general medical services part (allocated to cover payments to contractors). Neither are 90% of the funds in their general medical services budgets theirs to pay or withhold, but are allocated automatically to capitation payments and various centrally determined fees and allowances.

About a tenth of their general medical services budgets is available for "staff and premises," and since April 1990 family health services authorities have been able to determine the level of reimbursement of salaries paid to practice staff appointed after that date. Increasingly, the authorities are using their discretion over the level of reimbursement to negotiate for changes in the range and quality of services provided by practices. Similarly, they can negotiate service development through their ability to grant or withhold the use of the cost rent and improvement grant schemes to practices wishing to build or extend their premises.

General practitioners who are proud of their service are happy to negotiate with their family health services authorities, and indeed *Doctor* magazine, a keen

supporter of the independent contractor status, recently defended the actions of certain general managers of authorities who were trading resource allocation for service improvement. Its editorial argued that "The Department of Health must bid to the Treasury, Regions to the Department, FHSA to Regions and GPs to FHSA. It is no longer enough to say 'give us some money and we will decide how to spend it.' These days GPs must say why they need the cash and how they will use it."

The capacity to give or withhold a resource, however, is effective only if the target of the activity wants whatever is being given or withheld. In some areas which combine great population need together with low levels of primary care development, practices clamour neither for more staff nor for improved premises.

Such practices are typically very small, with lists of over 3000 patients per doctor and minimal support staff. They achieve few or none of the 1990 contract targets, offer fragmented child health surveillance and contraceptive services, and no minor surgery. They are much akin to what in the United States are termed "Medicaid mills." Their practitioners have typically trained overseas and entered general practice before vocational training became mandatory. For them, general practice is a business rather than a profession, a publicly subsidised business that enables them to enjoy all the advantage of private practice with few of the risks.

They may well receive deprivation payments that in view of their list sizes raise their incomes considerably with no consequent rise in volume of work. To complete the nightmare scenario, the practice area may well be designated "closed" by the medical practices committee, consequently with little possibility of the family health services authorities introducing a little competition.

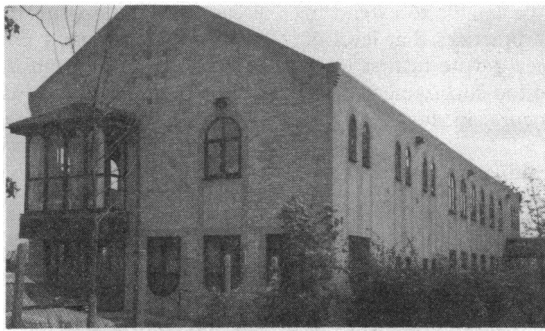
The ultimate challenge

If such practices represent the ultimate challenge to family health services authorities what powers do they have to address this? If in the new NHS the consumer is king and the practice were that bad, surely its patients would go elsewhere? The recent Bradford debacle in which a bogus general practitioner had practised for 15 years, drawing a decent living from the public purse, surely put paid to overly simplistic notions of consumer sovereignty in primary health care.

Books and journal articles too numerous to reference here have shown repeatedly that the old, the frail, the disadvantaged, and the deserted—all mainly women—are often without telephone or car, and therefore "choose" a practice for reasons of propinquity rather than quality. They also show little if any of the assertiveness we would normally associate with the term "consumer."

Even without the handicaps of Jarman payments and medical practices committee rulings, most family health services authorities in the situation I have described find it very difficult to "empower the consumer," and need rather to make personal contact with individuals and groups in the population than to depend on the colder and more distanced written word.⁶

Perhaps the biggest difference between the old family practitioner committees and the new family health services authorities lies in the degree to which most authorities now "manage by walking about." Their contact with practices now extends well beyond the fleeting and sporadic meetings between senior partner and family practitioner committee administrator, to involve other staff in both the practice and



FHSAs can grant or withhold resources for practices to extend their premises. This practice has added a new health centre (bottom) to its existing premises (top)

the authority. The authorities find in the course of these contacts that most practices want something they can offer or bring about. Once the nature of that potential incentive is clear, the authorities can use it positively to obtain service improvement.

Where practices prove resistant to any positive incentives, the family health services authority may decide to "work to rule," using all the considerable monitoring rights and responsibilities at its disposal to ensure that the practice measures up in terms of practice leaflet and annual report information, prescribing budget, adequacy of premises, hours of availability in surgery, involvement in postgraduate education and medical audit, complaints, deputising arrangements, and other terms and conditions of service.

Many of the general managers of family health services authorities who came in from outside family practitioner services argue that even the old family practitioner committees had teeth if their managers had really wanted to use them. Formerly, however, administrators who tackled local contractors on complaints and deputising arrangements were frequently "chopped off at the knees," as one senior civil servant put it to me, by a Department of Health under pressure from the general practitioner appeals mechanism.

The 1990 contract and the NHS reforms have strengthened the arm of family health services authorities, and under a barrage of "attention" from a determined authority most practices will change. The difficulty for the authority with several problem practices is the amount of managerial time, energy, and skill this deflects from other more positive developmental activities.

It could be said that this has always been true of tackling recalcitrant consultants, but trust hospitals, the purchaser-provider split, and general practitioner fundholding are modifying consultant practice. Where is the equivalent purchaser-provider split in family practitioner services? General practitioners do not have to find themselves a purchaser: the government left itself in that role. For a government which advocates locality sensitive purchasing, isn't it time that family

health services authorities or some joint district health authority and family health services authority commissioning agency took over the role?

Integrating primary care

Increasingly, both general practitioners and family health services authorities realise that improvement in service quality in general practice is contingent upon the closer integration of general practice and the community health services. Such integration is also seen to be a prerequisite of greater integration of primary and secondary care.

For these reasons, some family health services authorities have taken strong lead roles in the joint commissioning of primary and community health services. They often have a clearer vision of what is required than their partner districts, whose pre-occupations lie with the secondary care sector. Their experience also lies in the contracted rather than directly managed part of the NHS.

Joint commissioning enables the two major barriers to more effective development of the primary health care team—premises and staffing—to be addressed more positively when family health services authorities and district health authorities review the volume and deployment of capital stock⁸ and staff available to both. Together they are more able to challenge established but not necessarily effective and efficient practices in primary care.

Whether singly or jointly with their partner district health authorities, family health services authorities are increasingly demonstrating their capacity as commissioners of primary health care. The role contains components of both purchasing and provider development,⁹ a combination familiar to successful high street retailers, who invest considerable managerial time and energy in helping their suppliers deliver the goods.

The future—fundholding and beyond

What then of the future? The development of the next two or three years that will most affect the future of both family health services authorities and district health authorities is that of general practitioner fundholding. Within the next two years, in some districts over half of the population will be covered by fundholding, and there are now towns in which the whole population is served by fundholding practices.

Fundholding is not solely an experiment in doctor led, primary care driven purchasing of secondary care, but also an experiment in localisation of the general practitioner contract. Up to now what has been negotiated is a sum of money (the fund) rather than a volume and pattern of service. Let us not forget, however, that fundholding, like the rest of the NHS reforms suffered an induced rather than natural birth. The process was rushed, the available information minimal, and the easiest way out taken—namely, to let historical patterns of referral, staffing, and prescribing determine the fund. Negotiation of the second year's fund with first wave practices has been informed by a significantly increased quantity and quality of information on both practice and hospital patterns of work, offering greater potential for marrying local innovation with district, regional, and national targets and strategies. Increasingly, fundholding will represent not just a model for, but an example of, localisation of the general practitioner contract.

Yet some family health services authorities continue to be peripheral to this negotiation process, confined by their regional health authorities or themselves, or both, to a financial monitoring role. Without serious increase in their primary care management capacity,

regional health authorities will be unable to extend to second, third, and fourth wave practices that level of managerial time and energy they devote to first wave fundholders. Their focus is also too constrained to the changes fundholders can procure in hospital and consultant practice patterns.

What will be lost if family health services authorities do not deepen their involvement in fundholding will be an informed focus on the provider side of the development. The need for this will increase in April 1993 as fundholders extend their purchasing to parts of the community health services. While this deeper involvement of family health services authorities is desirable, it too would need to be resourced. Below the executive team in many of the authorities, the managerial capacity is thin and stretched tight across existing demands, and salary differentials between family health services authorities and district health authorities remain stark.

District health authorities are also developing closer relationships with general practitioner fundholders, again focusing on their purchaser rather than their provider role. As fundholding develops further, fundholding practices will need to be held accountable for the quality of both their purchasing and their providing functions, and for the relevance of both to the implementation of a national strategy for health gain.

As currently constituted, are family health services authorities in a position to commission a future pattern of service in which most normal diagnosis, treatment, and rehabilitation, as well as health promotion and

disease prevention, occur within primary care; are delivered by extended practice based primary health care teams; and are informed by practice based and locality based health needs assessment, a primary care patient's charter, and national health targets? The achievement of this vision will demand radical changes to the practice of both general practitioners and consultants and the relationship between them. While general practitioner fundholders can lead the way, this major challenge of all health care systems—that of shifting the balance between primary and secondary care—will require a strengthened purchasing authority that contains members and managers who are experienced and competent in commissioning both primary and secondary care.

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A MEMORABLE PATIENT

The last casualty of the first world war?

These men are worth your tears. You are not worth their merriment.

"Apologia Pro Poemate Meo," Wilfred Owen

Sam has just died at the age of 94. As with so many of the unsung heroes of the first world war he preferred to keep quiet about his exploits during those dark days, but one episode from that period in his life refused to keep quiet.

On his 86th birthday we received an urgent call to his home. He was suffering from severe abdominal pain and vomiting. With his distended abdomen and increased bowel sounds there was no doubt about the diagnosis of acute obstruction and he was admitted to our local general hospital where he was seen by one of my previous trainees who knew him. Although, at his age, we suspected a tumour, a radiograph of the abdomen revealed an opaque mass in the central region. Sam swore that he had not eaten anything unusually large or hard to account for his obstruction so the cause was initially a mystery.

Later that evening, at laparotomy, his bowels were relieved of their strangulating adhesions and a 0.5 cm diameter iron ball was extracted from the centre of the mesentery. He made a good recovery and was soon waving a cheery farewell to the surgical staff to embark on the remainder of his active life.

When we quizzed him about the strange cause of his problem, now proudly displayed in a pot on his mantelpiece, the truth came out:

On 3 September 1914 Sam and his fellow soldiers of the 49th division West Yorkshire Regiment were ordered to attack and capture three lines of trenches on the high land south of the Beaumont Hamel Valley as part of the Battle of the Somme. As they advanced into a huge barrage the enemy mounted a gas attack and Sam was one of those overcome by the gas. Just before losing consciousness, however, he recalled feeling a sharp stab of pain in his abdomen. "Nothing really bad, mind you," he said, "more like a sort of stab with a knitting needle." He recovered well from the gas and went back to the front some weeks later.

As Sam was covered in mud and scratches and suffering the effects of gas that solitary, quiet abdominal bullet wound went undetected at both the casualty clearing station and the hospital to which he was evacuated. Indeed, it remained undetected until he was 86, when it announced itself to create what was probably the last operation on a first world war casualty.

Sam was a stoic and a good man. He wished for no publicity at the time but now that he is no longer here I think that it is only right to stake his claim to immortality.

—JOHN R CLAYDEN, *general practitioner, Huddersfield*

We are delighted to receive submissions of up to 600 words on *A paper (or patient or book) that changed my practice, A memorable patient, The one message I would like to leave behind, or related topics.*