General practitioners and National Health Service planning

THE current plans for restructuring the NHS, with the establishment of new District Health Authorities in England, provide an opportunity to review the role of general practitioners in the health service planning process.

The present position

Before the 1974 reorganization, general practitioners contributed little to management and planning outside their own field of the executive council services. Some were members of hospital management committees or local authority health committees but were usually nominated rather than elected, and often tended to express their own views rather than those of local colleagues. As the concept of integration became more fashionable in the early 1970s, more cross-consultation began to take place, but the hospital service in particular largely continued to make its own planning decisions.

The reorganisation of 1974, outlined in great detail in the Grey Book (DHSS, 1972) and in a series of circulars, suddenly provided general practitioners with the opportunity of involvement in the planning of all parts of the health service at various management levels and in different forms (DHSS, 1974). The most significant proposals for general practice were the establishment of district management teams (area management teams in single district areas) with a general practitioner member elected by a district medical committee and representative of the whole profession within a district, and the presence of a nominated general practitioner member on all area and regional health authorities. A further obligation was placed on health authorities to consult their medical advisory committees, on which general practitioners were represented in equal numbers with hospital doctors. General practitioners also became involved in the multidisciplinary district planning teams and various other planning groups.

It is hardly surprising that in many parts of the country general practitioners were slow to grasp the opportunities offered to them by a system which even some so-called experts seemed not to understand fully. Having hitherto relied on a few medico-political enthusiasts, local medical committees (or their district equivalents) had to appoint representatives to a multitude of bodies, and subsequent events have shown that much has depended on the care taken in the selection process, semi-dormant representatives being worse than none at all. General practitioners' involvement in management takes time. It needs to be justified in terms of its benefits both to the development of general practitioner services and to the contribution the general practitioner representative is able to make to the planning of the NHS as a whole.

Despite their independent contractor status, general practitioners are vitally affected by changes and developments in the hospital and community services, and need to be involved in planning if they are not to be presented with a *fait accompli,* which may not be to their liking or in the best interests of their patients. The planning and commissioning of a new district general hospital, proposals for closure of peripheral units and development (or curtailment) of diagnostic facilities or community nursing are but a few examples. Those working in the hospitals often seem to have little understanding of the effects of what they regard as internal proposals on others, and are genuinely surprised when those proposals are challenged.

Perhaps even more significant is the contribution that general practitioners are able to make to NHS planning as a whole. Because they are family doctors, they should be able to scrutinize the general direction of plans in a more objective manner than those more closely involved, and to see the health service from the viewpoint of the consumer. Such a contribution at district management team level, in the planning teams or as an Authority member has already been shown to be extremely valuable and has been welcomed by many administrators and Authority members. As resources become more scarce, objective assessment amongst planners becomes vital, not only in planning and developing services but in eliminating waste and duplication. Such work can be extremely time-consuming. It requires involvement in the NHS outside the orbit of one's own clinical practice and a willingness and determination to learn the system of NHS committees and their interrelationships. Within the district management team it also requires an extensive knowledge of the district's services and future plans. Most general practitioners will naturally enough have interests elsewhere in medicine, but knowledge and experience gained in NHS management can provide useful training in managing one's own practice and helps one to get the most out of local NHS services for one's own patients.

The future

Although it involves general practitioners in planning, the present complex structure with its multiplicity of tiers and committees has stretched even the most dedicated clinicians. The Royal Commission on the NHS (1979) highlighted the difficulties for the profession and recommended removing a management tier and simplifying the medical advisory structure. The discussion

document, *Patients First* (DHSS, 1979), followed up by proposing the removal of the area tier and the establishment of district health authorities. These were usually to be based on existing districts and within them the 'unit' level was to be strengthened and functional management reduced. These proposals have now become decisions (DHSS, 1980), with a timetable for the new district health authorities to be established by April 1982 in most cases. There is great emphasis on delegating both strategic (10 years on) and operational planning to the new districts, and on reducing the role of the regions, but whether this will actually occur is doubtful. There is no doubt, however, that the new authorities will have great freedom in deciding the best management framework within their own district.

Although this greater simplicity is to be welcomed, the influence of primary care could well be reduced. The emphasis on integration, which was a feature of the 1974 changes, has faded away and much will depend on decisions taken by the new authorities over the next year or two. They will be established in 'shadow' form in the late summer. There are two issues which may create problems. Firstly, a revised medical advisory machinery within districts has been proposed by a working party of the Chief Medical Officer (DHSS, 1981) which, amongst other proposals, would eliminate the district medical committee and replace it by a system of cross-representation. Its recommendations will inevitably lead to a weakening of the role of general practitioners in the advisory system and in some places the task for the general practitioner member of the new district management team might become impossible. These proposals have already attracted criticism; they are not obligatory, and general practitioners would do well to ensure that such a system is not adopted in their own district.

Secondly, the new 'units' are likely to be interpreted by many districts as hospital units rather than the integration of health services within a geographical vicinity. The risk of general practice being excluded from local planning and decision-making is obvious, and there is danger of a return to the tripartite philosophy of pre-1974 unless we insist on involvement at unit management level and on all unit proposals of a medical content being channelled through district medical committees. The present obligation on health authorities to consult such advisory committees should be retained.

Amidst all this change, the Family Practitioner Committees in England and Wales are to remain as they are, and the DHSS has proposed that they become more involved in planning. Since most will have two or more districts within their area, it is hard to see such arrangements being successful. FPCs seem destined to become increasingly isolated unless they are re-established at district level. A more controversial prediction might be that, if general practitioners can develop confidence in their role within the new district health authorities and be assured about their own contractual status, FPC functions may eventually be taken over by the district authorities.

Summary and conclusions

There is now an opportunity to establish the fine ideals leading to the 1974 reorganization within a simpler and more workable framework. Many decisions in this process will be made at district level, and the way is open for general practitioners to become fully involved in planning their local health service, provided they have the will to assert themselves.

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The rehabilitation of stroke patients

COMPLETED stroke is the commonest cause of severe permanent physical disability in Britain, and the care of stroke patients consumes a considerable proportion of acute medical resources. The numbers of patients to be considered and planned for are based on an incidence of 150 per 100,000 per year, and a three-week survival ratio of 60 per cent (Langton-Hewer, 1976). For a doctor with an average list, this means about six new cases of stroke per year, with four survivors, three of whom will be left with considerable disability, usually a hemiparesis. Of these survivors, fewer than 10 per cent ever get to a residential rehabilitation centre. The corollary is that at least 90 per cent of patients with stroke are managed in the community.