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Information unbound

THERE are common strategies which doctors use to meet the needs of patients:

'I'll prescribe you these pills'.
'I'll get the nurse to come and visit your husband'.
'I'll write to the specialist at the hospital'.

But there are other initiatives which could be equally effective:

'I'll ring the social services department and see if they can provide ...'
'There is a carers' support group that meets at the church hall. Here's the phone number of the person who runs it'.
'I think you should apply for the attendance allowance'.
'If you ask the receptionist she has all the information about local voluntary societies'.

Unfortunately 'end of consultation' phrases tend to depend on the information that general practitioners have either in their head or easily accessible. Every general practitioner has a copy of the *British national formulary*. Other information about the latest drugs is also easily available; it comes in the post in copious quantities. The prescription pad is close at hand and may offer both the doctor and patient an apparently simple remedy for problems which at root may be social in nature. Although general practitioners are expected to assess the needs of their patients in social as well as physical and psychological terms, problem solving in the social dimension is impeded by a lack of information. Patients may not be aware of this lack of information and imagine that the general practitioner is the gateway to all services, social as well as medical. They may then find it difficult to understand why they have been left in ignorance for years about a benefit such as the attendance allowance.

From the doctor's point of view it is not as easy as the patient might think. There is the problem of raised expectations. For instance, a doctor may feel that a patient or a carer should have a home help, but it would be very unwise to say that he will provide one; that is the job of the home help organizer, who may not think that the referral is appropriate. Mentioning a self help group to a patient is likely to be understood as an endorsement of the activities of the group. It may seem safer to keep quiet, but important issues should not be avoided just because they are difficult.

What is needed is a 'social' version of the *British national formulary* which could be available to every general practitioner and to other workers who deal with the public. It would need to be in two sections, national and local. National information would include: (1) benefits available from the Department of Social Security, and grants available from charitable sources; (2) names, addresses and phone numbers of voluntary organizations and an indication of the services which they can offer; (3) specialist hospitals and homes able to cope with unusual conditions and disabilities. Local information would include: (1) address and phone number of social services officers and the facilities available locally, for example, homes for the elderly, day centres, home help services, respite care facilities, carers' support groups and transport services for the disabled; (2) addresses and phone numbers of local voluntary organizations and facilities that they can offer, for example, Crossroads care attendants schemes, Alzheimer's Disease Society sitter service; (3) addresses and phone numbers of nursing homes and rest homes; (4) names and addresses of special schools for children with learning difficulties; (5) address and telephone number

of the local office of the Department of Social Security.

Some of this information is already available. Local councils of voluntary service, health education units and social services departments all have useful lists, but there is no single reliable source of information for doctors and their patients. Looking through sheets of paper, booklets and brochures is hardly possible in the course of a five minute consultation.

The arrival of the computer in the surgery provides an answer to the difficulty and one which has already been proved to be worthwhile and an asset to both patients and professionals. Jarman[1] has described how he set up a computer programme for use at a health centre to deal with the problems of patients who have financial difficulties. The programme was started in 1980 and dealt with a wide range of benefits including attendance allowance, invalidity pensions and so on. At the time of writing Jarman could claim a 100% record of accuracy with the information provided by the computer being checked by the DHSS social security officer. With two or three enquiries a day the service was clearly meeting a need and, in addition, it provided doctors at the health centre with greater knowledge and confidence when talking to people in their own homes on matters to do with benefits. So successful was the project that in 1983 the DHSS provided one of their officers to work with the programme at the health centre and run an advice centre there for the patients.

It would not be too difficult to extend this service to include the range of information outlined earlier so that patients, carers and also the primary health care team could have at their fingertips the answer to the information needs of everyone. What is much more difficult is finding the right person or organization to provide and maintain the up to date information. Some general practices and health centres regard the work of the practice manager as including the gathering of information, but it would be very wasteful of time and energy for every practice to have to do its own research. As local information is vital to meet people's needs, it is necessary to find a local organization which could undertake the task. There are at least five organizations which have the expertise and/or the interest to develop such a programme on behalf of all surgeries in their area: family practitioner committees, community health councils, councils of voluntary service, social services departments and colleges of arts and technology.

Social services departments will have much greater responsibilities for the care of the frail and disabled now that the government has accepted the main recommendations of the Griffiths report.[2] From 1991 they are to be responsible for ensuring that an adequate level of care is available, to help people to stay in their own homes rather than be forced to go into residential care. To do this social services departments will need to develop efficient information systems which could be made available to the public not only through their own officers but also through every general practitioner's surgery.

Alternatively the health authorities could take the lead in providing this service. Wessex health authority has already taken steps in this direction with a computer based information service 'Help for health'[3] which supports a telephone enquiry service. It enables enquirers to find out just the sort of information that carers and their general practitioners need to know. For example, what is the new address of the Hyperactive Children's Support Group? Is there a self-help group for post-viral fatigue? It is now available to other health authorities, libraries and advice centres, and has so far been bought by 20 different organizations. This system is of particular value for national information; local organization is required for local information.

These schemes are just stepping stones to further developments. All professionals should have access to information at their place of work and the general public should have the same ease of access. In the future we are likely to see a computerized information system in every living room. At that point there should be no more difficulty in finding out about the local carers' group or the address of the Parkinson's Disease Society than in getting up-to-date information about the latest traffic jam on the M25 or the weather in the Mediterranean. That might give the doctor and his team rather less work to do; it would certainly allow patients to be more independent.

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Inner cities: primary health care in the market place

THE correlation between social deprivation and poor health is well known.[1] In what are loosely termed inner city areas, or more correctly areas of deprivation, the effects of poor social conditions on health are seen at their worst. The Royal Commission on the National Health Service[2] stated that 'Improving the quality of care in the inner city areas is the most urgent problem which NHS services in the community must tackle'. Other studies have voiced similar concerns.[3-8] Despite this little seems to have been done to channel resources into these areas. In *Promoting better health*[9] the government promised specific action and took on board a number of proposals from the Acheson report.[10] However, with the publication of *Working for patients*[11] and the new contract[12] the government has changed direction and looks set to tackle health care in the same way that it has approached other areas of government spending, by introducing market forces. The debate rages as to the effect this will have on both hospital and general practitioner services as a whole, but there is particular concern about the effect on health care in inner cities. Will the proposed changes bring about an improvement in standards or merely serve to increase the difference in the level of health care received by the rich and poor?

The government's proposals involve targets, incentives and competition, as well as the introduction of cash limits to curb spending. The most fundamental change for general practice is the move away from standard allowances towards a greater reliance on capitation fees, encouraging competition for patients. The worry is that there will be a concomitant increase in list sizes. It is difficult to know whether this is the government's intention or not. The government certainly envisages 'good' practices expanding as patients flock to join, but also that more time