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

should be spent on prevention. With higher list sizes practices will have an increased workload from patients who are ill and will therefore be unable to spend more time on prevention. Practices in deprived areas with high consultation rates and poor response to screening initiatives will be doubly affected.

The government has also proposed that general practitioners should provide a wider range of services, including minor surgery, child surveillance and health promotion clinics. Fees for these services will be expected to balance the removal or reduction of other allowances, such as the basic practice allowance. Who is best able to respond to these proposals? Bosanquet and Leese[13] noted that fewer general practitioners responded to professional and economic incentives in deprived areas than in more affluent areas, and observed that practices in deprived areas had a smaller margin for developing services. They concluded that decision making about the allocation of resources should be at a local level.

By adopting the World Health Organization's target of 90% immunization[14] and 80% cytology uptake the government have excluded many inner city practices from payment. Although the subsequent agreement to introduce a lower stage payment at 70% and 50% respectively provides a more realistic target, even these lower levels may prove difficult to achieve in areas of severe deprivation. Are such targets a fair indication of standards? There is a clear correlation between immunization rates and the social class structure of a practice population. If rates of immunization are to be used as an assessment of standards, they should be set after allowing for social factors.[15,16] The government is unwilling to consider locally agreed criteria of good practice but setting national targets takes no account of local difficulties and penalizes practices in deprived areas.

Peer influence and review[17,18] have been shown to be tools for change and the government looks to apply these to different aspects of clinical care. General practitioners want to improve their standards but what is often lacking is practical support, resources and encouragement at ground level to enable plans to be carried through.[19] This has been highlighted by a study which shows a greater proportion of low income practices situated in inner city areas as opposed to more affluent areas.[20] Leese and Bosanquet suggest that general practice is becoming increasingly divided between high income, high cost practices, and those with low incomes and few resources.[20] Practices with few resources face great disincentives to investment and local policies are needed to improve their viability. As low income practices are less able to respond to change, the introduction of market forces in health care will increase their present difficulties.

One step forward would be the payment of a deprivation supplement based on Jarman's index.[21] Underprivileged areas can be identified by weighting several variables relating to social conditions. The index has been validated by analysis of morbidity levels and general practice workload.[22] Clearly identification of areas of greatest need is an essential first step in the targeting of resources. The government has proposed a varying supplement to the capitation payment for each patient according to the degree of deprivation in an area. In addition, the Medical Practices Committee will be encouraged to allow more doctors to practise in proportion to this score. In effect inner city general practitioners working in deprived areas will be allowed to have a lower list size. Clearly this has significant implications on income which makes the deprivation supplement doubly important. The financial details of these arrangements have not yet been finalized but it seems likely that more resources will be needed for community health services in inner cities. General practitioners do not work in isolation and there is a need for nursing and health visitor services to expand in areas of deprivation.

The problems faced by primary care in deprived areas are complex and by no means uniform.[5,23] For a variety of political and economic reasons the response to reports highlighting the problems of social deprivation and health has been one of piecemeal uncoordinated action.[24,25] For all its faults the health review[11,12] does contain details of the first practical action by a government of any political persuasion to target resources to deprived areas. However, the associated imposition of a policy of market forces is unlikely to solve any of the basic problems faced in these areas. Indeed, the evidence suggests this is the opposite of what is required. In 1971 Tudor Hart[26] proposed the inverse care law: 'the availability of good medical care tends to vary inversely with the need for it in the population served.' He also noted that 'the inverse care law operates more completely where medical care is most exposed to market forces and less so where such exposure is reduced.' Little has changed since then. What is still lacking is a clearly defined strategic policy for inner cities and the mechanism to effect significant change. The introduction of market medicine into these areas is not the answer.

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