It is debatable whether these women should be on a diabetic diet before diabetes is biochemically demonstrable. A survey in Aberdeen[12] followed for a mean of 12.9 years a group of women diagnosed as having gestational diabetes who were put on a diabetic diet indefinitely. Only 6.4% of them developed overt diabetes but unfortunately there was no control group in this study for comparison.

In conclusion, the measurement of glucose tolerance in pregnancy, whether universally or in selected patients, enables a group of women to be identified who, over the following decades, are at substantial risk of developing non-insulin dependent diabetes. This diagnosis produces considerable morbidity and mortality as a result of complications which may be amenable to presymptomatic treatment. In addition, there is an association with hypertension and hyperlipidaemia, both of which may precede the development of hyperglycaemia. While a consensus on follow-up policy requires further assessment of feasibility and outcome analysis, general practitioners should ensure that the benefits of modern preventive approaches are available to women with gestational diabetes.

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The case for a primary health care authority

FOLLOWING closely on the many changes already taking place within the National Health Service comes the suggestion for further change in the structure for the delivery of primary care. The NHS Management Executive has commissioned two documents which set out the various options.[1,2] A further document looks at the relationship between primary and secondary care.[3]

Tension exists at the moment between the perceived need for consolidation, calling a halt to further change, and the perceived need to seize the opportunity to develop a sensible structure to fit the process of primary care. The definition of the process of primary care is crucial in determining what sort of structure should be developed. From the general practitioners' perspective, it would seem useful to examine what sort of work they are involved in and with whom they work most closely.

For the patients on their list general practitioners provide population based care and care on a personal level. They provide acute, continuing and often palliative care as well as a range of health promotion and illness prevention measures.[4] Health promotion and the care of increasing numbers of elderly people in the community are now key issues in general practitioners' work.[5] Not only do general practitioners provide primary care, they obtain (or as fundholders, purchase)[6] secondary care by referring patients to hospital specialists or open access departments. Patients in turn are received back into the community, where they may be given further care from general practitioners. This spectrum of care is delivered by a team of individuals, with help from patients' carers, and increasingly by social services and voluntary organizations.

Currently, general practitioners are independent contractors, working alone or in groups in contract with a family health services authority. Usually they employ receptionists, secretarial staff, managers and practice nurses. Other professionals, such as district nurses and health visitors, are attached to practices, but employed by and accountable managerially to a district health authority. Increasingly, other professionals, such as dietitians, psychologists and physiotherapists, are being incorporated into the team on a similar basis. Fundholding practices now have the potential to employ previously attached professional staff. It is this group of individuals working together which traditionally constitutes the primary health care team. Care is usually delivered in or close to the patient's home without much delay. The majority of patient problems within primary care are dealt with by the primary health care team without referral to secondary care.[7]

In the main, the delivery of primary care through the primary health care team and the referral system has served the NHS and patients well. Only those patients who cannot be managed in primary care or who require specialist services are referred to secondary care. Unnecessary referrals are minimized and the system allows the two elements, primary and secondary care, to collaborate in the interests of patients. Secondary care supports primary care but should not duplicate it. If the referral process were to be abolished, costs could rise in an uncontrolled way.[8]

This is the current scene for much of the work of primary care and its relation to secondary care. Clearly, patterns vary across the geographical and social spectrum. Any new structure that embraces primary care must take note of the work of the primary health care team and the referral process. It should place the needs of the patient at the top of the agenda. The structure needs to be flexible enough to cope with further development and must build on those existing strengths and seek to improve them.

Potentially the primary health care team has great strength, but varies in composition and quality depending on the prac-

tice structure, size and local professional attitudes.[9] The collection of professionals coming together from different educational disciplines and accountable to different managerial structures is a difficult starting point. Loyalty can be divided between patient, manager and the practice. Continuity of care does not always take place and at times there is a danger of duplication and conflicting care. Teamwork does not come easily for some doctors and health professionals. The skills of the individual members are not always recognized by their team colleagues and the process of work is not always seen as part of the whole.[10,11] Yet here lies the very potential for developing a wide range of services to patients in the primary care setting.

There is now a case to be made for bringing general practitioners, practice staff and all those health professionals who deliver care within the community setting under one management structure. General practitioners would remain independent as at present, having their contracts with the new primary health care authority. Practice nurses would, for the foreseeable future, remain in general practitioner employment, as would the practice administration staff. District nurses, health visitors and other professionals previously employed by a district health authority would now be employed by this new authority. By mutual agreement these professionals would now be attached to a practice or a number of small practices; this would provide a consistent relationship between the professionals.

This consistent relationship under one authority would facilitate the organization of joint training. Professionals would be able to make a collective case for obtaining protected time for training and extending this so that all primary health care team members could participate in the training of newly qualified general practitioners, community nurses and professionals allied to medicine. Education is a continuing process and this continuing education is supported by both the Royal College of General Practitioners and the nursing profession.[12,13] It is particularly appropriate to raise this issue at the moment as there are proposals for both postgraduate nurse education and community nurse education.[14,15] The recent legislation regarding nurse prescribing will involve further close interprofessional collaboration.[16]

While the ultimate responsibility for care delivered through the primary health care team rests with the general practitioner, the issues of leadership and cooperation need to be teased out. Recognizing each professional's role and learning together should enhance teamwork, leading to better integration of primary care, to the benefit of patients. It should also lead to a more effective working with social services in implementing the proposals in the government's white paper *Caring for people.*[17]

One of the models offered within the discussion documents is a merger of the district health authority and the family health services authority.[1,2] While this has the obvious advantage of centralization of management, it may not develop the necessary balance between primary and secondary care. Moreover, primary care would have to compete with secondary care within the structure for funding.

A key requirement of any new authority would be the integration of primary care. While having an overall management role for the delivery of primary care, it would have to ensure the delivery of that care by defined units within its boundaries. It would be the larger practices with their primary health care team, or a number of smaller practices and their shared team members, which would be regarded as the units of delivery of primary care. Through these units the new authority could offer practices assistance with developing their annual reports.[5] It could utilize this database of general practice and the knowledge base of a better coordinated primary health care team to create the basis of needs assessment for the provision of primary care. In addition, it would provide a wealth of information and opportunity for community research. This aggregated information would place the authority in a strong position to be a purchaser of secondary care, taking over that function from the district health authority. The transfer of expertise and funds to the new authority would be needed for this. Taking this further, the new authority could take the option of assigning managers with funding to the practice units to consider purchasing secondary care, putting these units on a par with fundholding practices, if they so wished.

The new primary health care authority would be accountable to the regional health authority. If the new authority took over the purchasing role for secondary care from the district health authority then the relationship between secondary services and the regional health authority would have to be reconsidered.

No organizational structure should be rigid. The interface between primary and secondary care will always be blurred. It would be up to the health professionals to advise managers on how to best overcome tensions and difficulties. Forging good communications across the interface, and the establishment of joint management protocols for common and important medical problems such as diabetes and asthma would be essential, and audit is likely to progress these issues. There are already examples of flexible working. Certain health professionals, such as midwives, have traditionally crossed the boundaries of primary and secondary care. Primary care within the hospital sector has been explored by general practitioners working in accident and emergency departments.[18] For some time certain consultants, such as psychiatrists, have provided secondary care within the community setting.[19]

Having one primary health care authority would integrate health care delivery in the community setting. The authority would carry out needs assessment for both primary and secondary care; it would be naturally placed to be a provider of primary care, but may also be a purchaser of secondary care. Furthermore, it would aid much needed research within the community setting. Bringing together health professionals and those allied to medicine who are involved in primary care should raise the quality of that care, bringing benefit to both patients and their carers.

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