Gatekeepers and goalkeepers: general practice advice to purchasers

MOST of us will have gathered by now that changes are taking place in the National Health Service and, in case we may have missed the occasional episode of the drama, previous editorials in the *Journal* have reminded us of the main features.[1-4] Keen followers of the plot will appreciate the main themes — that primary care should occupy centre stage and that general practitioners, in concert with their specialist colleagues, should assume an increasingly important role in helping the emergent purchasing health authorities develop services sensitive to their patients' needs.[5] More specifically, the government paper *Working for patients* recognizes that 'GPs will want to make sure that their views on the quality of care and shorter waiting times are reflected in DHA's contracts'.[6] It states further that 'the GP's advice will... be crucial if patients are to benefit fully from the reformed hospital service'.

In an NHS Management Executive document it is assumed that 'GPs' influence over secondary care provision will be enhanced by the introduction of GP fundholding and the development by DHAs of contracts sensitive to GPs' requirements' and, since 'the scheme is designed to develop the role of GPs as gatekeepers to secondary services by giving them direct control over a range of secondary care resources' we are advised that 'general practice will... have a pivotal role to play in the development of a more integrated service'.[7] A more recent NHS Management Executive discussion paper restates some of these objectives.[8] It attempts to define channels by which authorities might obtain independent professional advice, urging 'flexibility' and 'balance' in the shared advisory arrangements for the integration of primary and secondary care. An interesting, but perhaps controversial, suggestion is that while local general practitioners' views may be provided by the local medical committees the royal colleges' contributions would be by way of 'general guidelines'.

Perhaps it is appropriate to consider first whether providing advice to purchasing authorities is the legitimate business of the Royal College of General Practitioners. As an academic institution the RCGP is concerned with quality and high standards of patient care. Arguably then, that concern should extend beyond those services for which general practitioners themselves are directly responsible. The provision of secondary care over which few of us believe we can yet exert much control should also be considered. Practices which are fundholders can only purchase those services which are both available and fall within the highly restricted scope of the scheme. We need to know urgently and accurately what effects fundholding is having on overall service provision, since there are implications for patients in all practices, whether fundholding or not.[9] Meanwhile there is only largely anecdotal evidence suggesting widely varying standards of service in different areas since the commissioning of trusts, and more hard data are eagerly awaited.[10]

The next concern is whether the RCGP has the facility for gathering, collating and disseminating information for purchasing authorities in a useful way. The unpublished results of a recent internal questionnaire, distributed to the RCGP faculties, showed widely different levels of understanding of local management structures, and varied lines of communication. Thus, although the RCGP appears unclear just how its faculties should effect links with health service management at local, district and regional level, it is important that such mechanisms are established forthwith. A consequence of failing to do so would surely be the RCGP remaining excluded from key decisions affecting service provision for patients. This could result in primary care concerns again becoming dominated by unopposed interests among the most powerful groups in secondary care provision. Worse still could be the scenario where, in the absence of balanced professional medical advice, a managerial perspective could predominate and the sole criterion of service quality would be the accountant's balance sheet.

If then, as it seems it must, the RCGP is to become involved in providing professional advice to purchasers, certain questions follow. These concern not simply the quality and status of the advice itself and the mechanisms for providing it, but also its very nature, whether it should be organizational or purely clinical, broad in principle or specific in detail. More importantly, should such advice be given by the RCGP in isolation or, as it exorts 'jointly with others' (RCGP booklet on the aims of the College, 1990)?

Joint protocols for the management of specific conditions have been devised, for example the recent collaborative efforts between the Royal College of Psychiatrists and the RCGP for the 'Defeat depression' campaign.[11] This has resulted in mutually agreed management policies which could help streamline mental health service provision if accepted and implemented on a broad scale. As Hardy-Thompson and colleagues have recently acknowledged 'To plan or evaluate services, it is vital to know the needs of general practitioners'.[12] The potential for developing more medical management guidelines is currently being explored jointly by the RCGP and the Royal College of Physicians of London. This follows regional initiatives in East Anglia and the south west of England, where general practitioners and specialists have worked together to produce mutually agreed guidelines for managing chronic conditions such as diabetes mellitus (South west regional health authority, unpublished report, 1991).[13] While some general practitioners will naturally view such developments as exciting, others may regard them as long overdue since, in the field of obstetrics for example, most have long accepted sharing patient care with consultant colleagues. The concept of a range of broadly agreed intercollegiate guidelines, supplemented where appropriate by locally agreed modifications, for the management of specific conditions could provide an invaluable resource to any purchasing authority charged with placing sensitively balanced contracts with provider units.

In the south west of England, where it seems fundholding practices have as yet made minimal impact on service provision overall, the tradition has been to maintain strong medical advisory committees to deliver sound advice to the regional health authority for dissemination to the districts and family health services authorities. These mechanisms have been devised to ensure that, at regional level at least, the voices of hospital specialists are evenly matched by the input from general practice, embracing both RCGP faculty and local medical committee perspectives. Such machinery has required proper funding in terms of paid sessional time for the general practitioners' involvement, in return for which output includes not only guidelines for the management of various clinical conditions but also guidance on cancer and cholesterol screening. Assistance from colleagues in public health medicine has proved invaluable in drafting such documents. However, although there has been a firm general practitioner input at regional level, the mechanism

for direct advice from general practice at the district level is less clearly defined. This is unfortunate, since general practitioners are often well placed to identify gaps in local service provision, and as Hicks and Baker have shown, can act as a valuable and reliable source of information to authorities for service planning purposes.[14] Other public health physicians have recently added their weight to this argument. Stevens and Gabbay contend that 'The preferences of local general practitioners are becoming another powerful mechanism for improving the congruence between service contracts and local health needs, and are already being taken seriously'.[15] Similarly, Coulter has observed that 'Many health authorities are now taking considerable pains to determine the views of general practitioners'.[16]

If health authorities do not seek advice from general practitioners it is likely that the purchasing authorities will receive unbalanced advice, lacking a frontline general practice perspective which is manifestly what the new changes were supposed to eliminate. This is particularly important at this time before the new purchasing authorities, provider trusts and fundholding practice arrangements become fully effective, especially since there is now no longer a general practice voice at district health authority level. In contrast to the expressed intent of being given more power, many general practitioners may feel somewhat anxious that again they are being given more responsibilies but, as yet, apparently without really having the power to see that these responsibilities are properly discharged.

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Drug abuse and HIV infection: general practice treatment and research agendas

SINCE the late 1980s drug abuse and human immunodeficiency virus (HIV) infection have become two of the few areas of clinical research able to attract substantial financial support. The explosion of interest in all aspects of drug taking and of the sexual behaviour of those with or without HIV infection may be cynically viewed as the establishment's concern about the possible spread of HIV infection into the wider sexually active community rather than compassionate concern for those involved with drug taking. However, the development of active research in these areas has provided a wide understanding of the lifestyles of drug users and of sexual behaviour in the general population. This has led to changing views on the nature of drug taking and on the likely outcome for those involved, and to a new insight into sexual behaviour and factors influencing changes in risk taking.

The new understanding of drug taking is a welcome relief from the polemical arguments of the 1960s and 1970s about the ethics of treating drug users. The softening of attitudes in general practice has undoubtedly been associated with a maturing of primary care in its relationship with other agencies. Although not without its critics this progress has been to the advantage of everyone involved and has, to a certain extent, provided models for other areas of interest and for the development of community care as a concept. An example of these changes includes the substantial increase in community management of psychological and psychiatric problems.

Undoubtedly, there are problems associated with new initiatives, including the inevitable manipulation of medical personnel by poorly motivated or malicious drug users and the consequent leakage of prescribed drugs to the illegal market. A developing benzodiazepine abuse problem in parts of Scotland, Wales and other centres is also linked to increased prescribing of these drugs for those dependent on drugs.[1] These emerging problems reflect the difficulty of managing this group. Resources are required and postgraduate and undergraduate training for doctors is important, both of which have been neglected for decades. With adequate time and support, general practitioners are in an excellent position, perhaps a unique situation, to contact young people with drug problems. It is important to be aware that those dependent on drugs may become long term patients requiring support and prescribed drugs for 10 or even 20 years. Even a small group of such individuals can represent an enormous ongoing workload and responsibility for a practice.[2]

There are many areas of drug taking which remain obscure. The long term nature of drug dependency, the prognosis of those involved and the variability between individuals in terms of the severity of addiction are of more than academic interest.[3]