

A stakeholder analysis of developments at the primary and secondary care interface

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SUMMARY

Background. *The interface between primary and secondary care has become a major focus of health policy debate, but the differing perspectives of stakeholders on recent developments in policy and practice have seldom been researched.*

Aim. *To examine stakeholder perspectives on the extent of developments at the primary and secondary care interface, and the barriers and opportunities for future development.*

Method. *This qualitative study was based on semi-structured interviews with a purposive sample of 27 primary and secondary care stakeholders in Southampton and South West Hampshire in 1994. Respondents were asked to identify developments in seven areas: direct access, consultant outreach, shifted services, substituted services, shared care, workload shifts and communication.*

Results. *Key issues were identified relating to the cultures of primary and secondary care, communication and workload. Most respondents described an important shift in power from consultants to GPs. Although respondents identified several useful developments at the interface, including improvements in communication and increased direct access facilities, there were relatively few reports of shifts in resources and services to primary care. Respondents identified important continuing barriers to change, including the attitudes of consultants and the individualistic culture of GPs.*

Conclusion. *Policies to 'shift the balance' and to further 'a primary care-led NHS (National Health Service)' need to address the cultural and political factors which respondents identified as barriers to primary care development.*

Keywords: *primary health care; secondary health care; stakeholder; interface.*

Introduction

THE interface between primary and secondary health care has become a major focus of health policy debate. Rising consumer expectations, developing technologies and an ageing population have led to calls for a shift in the balance towards primary care.^{1,2,3} Predictions for the future included the rationalization of the secondary sector into fewer, more specialized acute units, and the emergence of extended forms of primary care organization.^{3,4}

The government has consistently emphasized the priority it places on developing primary care.^{5,6,7} The expansion of the role of the general practitioner (GP) is central to this strategic shift. There has been a long-term increase in the funding of general practice, which has allowed a 23% increase in the number of GPs and a 163% increase in practice staff since 1978/79.⁸ GPs have been encouraged to take on a purchasing role, particularly as GP fundholders. Fundholders are developing practice-based services

and pressing trusts to move services such as out-patient clinics into primary care settings.⁹ In some areas, locality purchasing arrangements enable non-fundholding GPs to exert similar leverage.¹⁰

There has been little research on the appropriateness and effectiveness of many shifts to primary care.^{11,12} More attention has been paid to efficiency at the interface, particularly variations in GP referrals and poor communication between consultants and GPs.¹³ Despite the avowed shift to a primary care-led NHS, there is evidence that increased GP workload and low morale are significant barriers to primary care development.¹⁴ Fundholding continues to be controversial with those GPs who remain firmly opposed to taking on this role.¹⁵ Some commentators have called for caution in primary care development.¹⁶ Thus, the aim of this study was to explore local perspectives on developments at the interface, and the barriers and opportunities for future development.

Method

A purposive sample of stakeholders from Southampton and South West Hampshire Health Commission, Southampton University Hospitals' Trust, Southampton Community Health Services Trust and local general practices was identified in discussion with commission senior managers. Additional informants were then identified from initial respondents. Fieldwork took place from July to September 1994. Respondents were asked semi-structured questions about the interface, beginning with an open question asking them to identify key local developments. Subsequent questions explored developments, barriers and opportunities in seven areas identified as important by the author and the commission: direct access facilities, consultant outreach, shifted services, substituted services, shared care, workload shifts and communication. Interviews were tape-recorded and transcribed. Transcript data were analysed by grouping and coding according to the seven development areas. Overarching themes were identified and coded by the author through an iterative process of reading, re-reading and summarizing the transcripts.¹⁷

Results

Twenty-seven stakeholders were interviewed out of a total of the 33 that were approached. Respondents comprised seven commission managers or professionals, six non-fundholding GPs, five fundholders, six acute trust professionals and managers, and three community trust managers.

Key developments

There were three main types of responses regarding key developments at the interface. The first category comprised several non-fundholding GPs and commission managers, who expressed disappointment at the limited nature of change. When asked about key developments, this group talked instead about barriers to change. Comments included, 'virtually nothing had changed' and 'a lot of rhetoric, but I haven't seen a lot happening'. The second type of response was that of a few GPs who identified developments that they regarded as mainly negative. These included the

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sense that a 'two-tier service' had developed, with non-fundholding GPs feeling like 'second-class citizens'. One fundholder identified a loss of morale in the profession following the 'humiliation' of the 1990 contract. Another GP felt that the contract had stifled GPs with bureaucracy, which inhibited dynamic practice.

The largest group of respondents, including GPs, trust and commission managers, identified a significant change in what was often described as 'culture'. They described the emergence of a new attitude in secondary care, characterized by dialogue between GPs and trust managers and consultants. The change was reported as particularly marked among consultants who now listened and took account of GP views, and was attributed to consultants' awareness of GPs' increased power. Many respondents saw this change as driven by fundholding.

Several respondents commented that there were few significant changes in service delivery; the real change was in GPs' sense of power. This perception of increased GP power was stronger in the trusts and the commission than among GPs themselves. One trust respondent commented that GPs had greater potential power, but had not yet worked out how to use it effectively. GPs were more likely to identify the limitations of their power and to perceive the acute trust as extremely powerful and resistant to change. Several respondents argued that, while most resources were 'locked into' trusts, it would be difficult to make any real change.

Communication

Most respondents believed that communication between GPs and the trusts had recently improved. The appointment of primary care liaison officers and the establishment of working groups in both local trusts (Southampton Community Health Services Trust and Southampton University Hospital's Trust) were seen as useful. However, GPs viewed other trust initiatives, including newsletters and directories, as wasteful 'PR exercises'. GPs also identified a major continuing problem in the failure of many consultants to provide timely information on discharge. Several reasons were identified for this, particularly that most consultants valued GP communication less than clinical care, teaching, research and private practice. Trust managers believed this problem would be resolved with the introduction of the new patient management system, but GPs were sceptical of technological fixes for communication problems.

Shifts in workload

General practitioners expressed a strong belief that workload was shifting from secondary to primary care. This perception was associated with discussions of overwork, low morale and a sense of being 'dumped upon'. Examples commonly cited included a shift in post-operative follow-up. Although GPs felt it was appropriate for them to provide this care, they complained that no resources were shifted in line with the shift in workload, and that this shift was imposed by trusts without any consultation. Trust managers expressed scepticism whether such workload shifts were significant. They felt that GPs were focusing on one aspect of a dynamic process in which workload, generated by GPs through increasing referrals, was ultimately channelled back into primary care. Several respondents pointed out that increases in GP workload were not necessarily caused by shifts from secondary care. When asked, GPs found it difficult to differentiate workload increases due to shifts from other factors, such as increased patient expectations.

Direct GP access

Many respondents saw this as one area where real progress had

been made locally. The introduction of direct access in audiology, endoscopy, radiology and cardiac investigations was perceived to be working well, allowing GPs to make more rapid assessment and to provide more appropriate treatment for patients. Although few of these schemes had been audited, the high levels of abnormalities reported from direct access endoscopy, for instance, was seen as evidence of appropriateness.

Consultant outreach

Long-running discussions regarding dermatology and ear, nose and throat treatment were referred to by several respondents. Beyond these limited initiatives there were few reports of new outreach services. The extent of consultant resistance was evident. Consultants were seen as regarding outreach as a waste of time, as losing economies of scale and as a threat to centres of excellence. Several respondents suggested that consultants did the same work privately, and that resistance was due to the desire to protect such lucrative work. One fundholder acknowledged that fundholders were using demands for outreach as a means to express their power; while not interested themselves in 'the power thing', his practice believed it was good for the consultants to get 'out and about'. Another fundholder did not see the cost-benefit arguments as relevant if outreach improved the service for his practice population.

Practice-based services

Fundholders reported switching providers or using the threat of switching to improve physiotherapy provision. One fundholder commented, 'I failed totally to get any movement until we went fundholding. I think that's an example of the sort of power fundholding gives you.' Respondents reported few other developments. Another fundholder said, 'Despite grand ideas, we have not advanced as far as we would have liked on this basis.'

Discussion

Although the small scale of this study necessitates caution in generalizing from the results, several important issues are raised by the data. First, the study suggests the importance of cultural and political factors in determining developments at the interface. Respondents consistently emphasized the shifts in power from consultants to GPs as being much more important than the limited changes in service provision. The data reveal perceptions of significant cultural barriers to developing the interface, both among consultants and GPs; these require further exploration. Second, there was no consensus on the extent of shifts in workload. Respondents were able to provide little data on which to assess the impact of changing practices on workload in the two sectors. The complexity and contentious nature of this debate indicates that it is an important area for research. A third issue relates to the diversity of views expressed on what constituted a shift from secondary to primary care. Respondents did not usually differentiate between shifts in service setting, personnel and control. The varying impact of these different types of shift on primary care suggests a need to clarify the nature of such shifts. Finally, the results indicate that most developments were not systematically evaluated and that the question of evaluation was contentious. Although respondents accepted that primary care developments should be evidence-based in principle, in practice, evaluation was often seen as impractical. GPs and primary care managers argued that they were asked to subject their initiatives to a level of scrutiny that most existing secondary services had never undergone, and that the call for evaluation was occasionally a tool to block innovation. There was little consensus on the

appropriate criteria to evaluate developments, with GPs in particular stressing accessibility and responsiveness while resistant to assessing cost-effectiveness. These results suggest that policy makers and health authorities need to address the cultural and political factors that shape the interface if they are to succeed in their objective of shifting the balance to primary care.

References

- Hughes J, Gordon P. *Hospitals and primary care: breaking the boundaries*. London: King's Fund Centre, 1993.
- Boufford J. *Shifting the balance from acute to community health care*. London: King's Fund College, 1994.
- Warner M, Riley C. *Closer to home: healthcare in the 21st century*. Birmingham: National Association of Health Authorities and Trusts, 1993.
- Mead G. *Future options for general practice*. Oxford: Radcliffe Medical Press, 1996.
- NHS Executive, EL(95)68 *Priorities and planning guidance for the NHS*. Leeds: NHS Executive, 1995.
- NHS Executive, EL(94)79 *Developing NHS purchasing and GP fundholding: towards a primary care led NHS*. Leeds: NHS Executive, 1994.
- Department of Health. *Making London better: a response to the inquiry into London's health service, medical education and research*. London: HMSO, 1993.
- Robinson R, Evans D, Exworthy M. *Health and the economy*. Birmingham: National Association of Health Authorities and Trusts, 1994.
- Glennerster H, Matsaganis M, Owens P, Hancock S. GP fundholding: wild card or winning hand? In: Robinson R, Le Grand J (eds). *Evaluating the NHS reforms*. London: King's Fund Institute, 1994.
- Graffy J, Williams J. Purchasing for all: an alternative to fundholding. *BMJ* 1994; **308**: 391-394.
- Coulter A. General practice fundholding: time for a cool appraisal. *Br J Gen Pract* 1995; **45**: 119-120.
- Advisory group on the interface between primary and secondary care. *R&D priorities in relation to the interface between primary and secondary care: Report to the NHS Central Research and Development Committee*. London: Department of Health, 1994.
- Roland M, Coulter A (eds). *Hospital referrals*. Oxford: Oxford University Press, 1992.
- Hayter P, Peckham S, Robinson R. *Morale in general practice*. Southampton: Institute for Health Policy Studies, 1995.
- Robinson R, Hayter P. Reluctance of general practitioners to become fundholders. *BMJ* 1995; **311**: 166.
- Maynard A. A primary need for knowledge. *Health Service Journal* 1994; **5404**: 19.
- Robson C. *Real world research*. Oxford: Blackwell, 1993.

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