maintained but within a framework of quality and accountability that does not operate via the heavy hand of quality assurance machinery and costly inspectorates. Instead the process of franchise renewal, overseen by a multidisciplinary governing body (the primary care group or trust), creates a drive for quality improvement within an organisational structure that fits primary care, ensuring appropriate rewards for high quality care.

It is often only when you go abroad that you appreciate things at home, and such it is with our primary care system. It is always a surprise how much it is envied by many in countries who spend more on health. They recognise three features crucial to our success: a defined list of patients, a gatekeeper role to secondary care, and the freedom to innovate. We tamper with any one of those at our peril. Independent status for practices ensures their survival.

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Community development, user involvement, and primary health care

Community development has much to offer to primary care groups

The new primary care groups (local health groups in Wales) will need to shape services, assess health needs, reduce health inequalities, listen to users' views, and work in partnership with local agencies. This will require a range of skills which few primary health professionals currently have.[1] Few fundholders undertook any health needs assessment or involved patients in purchasing,[2] and the government has provided little conceptual, managerial, or financial infrastructure for public involvement. Public meetings are the only mechanism for consultation mentioned in the white paper—yet these are an inadequate means of genuinely engaging communities in the health issues that matter to them, particularly for marginalised groups. One solution is for primary care to work with community development projects, which have been tackling these issues for years.

Community development recognises the social, economic, and environmental causes of ill health and links user involvement and commissioning to improve health and reduce inequalities. Communities can be geographical—such as particular housing estates—or communities of interest, such as user groups. Trained community development workers bring local people together to:

- identify and support existing community networks, thus improving health;
- identify health needs, in particular those of marginalised groups and those suffering inequality;
- work with other relevant agencies, including community groups, to tackle identified needs;
- encourage dialogue with commissioners to develop more accessible and appropriate services.[3]

Many examples of these activities exist. Studies show that community support through social networks is protective of people's health.[4] High levels of trust and density of group membership are associated with reduced mortality.[5] Conversely, lack of control, lack of self esteem, and poor social support contribute to increased morbidity.[6]

Needs assessment that is focused on communities can identify solutions as well as problems. Results of such initiatives include a new post of youth health adviser to support youth centred health activities across practices in Lewisham, which has led to improved learning about contraception and sexual health, improved liaison with practices, and changes in practice provision to make services more appropriate for the young people they serve.[7] In St Peter's Ward, a deprived area of Plymouth, a community development approach has resulted in free pregnancy testing in a local community project, the setting up of a "parentwise" project that draws on resources within the community, changes in health visitors' working, and the provision of more acceptable antenatal classes.[8] The more involved the community is in needs assessment, the more likely changes are to ensue.[9] These assessments can provide representative views, particularly if quantitative approaches are used to triangulate these views, and there is little evidence that patients make unreasonable demands.

Community development can also lessen the impact of poverty on health. In Torquay concern about nutrition has led to the setting up of a food cooperative managed by local people that makes available cheap, healthy food.[10] Community development can reduce social exclusion by ensuring that marginalised groups influence health services. In Bradford such an approach increased the uptake of cervical and breast screening among women from ethnic minorities.[11] Minority ethnic communities, disabled people, adolescents, and elderly people have all been involved in the commissioning process in Newcastle, where a community development worker, accountable to the commu-

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nity, brings together community groups with purchasers and providers to implement change.[12]

Examples of community development interagency activity include the work of a safety group in Torquay which resulted in policy changes within the housing department, play areas, and other borough and police services. While health professionals prescribed drugs to patients in their hilly area in Lewisham, a community development solution was found through a new bus service.[13] By involving the local authority, it was possible, in a single intervention, to respond in a practical way to issues of loneliness, isolation, and problems of exercise tolerance.

Such initiatives need to be judged by the amount of change and public involvement generated—and by changes in health status. Primary care groups need to understand community development and be open to alternative methods of evaluation. Collecting baseline data is of limited use as measurable objectives cannot be set until needs have been identified. It takes a long time to establish a project and to show reductions in inequalities or improvements in health. However, by examining intermediate health and social indicators (uptake of health services, improved housing and social support) rather than health status, and by using appropriate, often qualitative, research methods, rigorous evidence can be produced.[3]

Community development techniques could help primary care groups develop decision making processes that truly involve users. The lay member on the group will become an isolated figure unless supported by a vigorous and effective infrastructure. A community development agency, with a representative co-opted on to the board, should be established in each primary care group, perhaps by expanding an existing organisation. By continuing existing locality community development and drawing together voluntary groups and local authority initiatives, an agency could support and challenge planning by the primary care group. Information and recommendations from local people could go directly to the primary care group while the group could also request representative lay views or action on particular issues. This structure may provide for some measure of accountability and help the primary care group focus on key social determinants of health. It would enable users' views to be given appropriate respect and weight in the planning process.

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Bone marrow transplantation for autoimmune diseases

An interesting approach—but only for patients with few alternatives

The cross fertilisation of ideas between different medical specialties means that traditional techniques from one field are beginning to find surprising roles in others. Bone marrow transplantation, for example, is becoming more sophisticated and safer, particularly since the advent of peripheral blood stem cell transplantation, and this is now being studied as a treatment for autoimmune diseases.[1–3]

Conventionally, long term immunosuppressive drugs are administered to control the autoimmune disease process, but these offer little in the way of a cure. Because autoimmunity is viewed as a failure of the immune system to protect against self reactivity, however, some have argued that by completely "resetting" the immune system, it might be possible to eradicate the autoimmune disease process altogether. People with both haematological malignancies and autoimmune diseases sometimes go into remission from both conditions after undergoing bone marrow transplantation. This incidental observation has prompted some haematologists to argue that such a reset of the immune system may be provoked by completely ablating the patient's lymphoid system and then rescuing the bone marrow with a haemopoietic stem cell transplant.

In recent years, in Europe and the United States, stem cell transplantation has been offered to selected

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