

The future of FHSAs

EDITOR,—June Huntington's article on the future of family health services authorities contains several misleading assertions.¹ I practise in the London Borough of Newham and also give medical advice to the family health services authority through the department of general practice and primary care of the Joint Medical Colleges of St Bartholomew's and the London Hospitals. As medical adviser, I have met some of the practitioners with "typically small lists, [who] have trained overseas and entered general practice before vocational training became mandatory."²

My experience of practitioners trained overseas and with small lists is that most are good doctors committed to caring for their patients to the best of their ability. Historically, they were exploited because of their lack of understanding of the complex regulations related to the status of "independent contractor," and in this respect I agree that proper vocational training would have been beneficial. Their delivery of services has also been handicapped by inadequate investment in both community and primary care services and practice resources. The evidence suggests that they have "clamoured for more staff and for improved premises," but the family health services authority has not had the resources to support this, nor were suitable vacant sites in which premises could be developed easily available in inner London.

With regard to deprivation payments, the system for remuneration in general practice before the 1990 contract took no account of the increased cost of living, increased cost of running a practice, and increased workload of general practitioners in inner London. Deprivation payments only partially redress the financial inequity that general practitioners in inner London suffered.

There is much to be done to develop primary care services in inner London, of which general practice is an essential part. An appreciable proportion of practices in east London are of the type cited in the article. A properly planned and monitored investment programme is needed, but ill informed and pejorative assertions are unhelpful.

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1 Huntington J. From FPC to FHSAs to... health commission? *BMJ* 1993;306:33-6. (2 January.)

EDITOR,—June Huntington's article on the future of family health services authorities' needs clarification and ratification to prevent misunderstanding and disharmony. The account, I consider, is not conducive to professional or racial harmony.

General practice is a British success. It is achieved entirely through the contribution made by practitioners before the inception of the vocational training scheme (VTS), by those trained overseas and subsequently by vocationally trained practitioners. These practitioners' eligibility to do their job was approved by the Medical Practices Committee. June Huntington's allegation that these practitioners are businesslike rather than professional questions the selection procedure of the committee. Some of the practices that do not comply with the 1990 contract targets are situated in demographically less attractive parts of the cities. Most of these practices have practitioners trained overseas or before the vocational training scheme became mandatory. Their dedication, determination, commitment to the profession, responsibility, and challenge to serve the community should not be undermined. These premises are often inadequate to support good practice. The threat of vandalism and burglaries deter practitioners from investing money in property

and equipment. The difficulties in achieving the contract target and offering child health surveillance and minor surgery after meeting the demand for patient care without proper facilities, equipment, and computerisation needs to be appreciated. The inducement offered in the form of deprivation allowance is not adequate.

The fundamental deficiencies in promoting care are poor quality of information,³ inadequate record systems,² bad communication,^{2,5} and lack of coordination between health care agencies.⁵ Lack of resources and strong resistance to breaking down barriers between health care agencies are other contributing factors. Mobilising resources, even with a clear account of their use, is often difficult. I sincerely hope the prejudice of my overseas training and lack of vocational training do not account for my lack of success in gaining access to resources.

To preserve the image and integrity of the profession and to build bridges between the existing gaps in our service it is necessary to unite and not to create divisions with personal prejudices. The Hippocratic oath does not permit professionals to find a peg in class, cast, colour, and creed to hang our deficiencies.

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- 1 Huntington J. From FPC to FHSAs to... health commission? *BMJ* 1993;306:33-6. (2 January.)
- 2 Jachuck SJ, Price P, Bound CL. Evaluation of quality of contents of general practice records. *BMJ* 1984;289:26-8.
- 3 Jachuck SJ, Bound CL, Jones CE. Role of the occupational health service in screening and increasing the uptake of rubella immunisation. *BMJ* 1985;290:119-20.
- 4 Jachuck SJ, Mulcahy JR. Minimum data set needed to promote care of the elderly in a general practice. *J R Coll Gen Pract* 1987;37:207-9.
- 5 Jachuck SJ. Caring for the elderly. In: Royal College of General Practitioners. *Members' reference book*. London: RCGP, 1989: 375-8.

EDITOR,—Virginia Morley gives an example of locally sensitive purchasing, attributed to North Derbyshire Health Authority.¹ There is no recognised project in the north of England at this stage and on the basis of existing interest it is likely that there will be an 80% uptake of general practitioner fundholders by the third wave, covering a similar ratio of the district's population.

I can see no greater option to empower general practitioners than in practices themselves holding funds for purchasing responsibility for their practice population. This requires family health services authorities to develop a much more facilitative role of management and also for district health authorities to review the manner in which they plan services. The whole concept of fundholding is to move the purchasing power to the closest point of delivery of the service to patients. I find that too many people are hung up in retaining the bureaucracy of organisations under the premiss that they are purchasing services when in fact they are funding activities that already exist—a referral, for example. Clearly, the fundholding uptake will not be mirrored across the country, but that is not the case in Derbyshire.

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1 Mosley V. Empowering GPs as purchasers. *BMJ* 1993;306: 112-4. (9 January.)

EDITOR,—Andrew Harris put forward some suggestions for improving research in general practice.¹ He says that we should harness the expertise of the various agencies involved in health care.

I have a project running which aims to achieve collaboration between patients, general practitioners, and researchers. For many constraints, including time, finance, and perhaps inclination, research will not be an option for most general

practitioners. However, in the same way that they are ideally placed to assess patients' needs, so they have an idea of the important areas requiring research. In addition, their training in the scientific method and their daily exposure to clinical problems results in the development of ideas and the formulation of questions and hypotheses. Unfortunately, most of these useful and innovative ideas go to waste without investigation. There is no outlet for the thoughts and observations of the non-researching general practitioner.

I am therefore setting up *Exe Directory*. This is a collection of research ideas, proposals, and hypotheses collected initially from general practitioners. The ideas should be less than 20 words, dated, and with the name and address of the contributor. The directory will then be made available to students, trainees, and researchers who are better placed to carry out the studies. This would be on a charitable basis and any cash surplus would be made available to fund research projects. Thus those with good ideas would still keep credit for having them, and researchers would benefit from a source of interesting proposals generated at the front line.

Research should be done by experts to ensure useful results. The subjects of research can be suggested by those closest to the problem. With improved conditions more general practitioners may wish to combine these roles. Otherwise, *Exe Directory* is a way of matching the supply and demand of research ideas. In this way every general practitioner could shape and contribute to the future research and development of primary care. Any contributions can be sent to the address below.

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1 Harris A. Developing a research and development strategy for primary care. *BMJ* 1993;306:189-92. (16 January.)

EDITOR,—I must disagree with Graham Butland's generalising statements about general practitioners lacking plans for development and decision making due to the "dependency culture" related to their methods of payment.¹

General practitioners have always had to manage and plan their businesses and are constantly adapting to changes in medical care. Survival has always involved flexibility. Although family health services authorities may have been oblivious to these activities, this does not indicate their absence.

Before 1990 many general practitioners were improving the quality of care of their patients in a spontaneous desire to improve standards. General practitioners have served on numerous planning committees with no remuneration, and many are dedicated to undergraduate and postgraduate education, evolving professional standards and performing research.²

General practitioners generally cope with whatever is thrown their way, be it the shift of complex clinical management of cases into the community with less hospitalisation, changes in hospital policy resulting in a shift of costs to the community budget, underfunding of secondary sector posts and beds, the 1990 general practitioner contract, or patients' increased expectations in a cost cutting climate of health care. If anything it is the managers in family health services authorities and the NHS who have failed to anticipate and plan for the first three of these contingencies that has caused the current workload crisis.

Dedicated, hardworking general practitioners have kept the system running in the interests of their patients and are not led by "whim," as the writer's subsequent comment on accreditation seems to suggest. Butland seems to have failed to appreciate that in the government reforms the general practitioner is the purchaser of services and the family health services authority's role is to facilitate this and not to act as Big Brother. General