General practice

What does locality commissioning in Avon offer? Retrospective descriptive evaluation

Christine E Hine, Max O Bachmann

See editorial by Mays

Department of Public Health Medicine, Avon Health Authority, Bristol BS2 8EE
Christine E Hine, *consultant*

Department of Social Medicine, University of Bristol, Bristol BS8 2PR
Max O Bachmann, *lecturer*

Correspondence to: Dr Hine.

BMJ 1997;314:1246–50

Abstract

Objective: To describe the impact, direct costs of, and participants' attitudes to the first two years and eight months of locality commissioning in Avon.
Design: Retrospective description of programme.
Setting: Thirteen localities in Avon Health Authority area, covering 982 000 population and 147 general practices.
Methods: Postal questionnaire survey of 147 general practitioners (one per practice); interviews with and questionnaire survey of 13 lead general practitioners and 13 so called link staff from the health authority.
Main outcome measures: Locality initiatives, perceived influence, general practitioners' attitudes, management costs.
Results: Twenty initiatives were identified that had changed services to patients, and another nine were planned. The commonest initiatives concerned primary mental health care (seven), nurse specialists for primary care of chronic diseases (three), referral and clinical practice guidelines (seven), and access to hospital outpatient departments (one, with two others planned). Localities were more likely to have influenced the authority, trust managers, and consultants than social services, community health councils, and voluntary organisations. Activity varied between localities, lead general practitioners estimating that 120/147 (82%) of practices had been involved in locality meetings (range 44-100% in different localities). The authority had spent 6 p per capita on running the scheme, and the total time used by general practitioners for locality commissioning was estimated at 1.5 whole time equivalents.
Conclusion: Locality commissioning has selectively changed services with limited extra funding and without delegation of hospital and community health service budgets. General practitioners wanted more policy and financial support. Further development should be based on evidence of costs, benefits, and limitations of locality commissioning schemes.

Introduction

Locality commissioning is one of a range of methods whereby general practitioners can influence health services commissioning.[1] In Avon it differs from fundholding and total purchasing by emphasising collaboration between practices covering geographically defined populations and by not delegating hospital and community health service budgets from health authorities to general practitioners.

Both the government and the opposition support locality approaches to commissioning, including delegation of budgets (C Smith, *Health Service Journal* conference, London, December 1996).[2] The various models and their costs and benefits are only beginning to emerge. This study describes the consequences for general practitioners and patients and the cost to the health authority of locality commissioning without delegated budgets in one of the largest health districts in the United Kingdom.

Avon Health Authority serves 982 000 people, registered with 450 general practitioners in 147 practices (42 were fundholding in 1996-7). In 1993 general practitioners from north west Bristol formed a group to discuss locality commissioning with the health authority, and a scheme was implemented in partnership with the local medical committee and Bristol and District Community Health Council. From April 1994 all practices in the district (fundholding and non-fundholding) were encouraged to participate in 12 locality groups. Geographically close groups of practices were proposed by the authority and agreed through discussion with general practitioners. A 13th locality was added in 1996 after the local authority's boundaries were changed.

General practitioners were influential in developing the scheme. Their participation was voluntary and encouraged by the local medical committee. Representatives of more active locality groups visited and encouraged the formation of new groups. The local medical committee managed the reimbursement of lead general practitioners and practice representatives from a health authority budget. In each locality a lead general practitioner was paid to organise at least two locality meetings annually, and he or she was expected to act on issues arising. Locality groups largely set their own agendas. Agreements ranged from informal arrangements to explicitly documented agreements for new services. Locality commissioning representatives comprised five of the 13 general practitioners in the authority's general practitioner strategic advisory group. The health authority was represented in each locality group by a link person, who was a senior staff member from primary care, contracting, or public health directorates. The authority intended to develop

public involvement in locality commissioning. It funded a community health council project that aimed to bring forward public opinion on locality issues.

We studied how well the objectives of locality commissioning had been met after two years and eight months, from April 1994 to November 1996. We examined evidence of service changes, costs to the health authority, time used, acceptability of locality commissioning to general practitioners, and general practitioners' perception of their influence.

Subjects and methods

We evaluated progress towards three objectives for locality commissioning that had been outlined in authority documents.

- Exploitation of local opportunities to improve health and health services
- Better understanding of local needs and priorities
- Local contribution to policy development.
- In this paper we describe the assessment of general practitioners' influence and impact (in terms of changes to services) on these commissioning objectives.
- The study was designed in consultation with the link staff and lead general practitioners. Data were collected between August and November 1996. All lead general practitioners and authority link staff were interviewed and completed a questionnaire. Interviews with the link staff were conducted by MOB, who was not otherwise active in locality commissioning. Interviews with lead general practitioners were conducted by MOB and two link staff, who did not interview lead general practitioners from their own localities. Interviews were based on an interview schedule, but interviewees were encouraged to elaborate on issues that were important to them. Link staff completed a questionnaire on each locality project and activity until the end of August 1996. Responses were validated by lead general practitioners (but not by providers). A postal questionnaire survey was conducted of a random sample of all general practitioners who were not lead general practitioners. One general practitioner was selected from each of the 147 practices by means of a random numbers table. Each respondent's answer was weighted according to the size of his or her practice to adjust for the overrepresentation of general practitioners from small practices. We examined the minutes and agendas of locality meetings.

Results

The response rates for the surveys of lead general practitioners and link staff were 100% (13/13), and for the survey of non-lead general practitioners the response rate was 74% (108/147).

Localities varied in size from five to 22 practices. Participation in locality groups was generally high but varied. Non-lead general practitioners reported that 82% (88/108) of practices had been represented at locality meetings (range 44%-100% for different localities). Lead general practitioners estimated that 82%

Table 1 Changes to services that were planned or implemented by locality commissioning groups

Change	Aim of change
Implemented	
Develop shared care, counselling, and prescribing services for drug misuse (2 localities)	To improve access to care for local drug misusers
Increase GP care for drug misusers in coordination with voluntary organisations	To provide a better service to patients and better use of resources
Establish primary mental healthcare team	To improve primary mental health care for patients with non-psychotic mental illness in inner city
Develop referral criteria for community mental health services	To reduce waiting times for community mental health services
Contest trust's referral criteria for community mental health teams	To protect access for patients in need of secondary care
Designate links for liaison with community mental health teams	To provide better coordinated care for mental illness
Appoint diabetes specialist liaison nurse (2 localities)	To develop diabetic care in general practice
Appoint primary care epilepsy nurse	To improve care of epilepsy in general practice and reduce waiting times for outpatients with neurological diseases
Set up agreements between practices and providers of community services (2 localities)	To increase GP ownership of community services, with non-fundholders gaining similar benefits to those of fundholders
Develop referral criteria and patient information on community physiotherapy	To reduce waiting times for community physiotherapy
Develop practice based physiotherapy services	To improve local access for patients
Start more chiropractic and physiotherapy session in the locality	To shorten waiting times
Develop local guidelines on management of back pain	To achieve better coordinated and effective response to patients' needs and appropriate access to specialist services
Introduce ambulance car scheme	To reduce waiting times for an ambulance
Appoint voluntary organisations referrals facilitator (3 localities)	To increase GP awareness of voluntary services available and to improve patients' access
Planned	
Employ a locality nurse manager	To use nurses more efficiently to avoid gaps in and duplication of services
Develop shared care, counselling, and prescribing services for drug misusers (2 localities)	To improve access to care
Develop primary care mental health counsellor services (2 localities)	To improve access to counselling services for people with less severe mental health problems than required for eligibility for secondary care referral
Train GPs to manage less serious outpatient orthopaedic problems in local hospital	To improve orthopaedic waiting times
Develop locality drug formulary with local hospital	To promote cost effective, efficient prescribing in primary and secondary care
Develop locality orthopaedic service, including increased GP role in prioritising cases and use of physiotherapist clinical assistant	To improve waiting times and adapt service to local needs
Change community physiotherapy service	To reduce waiting times

Table 2 Attitudes to locality commissioning of general practitioners and health authority link staff. Values are proportions (percentages) of subjects agreeing or strongly agreeing with statements unless stated otherwise

	Non-lead GP	Lead GP	Authority link staff
Effects of locality commissioning, apart from specific initiatives of individual localities			
There is a more constructive relationship between Avon Health Authority and GPs	58/98 (59)	12/13 (92)	11/12 (92)
There was useful development of relations between practices in the locality	65/98 (66)	13/13 (100)	11/12 (92)
GPs have benefited from sharing ideas and information	68/99 (69)	13/13 (100)	10/12 (83)
GPs feel more powerful about having a say on what services are available for their patients	57/98 (58)	5/13 (39)	8/12 (67)
GPs have a better understanding of how to change things	57/98 (58)	7/13 (54)	9/12 (75)
Influence on other agencies			
My group has the potential to influence other agencies	75/101 (74)	11/13 (75)	9/13 (68)
My group has influenced Avon Health Authority	42/102 (41)	8/12 (67)	8/13 (62)
Do you want your group to have more influence? (Those answering yes)	83/88 (94)	12/12 (100)	10/11 (91)
How would you sum up the influence your group has had in contacts with*:			
Trust managers	39/100 (39)	8/13 (62)	8/12 (67)
Trust consultants	41/100 (41)	7/13 (54)	7/12 (58)
Other trust staff	10/100 (10)	4/10 (40)	7/13 (55)
Social services staff	6/100 (6)	2/13 (15)	0/13
Community health council staff	10/100 (10)	3/13 (23)	2/12 (17)
Voluntary organisations	14/100 (14)	4/13 (31)	3/12 (25)
Managerial and financial support			
Current arrangements for Avon Health Authority support are about right for my locality	NA	6/12 (50)	6/11 (55)
Our locality link does not meet our expectations of what practical support Avon Health Authority should offer	NA	1/13 (8)	NA
Current payments to lead GPs are adequate for the amount of work I do in my locality	NA	7/13 (54)	NA
The overall benefits from our having a locality commissioning group currently outweigh the costs	NA	11/13 (85)	6/11 (55)
I like being involved in locality commissioning	33/97 (34†)	12/13 (92)	10/12 (83)

NA=not asked. GP=general practitioner.
*Those reporting some or a lot of influence.
†45% Neither agreed nor disagreed.

(120/147) of practices (range 60-100%) aimed to participate in their groups. Of non-lead respondents, 25% (27/108) regularly attended locality meetings and 8% (9/108) represented their practice on a locality group but did not attend regularly. Locality groups had met an average of six times (range 2-11) during the previous year. Eleven of the 13 lead general practitioners reported that their group had planned at least one activity or project, and 10 reported having already taken action, with tangible results. Nine lead general practitioners reported acting on primary care issues, nine on secondary care issues, and six on issues to do with other agencies.

Link staff reported implementation of 20 changes to services and the planning of nine (table 1). The commonest initiatives concerned primary mental health care, nurse specialists for primary care of chronic diseases, referral and clinical practice guidelines, and access to hospital outpatient services. Locality groups initiated some changes, and they helped implement others that might have happened anyway, such as organisation of out of hours schemes. Apart from the service changes shown in table 1, we identified 29 further activities, including educational events such as a locality training day on the health needs of Somali patients, development of an information base for the locality, and investigations of issues without demonstrable changes in services to patients. External funding was not a prerequisite for changes, and several groups worked on ways of improving services within existing resources. Comments from lead general practitioners showed that the main benefits for patients were improved access to services. The main benefits to practices were improved cohesion and communication between practices, and their perception of "having a voice."

Lead and non-lead general practitioners' attitudes to potential benefits of the scheme were assessed by the degree of agreement with statements on a five point scale (from "strongly agree" to "strongly disagree"). All lead general practitioners and two thirds of non-lead general practitioners agreed—that is, answered "agree" or "strongly agree"—with statements that communication and relationships between practices had improved (table 2). Fewer agreed that general practitioners felt more powerful or had a better understanding of how to change things. Half of the lead general practitioners agreed that current support arrangements and payment were about right for the work they did in localities. Most agreed that they enjoyed locality commissioning and that benefits outweighed the costs. The main strengths of locality commissioning identified by lead general practitioners were a flexible local approach, changes made at negligible costs, and developing larger commissioning groups to avoid "too much devolution" in fundholding.

The main barriers to greater influence identified by lead general practitioners were their lack of time and information (nine mentions), their reluctance to take on extra work (one mention), the indifference or lack of cohesion among practices (six mentions), the ambivalence about locality commissioning within the authority (three mentions), and hospital consultants' lack of understanding of primary care (one mention). To increase their groups' influence most wanted a more structured scheme with better funding (six mentions) and training (one mention). Although they were not asked their views on budgets, a few general practitioners said that they favoured budget holding as a means of increasing their influence, while one lead general practitioner wished to "steer clear of indicative budgets." Eight lead general practitioners did not con-

sider the scheme sustainable in its current form. Lack of time and funds were the reasons mentioned most frequently. There were comments about the scheme relying on goodwill and about the problems of lack of empowerment and visible success. They reported frustration at trying to motivate uninterested general practitioners, the slow pace of change, lack of leadership and confidence to change things, and work overload. They felt a lack of support structures and resources for their work.

Locality commissioning costs mainly comprised the time of staff in primary care, of providers in secondary care, and of the health authority. Lead general practitioners estimated that in the month before the survey they had together used 62 general practitioner half day sessions (range 0.5-8.0) on locality commissioning, which is the equivalent of just over 1.5 whole time general practitioners. Over the previous month other primary care staff used 14 sessions (0.4 whole time equivalents) and authority link staff and their secretaries used 37 sessions (0.9 whole time equivalents) on locality commissioning. The local medical committee had spent £57 687 ($92 299) on locality commissioning, which amounts to 6 p per capita. Of this, 30% was paid to lead general practitioners, 51% was paid to other general practitioners for attending locality group meetings, and 19% was spent on other items such as running meetings. Other use of time by staff of the health authority and provider units was not estimated because of the range of staff participating and because locality work could not be clearly distinguished. By November 1996 the authority had allocated £429 000 to 14 of the new service projects organised through localities. These projects were mainly primary care developments.

Discussion

This case study illustrates the potential and limitations of locality commissioning according to this model. General practitioners changed some services. Although there were no restrictions on what services could be worked on, primary care and community services were affected more than were hospital services. Most new projects arose when additional funding was available. High cost hospital services rarely encountered by general practitioners did not feature. No changes were reported for local authority services, but several localities had worked with voluntary organisations. This selective approach could reflect the early stage of development, limited financial support, or the preference of general practitioners to work only on certain issues. With greater financial and political support, general practitioners and health authorities might adopt a broader agenda, but this cannot be assumed.

General practitioner purchasers also take a selective approach. Standard fundholding is explicitly restricted. Total purchasing potentially covers all hospital and community services, but an initial survey of total purchasing sites showed that they all intended to focus on selected issues.[3] Topics addressed here overlapped with those addressed by standard fundholding[4] but for larger populations served by several practices.

Locality commissioning varies widely across the United Kingdom.[5-7] The Avon scheme, in which locality groups worked directly with trust consultants and managers or reorganised services themselves, is similar to that of Newcastle and North Tyneside, in which localities were given budgets for primary care development and locality projects.[7] It differs from locality commissioning in Northumberland, which emphasised general practitioners' influence on health authority contracting.[8] In County Durham primary and community care needs assessment and the participation of local people were emphasised.[7] Locality commissioning differs from non-fundholding schemes in Nottingham[9] and Hackney,[10] in each of which a single general practitioner forum worked to influence health services.

Factors influencing locality commissioning activity

Some localities were much more active than others, raising the possibility that patients in inactive localities could lose out. Activity was not consistently related to the deprivation of the population. Some of the most active locality groups were in comparatively deprived areas. The mix of fundholding and non-fundholding practices did not influence activity in a locality. Some of the most active localities had mainly fundholding practices while others had few fundholders, suggesting that locality commissioning and fundholding are complementary rather than competitive models.

A key to the scheme's successes has been the enthusiasm of participants. The doubts expressed by lead general practitioners about the sustainability of the scheme without clearer policy, more paid time, and more tangible gains suggest that this enthusiasm could decline. Limited management and funding may cause busy general practitioners to abandon the scheme while others might do comparatively little. Commissioners need the safeguards and constraints of clearer guidelines on expectations and accountability, particularly when schemes include greater financial control by general practitioners.

In Avon changes were achieved at limited additional management cost to the health authority. Development funds supported the establishment of many of the projects, but some localities pursued service improvements within existing resources. Although the time spent by general practitioners on locality commissioning seemed to exceed that funded, there was a wide range of general practitioner activity between the least and most active localities, and the previous month assessed in the survey was probably not representative of the less active early years of the scheme. Unlike standard fundholding and total purchasing, none of the management costs of locality commissioning were met with national funds. Direct comparisons with costs of standard fundholding and total purchasing were not possible as the schemes have different aims, but they seem to be greater. The direct management costs of the preparatory year of total purchasing pilot schemes ranged from £0.26 to £8.05 per capita.[3] For standard fundholding, practices received £232m for staff, equipment, and computers over the first four years,[4] by which time 34% of the population was covered,[11] amounting to £12.90 per capita.

Methodological issues

This evaluation is different from other published evaluations of locality commissioning in terms of the duration and scope of the scheme, the range of views considered, and the inclusion of costs and consequences, but it has methodological limitations.

Firstly, we did not compare practices and populations covered and not covered by locality commissioning because the authority and the local medical committee wanted the whole district to be covered. A direct comparison with fundholding was inappropriate because most fundholders also participated in locality commissioning and the two approaches have different aims.

Secondly, information was largely based on the subjective reports and opinions of key participants. This was tempered by use of both quantitative and qualitative data and by comparing the views of lead general practitioners, non-lead general practitioners, and authority link staff, who concurred on most issues.

Thirdly, we have not measured the effectiveness of each of the changes in services that were implemented. However, three of the projects are currently being formally evaluated, and others are being monitored by audit and analysis of routine data.

Finally, a limited range of costs were measured, reflecting the difficulty in measuring indirect costs such as support from providers and the health authority.

Published reports do not allow direct comparison of costs, benefits, and limitations of these different approaches, but policy makers need to understand which combination of approaches will bring the best results and at what cost. Devolved commissioning brings additional costs, and evidence that general practitioners will take responsibility for all commissioning work is still awaited.[3] Further developments in locality commissioning should be evidence based and fully costed.

We thank Marcia Momber for survey administration, Pauline Begley for help with interviewing, and Gwyn Bevan for comments on the paper. We also thank participating general practitioners and staff of Avon Health Authority.

Funding: None.

Conflict of interest: None.

Key messages

- Locality commissioning proved feasible in one of the United Kingdom's largest health districts
- Locality groups were selective in scope, emphasising primary mental health and chronic disease care, guidelines, and outpatient access
- Cooperation between general practices serving geographically defined populations was enhanced
- Costs of general practitioners' participation were negligible, but some general practitioners contributed unpaid time
- Lead general practitioners were frustrated by the lack of clear management framework and political impetus

1 Mays N, Dixon J. *Purchaser plurality in UK: is a consensus emerging and is it the right one?* London: King's Fund Institute, 1996.
2 Department of Health. *Primary care: delivering the future.* London: HMSO, 1996.
3 Total Purchasing National Evaluation Team. *Total purchasing. A profile of national pilot projects.* London: King's Fund, 1997.
4 Audit Commission. *What the doctor ordered: a study of general practitioner fundholders in England and Wales.* London: HMSO, 1996.
5 Balogh R. Exploring the roles of localities in health commissioning: a review of the literature. *Social Policy Administration* 1996;30:99-113.
6 Ham C. *Locality purchasing.* Birmingham: Health Services Management Centre, University of Birmingham, 1992. (Discussion paper 30.)
7 Smith J, Shapiro J. *Holding on while letting go. Evaluation of locality commissioning in County Durham and Newcastle/North Tyneside Health Authorities 1995-1996.* Birmingham: Health Services Management Centre, University of Birmingham, 1996.
8 Balogh R, Thomasson G. The pretenders. *Health Services Journal* 1995 Aug 10:26.
9 Black DG, Birchall AD, Trimble IMG. Non-fundholding in Nottingham: a vision of the future. *BMJ* 1994;309:930-2.
10 Graffy JP, Williams J. Purchasing for all: an alternative to fundholding. *BMJ* 1994;308:391-4.
11 NHS Executive. *Annual report 1995/96.* Leeds: NHS Executive, 1996.

(Accepted 1 April 1997)

Are the Health of the Nation's targets attainable? Postal survey of general practitioners' views

Philip Cheung, A Pali S Hungin, Jo Verrill, Andrew J Russell, Helen Smith

Centre for Health Studies, University of Durham, Durham DH1 3JT
Philip Cheung, *director*
Jo Verrill, *research associate*

BMJ 1997;314:1250–1

continued over

The Health of the Nation's targets were introduced by the government in 1992 as part of a strategic approach to health.[1] We aimed, in 1996, to elicit the views of general practitioners on the attainability of these targets.

Method and results

We sent a piloted and validated questionnaire using ranking lists, Likert scales, and open questions to 390 general practitioners: 196 in the Northern region (98 (50%) were members of the Northern Primary Care Research Network) and 194 in Wessex (94 (48%) were members of the Wessex Research Network). The overall response rate was 66% (n = 257): 70% (138/196) from the Northern region (network members 77% (75/98), non-members 64% (63/98)); and 61% (119/194) from Wessex (network members 76% (71/94), non-members 48% (48/100)). The response rate was thus higher for network members. The respondents' age, sex, and fundholding status reflected the overall situation in England.[2]

Most of the respondents considered the targets to be unattainable (table 1). The targets for cancer were ranked as the relatively most attainable nationally and

Table 1 Responses of 257 general practitioners about the national attainability of Health of the Nation's targets and about the targets for which they have a strategy for meeting.* Values are numbers (percentages) of respondents

National target	Agree	No opinion	Disagree	Have target
Coronary heart disease				
Reduce death rate in those aged <65 by 40% by 2000	75 (31)	17 (7)	147 (61)	99 (72)
Reduce death rate in those aged 65 to 74 by 30% by 2000	57 (24)	35 (15)	147 (61)	97 (71)
Stroke				
Reduce death rate for stroke in those aged 65-74 by 40% by 2000	55 (23)	36 (15)	148 (62)	92 (67)
Cancers				
Reduce death rate for breast cancer in women invited for screening by ≥25% by 2000	90 (38)	45 (19)	104 (43)	47 (34)
Reduce incidence of invasive cervical cancer by 20% by 2000	137 (57)	37 (15)	65 (27)	62 (45)
Reduce death rate for lung cancer in those aged <75 by 30% (men) and 15% (women) by 2010	84 (35)	37 (15)	118 (49)	44 (32)
Halt year on year increase in incidence of skin cancer by 2005	112 (47)	33 (14)	94 (39)	23 (17)
Mental illness				
Improve appreciably health and social functioning of mentally ill people	84 (35)	52 (22)	102 (43)	18 (13)
Reduce overall suicide rate by 15% by 2000	34 (14)	45 (19)	160 (67)	12 (9)
Reduce suicide rate of severely mentally ill people by 33% by 2000	27 (11)	46 (19)	166 (69)	7 (5)
HIV and AIDS				
Reduce incidence of gonorrhoea by 20% by 1996 as an indicator of HIV/AIDS trends	69 (29)	81 (34)	79 (33)	4 (3)
Reduce rate of conceptions in girls aged <16 by 50% by 2000	73 (30)	34 (14)	132 (55)	17 (3)
Accidents				
Reduce death rate for accidents in under 15s by 33% by 2005	78 (33)	65 (27)	95 (40)	7 (5)
Reduce death rate for accidents in those aged 15-24 by 25% by 2005	67 (28)	57 (24)	114 (48)	4 (3)
Reduce death rate for accidents in those aged ≥65 by 33% by 2005	62 (26)	62 (26)	110 (46)	3 (3)

Some respondents did not answer all the questions.
*137 Respondents said that they had a strategy.

Department of Anthropology, University of Durham
Andrew J Russell, *lecturer*

Northern Primary Care Research Network, The Health Centre, Eaglescliffe, Stockton on Tees
A Pali S Hungin, *director*

Wessex Primary Care Research Network, Aldermoor Health Centre, Southampton
Helen Smith, *director*

Correspondence to: Dr Cheung.

the reduction of suicide rates the least attainable. Likert responses confirmed the ranking results, with cancer again regarded as most attainable, followed by HIV infection and AIDS, accidents, coronary heart disease and stroke, and mental illness.

For their own practices respondents ranked coronary heart disease and stroke as the priority target, followed by cancer, mental illness, accidents, and HIV infection and AIDS. Of the respondents, 159 (58%) agreed that their practice should have a strategy for working to meet the Health of the Nation's targets; 137 (50%) respondents reported having such a target in the following categories: coronary heart disease and stroke; cancer; mental illness; HIV infection and AIDS; and accidents (table 1).

Obstacles to pursuing the targets at practice level were: excessive workload in the primary healthcare team, targets too ambitious, time scales unrealistic, apathy among patients, and lack of funds. Comments also centred on the lack of influence of the primary care team over socioeconomic factors linked to ill health; difficulty in persuading the public to change established habits and lifestyles; the lack of centrally controlled media campaigns and of political will towards smoking; and low morale. More practice nurses, health visitors, and health education specialists were needed with emphasis on health education for interventions already proved to be effective. Help was also needed with further team training, information technology, and better accommodation.

Comment

Despite a climate of questionnaire fatigue[3] the response rate was high, with many respondents clearly eager to make their views known, as indicated by the strength of feeling in the comments. The overwhelming view that the targets were unlikely to be achieved reflected the recent House of Commons inquiry.[4] It was unclear why respondents were relatively more optimistic about targets for cervical and skin cancer, although this may be linked to existing campaigns and public awareness, factors largely outside the control of the practice team.

Despite a lack of belief in the attainability of the targets, half of the respondents had practice based strategies for meeting them. Some clear messages emerged about these: an over ambitious time scale, a lack of resources, and the inability to influence the root of the disease locally. Additionally, there is uncertainty about the effect of continuing morbidity trends and the effectiveness of national health campaigns.

Effecting mass change in behaviour that is a risk to health and influencing factors such as personal motivation and socioeconomic conditions are beyond the remit of the primary healthcare team and possibly even beyond national campaigns. This study confirmed a wide gap between nationally set targets and belief in their success, pointing to a need for a better understanding of the role of general practice for focusing policy and activity.

We thank Dr Mark Williamson, general practitioner, Marske Medical Centre; Mrs Kate Hewitt, administrative secretary, Northern Primary Care Research Network; and Mrs Vivien Flowerday, secretary, Centre for Health Studies, University of Durham.

Funding: No special funding.

Conflict of interest: None.

1 Secretary of State for Health. *The health of the nation: a strategy for health in England.* London: HMSO, 1992.
2 Department of Health. *Health and personal social services statistics for England 1995.* London: HMSO, 1995.
3 McAvoy B, Kanor EFS. General practice postal surveys: a questionnaire too far? *BMJ* 1996;313:732-3.
4 House of Commons Committee of Public Accounts. *Health of the nation: a progress report.* London: Stationery Office, 1996.

(Accepted 14 April 1997)