ing health problems available at the practice level often allows identification of people with chronic diseases (most commonly diabetes, asthma, and hypertension) and some information on those lifestyle and risk factors assessed as part of health promotion activity (for example, cigarette and alcohol consumption). Prescribing data in the practice can be a useful proxy measure for those conditions that are treated by specific drugs (for example, methadone mixture for opioid dependency; insulin for diabetes), assuming that prescribing activity mirrors prevalence. Data from several practices can be aggregated to provide information on a locality.

With the same aim, data that are held centrally, such as national census information or district mortality, can be disaggregated to small area levels by use of postcodes. Data derived from practices usefully complement centrally held data. Practice data can be very up to date and rich in information about morbidity and qualitative aspects of patients' experience. That they may be of variable quality and available only for registered patients are limitations. Centrally held data are uniformly available for all practices, are more consistent in quality, include people not registered with a general practitioner, are strong on mortality but may be out of date, and miss the qualitative dimension altogether. The combination of practice based and centrally held information for the same locality therefore provides a more complete picture of needs than either could separately.

Such information can inform locally sensitive commissioning of hospital and community health services. It can also help to guide the allocation of additional resources to practices and can help primary health care teams set priorities for themselves in their role as providers.[7] An estimate of relative need in one practice compared with other practices or localities in the commissioning area is generally more realistic and useful than a calculation of absolute need. A practice with a socially deprived population containing a high proportion of young adults is likely to have a greater need for contraceptive and drug misuse services than a similar sized practice whose population is mainly affluent and middle aged. Although this sort of information has been available for some time, the current distribution of services often fails to reflect local variation. An individual contract between each practice and the community health services trust would be one example of matching services to need more closely.

The volume and quality of data vary,[8 9] and complex soft information may be difficult to handle and analyse. Among general practices in Lambeth some enter on computer a Read disease code at each consultation while others record manually only basic minimum information such as data obtained when new patients are registered (T Crayford, personal communication). The extent to which practice based data can be taken as representative of the local population is greater in areas where almost everyone is registered with a general practitioner. In some parts of inner London, however, the proportion may be as low as 70%.[10] Registration rates are also lower for some marginalised groups, such as single homeless people, who have special health needs.

Perhaps the greatest obstacle to the sort of synthesis of information described here has been the historical separation of the family health services authorities from district health authorities. Like the holders of two halves of a prize draw ticket who live next door but don't often speak, these two groups have found that circumstances have prevented either from claiming their winnings. Planned legislative changes should soon permit them to discover the benefits of an arranged marriage.[11]

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Community oriented primary care

Not a panacea for the problems faced by primary care

Over 9000 general practitioners, covering more than a third of the population of England and Wales, have opted to become fundholders.[1] They have taken the responsibility for managing budgets for staff, premises, and prescribing and for some hospital and community health services. The remaining 21 000 non-fundholding general practitioners are also taking greater responsibility for commissioning health services, either as part of commissioning groups or through locality purchasing. To become effective commissioners of health services, fundholding general practitioners will need skills in disciplines that are usually seen as the remit of public health specialists and health service planners, such as epidemiology, needs assessment, and health service planning. In short, fundholders are expected to take on many of the roles of district health authorities and family health services authorities but at a practice level.

The King's Fund has recently suggested community oriented primary care as one method of teaching and applying public health skills in a primary care setting.[2] Originally developed in Israel, community oriented primary care has several requirements. These include a primary care practice based in the community; an identifiable population or community for which the practice assumes responsibility for improving its health status; a planning, monitoring, and evaluation process for identifying and resolving health problems; and liaison and collaboration with local community leaders.[3] Readers might be forgiven for mistaking this as a description of the work done by their local

health authority (which to all intents and purposes it is).

Community oriented primary care was started in Israel because of concerns about the lack of coordination of health services. A nationalised model with planned health services (like the NHS) was not considered feasible because of the political problems of coordinating the diversity of purchasers and providers of Israeli health services. Community oriented primary care was deemed a practical, alternative solution. It now also has advocates in the United States.[4]

Until recently, many of the problems that community oriented primary care aims at redressing were not present in Britain, which has a strong primary health care service. Everyone has the right to register with a general practitioner and has access to health care that is free at the point of use. Moreover, NHS health authorities are already responsible for assessing need and commissioning health services, and Britain has a tradition of applying public health skills in primary care.[5,6] But the introduction of community oriented primary care into Britain by the King's Fund coincides with the dismantling of the centralised and coordinated planning structures which have been the hallmark of the NHS and with the fragmentation of the NHS into a multitude of purchasers and providers.

In its pilot project the King's Fund invited members of staff from 11 primary health care teams from four sites (Haringey, Northumberland, Sheffield, and Winchester) to a foundation course in community oriented primary care. During the four day course the participants spent the first morning learning basic epidemiological skills. For the remainder of the course each primary care team identified an aspect of its work that was of interest and was thought to be a priority. The main objectives of the programme were to teach the team the public health skills required to design a strategy for managing a health problem that affected a group of patients (as opposed to their usual task of managing an illness in an individual patient) and to start to work together more effectively. A further objective was to improve links between primary health care teams and health authorities. While these are worthy objectives, they are far removed from the original aims of community oriented primary care, which were strategic planning and coordination of services.[3] This was apparent in the participants' perceptions of the aims of the project—for example, one participant saw community oriented primary care as "a learning exercise trigger for practice development and a way of changing behaviour within the team."[2]

Although community oriented primary care allows members of the primary health care team to consider the needs of their patients from a population perspective, it runs the risk of excluding minority groups and less common diseases from the planning process, either because they are overlooked or because small numbers of cases diminish their importance as priorities. This was evident in the priorities identified by the participants: these were mainly common conditions and risk factors such as smoking, cardiovascular disease, urinary incontinence, and depression in women. Some sections of the community—such as homeless people, vagrants, refugees, and other mobile sections of the population—may find themselves excluded from needs assessments. All these groups require good access to primary care and hospital care but not always through general practitioners. How will fundholders and health authorities ensure that services are available for these groups if the planning of health services is skewed to practice populations?

Needs assessment depends on the ability to quantify diseases, risk factors, and population subgroups. The epidemiological and public health skills to do this cannot be taught in four days—the training for specialists in public health medicine takes five years. Needs assessment also requires the use of routine information systems, and the King's Fund's programme highlighted the dearth of good routine information in general practice. Practice computers could not produce the data necessary for needs assessment because most had been set up to perform only routine administrative tasks. Practices that commission health services, either as fundholders or as part of commissioning groups, will require substantial support from health authorities and their public health departments.

But will health authorities be able to provide the support needed? They currently have other preoccupations. Firstly, they have the huge organisational task of managing the mergers between district health authorities and family health services authorities. Secondly, they must take over the many responsibilities being devolved by regional health authorities. Thirdly, at a time when the internal market is increasing administrative costs and bureaucracy they must keep down management costs. Fourthly, they need to develop strategies and partnerships with social services departments (which are responsible for community care). Finally, and most urgently, they need to adapt their population based strategic planning mechanisms to fit in with the plans of fundholding general practices. Health authorities have always found frustrating their lack of coterminosity with local authorities and their social services departments. They now also face the prospect of negotiating with hundreds of fundholders, whose patients may straddle many local authority and health authority boundaries. Similarly, fundholders will have to negotiate with many health authorities and local authorities. How are the needs of minority groups to be represented when the boundaries and responsibilities for care will be so unclear?

The practices participating in the pilot project thought that primary health care teams were drowning because of their increasing workload and many responsibilities; clinicians, managers, public health specialists, and others working in the health service probably think the same of themselves. The NHS is drowning in organisational tasks while the real work of planning and needs assessment is disappearing in the quicksand of the internal market.

Community oriented primary care may provide members of the primary health care team with "the feelgood factor" simply by giving them time out from their day to day work to think and work together as a team. Community oriented primary care cannot, however, impart highly technical public health and planning skills.

How can health authorities and public health departments support general practitioners in the task of acquiring these skills? General practitioners must first ask if the needs of the population are best served through the needs of the practice. This might lead to a more constructive dialogue on the issues of equity and resource allocation, especially for minority groups and patients of non-fundholding practices. The King's Fund's community oriented primary care programme is only one small step in this process. It is no substitute for the public health and planning skills of health authorities.

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