How will primary care groups work?

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Delivery of the 10 year strategy for health set out in the white paper will depend to an important degree on the effectiveness of the new primary care groups in delivering local health improvement programmes, in partnership with health authorities. From April 1999, 500 new primary care groups, typically serving populations of 100 000, will replace nearly 4000 existing commissioning organisations, including general practice fundholders. They will be resourced out of current fundholding allowances.

Primary care groups will involve all local general practitioners, along with community nurses. The white paper outlines four progressive forms of primary care group: giving advice to health authorities on commissioning; managing devolved budgets; independent primary care trusts responsible for some devolved commissioning; and primary care trusts responsible for commissioning all primary and secondary care services with a fully integrated budget. It is not yet clear how primary care groups will relate to optometrists, pharmacists, or dentists. For the first time, primary care budgets will be fully cash limited, but groups will be able to move money between different parts of the service to balance their books. Although national standards will be set to ensure fair access to services and uniform quality, the planning, commissioning, and delivery of services will be local responsibilities.

The fully developed model looks much like an extension of total purchasing, with the addition of fully integrated primary and secondary care budgets—not unlike an American health maintenance organisation. Primary care groups with trust status will be managed by a board consisting of general practitioners, community nurses, managers, social services representatives, and lay members.

Will the new system work, and will it represent an improvement on what it replaces? The success of primary care groups will depend largely on two issues: engaging the support of people in primary care, and demonstrating local accountability and control of decision making.

How can primary care professionals be engaged?

One incentive which made it possible to harness the enthusiasm and drive of general practitioners for fundholding and total purchasing was the ability to produce change and improve services. Primary care groups will also require incentives to encourage local commissioning, now on behalf of much larger groups. General practitioners and community nurses will need access to public health skills to enable them to purchase effectively for their communities and will also need the authority and management support to enable them to provide high quality, coordinated, and equitable care. This will prove a major challenge to health authorities as they develop new relationships with primary care groups.

Primary care groups will have to resolve the conflict of interest of being both providers and purchasers

Another incentive would be to widen the approach to coordinated information technology. The white paper promises that all general practitioners will be connected to the NHSnet by 2002. But all the primary care health professionals within primary care groups will need access to high quality data. Only then will they be able to use the full potential of information technology to plan services and improve quality of care.

How will primary care groups be accountable?

Shaping new services will prove a testing time for primary care groups and health authorities. Conflicts may arise in achieving a balance between local, appropriate, and cost effective needs, and especially between services provided in hospitals and in the community. In theory primary care groups will have to work within the strategy of local health improvement programmes. How accountability will be managed and control exerted will be central to resolving the conflicts that will arise.

Part of the answer is set out in the white paper in terms of lay representation on the new boards. At best this could be a genuine attempt to meet the democratic deficit in the health service. At worst it will be simply a gesture. The challenge to the health authorities will be to bridge this credibility gap by showing adequate accountability to local communities through the appointment of local representatives to primary care boards.

Who will ultimately have control?

Primary care groups will face difficult and demanding decisions if they are to meet the objectives of the white paper on issues such as quality and equity. They will have to make difficult decisions about priorities and the configuration of local services, and they will have to resolve conflicts of interest which will arise through being both purchasers and providers of primary care services. The key test of the white paper in the new NHS will be where control lies. If primary care groups become effective agents of change and create workable mechanisms for local accountability they can expect the final say to rest with them, and not with Whitehall.