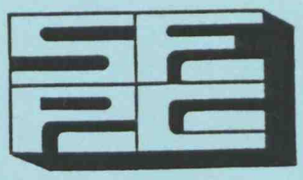

SOCIETY OF FAMILY
PRACTITIONER COMMITTEES

THE FAMILY HEALTH SERVICE

Evidence to the
Prime Minister's Review
of the National Health Service

See letter dated 1/7/88

THE FAMILY HEALTH SERVICE

THE SOCIETY OF FAMILY PRACTITIONER COMMITTEES' EVIDENCE

TO THE PRIME MINISTER'S REVIEW OF THE NHS

SOCIETY OF FAMILY PRACTITIONER COMMITTEES
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INDEX

1. INTRODUCTION

1.1 The Society of Family Practitioner Committees has in its membership all 90 English and eight Welsh Family Practitioner Committees. It is an autonomous section of the National Association of Health Authorities (to which FPCs also belong) and, on behalf of FPCs, deals amongst other matters, with;

- the four Family Practitioner Services;
- Primary Health Care;
- the interface with both the Secondary Health Care Services and Private Care;
- the Department of Health and Social Security

1.2 The Society, on behalf of FPCs, was involved in the preparation of the evidence recently submitted by NAHA to the Prime Minister's review of the NHS - 'The Nation's Health - A Way Forward'. It endorses those sections of the evidence which deal with the financing of the NHS, and the possible implications in terms of range and quality of services which would be provided for all using them (i.e. the NHS' customers). The Society generally supports the proposals relating to the Hospital Services. It does not therefore wish to submit further evidence on these issues.

1.3 The Society however, wishes to submit its own evidence on the Primary Health Care services. The views expressed in paragraph 111 of the Association's evidence are, as there indicated, made on behalf of Health Authorities. They are not shared by the 98 Family Practitioner Committees or the Society.

1.4 It is understood that the main concerns of the Prime Minister's review relate to the Hospital Services (particularly the Acute Services) and their interaction with the other medically related services of the NHS. The Society on behalf of FPCs therefore wishes to comment on the following:

- The White Paper - Primary Health Care proposals
- The Interaction of Hospital Services with the Primary Health Care Services
- Family Practitioner Committees
- Primary Health Care - The Way Ahead

1.5 Should the Review be extended at any stage to the non medical parts of the NHS, the Society would wish to have the opportunity to submit evidence thereon.

1.6 The basis of the Society's evidence is a commitment to a comprehensive health service for the nation with genuine equity of access irrespective of means, locality, social or ethnic status. This principle appears to have virtually universal support within the country.

1.7 "Equity of access irrespective of means" can only be achieved if general funding rather than specific charges continues to be the principal source of financing the various services. Also, where charges are made full account needs to be taken of any potential deterrent effect when fixing the level of charges.

1.8 Despite imperfections, the NHS has played a key role in improving the nation's health, and has relieved individuals from worry about the personal costs of being ill.

1.9 Paragraph 4 of NAHA's evidence draws attention to the popularity of the NHS and the high degree of satisfaction amongst those receiving treatment and their immediate family. Local and national surveys amongst users of the four Family Practitioner Services and the immediate families of those users also show very high levels of satisfaction as well as belief that the services are provided efficiently.

2. THE WHITE PAPER - PRIMARY HEALTH CARE PROPOSALS

2.1 The Primary Health Care Services (i.e. those provided outside hospitals) cover the four Family Practitioner Services provided by family doctors, dentists, community or retail pharmacists and opticians and their staff, and the District Health Authority Community Health Services provided by community nurses, midwives, health visitors and other professions allied to medicine (such as physiotherapists and chiropodists). Collectively they provide the 'front-line' day-to-day health care of the Health Service. This represents more than 90% of the nation's contact with the NHS.

2.2 The Secretary of State, in paragraph 2 of the consultative paper 'Primary Health Care - An Agenda For Discussion' (command 9771) published in 1986, at the start of the Government's review of Primary Health Care, said:

> "Primary Health Care Services are more fully developed in the United Kingdom than in other countries, where patients have more direct access to specialist care and rely less on General Practitioner and Community Health Services. Our services are generally provided to a high standard and are well appreciated by the public. The Government considers that British primary care arrangements have made an important contribution to both the quality and cost-effectiveness of our health care system, and this view is widely held by commentators both in this country and abroad."

2.3 It is generally recognised that these services, even before that review, provided the most comprehensive and probably the most cost-effective Primary Health Care cover in the western world (Western Europe, North America and Australasia). Notwithstanding this, the Government felt that more could be achieved through these services in terms of providing a **Family Health Service**, with an increasing emphasis on promotion of good health rather than merely on the treatment of illness. The Society shares this view.

2.4 The White Paper 'Promoting Better Health' published in November 1987 sets out the Government's plans for the future, based on the six objectives identified by it in the earlier discussion document, viz:

- to make services more responsive to the needs of the consumer
- to raise standards of care;

- to promote health and prevent illness;

- to give patients the widest range of choice in obtaining high quality primary care services;

- to improve value for money;

- to enable clearer priorities to be set for Family Practitioner Services in relation to the rest of the health service;

and the themes which emerged as a result of the consultation process (for details see Annex 1).

2.5 Listed at Annex 2 are the main changes the Government is seeking. In paragraph 1.8 of the White Paper, the Government set out three inter-related ways of achieving its aims, namely;

- no opportunity should be lost to increase fair and open competition between those providing Family Practitioner Services;

- to that end, consumers should have readier access to much more information about the services provided;

- and the remuneration of practitioners should be more directly linked than at present to the level of their performance."

The Society, on behalf of FPCs, has strongly supported the thrust of the Government's approach and the main changes envisaged.

2.6 In its view, the proposals for actively promoting good health and preventing ill-health; for enhancing the treatment of illness; for raising the quality of services and facilities, and for increasing value-for-money will further improve the Primary Health Care Services as well as making them more cost-effective. The enhanced managerial and monitoring roles envisaged for FPCs are welcomed and will raise standards, improve services and help to contain costs for the benefit of the NHS as a whole. Collectively the proposals, coupled with the improving collaboration between DHAs and FPCs, will have an impact on the use made of the Acute Hospital Services and their resources - albeit some of the impact will be in the longer term. With the caveats mentioned later, the Society hopes that the various proposals will be implemented as quickly as possible.

2.7 FPCs are concerned to ensure that the cash-limiting proposals in relation to ancillary staff and premises, are operated in such a way as usefully to increase the range and numbers of ancillary staff employed by GPs and likewise improve standards of accommodation, taking the existing best practices as the base lines for further improvements. FPCs and the Society have expressed elsewhere reservations as to whether a small number of the changes set out in the White Paper are not counter-productive to its overall aims. However, these are not germane to the present review.

2.8 The Society, in connection with implementation of the White Paper, proposes to explore with the Department of Health and Social Security ways in which greater flexibility in resourcing can be given to FPCs to achieve improved value for money and containment of costs within FPS expenditure.

3. INTERACTION OF THE HOSPITAL SERVICES WITH THE PRIMARY HEALTH CARE SERVICES

3.1 There are three main interactions between the Primary and the Hospital Services:

- GP referrals to, and use of, hospital facilities;
- reduction in the time patients spend in hospital and changing treatment patterns;
- care in the community.

3.2 Access to specialist services and secondary care is normally obtained only on referral by the General Practitioner who performs the functions of gatekeeper, adviser and co-ordinator/mobiliser of secondary care.

3.3 Paragraph 3.61 of the White Paper draws attention to the very substantial costs incurred through family doctors' decisions to refer patients to hospital and the need to ensure that these expensive facilities are used in the most cost-effective way. The White Paper also draws attention to the variation in referral rates and to the work already being done in some areas by family doctors and specialists to examine the criteria used in making referral decisions.

3.4 It is generally considered that the GPs' filter and referral roles (even allowing for the variations mentioned) are already very effective in ensuring patients obtain the treatment (whether primary or secondary) most appropriate to their needs, and reduce the level of hospital admissions which might otherwise occur. The following table based on OECD data shows that the United Kingdom has one of the lowest hospitalisation rates amongst OECD countries:

TABLE - HOSPITAL ADMISSION RATES (1983 OR NEAR DATE) IN RANK ORDER (LOWEST FIRST)

COUNTRY	RATE (% OF POPULATION)	DATE
Japan	6.7	1983
Spain	9.2	1981
Portugal	9.6	1982
France	11.8	1983
Netherlands	11.8	1983
Greece	11.9	1982
United Kingdom	**12.7**	**1981**
Switzerland	12.8	1982
Belgium	13.9	1981
Canada	14.7	1982
Norway	14.9	1983
Italy	15.4	1983
New Zealand	15.7	1983
Ireland	16.4	1982
United States	17.0	1981
Germany	18.1	1982
Luxembourg	18.1	1983
Denmark	19.2	1983
Sweden	19.2	1983
Iceland	20.2	1982
Austria	20.7	1983
Finland	20.9	1983
Australia	21.0	1980

3.5 The referral system is also an important part of the 'continuum of care' which family doctors provide for their patients through diagnosis, treatment, after care, advice and support.

3.6 The Society supports the proposal in paragraph 3.62 of the White Paper:

> "that FPCs should use independent medical advisers to encourage good practice in the referral of patients to hospital. Doctors with abnormally high or low rates of referral will be invited to take part in an assessment of their approach to help them in making effective use of hospital resources."

It also supports the linked proposal in paragraph 10.10 of the White Paper:

> "that FPCs and DHAs should act to ensure that the use of hospital facilities achieves the maximum benefit for patients, and that services are used to ensure quality of care in a cost-effective way."

3.7 Information about the size of waiting lists and likely length of any waiting period for appropriate hospitals should be automatically available to all family doctors to enable them better to advise their patients. Similarly FPCs should be given this information to assist them in their monitoring roles. GPs and FPCs should also be provided with information as to the cost of referrals (which is not currently available). The introduction of clinical budgeting should help in this connection.

3.8 Family doctors make extensive use of hospital pathology and radiology facilities in assisting them to diagnose and treat patients. These are essential aids and need to be provided locally at hours which are convenient to patients. Direct access by family doctors helps to avoid the need for more expensive hospital based diagnosis and should be encouraged. Given the extensive use also made of the pathology and radiology facilities by hospitals themselves, it seems that in general they are most cost-effectively located within the hospitals.

3.9 The shorter periods spent in hospital by patients, as well as changes in treatment methods for a number conditions, such as peptic ulcers and diabetes, have resulted in a greater involvement of the Primary Health Care Services in the management of treatment and in after care for a wide variety of patients. Changing methods of diagnosis are also having an impact on referrals/non-referral patterns. Diagnosis and treatment within the community setting is much preferred by patients to hospital referrals and, generally speaking, also is considerably cheaper. On both grounds the Society believes these trends (which are in keeping with the White Paper's aims) should positively be encouraged where-ever practical.

3.10 The Society supports the trend towards care in the community of the elderly, the mentally-ill, the mentally-handicapped and the physically-handicapped wherever it is in their interests and adequate support services can be provided both for the patients and their carers so as to ensure equal or improved quality of life to that which can be provided by "in hospital" care. This involves a shift in resources from Hospital Services. Evidence suggests the overall costs for the nation of care in the community may be higher than at present.

3.11 "The Nation's Health - The Way Forward" draws attention to the potential implications for patients and their family doctor advisers, of health maintenance organisations, health care vouchers and internal markets. These need to be taken fully into account in any evaluation of the implications of such arrangements so as to ensure that the

choice, quality and accessability of care which patients receive is not eroded whilst also ensuring hospital facilities are used cost-effectively.

3.12 Should any of these three proposals find favour as a result of the review, the Society would wish to have the opportunity of commenting in more detail. However, it is important at this stage to express particular concern regarding the internal market approach. If the concept is carried too far it could result in patients having less immediate access to hospital treatment. Specialisation by hospitals should not detract from their ability to provide the kinds of immediate treatment needed by a large proportion of patients for the more routine types of acute surgery and illness as well as accident and emergency cases.

3.13 The proposal in paragraph 3.63 of the White Paper to encourage family doctors to undertake minor surgery is welcomed. It will provide a more convenient service to patients and reduce the calls on out-patient departments. It will also help to prevent out-patient facilities being used inappropriately and aid in the containment and marginal reduction of hospital costs. The G.P. manpower implications will need to be carefully monitored.

4. FAMILY PRACTITIONER COMMITTEES

4.1 The future management and administration of the four Family Practitioner Services was the subject of detailed consultation and consideration in 1981. As a result the Government decided to separate FPCs from the then Area Health Authorities and make them autonomous. This was seen as the best means of developing the Family Practitioner Services; ensuring that these meet local needs; increasing value-for-money; streamlining the management process, and ensuring better collaboration with other sections of the NHS to provide effective and economic health services for the nation.

4.2 Since the grant of autonomy in 1985, and notwithstanding considerable resource and staffing difficulties, FPCs have shown that they are well suited to plan and manage the Family Practitioner Services and take full account of the customer aspects of those using the services. No longer reactive, FPCs are increasingly monitoring and where appropriate challenging individual contractor's standards and ensuring better value for money. In so doing, they are building on the very constructive relationship with the contractors, which has always been one of the strengths of FPCs.

4.3 Last November's White Paper, which included the Government's response to the House of Commons Social Services Committee Report on Primary Care, confirmed that the Government too believes that the separation of FPCs from DHAs has provided the base and impetus for better planning, development and management of the Family Practitioner Services. The additional responsibilities and functions proposed for FPCs and the changes proposed for practitioner's contracts will significantly help FPCs to ensure more sensitive services of a high quality; wider consumer choice; improved value-for-money; better Primary Health Care Services and improved collaboration with DHAs.

4.4 FPCs and the Society believe that the unification of FPCs and DHAs suggested by NAHA in paragraph 111 of its evidence would in fact stultify the progress being made and prove seriously detrimental to the provision of effective Primary and Secondary Health Care Services.

4.5 NAHA, in its evidence, rightly says that 'good foundations should not be undermined'. It draws attention to the fact that 'an effective Primary Health Care System can absorb and cushion demands which would otherwise be made on the more expensive hospital service' and that 'collaboration between the two sectors is therefore vital'. However, it produces no evidence to support its claims that the unification of such services

under the District Health Authority would enhance such collaboration and that 'all the Primary Health Care Services should be brought within the jurisdiction of District Health Authorities'. Past experience, up to 1985, tends to refute both NAHA's assertions and its conclusions. Evidence available suggests that at present the Primary Care Services may be suffering at the expense of secondary care in a number of DHAs.

4.6 The Society believes there are eight main reasons against any such unification:

(1) The Acute Hospital Services account for some 58% of the NHS budget, whilst the DHA Community Services account for a further 6%. This is big business, which needs effective management. It is probable (indeed, probably inevitable) that given the proportion spent on Acute Hospital Services these will continue to demand most of the time and expertise of DHA members and senior staff.

(2) FPCs are very largely concerned with health services in the community, which are becoming increasingly important. Both elements (FPS and CS) need full consideration and effective management.

(3) Given the breadth of services involved, it is likely that any unification of responsibilities along the lines envisaged by NAHA, would result in too diverse a range of services under one Authority and too wide a span of control for effective and efficient management.

(4) Authority Members of both DHAs and FPCs already find significant demands on their time. It is unlikely that the two bodies could be merged without making impossibly heavy demands on Member's time, thus leading to increasing difficulties in recruiting and retaining persons of the right calibre - a problem which already exists in some areas.

(5) If, on the other hand, NAHA envisages that at Member level there should continue to be a separate Family Practitioner Committee, this would seem to be little different from the 1974 re-organisation which was intended to bring about a closer working relationship between the 'managed' predominantly hospital services and the 'independent' family practitioner services. It proved unsatisfactory and led to FPCs becoming wholly independent in 1985.

(6) As already indicated, autonomy has led to increasingly effective planning and management of the Family Practitioner Services and to improvements being made to them and the other Primary Health Care services. The separation of FPCs and DHAs enables both to question constructively the services provided by themselves and each other so as to bring about the most effective arrangements for NHS users.

(7) Paragraph 7 of the Government's discussion document on Primary Health Care drew attention to the significant differences between the Family Practitioner Services provided by independent contractors and the Hospital Services which are employee based.

(8) The management costs of District Health Authorities are some 4.5% of their budgets. Those of FPCs are currently around 1%. Whilst these are not wholely comparable the type of unification envisaged by NAHA is likely to result in significant additional expenditure in providing continuing management of the Family Practitioner Services.

4.7 The Society shares NAHA's view (expressed at para 111) that family doctors need to be more involved in the managerial and planning processes. The White Paper envisages new contracts between GPs and Family Practitioner Committees, which will ensure that the family doctor services are more sensitive to national policies and local needs. Given the independent contractor status of GPs (an arrangement which as the Government has repeatably confirmed, helps to ensure user orientated and cost-effective services) the type of contract envisaged by NAHA would not be appropriate. The GP services, unlike most acute hospital treatments, are not about separate incidents, but about providing a continuing Family Health Service. There needs to be a long-term commitment to patient understanding and relations and development of the doctor's practice. However, GPs should provide their services within the framework of nationally and locally determined needs, which are regularly reviewed and updated. Their contract should clearly specify the functions and obligations of both parties (i.e. FPC and GP) and enable performance to be appropriately monitored and guaranteed. Where services prove unsatisfactory there needs to be speedy, fair means of rectifying this so as to ensure that the patient/customers receive the standard of care to which they are entitled.

5. PRIMARY HEALTH CARE SERVICES - THE WAY AHEAD

5.1 Both the Government's discussion document 'Primary Health Care' and the recent White Paper 'Promoting Better Health' draw attention to the fundamental importance of the Primary Health Care Services in meeting the non-hospital health needs of the country's population. These are naturally focused around the Family Practitioner Services. The Cumberlege Report; the Government's response to it; and the Edwards Report each underlines the need to provide comprehensive Primary Health Care Teams, and for the Community Nursing Services to be linked to General Practice Services.

5.2 The Society believes that implementation of the White Paper; creation throughout the country of effective Primary Health Care Teams linked to General Practices, and their further broadening out to include appropriate allied paramedical services should be the immediate objective.

5.3 The Edwards Report for Wales further recommends that the four Family Practitioner Services managed by FPCs, together with the Community Nursing Services managed by District Health Authorities should be combined within a Primary Health Care Authority.

5.4 The Society in principle supports such a concept as the way ahead. A Primary Health Care Authority makes a more logical division of the health services; would better reflect patients' and users' needs; would create two better matched and manageable ranges of services; would help to give impetus to the Government's wish for a Family Health Service with appropriate emphasis on promotion of good health, screening and other measures to prevent illness as well as the treatment of illness. It should be responsible for identifying and meeting the personal health needs of local communities. It would work with District Health Authorities, local authorities and the private and voluntary sectors in ensuring that these needs are met in appropriate, practical and cost-effective ways. It should also have responsibility for providing health education with the Health Education Authority continuing to act as the national specialist body. The Society believes that such arrangements would be in keeping with the approach of both the White Paper and the Griffiths Report on Community Care.

5.5 However further study needs to be given to a number of aspects, including so far as England is concerned the differing patterns of DHAs and FPCs that exist. Also studies are needed into the financing of PHCA's, their staffing and the most appropriate management arrangements.

The objective would be to ensure sensitive cost effective Primary Health Care Services to which the Hospital Services are closely linked so as to jointly provide personalised comprehensive health care and treatment for all who use the NHS. Consideration should also be given to how Primary Health Care Authorities can best contribute to effective Care in the Community facilities and services.

5.6 Because the Primary Health Care Services are naturally focused around the Family Practitioner Services, the Society believes that FPCs are well-placed to play a leading role in the creation of Primary Health Care Authorities.

SUMMARY OF KEY POINTS

(i) The Society has in its membership all 98 English and Welsh FPCs and is an autonomous section of the National Association of Health Authorities.

(ii) The Society on behalf of Family Practitioner Committees, endorses the evidence submitted by the Association in relation to the future financing of the National Health Service, and the implications for all who use the services. It also generally supports the Association's proposals relating to the Hospital Services.

(iii) The views put forward by the Association on behalf of Health Authorities regarding Primary Health Care, are not shared by Family Practitioner Committees and the Society.

(iv) There appears to be total support within the nation for a comprehensive health service with genuine equity of access irrespective of means, locality, social or ethnic status. "Equity of access irrespective of means" can only be achieved if general funding rather than specific charges continues to be the principal source of financing the services and full account is taken of any potential deterrent effect when fixing the level of charges.

(v) Despite imperfections, the NHS has played a key role in improving the nation's health and has relieved individuals from worry about the personal cost of being ill.

(vi) At the forefront are the services provided by Family Doctors, Dentists, Community (Retail) Pharmacists and Opticians who handle over 90% of the calls made on the NHS. Local and national surveys show very high levels of satisfaction with these Services.

WHITE PAPER PROPOSALS FOR PRIMARY HEALTH CARE

(vii) The Primary Health Care Services in the United Kingdom are the most comprehensive amongst the western nations and are probably the most cost-effective. The White Paper 'Promoting Better Health' published last November, outlines proposals for further improvements. With a few caveats the Society strongly supports the proposals and believes they offer the best way ahead for creating a cost-effective **Family Health Service.** When implemented they will also help to reduce demands on the Acute Hospital Services and contain those costs.

(viii) The Society believes that greater flexibility in resourcing would assist in achieving better value for money and the containment of costs.

INTERACTION OF PRIMARY HEALTH CARE SERVICES WITH ACUTE HOSPITAL SERVICES

(ix) The referring role of family doctors is on the whole already very effective in ensuring patients obtain the treatment most appropriate to their needs, and reduces the level of hospital admissions (and costs) which might otherwise occur. The Society supports the White Paper proposals to make this role even more effective. Additionally all family doctors (and FPCs) should be provided with up to date information on waiting lists and length of waiting time so that they can better advise their patients. Information about the cost of referrals should also be made available to family doctors and FPCs.

(x) The changing diagnostic and treatment patterns with shorter stays in hospital and the greater involvement of the Primary Health Care Services (including after care) are preferred by patients and are more cost-effective. On both grounds these trends should be positively encouraged wherever practical.

(xi) The trend towards increasing 'Care in the community' for the elderly, mentally-ill, mentally-handicapped and physically-handicapped is supported where it is in the patients' own interests and adequate support can be provided for them and their carers. This means a shift in resources away from hospital services. Evidence suggests that the overall costs for the nation may be higher than at present.

(xii) The pathology and radiology services provided by hospitals are essential in aiding family doctors to diagnose and treat their patients. Direct access should be increased and can help to contain costs.

(xiii) Proposals to encourage family doctors to undertake minor surgery will provide a more convenient service to patients, reduce calls on out-patient departments and reduce hospital costs.

FAMILY PRACTITIONER COMMITTEES

(xiv) The Society shares the Government's view that the Family Practitioner Services can be more effectively managed by FPCs which are independent of DHAs. In the three years since autonomy, significant advances have been made and more are planned as a result of the White Paper.

(xv) Close collaboration between all the health groups in the NHS is essential in ensuring the effectiveness of the NHS. The Society believe that NAHA's suggestion for DHAs to take over responsibility for the four Family Practitioner Services would result in poorer, and not better, primary and secondary health care services. Also it is anticipated that costs would increase.

PRIMARY HEALTH CARE SERVICES - THE WAY AHEAD

(xvi) The White Paper and other recent reports have confirmed the fundamental importance of the Primary Health Care Services in meeting all the non-hospital health needs of the country's population.

(xvii) Implementation of the White Paper proposals; the creation throughout the country of effective Primary Health Care Teams linked to General Practices and their further broadening out to include appropriate allied paramedical services should be the immediate priority.

(xviii) The Edwards Report 'Nursing in the Community' suggests that the four Family Practitioner Services together with the Community Nursing Services, should be combined within a Primary Health Care Authority. The Society in principle supports such a concept as the 'way ahead', but recognises that a number of issues need first to be the subject of detailed studies, including for England the differing patterns of FPCs and DHAs which exist.

(xix) Because the Primary Health Care Services are naturally focused around Family Practitioner Services, FPCs are well-placed to play a leading role in the creation of PHCAs.

THEMES IDENTIFIED IN PARAGRAPH 1.7 OF THE WHITE PAPER AS ARISING FROM THE CONSULTATION PROCESS ON THE DISCUSSION DOCUMENT

- concern about the extent of preventable disease;

- the value which consumers - whether individuals or families- place on accessible, effective and sympathetic Family Practitioner and Community Health Services;

- the need of consumers for better, more detailed, and more accessible factual information about practitioners and the range and pattern of services they provide;

- the need to meet the varied requirements of elderly people, whose numbers are increasing;

- a growing interest in the promotion of good health;

- the need to improve services in deprived areas, particularly inner cities and isolated rural areas.

ANNEX 2

MAIN CHANGES WHICH THE GOVERNMENT IS SEEKING TO FAMILY PRACTITIONER SERVICES (PARAGRAPH 1.15 OF THE WHITE PAPER)

- Agreed targets for achieving higher levels of vaccination and immunisation and screening for cervical cancer;

- more health promotion sessions in general practice (to advise and assist on, for example, prevention of heart disease, on how to give up smoking, and on diet);

- regular and frequent health checks for particular sections of the community (for example children and some elderly people);

- more information for consumers to enable them to choose the doctor who best meets their needs;

- a wider range of services for the consumer at the doctor's surgery (for example interpreter services, counselling, chiropody, minor surgical operations and more nursing services);

- a new contract for dentists which will encourage prevention and promote the quality of treatment provided;

- measures to improve the distribution of dentists;

- a dental health campaign to promote an awareness of the value of regular check-ups among the young;

- free spectacle repairs for the handicapped and a domiciliary sight-testing service for the housebound on low income;

- an extended use of the pharmacist's skills;

- an enhanced role for Family Practitioner Committees (FPCs) in England and Wales in administering these changes.

FHS (June 1988)

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FHS

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FHS

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SOCIETY OF
FAMILY
PRACTITIONER
COMMITTEES

75 YORK ROAD,
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The Right Honourable Margaret Thatcher FRS MP
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Our Ref: DDC1/GB

1 July 1988

Dear Prime Minister

REVIEW OF THE NATIONAL HEALTH SERVICE

On behalf of the Society which has in its membership all 98 English and Welsh Family Practitioner Committees I submit the enclosed evidence which the Society wishes to be taken into account as part of your Review of the National Health Service. I have also sent a copy to the Secretary of State for Social Services.

The Society is an autonomous section of the National Association of Health Authorities. It contributed to and endorses the evidence submitted by the Association under the title "The Nations Health - a Way Forward" except that relating to the Primary Health Care Services.

The Society's evidence is therefore concerned with the Primary Health Care Services and their interaction with the Hospital Services.

The Society understands that your Review is only concerned with the funding, provision and operation of hospitals and related medical services. Should the Review be extended beyond this to cover the whole of the four Family Practitioner Services provided by Family Doctors, Dentists, Community Pharmacists and Opticians, the Society wish to submit evidence thereon.

Yours sincerely

D D Cracknell

President
Enc.