

# The long term importance of English primary care groups for integration in primary health care and deinstitutionalisation of hospital care

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## Abstract

**Purpose:** This article reviews the impact of successive experiments in the development of primary care organisations in England and assesses the long-term importance of English primary care groups for the integration of health and community and health and social care and the deinstitutionalisation of hospital care.

**Theory:** Governments in a number of Western countries are attempting to improve the efficiency, appropriateness and equity of their health systems. One of the main ways of doing this is to devolve provision and commissioning responsibility from national and regional organisations to more local agencies based in primary care. Such primary care organisations are allocated budgets that span both primary and secondary (hospital) services and also, potentially, social care.

**Method:** This article is based on a systematic review of the literature forthcoming from the UK Government's Department of Health-funded evaluations of successive primary care organisational developments. These include total purchasing pilots, GP commissioning group pilots, personal medical services pilots and primary care groups and trusts.

**Results:** Primary care organisations in England have proved to be a catalyst in facilitating the development of integrated care working between primary and community health services. Conversely, primary care organisations have proved less effective in promoting integration between health and social care agencies where most progress has been made at the strategic commissioning level. The development of primary care trusts in England is heralding an end to traditional community hospitals.

**Conclusions:** The development of primary care groups in England are but an intermediate step of a policy progression towards future primary care-based organisations that will functionally integrate primary and community health services with local authority services under a single management umbrella.

## Keywords

primary care, integrated care, managed care, England

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## Introduction

A key challenge facing health systems in Western countries is how they can be made more appropriate, efficient and equitable. As Mays et al. argue, common problems include variations in patterns and levels of prescribing in primary care, and of referrals for specialist care [1]. Other problems include rising demand for unplanned admissions to hospitals and lengthening waiting lists in systems that do not ration services by price [1]. Key responses to these problems have been to break down barriers between funding streams within the health sector; encourage providers to work to clear budgetary limits; encourage contractual relationships between procuring (purchasing) and providing agencies; and encourage competition between providers

for the contracts of public and private purchasers of health care [2].

One way in which countries have sought to address these problems has been to allocate health care budgets on a capitation basis to organisations, which are then responsible for securing the delivery of the health care for their enrolled populations. Such organisational and budgetary developments are generally referred to as 'managed care' and have been most fully developed in parts of the United States of America. One characteristic of managed care is that it encourages more vertically integrated forms of service delivery. For example, the approach can be characterised by a single delivery organisation and the provision of comprehensive care for a specific chronic condition such as diabetes or asthma. Thus, managed

care brings together previously separate primary, secondary and tertiary service providers as is common in other health systems [3].

The purpose of this article is to provide a descriptive study detailing the development of primary care organisations in England. The study does not attempt to examine why health care services in England have chosen this route. Rather, the study focuses on mapping the development of primary care innovations and, in particular, the impact these have made on promoting integrated care.

The evaluation within the study is based on a systematic review of the literature forthcoming from the UK Government's Department of Health-funded evaluations of successive primary care organisational developments. This restriction in the choice of literature for review was made for a number of reasons. First, though Government funded, the evaluations were undertaken by *independent* groups of academic research institutions. This independence was manifest in the selective nature in which the findings and recommendations of this research was taken forward by policy makers [1]. Indeed, the establishment of the national evaluation process was a reaction to criticism of the lack of central evaluation given to GP fund holding. The assessment of the merits of GP fund holding was severely hampered by the politically biased way research was conducted [4]. Second, the national evaluations were *comprehensive* in design. This meant that the research was able to examine the 'whole' system in comparison to other studies that only examined isolated case studies or just one aspect of care. Thus, the literature from the national evaluations present evidence that is the least biased and most comprehensive.

## The growth of primary care organisations in England

Before the introduction of the internal market reforms into the British National Health Service in 1991/92, health authorities had been responsible for planning and delivering health services to the populations within their boundaries. All hospital care was managed directly whilst primary care services (general medical services) were provided by independent general practitioners working to a national contract with the government.

In 1989, following The White Paper *Working for Patients* [5], responsibility for purchasing services was separated from providing services. Acute hospitals and other provider organisations responsible for community health services and mental health services

became self-governing. Health authorities ceased to have any direct responsibility for provision and instead became the purchaser of services for their resident populations. In addition to the health authority as purchaser, the parallel innovation of general practitioner fundholding was introduced—a kind of managed care peculiar to Britain. Under fundholding, large general practices or groups of practices were encouraged to take on responsibility for managing budgets. Fundholding budgets covered a range of elective (non-emergency) hospital and community health services, non-medical practice staff costs and prescribing. The health authority continued to have responsibility for purchasing emergency services for the patients of fundholding and non-fundholding practices alike.

The proponents of fundholding claimed great benefits for the scheme. These benefits included downward pressure on prescribing costs [6–8], improved access to primary care-based services [8–10], and the greater responsiveness of providers to fundholders' demands [9, 11]. However, the only systematic review of the evidence showed that the balance sheet for fundholding was less positive [4]. The Audit Commission, for example, concluded that most fundholding practices had produced only modest improvements despite high costs [12]. Nevertheless, rather than abandoning the concept of primary care-based purchasing, the concept of a 'primary care-led National Health Service' [13] was embraced with cross-party political support [14]. Moreover, primary care became the focus of a variety of attempts to adopt a more comprehensive and integrated approach to health care. The most important legacy of the fundholding scheme, it could be argued, was the acceptance for the concept of general practitioners being involved in the commissioning process [4].

By the mid-1990s, the concept of a primary care-led service became firmly established in the NHS. The argument had moved from whether primary care organisations should be involved at all to finding new ways of extending current approaches to those locations where there was little or no involvement [15]. As a result, a wide range of primary care-led organisations developed to purchase or commission health care for smaller populations than a typical health authority. As Mays and Dixon [14] described, by 1996 numerous types of primary care-based organisations had developed in England. These organisations included 'locality commissioners', consultation schemes designed to directly influence the range of services provided locally by exerting pressure on health authorities without holding a budget directly. Such commissioning organisations largely emerged spontaneously among general practices opposed to

fundholding [14]. Fundholding models also evolved into larger and more influential organisations through the creation of consortia arrangements. Larger purchasing organisations were able to exert greater contractual leverage over hospital providers.

The scope of what primary care organisations in England could purchase had also extended. In 1994, following pressure from some pioneer fundholders to take on additional purchasing responsibilities, the National Health Service Executive decided to launch a larger scale, three-year, national initiative as part of the development of a so-called *Primary Care-led NHS* [13]. One part of the initiative comprised 'extended' fundholding practices to purchase a single, additional service (typically maternity, mental health services, palliative care and certain complimentary therapies). In the other part, volunteer fundholders were recruited to purchase potentially all hospital and community health services for their patients on a pilot basis. These 'total-purchasing pilots' enabled general practitioners for the first time to purchase services such as accident and emergency, maternity, inpatient mental health and geriatric medicine. The total purchasing pilot experiment was also the first such initiative to be evaluated centrally [16].

As the primary care-led NHS developed, the offspring of fundholding were generally larger and enjoyed greater commissioning responsibilities. Moreover, primary care organisations had begun to develop a general recognition for the need to plan and budget for comprehensive provision. Thus, despite the policy emphasis on the role of primary care in purchasing services [17, 18], primary care organisations had begun to take on a wider role as providers of care. For example, there is overwhelming evidence to show that fundholding practices were able to extend their range of services to provide better access to care for their patients [4, 8–10]. Evidence from the national evaluation of total purchasing suggests that most pilots were primarily concerned with developing primary care services as part of an integrated network of provision [1, 19].

## Personal medical services

The move to primary care organisations as providers of services, rather than commissioners, was emphasised in the creation of 'personal medical services pilots' following the 1997 *NHS (Primary Care) Act* [20]. The Act presented opportunities for general practices and hospital trusts in England to extend and develop primary care services in a new way. A key feature of the Act was that it instituted the possibility of a new contractual relationship between the health

authority and the primary care provider. This was achieved by setting aside the existing national contract for general medical services in favour of a regular payment from the health authority for the provision of an agreed set of services under a locally negotiated contract. Importantly, the new contractual relationship between the health authority and the primary care provider enabled health authorities to take a more active role in the integration of general practitioner, community and specialist services.

Since general practitioners would be salaried, rather than working to a national contract, it was argued that such developments may shift organisational and professional boundaries. For example, doctors could share an equal status with nurses as employees of the same provider organisation [21]. A further reason for the development of personal medical services pilots was to reduce inflexibilities of existing contractual relationships in primary care. Historically, the development of primary care-based services were impeded because of the legal separation of the general medical services budget from the rest of the health services budget. The inflexibility of existing contractual arrangement was frequently cited by those involved in total purchasing pilots as a major barrier to further developments [22, 23].

In April 1998, 88 personal medical services pilots went live on a three-year pilot basis [22]. On the whole, personal medical services pilots have been concerned with broadening the range of services provided outside hospital on a flexible and locally-determined basis. This has been promoted by encouraging general practitioners to step outside their national contract for general medical services and by allowing health authorities to commission primary care and related services from any NHS provider. For example, contracts have been negotiated for nurse-led provision of primary care services for patients with specific chronic conditions. Salaried general practitioners have also been employed in deprived areas where the national contract has failed to attract sufficient practitioners. The personal medical services approach, therefore, has enabled functionally separate parts of the English health care system, notably that of general practitioner services, to be integrated into a single managed care system.

## The development of primary care groups

Primary care groups were introduced in April 1999 following the White Paper, *The New NHS* [24]. Primary care groups represented a central component of the Labour Government's plans to move towards a

more collaborative and integrated system of care. In doing so, a basic feature of the English system—the separation between commissioning and providing services—was retained. The aim in introducing primary care groups was to build on the experience of previous initiatives that had involved primary care professionals in the process of shaping and negotiating local patterns of service provision. At the same time, primary care groups were designed to remedy what was perceived by the Labour Government as three principal drawbacks of previous commissioning models:

- fragmentation of decision making produced by the wide variety of different emerging commissioning organisations in the NHS;
- inequity between fundholding and non-fundholding practices, commonly referred to as ‘two-tierism’; and
- high transaction costs generated by a large number of local commissioning agencies.

In order to retain the advantages of devolved, primary care-led commissioning, while overcoming the drawbacks outlined above, primary care groups were to become far larger bodies involving *all* general practices in a determined geographical area. The groups varied in size and covered between 50,000 and 250,000 patients. Primary care groups would be responsible for commissioning a wider range of services than previous models. As a result, the 4,000 voluntary commissioning organisations that included the remnants of total purchasers and locality commissioners were replaced with a network of 481 primary care groups. Unlike previous groups that were voluntary, primary care groups required compulsory participation. One exception to this rule were the personal medical services pilots that were to continue to the end of their pilot period.

At the outset, the Government envisaged that it would take a decade for primary care groups to become fully mature [25]. The approach was evolutionary and primary care groups were free to start operating at a number of different levels (see box 1). Nevertheless, there was the clear expectation that primary care

groups would, over time, progress from advisory groups (level one) to primary care trusts (level four). Primary care trusts would take on responsibility for commissioning, purchasing *and also* the provision of community health services. From their inception, therefore, primary care groups implied both the long-term integration of primary and community care services and the end of self-governing community trusts.

Primary care groups are expected to undertake three principal functions on behalf of their local populations [26]:

- improve the health of the population and address health inequalities;
- develop primary and community health services; and
- commission a range of community and hospital services.

In order to achieve these objectives, primary care groups and trusts were tasked with overcoming historical fragmentations and differences in the provision of primary and community services locally. In addition, a key task was to make efficient use of their budgets and to address the health needs of their local population. By implication, therefore, the primary care group proposals instituted a process towards an integrated local health care system accountable to the people served and capable of delivering high quality care. Thus, the primary care group initiative in England represents a fundamental reform of the NHS with similarities to managed care organisations in North America and to the independent practice associations of New Zealand.

## The current progress of primary care groups in England

An immediate task facing all primary care groups on inception was to develop an effective organisation. This process included building an appropriate infrastructure including staff, premises and equipment, and developing corporate policy with respect to their core functions. The Government required primary care

### Box 1: Levels of primary care groups

<p><b>Level one – primary care group.</b> A group of general practitioners and community nurses acting as an advisory group to the health authority.</p> <p><b>Level two – primary care group.</b> A group of general practitioners and community nurses with devolved responsibility for the commissioning of approximately 90% of services for their population, acting as a subcommittee of the health authority.</p> <p><b>Level three – primary care trust.</b> A free-standing trust comprising general practitioners and community nurses, commissioning services for its local population, and accountable to the health authority.</p> <p><b>Level four – primary care trust.</b> A free-standing trust comprising of general practitioners and community nurses, commissioning services for its local population. Responsibility also for managing the provision of community services (such as district nursing and health visiting) and remaining accountable to the local health authority.</p>
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Source: [24].

groups to establish a formal governing Board. This Board comprised general practitioners, nurses, social services and lay representatives to be led by a locally appointed chief executive. It is not surprising, therefore, that the evaluations of primary care groups have shown that a great deal of time and energy has been required in the set up phases on internal organisational development. In particular, practical issues of management arrangements, funding support functions, and learning to work together as a corporate entity dominated activity [18, 27–30]. Taking time to establish organisational structures and processes before tackling service issues directly is a common theme in the early developments of previous primary care schemes. For example, in total purchasing, it was found that the larger multi-practice pilots needed up to two years to develop as organisations before making progress against service objectives in subsequent years [31]. In general practitioner-commissioning pilots it was also observed that the initial focus was on issues of structure and process [30]. Such pilots required time to determine arrangements for carrying out both strategic and operational work involving the development of complex organisations.

This propensity for organisational development prevented primary care groups from addressing their principle functions. Few had developed clear policies or strategies for implementation within the first few months [18]. As a result, few groups addressed the commissioning of care. Primary care groups reported most progress in developing primary care-based services, managing prescribing budgets, and establishing governing arrangements [17, 18].

More recently, primary care groups have made progress in demand management. For example, many primary care groups are now using scoring systems as a means of prioritising and managing referrals to secondary care. Intermediate care services are also being prioritised to help reduce admissions to hospitals and to facilitate early discharge. For example, and in partnership with social services, one particular group was able to establish a multi-disciplinary community support team to provide services to people within the community. As a result, admissions to hospitals reduced and discharges were more efficient [18].

Over the past few months, however, the transition to primary care trust status has become the dominant agenda item for most primary care groups. On the whole, this process has been to the detriment of developing health care services. Indeed, many primary care groups are still in essence 'developmental', wishing to focus on internal organisational development and the achievement of core primary care group

functions without the distraction of trust status [18]. However, there has been increasing dissatisfaction from Government at the progress of primary care groups. As a result, Government has driven forward the time-scale for transition to primary care trust status to 2004 at the latest [32]. Currently, 40 primary care trusts have been established and there are over 130 proposals out to consultation for primary care trusts in April 2001 [33].

A bi-product of this transition has been the reconfiguration of primary care group boundaries and a series of mergers. Mergers have been prolific because the functions of primary care trusts require a larger population base in order to consolidate management capacity and resources. Two-thirds of primary care groups are actively undergoing mergers at the present time. It is likely that primary care trusts will average over 200,000 patients compared to the average of 100,000 for primary care groups [17]. There is concern amongst many primary care groups about the rapid pace of change within primary care. Health authorities have also expressed concerns about the readiness of primary care groups to take on the additional responsibilities that trusts require [18]. A common conclusion from the evaluation studies [17, 18] is that primary care groups should be allowed more time to develop themselves as organisations and deliver tangible service changes before any move to primary care trust status. In particular, there is consensus that a greater number of more senior and experienced managers will be required within these organisations.

## **The impact of English primary care organisations on the integration of primary, community and secondary care services**

Working for Patients [4] created an internal market for care delivery through the introduction of the purchaser-provider split. It was argued that integrated approaches to care between health and social services might be encouraged in the internal market since. The logic of the market system allowed for new opportunities for purchasers to contract with a range of health and social care providers. However, the dominance of a competitive imperative rather than a collaborative imperative generally precluded integration. The need for organisations to control costs and protect budgets meant that there was a greater incentive to shift costs to other organisations rather than develop service systems collaboratively [34]. Thus, the development of integrated systems of care in England remained

limited to a few 'leading-edge' examples. These examples of integrated care were located where all agencies recognised that there was a local need for partnership to address areas of unmet need.

A key exception to this was the development of forms of integration established through the introduction of fundholding and subsequent primary care innovations. A common development has been the integration of primary and community care services in order to provide an extended range of care options to local patients. For example, under fundholding, the range of services available within a single primary care setting was often extended through the employ of service providers such as physiotherapists. In addition, fundholders were able to purchase sessions of care from hospitals to be provided within their surgeries. These ranged from eye care and minor surgery to counselling and dietetics [4].

Delegating hospital and community health services budgets to primary care organisations encouraged greater integration between primary, community and secondary care services. This process strengthened as the different forms of primary care organisation in England matured and grew larger. For example, many large total-purchasing pilots attempted to integrate primary and community health services by persuading community trusts to allocate designated community nurses to primary health care teams. Other pilots were able to negotiate new arrangements for team midwifery to ensure continued contact between general practitioners and midwives and between general practitioners and women [35]. Moreover, total-purchasing pilots also worked to integrate primary, community and secondary care services. The most common examples have been the development of alternatives to hospital-based care such as:

- the development of general practitioner beds in community hospitals or nursing homes;
- the employment of hospital discharge co-ordinators to speed discharge;
- the creation of multi-disciplinary elderly care teams with access to day care and respite facilities; and
- testing the provision in primary care of facilities formerly available only at hospital after a consultant referral [36].

Many of these techniques to developing services would be familiar in 'managed care' settings in other health systems [3]. Indeed, Myles et al. [37] identified a range of managed care techniques used by total purchasing pilots when developing community and continuing care services. For example, total purchasing pilots were using utilisation review of admissions, discharge planning, and performance management of

contracts. Whilst the performance of total purchasers was highly variable [19], many were able to demonstrate the advantages of a managed care approach to providing services for older people with complex needs.

Primary care groups were given core functions related to health improvement and developing primary and community health services. These functions implied that co-operation with partner agencies was a necessary requirement. To date, primary care groups have largely failed to establish strategies for achieving such partnerships [17]. Indeed, few had invested time or resources in developing relationships between primary, community and secondary care [18, 30].

Institutional and financial barriers to joint working have long hindered the integration of primary and community care in England. Despite poor progress to date, the establishment of primary care groups and trusts and the move towards unified budgets present longer-term opportunities to integrate service provision. They also provide the conditions for a comprehensive approach to the development of general practitioner services.

In contrast to primary care groups, about half of the personal medical services pilots had started to develop closer links with their community trust. The development of integrated nursing teams, in particular, was a common feature across these pilots [22]. Many individuals within primary care groups also realised the potential flexibilities that personal medical services offer, including the option of salaried general practice. As a consequence, the number of primary care groups and trusts opting to use these different contractual arrangements has been increasing over the last year. This is because personal medical services pilots offer the opportunity to develop stronger practice-to-primary care group accountability arrangements by bringing general practitioners directly accountable under a managed system [38].

## **The impact of primary care groups on the integration of health and social care services**

Problems associated with the functional separation of health and social care activities have been well known to policy makers in England for many years. Indeed, the search for more integrated ways of planning and delivering care services has been a recurring theme in successive government policy initiatives [39]. By the end of the 1980s there was considerable criticism of the slow progress and limited achievements of joint planning initiatives in delivering better and more inte-

grated care. Indeed, in the Griffiths report *Community Care: Agenda for Action* [40], attempts at integration between health and social care agencies in the 1970s and 1980s were criticised as ‘*the discredited refuge of imploring collaboration and exhorting action.*’ This statement reflected the lack of progress in turning the planning of integrated care into action.

More recently there have been some significant moves to creating new integrated organisations. This has been aided by the ability for organisations to apply for pooled budgets following the *Health Act 1999* [41]. For example, health and social care organisations were given the opportunity to pool budgets to create new joint commissioning organisations for particular services (in particular, for learning disability and mental health services). Plans were also developed for larger strategic and combined health and social care commissioning agencies. In terms of integrated provision, the *Somerset Partnership*, a combined NHS and Social Care Mental Health Trust initiated in 1998, is an example of one of the earliest integrations of trusts and social services into a single provider organisation [42].

To aid joint planning and provision, it was the intention that primary care groups be formed in the same geographical configuration as local authorities (although in practice most were not). Moreover, a local authority representative was a requirement on the governing boards of primary care groups. At present, however, primary care groups do not appear to have addressed the integrated care agenda as vigorously or as successfully as was hoped. According to Wilkin [43], most primary care groups have only just begun to develop closer links with local authorities. Very few groups have been looking to use pooled budgets to help integrate service provision. Boundary difficulties, in particular, remain a significant obstacle to joint working.

Nevertheless, social care services have been increasingly integrated into primary health care teams. This has been achieved through the development of initiatives such as attached community care co-ordinators and the development of multi-disciplinary teams to provide services to the frail elderly and mentally ill. As primary care trusts become the model of choice, they potentially represent an agency which will integrate health and social care as well as the commissioning and provision of community services.

Though the two agendas are related, the future of primary care through primary care trusts and the strategic integrated care agenda manifest in the *Health Act 1999* [41] appear to have developed as separate, rather than integrated, policy strands. As a

result, there is uncertainty as to the future role of some institutions. For example, whilst the *Health Act 1999* [41] envisaged a strong commissioning role for health authorities in partnership with local authorities, the development of primary care trusts suggests that this function might be devolved to these new primary care organisations. It is the fast pace of change which has led to a ‘compartmentalisation’ of approaches to partnership working. This has resulted in the creation of a range of disconnected innovations leading to significant geographical and administrative discontinuities. Ironically, the sheer volume of different innovations has the potential to create the same kinds of barriers to cross-agency working that integrated care policies sought to avoid. This process could be termed the ‘disintegrated integration syndrome.’

Within developments in primary care, the potential for such ‘disintegrated integration’ is no better expressed than through the development of personal medical services pilots. These pilots are not necessarily complimentary to primary care groups and trusts. Amongst the range of personal medical services pilots developed include groups of practices using the freedoms of the scheme to engender changes in practices and design new roles for general practitioners and nurses. Whilst personal medical services pilots have provided great scope for innovation in integrated care they appear also to be somewhat divorced from the clinical governance and corporate governance agendas of primary care groups.

Currently, contracts with personal medical services pilots have had little, if any, involvement from public health medicine. Contract monitoring mechanisms also remain loosely administered [22]. As a result, personal medical services pilots enjoy reduced bureaucracy, independence and the flexibility and freedom within their contracts to explore innovative ways of delivering care. Primary care groups, on the other hand, have been imposed organisations, have proven bureaucratic to set-up and have been tackling the need to develop as corporate bodies. For the future, it is likely that the different cultures and styles inherent to each approach may provide difficulties, even hostility, when creating primary care trusts that comprise personal medical services pilots within them.

## **Primary care trusts and the deinstitutionalisation of community hospital services**

The accelerated move to primary care trust status implies that these organisations will take over the provision of community health services currently pro-

vided by NHS trusts. This has led to concerns about their capacity to manage these services effectively and to avoid potentially destabilising effects on the local health economy. Many community trusts, which generally provide care for elderly patients (such as district nursing, health visiting, physiotherapy), regard the development of primary care trusts as a threat. This threat has begun to take shape as parts of their services are transferred to primary care trusts leaving them to manage the residue. The move to primary care trust status has meant that a growing activity has been negotiations between primary care and community trusts over the disaggregation of services that they provide.

According to Wilkin and Coleman [44], the most commonly expressed reason for seeking Trust status was the desire for independence, usually from the health authority. Although some mentioned service specific development initiatives, which would be facilitated by the trust, most expressed only a general interest in integrating service provision. The current focus has been to develop medical services rather than improving the health of the local population according to need.

Interestingly, in several cases, community hospitals have sought to become a variant within the personal medical services scheme. In one case, a community hospital employed part-time salaried general practitioners to perform personal medical services. In another pilot, a nurse was employed to lead the delivery of primary care services and is being supported by two part-time salaried general practitioners. Both of these pilots are located in deprived parts of London and are using the flexibilities of the personal medical services initiative to set up new services in 'under-doctored' areas [22]. Several community hospitals trusts have also agreed alliances with primary care practices in order to limit the potentially damaging consequences of deinstitutionalisation.

## The future of primary care organisations in England

In July 2000, the publication of the *NHS Plan for England* signalled a watershed in health and social care policy [45]. The Plan stated that 'fundamental reform' was required to make the NHS and social services work more effectively and create 'seamless', or more integrated, services tailored to patient needs [45]. In other words, it introduced a strong element of compulsion to the integrated care agenda that had previously not been present. The *Health Act 1999* [41] enabled health and social care services the opportunity to pool budgets and create integrated

providers. The Plan has made it clear that future integration will become compulsory. A 'new relationship' between health and social care is proposed requiring a 'radical redesign of the whole care system' [45].

The vision set out for integrated care included the delivery of social services in new settings such as primary care surgeries. It also suggested social care staff would be working alongside general practitioners as part of a 'single care network'. Moreover, the Plan envisaged the greater co-location of services to make easier the joint assessment of patients needs and the development of 'personal care plans'. Intermediate care facilities, such as the development of rapid response teams, intensive rehabilitation, one-stop services and home care teams, was to be given a particular boost. Social services who were able to demonstrate the achievement of intermediate care in partnership with the health service would receive financial incentive payments. The NHS Plan suggested that £50 million would be made available to social services from April 2002 rising to £100 million in 2003.

The most radical element of reform, however, was reserved for the Plan's vision of 'Care Trusts'. Care Trusts are single multi-purpose organisations designed to be responsible for the commissioning and provision of all local health and social care. Care Trusts will be created from the extension of primary care trusts, thus providing a new 'end point' in the direction of travel for both integrated care development and the progression of different forms of primary care organisation. In their development, the Plan provides for an element of choice and flexibility in their creation by stating that they are likely to be created in local areas where joint agreement for such a model is present. However, an element of compulsion for the long-term move to Care Trusts is also evident. The Plan states that where local health and social care organisations have failed to establish effective joint partnerships the Government 'will take powers' to establish integrated arrangements through the new Care Trust. It is likely that first Care Trusts will become operational as early as April 2002.

## Conclusion

The English experiment with differing primary care organisations over the past ten years has taken its health professionals on a rapid journey away from small general practitioner-led purchasing. Today, these professionals are working within larger organisations with greater responsibilities for health improvement and service integration. The medical profession is beginning to collaborate better between health and



social care. Existing primary care groups are but an intermediate step to the creation of primary care trusts. The eventual creation of Care Trusts has the potential for the long-term integration of primary, community and social care services in England.

The growing flexibilities for partnership working in England have been manifest in the breaking down of existing organisational barriers through the ability to merge budgets between health and social care agencies. New local contracts for primary and community health care provision via personal medical services have also contributed to the delivery of more integrated care. These developments are providing some of the mechanisms through which to address the current dysfunctional arrangements in the English health care system.

The Care Trust vision implies the development of new integrated care agencies in a style similar to those of managed care organisations in other countries (such as the United States). Many of the techniques that are likely to be used to develop services within Care Trusts are familiar to managed care settings in other

health systems. However, the pace of change must be of some concern to the effective management of the 'direction of travel'. For example, the *NHS Plan* [45] implies not only changes in organisational structures, but also changes to the traditional roles of staff and professionals. The medium term future is most likely to see a range of organisational approaches that attempt to integrate health authorities, primary care trusts, personal medical services, hospital trusts and social services. The longer term vision, the move towards fully integrated Care Trusts, means that the integration of health and social care systems will be a theme defining policy and development in England for the foreseeable future.

## Vitae

**Nick Goodwin** has been lecturer at the Health Services Management Centre, University of Birmingham, UK since 1998. His main research interests are integrated care and the development of primary care organisations. He has been a lead researcher within the Department of Health-funded evaluations of total purchasing pilots and primary care groups.

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