Primary Health Care Research and Development 2000; **1**: 133–134

Editorial

Personal Medical Services: accelerating the pace of change in primary health care

Personal Medical Services (PMS) are a central experiment explicitly designed to reshape the NHS. The Department of Health's brief to the five university-based teams undertaking the PMS evaluation described the basic purpose of the pilot schemes as 'to provide a sound evidence base for policy formulation and development' (NHS Executive, 1997). Whilst operational feasibility was the local focus, without question the chief client of PMS remains central government.

With each of the five research teams at Birmingham, Manchester, Nottingham and Southampton (plus ourselves) having now prepared their initial reports and shared their preliminary findings at the Department of Health, it is clearly the right time to take stock. What are the questions emerging that those responsible for policy formulation and development may need to address? And what, too, are the consequences for conventional general medical practice of a PMS initiative which has over 200 sites in its second wave and the realistic prospect of continuing to double in size annually as primary care groups and trusts eagerly assume responsibility for its delivery.

The multidisciplinary research team of which we are members is a collaborative venture between Queen Mary and Westfield College, University of London and the School of Social and Human Sciences at City University. Its responsibility is the evaluation of 41 first-wave PMS pilots set up to meet the primary care needs of vulnerable groups. These include homeless people, intravenous drug users, HIV-positive individuals, people from minority ethnic groups, refugees and mentally ill patients cared for in the community. The research teams are using a variety of methods, including information from a screening survey, key informant telephone interviews, geographical mapping and site visits to ascertain achievements and concerns, particularly in relation to models of NHS organization and care. Our preliminary findings accord with, for example, those of the King's Fund in London, where Stephen Gillam has argued that the second wave of PMS pilots should be nurtured rather than disturbed, and that as experimental examples they can help to develop cost-effective, responsive and accountable primary care, especially in areas of health need and poor service provision (Gillam, 1999).

Even at this early stage of the evaluations, such modest and even muted phrasing should not disguise the potentially major policy repercussions for the NHS. The questions raised by PMS could well be genuinely transformational in their answers. Within the confines of our own Steering Group three questions, in particular are now being posed.

Where should the organizational responsibilities for the local commissioning of primary care lie?

Early PMS sites report wide variations in performance by both health authorities and NHS community trusts. Basic lack of understanding and knowledge about General Medical Services and low-level management accountability for PMS in a number of these organizations have delayed implementation and hindered progress. The fragility of some health authorities has been especially apparent in the absence of viable financial frameworks and performance measures for PMS, and several of them had to rely on external consultancies to draft their PMS contracts. The policy issue of 'best value' commissioning raises the prospect not just of further deregulation and out-sourcing of this function as responsibilities transfer to primary care trusts, but also, more radically, of the opportunity for local authorities to become involved in the joint commissioning of primary care.

1463-4236(2000)PC018ED

Which agencies should be entitled to provide PMS services?

Under the terms of the 1997 NHS (Primary Care) Act the limits were set at the extended NHS family. However, it is already clear that the more innovative PMS pilots, with their nurse practitioners, service co-ordinators and care networks, are creating new personal and organizational roles which do not readily accord with the standard NHS framework of individual trusts and general practices. In many ways the service models appear to us to be more akin to those of independent sector charities, the commercial sector and professional agencies. With recent research on primary care groups highlighting their range of relationships and possible resources, and their already mixed organization status (Ashcroft and Meads, 2000), the advent of primary care trusts could be the appropriate time to widen eligibility for PMS provision.

Should PMS become the rule and not the exception?

The essential justification for PMS was that the pilots were required in special circumstances to meet special needs. They were the exception, and not the rule. Yet standard general practice remained the rule. Increasingly, however, our experience of PMS pilots suggests that this traditional thesis is vulnerable and may no longer be able to stand up to serious scrutiny. Many of the PMS schemes we are studying are showing signs of proving attractive (to anyone) in terms of their new services, improved teamwork, public health focus and relative cheapness – not to mention better GP recruitment and use of social and secondary care. Why should they not be open and available to everyone everywhere? This is a question that seems likely to loom larger as the PMS scheme expands.

Where, finally, does this leave general practice? The answer is in a real quandary. Its deep ambivalence about PMS is captured by two of its most prominent representatives at the Royal College of General Practitioners. Its President has argued that it is vital for GPs as a profession to continue to exercise their rights of self-determination, but also that general practice must recover its lost 'social dimension' in line with the PMS pilots (Pereira Gray and Evans, 1999). Dr Iona Heath has similarly welcomed the latter as a means of addressing local health inequalities, while at the same time warning that the salaried status of GPs could threaten their advocacy role in campaigning publicly about service under-provision, particularly in inner cities where the effects of socio-economic deprivation are greatest (Heath, 1997).

Heath pinpoints the latent threats to the cohesion and equity of a *national* health service posed by PMS. If local communities are to counter these threats through their real ownership of the new primary care initiatives, then consideration needs to be given to the radical policy developments required sooner rather than later. We find it encouraging that the 'modernization' of health and social care provides a sympathetic context in which such a reappraisal can be undertaken.

Yvonne Carter
Professor of General Practice and Primary Care,
Queen Mary and Westfield College,
University of London, London, UK

Geoff Meads
Professor of Health Services Development,
Health Management Group,
City University, London, UK

References

Ashcroft, **J.** and **Meads**, **G.** 2000: Organisation. In: *Relationships in the NHS. Bridging the gap*. London: RSM Press, 57–69.

Gillam, **S.** 1999: Does the new NHS need personal medical services pilots? *British Medical Journal* 319, 1302–3.

Heath, **I.** 1997: Distributing primary care fairly. Threat to social justice. *British Medical Journal* 314, 598–99.

NHS Executive 1997: *Personal medical services pilots under the NHS (Primary Care) Act 1997*. London: Department of Health.

Pereira Gray, **D.** and **Evans**, **P.H.** 1999: Three-dimensional care? *European Journal of General Practice* 5, 135–36.