Formal and Informal Systems of Primary Healthcare in an Integrated System:

Evidence from the United Kingdom

COMMENTARY

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LEATT, PINK AND GUERRIERE advocate creating integrated healthcare delivery systems in Canada, founded upon primary healthcare. They argue that integration involves organizational structures, financial incentives and information systems. They point to the need to focus on the types of integration occurring at different levels within a system of healthcare and the need to examine the performance of integrated health systems as a whole. Most importantly in assessing the strategies needed for moving ahead in Canada, Leatt et al. point to the need to pay greater attention to healthcare as experienced by individuals and their families.

In this commentary, we wish to

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expand on two themes that are currently important in a British context. The first theme is the nature of formally integrated primary care – the way in which integration has accelerated under recent healthcare reforms and the conditions that appear to facilitate or obstruct the integration of primary care services. The second theme, which conventionally receives little attention in the integrated care literature, is the nature and relevance of the informal sector as part of an integrated system of care, that is, how to integrate formal and informal systems of care. As evidence, we use published studies; a multiple-case study of the formation of Personal Medical Services projects and Primary Care Groups in the United Kingdom; a stratified random sample survey of 72 (15%) of 481 English Primary Care Groups; and an analysis of the first-wave Personal Medical Services contracts.

Primary Care Integration

In many respects Britain has one of the most integrated, and centralized, health systems in the world. Of the characteristics of an integrated delivery system listed in Figure 1, (page 19) of Leatt, Pink and Guerriere's paper, the British National Health Service (NHS) unequivocally has seven, another one in theory, and the remaining three are being introduced. In theory, it has competition even at the primary care level because patients can choose their general practitioner (GP). The British government is currently promoting the use of evidence-based medicine ("clinical governance"), including clinical guidelines and protocols. Legislative changes in 1997 and 1999 permitted GPs to negotiate

their own contracts with their local Health Authority instead of using the standard national contract. The new Personal Medical Services (PMS) contracts can accommodate incentive payments. A national information strategy is being implemented to improve providers' exchanges of information including, in future, standardized, nation-wide electronic patient records. Finally, virtual integration, in the form of promoting the networking of primary healthcare providers, is occurring through the formation of Primary Care Groups (PCGs) in each region. GP membership in PCGs is mandatory. U.K. experience thus appears relevant to other health systems interested in integrated delivery.

In some respects the British NHS has been what Leatt, Pink and Guerriere call "functionally integrated" since 1947. While all GPs are independent contractors (as in much of North America), their payment and terms of work are defined in a nationally uniform General Medical Services (GMS) contract. Similarly, in relation to "physician integration" credentialing for both hospital doctors and GPs is nationally uniform, as is their managerial role. Yet, despite this considerable degree of functional integration and the growing pressure to transfer healthcare from inpatient to community settings, NHS primary care has been far from integrated at the service delivery level. This experience corroborates Leatt, Pink and Guerriere's claim that integration at "corporate" and "functional" levels is one thing, integration at "clinical" and "physician" levels quite another.

Until the recent formation of Primary Care Groups, GPs have been almost completely detached from NHS

management, in contrast to their salaried, hospital-based counterparts. During our survey of Primary Care Groups, we learned that the majority of GPs, in the areas surveyed, tended to practise alone or in small groups. (A mean of 26% of practices were solo, while group practices had a mean of 3.2 doctors.) Some GPs employed their own practice nurses and, less often, other paramedical staff including psychological counsellors. Others were served by nurses and other paramedical staff employed by community health services (CHS) trusts and out-posted to general practices. CHS trusts provided a small proportion of domiciliary services independent of general practices and also managed small-scale community hospitals used by GPs in many areas (although many closed during the 1980s and 1990s). NHS dentists, pharmacists and opticians were organized independently. In deprived inner-city areas, hospital accident and emergency departments partly substituted for GP care of minor injuries and illnesses. One reason for this was that emergency departments offered greater accessibility for people living and working in or visiting the city centres. As well, standardized GP health authorities had removed many hospitals' financial ability to recruit GPs to areas where the quality of urban environment was poor, resulting in physician shortages there. Leatt, Pink and Guerriere's manifesto for integrated service delivery is thus relevant to English primary healthcare, too. However, since 1990 several new policies began accelerating the integration of English primary care delivery systems – one accidentally and two deliberately.

Fundholding: An Accidental Stimulus to Integration

The accidental stimulus to integration was GP fundholding, in which general physicians as gatekeepers to the healthcare system were given funding and management responsibility for a capitated patient population. Fundholding was introduced mainly for the purpose of reducing hospital costs and waiting times. Although GPs volunteered for fundholding, it was implemented with the usual high degree of functional integration in NHS corporate matters – national rules stipulated criteria for becoming a fundholding GP, and how the funds might be used. For example, the rules forbade GPs from converting any unspent funds into personal income, and created the "one-way valve" – fundholding GPs could transfer savings on hospital referral costs into primary care, but not vice-versa. In fact, 60% of fundholders used fund savings to upgrade practice premises that they personally owned and would sell on leaving practice (Audit Commission 1995). The next most common use was to develop primary care services, most often by setting up practice-based counselling services and by strengthening their nursing or physiotherapy support. In a few cases, fundholders set up outreach outpatient clinics staffed by hospital specialists.

Fundholding also gave hospitals hoping to attract extra income an incentive for routine negotiations with fundholders (promoting vertical virtual integration). The same desire to negotiate with GPs for a portion of funds applied to community health service providers (promoting horizontal virtual integration). In many parts of England, fundholding general

practices pooled their funds as "multifunds" to reduce the management costs of fundholding and to increase their bargaining power with community health service and hospital trusts. This approach became officially recognized when an experimental set of Total Purchasing Pilot Projects extended the scope of fundholding from non-urgent hospital and CHS cases (excluding, for instance, maternity and mental healthcare) to all services. In some districts, Health Authorities that wished to forestall the spread of fundholding (because it diminished their budgets and influence) and GPs with political objections to fundholding constructed local commissioning groups, under which the Health Authority either consulted groups of GPs about how to spend hospital and CHS budgets, or practically delegated control of these budgets to specific groups of GPs (Boswell and Girling 1993).

Personal Medical Services, Primary Care Groups and Primary Care Trusts: Deliberate Stimuli to Integration

A more deliberate attempt to integrate service delivery in NHS primary care services came with three innovations in the National Health Service (Primary Care) Act of 1997. It permits:

1. GPs to work as the salaried employees, either of NHS trusts or of general practices. This ends the monopoly of the independent-contractor model of organization.
2. General practices to make specific Personal Medical Services (PMS) contracts with their local Health Authority instead of using the broad national contract. Provided the range and quality of services that the general practice gives are no less than before, the two parties may formulate their PMS contract as they wish.
3. Health Authorities to make contracts with primary healthcare providers other than general medical practitioners. This ends the general medical practitioners' monopoly by permitting nurse practitioners to provide primary medical care.

In 1998, 81 Primary Care Group pilot projects were initiated, and at least that many more will follow by Autumn 2000. Again, GP participation is voluntary. In the first wave of projects, 49% used the NHS (Primary Care) Act essentially to reformulate their contract with the NHS in a simpler, more flexible way. However, 51% of the pilot projects were "PMS-plus" projects (Jenkins 1999), which extended existing general practice services by adding services previously provided by separate CHS trusts, or by introducing new services for undeserved populations (e.g., homeless people, refugees, students). At least two projects consisted of extensive networks with a central coordinating body – ensuring horizontal and clinical integration of general practices with community health services, social services (which in England are provided by local government), voluntary organizations and (in one case) an urban redevelopment project. In three other projects, nurse practitioners, wholly or partly, replaced medical GP contractors. There it was necessary to ensure that the nurse practitioners could refer patients to a doctor as necessary.

The Labour government faced a dilemma in dealing with fundholding. Publicly, the Labour government had opposed GP fundholding; however, when it came to power 1997 about half of all English GPs were fundholders. As well, fundholding appeared to have assisted with both the horizontal integration of primary care and, to GPs' advantage, vertical integration with secondary care (Glennister et al. 1994).

Labour's policy solution was to create Primary Care Groups (PCGs) for every population of (typically) 100,000. Every GP in the territory is a member. PCGs took over fundholders' funds from April 1999, and are more gradually taking over most of the Health Authorities' budgets for NHS hospital and community health services. Eventually PCGs will convert into independent Primary Care Trusts (PCTs) which will have additional responsibility for contracting and providing primary health services. In particular, the 1999 Health Act enables them, instead of the Health Authority, to make contracts with local GPs.

The new Primary Care Groups are GP dominated. Both the chair and a majority of board members are GPs. These boards will become the Management Executive (committees) when the PCG converts to a PCT. A critical function of PCGs (and PCTs) is the "clinical governance" of GPs – that is, the group monitors the quality of GPs' clinical work, devises and implements clinical protocols and guidelines and is responsible for the concomitant professional development (Department of Health 1997).

If they materialize as planned, PCTs will be able to do much to integrate NHS primary care delivery systems. Insofar as they succeed in influencing GPs' clinical and referral behaviours, PCTs will be in a position to horizontally integrate the main sources of NHS primary care: the GPs and CHS services. New NHS providers such as walk-in clinics and NHS Direct (a help-line operated by nurse practitioners) are also being added. The PCG will also play a role in vertically integrating these with general practice. Nearly all this will be "virtual" integration of the kind Leatt, Pink and Guerriere favour, because the majority of GPs will remain independent practitioners for the foreseeable future.

The process of forming PCGs and PMS pilots is also relevant to health systems outside the United Kingdom. The studies mentioned above indicate that informal relationships among GPs, and between GPs and others, are an important aid – or obstacle – to horizontal integration. For example, the British Medical Association (BMA) played a significant role in acceptance of Primary Care Groups both nationally and through Local Medical Committees (LMCs). When PCG formation was originally announced, BMA leaders appeared relatively willing to collaborate with government, notwithstanding elements of the GP press that argued PCGs and PMS projects threatened GPs' independent contractor status (e.g. Reggler 1998; Marval 1999). Asthe 1998 BMA conference approached, a strong current of GP opposition to PCGs became evident. As a result, the BMA leadership hardened its position, and the government conceded a guarantee that all GPs who wished to could remain independent practitioners. The government also

conceded a GP majority and GP chairmanship of PCG boards. Many local medical committees organized the election of GP members to PCG boards in many locales, arranging candidatures and divisions of board seats behind the scenes so that in some cases the election was a foregone conclusion.

At a local level, GP "entrepreneurs" (cp. Hanlon 1998) have also played an important part in the formation of PCGs, because they are often able to communicate with and recruit other GPs who would have been more skeptical and resistant to NHS management approaches. Yet, by the same token, their role has raised obstacles to integration in some regions where past instances of "entrepreneurship" had divided GPs. In particular, the division between fundholders and non-fundholders, and the ensuing discussions over how to redistribute the extra resources that many fundholders had accumulated, proved a point of tension. In some places, groups of GPs attempted to form PCGs separate from those controlled (they feared) by colleagues with whom they had past or present disagreements, only to be overruled in most cases by the Health Authority or the regional office of the NHS Executive (the management tier above Health Authorities). One consequence of these informal processes has been, in a few areas, early signs of a possible GP "restratification"; a process also reported in Canada as doctors have become increasingly drawn into health service management (Coburn, Rappolt and Bourgeault 1997). Whatever effect restratification may have on the power of the medical profession (opinions differ), from PCG managers' viewpoint

the process would have the advantage of creating a layer of medical managers who would horizontally integrate general practice and other primary care services at the local level. This tends to corroborate Leatt, Pink and Guerriere's views.

Some of the larger PMS projects and, before them, multifunds, were formed by consolidating existing informal networks and links that GPs and others had already formed for the purpose of solving a common problem (e.g., opposing hospital closures, reducing administrative costs, improving coordination between different primary care and related services). As though repeating such a process, many PCGs in our survey reported "simply getting people to collaborate" (or words to that effect) as a main achievement during their first year. Conversely, where certain GPs informally opposed the creation of a particular PCG or PMS project, it was often because they feared losing either influence or patients (and therefore income, under a capitation scheme) to alternative providers such as nurse practitioners or CHS trusts. While British experience illustrates, as Leatt, Pink and Guerriere mention, the importance of aligning financial incentives in securing collaboration, it also shows other motives at work. For instance, collaboration is fostered when primary healthcare organizations cooperate to solve problems in service provision; and by developing projects and services for which health workers have a personal enthusiasm and which will raise the technical level of their clinical practice (e.g., by protocol development). These experiences also seem to suggest that one strategy for achieving integration, whether horizontal or vertical,

physician or clinical, is by creating ad hoc informal working relationships to tackle specific tasks, including what Leatt, Pink and Guerriere call clinical integration at patient level, and then gradually consolidate and formalize these relationships over time.

The Role of Local Communities, Laypersons and Users of Services in Integrated Care

Leatt, Pink and Guerriere argue – and the present authors agree – that the justification for integrated delivery systems is to meet patients' needs rather than providers'. Unfortunately, it is too early to draw conclusions about what impact greater integration is having on clinical quality in British primary healthcare. Neither is it yet known what impact the more integrated service delivery is having on patient choice of provider. In principle, NHS patients have the choice of any GP willing to sign them onto his or her list. But having found a GP, patients rarely exercise their choice so as to reward or penalize levels of service quality. On average, only about 12% of patients change their GP each year, the majority because they have changed address or their doctor has moved or retired. Only about 11% are prepared even to contemplate changing their GP in other circumstances (Corney 1999). The GPs also attempt to minimize "poaching." As an innovation, PCG boards all include at least one lay member, as did a handful of PMS project management committees. However, our survey found that these members have less influence on PCG board decisions than managers or GPs.

Recognizing and maximizing the potential of users and local communities as co-producers and providers of healthcare is also relevant to providing integrated care that crosses the formal-informal healthcare divide. As with the involvement of the lay member on PCG boards, at present there are signs that involvement of the informal sector is lagging behind the forging of partnerships between state-run health and welfare agencies. For example, in our survey mental health was found to be an area where partnerships with those with formal responsibility for community and social care agencies are emerging, but this is not mirrored in relationships or involvement with user and voluntary organizations outside the statutory sector. So there is little sign, at this early stage, that more integrated service delivery has done much in practice to increase user influence over the management of primary care services.

Nonetheless, outside PCG boards numerous initiatives are being set up in the United Kingdom and elsewhere to improve the health of people living in an area by engaging with users and community resources. In the United Kingdom this is the focus of initiatives such as Healthy Living Centres that form the basis of strategic thinking in localities, articulated in "Health Improvement Programs" (HImPs). These initiatives regard primary care services as a broader public health resource besides a means of simply providing treatment to individuals. A recent evaluation study of a PMS nurse-led project in the deprived inner-city area of Salford (in northwest England) suggests that local people perceived the service as providing a stable source of social support in an area where

other sources of "social capital" and long-standing social networks were being eroded (Chapple et al. 2000). After May 1997, the Labour government greatly expanded area-based initiatives aimed at regenerating deprived communities. Health Action Zones form part of this agenda, and many regions are looking at implementing models of care that seek to integrate community development-type projects involving laypersons as volunteers within a broader system of health and social care resources. The Manchester Salford and Trafford Health Action Zones, for example, are introducing a primary care physician can scheme based within hospital accident and emergency departments. This scheme is designed to deal with people's problems in a way that goes beyond addressing the presenting complaint, through outreach work by GPs seeking to mobilize relevant resources and networks in the local community and health agencies.

The Relevance of an In-Depth Understanding of the Use of Services

No theory of integrated care would be complete without understanding the way in which patients move within and between different health and social care agencies. The complexity of patient action is often not considered by those concerned with designing the configuration of services. There is evidence that care pathways are not unilinear and may be highly individualized. Individuals, particularly those with a chronic illness, may move between several different forms of community and institutional care in the course of their illness. Formal system integration and patient experience do not

necessarily coincide. Patient experience often belies the assumption that formal healthcare delivery services are integrated. This is exemplified in a study of psychiatric patients receiving care from a number of different sectors – the voluntary sector, hospital and community support (Spicker et al. 1995). While a relatively coherent picture of formal care pathways could be established from documentary evidence, the researchers found that this was not reflected at the level of patients' experience. Informants did not conceive of their treatment in a coherent, linear way. They perceived a variety of institutional and community services contacts, fragmentation in receiving treatment and in the lengths of time they had experienced both symptoms and care. These perceptions gave them little sense of the progression or purpose associated with an integrated pathway. Instead, informants typically experienced an apparently aimless movement between services and felt they had little control over care decisions. When we turn to explore the nature of the patterns and processes of utilization, further discrepancies emerge between the way in which services are delivered and the way in which patients act. These aspects are often masked in large-scale, correlational, quantitative surveys of healthcare utilization (Pescoslido 1992). Qualitative research has been more illuminating about referral, access and help-seeking. The experience of patients is important in judging the nature and extent of care that needs to be integrated in order to meet patients' needs appropriately.

Various studies have illustrated the importance of the timing between the onset of problems and consultation in

decisions to seek care. They have also illustrated the importance of the extent to which people are able to contain and cope with signs and symptoms within socially defined situations and contexts; and the multiple possibilities in the decision-making process (e.g., Zola 1973; Alonzo 1980; Cunningham-Burley and Irvine 1991). The relationship between everyday events (activities and work) and the role of individuals' social networks likewise influence their decisions to seek care. A recent study of the use of primary care illuminated the way in which the past experience of health illness and service contact coalesced with people's more immediate social and domestic context in influencing their decisions to contact health services. A variegated relationship between need and use was found for those with long-term health needs. Those with ostensibly high needs might avoid service contact, preferring to accommo-date symptoms in a different way if they had used services for a long time and found that they had little further impact on relieving pain or managing disability (Rogers et al. 1998). Understanding the way in which people use services is a necessary precursor to delivering a system of integrated care. The role of self-care as part of integrated care is also important.

Self-Care:
A Hidden System of Care

Informal care and self-care are an important but often hidden aspect of the supply of healthcare. Ordinary people as providers of care have experience in caring for themselves and others. They regularly provide advice about and take responsibility for matters of health and illness. Self-care can act as both an

alternative and a supplement to formally provided care. This is clearly indicated in a recent survey undertaken at NPCRDC (Rogers and Nicolaas 1998). A four-week health diary was completed by 518 individuals. Half of these individuals had experienced one or more illness episodes, ranging from minor ailments to more serious conditions. Two hundred and fifty people experienced a total of more than 500 illness episodes within the four-week period. Just over 110 of these episodes resulted in contact with formal healthcare services. About 70% of all illness episodes involved some form of self-care activities. Self-care only activities were reported for 54% of illness episodes. Both self-care activities and professional healthcare were reported for 17% of illness episodes.

The amount of self-care undertaken is likely to have increased in recent years. In one area of self-care, self-medication, U.K. sales of non-prescribed, over-the-counter medications in the 1990s were equivalent to one-third of the NHS drug bill. They were used to treat one in four symptoms. Homeopathic and herbal preparations are an increasing source of self-medication for both acute and chronic conditions. The International deregulatory trend towards reclassifying prescription-only as over-the-counter medicines has increased the potential for lay choice in symptom treatment. The amount and nature of self-management undertaken is intrinsically bound up with what is provided and used by people from the formal care sector.

The familiarity of symptoms, familial and personal history of illness and experience of identifying and managing illness all form a backdrop to lay action. Additionally, assessments of what can and

what cannot be done about a problem are based on people's prior service contacts. Patients learn over time how to fit into what health professionals require of them. They get a sense of what doctors consider legitimate illnesses and the way in which health professionals respond to illness. This feeds back and coalesces with knowledge derived from other lay and folk sources and influences how illnesses are subsequently perceived and managed. The combination of personal knowledge and the way in which care is made available can limit or expand the control people have over their ability to self-manage and their engagement with formal healthcare services. For example, good evidence exists that prescribing antibiotics for sore throats does little to alleviate symptoms, but does enhance belief in the efficacy of antibiotics and makes patients more likely to consult again (Little et al. 1997).

Patient-Led Health Services? Integrating Services at the Interface between Lay and Formal Care

There are persuasive arguments for ensuring that formal care systems integrate with both the experience of patients and the care that people provide for themselves. A truly integrated model of healthcare needs to respond to the actual types of self-care undertaken by people prior to and in addition to contacting services; and to the reasons for and ways in which people actually access formal healthcare. This requires recognition that within the lay arena, responses to illness are in constant flux and vary according to both changes in a condition and everyday contingencies.

The responses reflect both the ways in which people assess their health situations and the resources available to them at the time to manage illness. There are emerging examples in the United Kingdom of how a formal system of care can interface and provide a link with lay systems of care and help-seeking. The first is through promoting graduated access from informal to formal healthcare. An example of a service that attempts to map on closely to patient experience is the newly established NHS Direct, a nurse-led telephone help-line that was launched in the United Kingdom in three pilot sites in 1998 and is being rapidly extended nationally. (Similar schemes have been used in Denmark, Sweden and some American HMOs.) Though full evaluation is awaited of the British system, there are indications of high rates of satisfaction among callers. There is also evidence that this service provides a contact with the NHS that includes the option of integrating patients' own actions by reinforcing self-care activities, by providing reassurance and advice and offering supplementary advice on alternative sources of information or help (Munro et al. 1998).

Other services introduced under the "modernizing the NHS" policy are similarly designed to open up access to previously restricted knowledge and primary care. These include NHS Direct On-Line (a version of the triage system available through the Internet), walk-in centres and a wider role for community pharmacies in dealing with minor ailments. These services provide additional points of access, which in theory coalesce more closely with patient decision-making. Much more than

this could, of course, be done to provide resources, infrastructure and legitimation for the development of mutual support and self-help groups. That would require a change in ethos among healthcare professionals and commissioners of services too, which is not easily achieved. There has been resistance among some GPs to the introduction of the NHS Direct, which they perceive as threatening their traditional autonomy and gatekeeping powers.

Professionals are also likely to have low levels of understanding of the expertise that patients have in managing their own illnesses (including accessing a range of traditional and alternative healing practices). Thus, knowledge flows and changing behaviour among professionals are likely to be as relevant and important as providing more comprehensive and empowering information to laypersons. Integrating systems of care may also require planning and redirection of some resources. It may mean, for example, that buildings and space used by general practices should be made available to community groups and others (e.g., voluntary groups) wishing to set up mutual support groups. Mixed models of care might also form part of official strategies for the commissioning and providing of healthcare. NPCRDC is, for example, currently involved in setting up and evaluating an Internet clinic based in an inner-city practice and aimed at providing Internet access for people who currently do not have it. The service is designed to act as both an alternative and a supplement to consultations with primary care professionals.

Conclusions

It is clear from Leatt, Pink and Guerriere's paper that as a solution to many of the problems that bedevil national health systems, integrated delivery systems should be met with both enthusiasm and caution. In the United Kingdom there is evidence of a high degree of functional integration. However, physician and clinical integration is far from complete. Informal mechanisms for integration among healthcare professionals are likely to be as important as formal structures and organizations designed to promote greater system integration. It is important that formal systems of care, however integrated, do not function as "black boxes." This will necessitate that the formal primary care system take greater steps towards acknowledging and involving the informal system of lay primary care in order to provide a truly integrated and accessible system that is able to meet the diversity and complexity of people's needs and demands for healthcare.

References

Audit Commission. 1995. Briefing on GP Fundholding. London: HMSO.

Alonzo, A. 1980. "The Mobile Coronary Care Unit and the Decision to Seek Medical Care during Acute Episodes of Coronary Artery Disease." *Medical Care* 18: 297-318.

Boswell, C. and J. Girling. 1993. Locality Based Practice Sensitive Purchasing. The Worth Valley Health Consortium.

Chapple, A., A. Rogers, W. Macdonald and M. Sergison. 2000. "Patients' Perceptions of Changing Professional Boundaries and the Future of 'Nurse-led' Services." *Primary Health Care Research and Development* 1:51-9.

Coburn, D., S. Rappolt and I. Bourgeault. 1997. "Decline vs. Retention of Medical Power through Restratification: An Examination of the Ontario Case." *Sociology of Health and Illness* xix (1):1-22.

Corney, R. 1999. "Changes in Patient Satisfaction and Primary and Secondary Care: The Effect of General Practice Fundholding." *British Journal of General Practice* 49: 27-30.

Cunningham, Burley S., and S. Irvine. 1987. " 'And Have You Done Anything So Far?' An Examination of Lay Treatment of Children's Symptoms." *British Medical Journal* 295: 700-2.

Department of Health. 1997. *The New NHS: Modern, Dependable.* London: HMSO.

Glennister, H, P. Matsanganis, P. Owens and S. Hancock. 1994. "GP Fundholding: Wild Card or Winning Hand?" In R. Robinson and J. Le Grand eds. *Evaluating the NHS Reforms.* Newbury: Policy Journals.

Hanlon, G. 1998. "Professionalism as Enterprise." *Sociology* 22: 43-63.

Jenkins, L. 1999. "Personal Medical Services Pilots – New Opportunities" in R. Lewis and S.Gillam eds. *Transforming Primary Care. Personal Medical Services in the New NHS.* London: Kings Fund.

Little P., G. Williamson, G. Warner, C. Could, M.Gantlet and A.L. Kinnmouth. 1997. "Open Randomised Trial of Prescribing Strategies in Managing Sore Throat." *British Medical Journal* (March) 314.

Marval, M. 1999. "Why Becoming a Primary Care Trust Has Many Pitfalls." *General Practitioner* (April).

Munro, J., J. Nicholl, A. O'Cathain and E. Knowles.1998. *Evaluation of NHS Direct First Wave Sites. First Interim Report to the Department of Health.* Sheffield: Medical Care Research Unit, University of Sheffield.

"Personal Medical Services Pilots - New Opportunities." In R. Lewis and S. Gillam, eds. *Transforming Primary Care*. London: Kings Fund.

Pescolido, B.A. 1992. "Beyond Rational Choice: The Social Dynamics of How People Seek Help." *American Journal of Sociology* 97(4): 1096-138

Reggler, J. 1998. "My Point by Point Rejection of the Deal." *Pulse*. (June).

Rogers, A., K. Hassell and G. Nicolaas. 1998. *Demanding Patients? Analysing the Use of Primary Care.* Open University Press.

Rogers, A. and G. Nicolaas. 1998. "Understanding the Patterns and Processes of Primary Care Use: A Combined Qualitative and Quantitative Approach." Sociological Research on Line 3, 4, http://www.socresonline.org.uk/socresoon-line/3/4/5.html

Spicker , P., I. Anderson, R. Freeman and R. McGilp. 1995. "Pathways through Psychiatric Care: The Experience of Psychiatric Patients." *Health and Social Care in the Community*. 3(6): 343-52

Zola, I. 1973. "Pathways to the Doctor: From Person to Patient Social." *Science and Medicine* 7: 77-89.