two clusters (British medical school and data containing publication) were not independent of each other. This provides at least some reassurance (particularly in the light of the recent concern expressed by Mbubaegbu (1992)) that purely ethnic bias was not responsible for our findings.

We were surprised to find so few demographic differences between SR and REG applicants, although predictable differences in academic achievements were present. In particular, REG applicants were hardly younger than SR applicants. This may reflect a subgroup of relatively old and unsuccessful REG applicants, since age was associated with non-appointment to REG posts. Indeed younger age was significantly associated with most of the other predictors of REG success (single status, British undergraduate education and not having spent more than a year out of psychiatry). It was reassuring that, even at REG level, an academic achievement (having a first degree) was positively associated with appointment.

Our results are based on a relatively small sample, and we may be accused of not achieving full independence in analysis since we were involved in the appointment process. What career advice, with these provisos, do our findings enable us to offer aspiring psychiatrists? We are reluctant to suggest recourse to celibacy or name change by deed poll. Trainees do, however, appear well advised to publish (preferably with data) or be damned, and to start young. Members of appointments committees should also become still more aware of their commitment to equal opportunities and their vulnerability to prejudice.

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Trainees' forum

Psychiatry and the new NHS

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The NHS and Community Care Act 1990 has been described as the biggest shake-up to the NHS since its inception. Most psychiatrists will by now be familiar with the new arrangements for community care, but what are the implications of the structural changes in the NHS for psychiatry?

Separation of purchaser and provider

One of the key changes has been to separate the task of providing care from that of commissioning or purchasing care. The composition of each side of this organisational divide, and the balance of power between the two is as yet unclear, but ground rules are beginning to emerge.

(a) Purchasing authorities

The broad remit of purchasing authorities is to assess the health needs of their resident populations, using a variety of epidemiological and survey methods, and to purchase services accordingly.

Although there has been some delay in implementation, it is intended that the resources made available to purchasers will be allocated according to the structure and needs of the population in question. This represents a significant shift from the existing pattern of funding based on previous activity levels.

The organisations most clearly identified with the purchasing function so far have been the District Health Authorities. The exact composition of their purchasing teams varies but will usually include a

strong influence from the Public Health Medicine Department, plus planning, finance, health economist, and management input. For purchasing purposes some DHAs have merged with local Family Health Service Authorities (the old Family Practitioner Committees) while others actively seek input from local GPs. In future local authorities may be involved in collaborative ventures.

These organisational changes present psychiatrists with a rare opportunity to redress what they have traditionally viewed as inequalities in provision in favour of acute high-tech medicine. If mental illness services can demonstrate significant unmet need in the community, then, in theory, purchasers can redistribute finances accordingly. Existing detailed research in this field (Goldberg & Huxley, 1980) means that psychiatry is well placed to estimate community levels of mental illness, and in this respect is well ahead of most specialties.

The other side of the coin is that purchasing authorities and providers of care may have different agendas for mental illness services, a situation which is most likely to occur where purchasers consider existing service provision to be reactionary or unduly hospital based. In this situation it is vital that purchasers and providers work together, sharing their expertise in planning services; as Reed (1991) pointed out in his paper on the future of psychiatry, public health doctors are aware of "a great need for good quality advice on mental health matters". In a paper originally presented to their District Health Authority, Goldberg & Gater (1991) provided a useful example of the type of information which purchasers require. The authors reported for their district the number of mentally ill people recognised by GPs, referred on to the mental illness services and admitted to hospital within a one year period. They went on to describe the change in workload seen with the creation of an experimental community mental health team and the resource implications of expanding such a service to the whole district, should the purchasing board of the DHA chose to do so.

With the move toward care in the community, option appraisals of this kind are essential. Breakdown in communication between purchasers and providers will result, at best, in retention of the status quo, with its inherent bias towards more glamorous specialties, or, at worst, in purchasers seeking either to develop services which psychiatrists consider inappropriate or to purchase services elsewhere.

GP fundholding

GPs deal with around 95% of all psychological problems known to health services (Goldberg & Huxley, 1980) and as such are the main potential "purchasers" of specialist mental illness services.

At present GP fundholders are able to purchase only a limited range of services, but from April 1993 non in-patient mental illness services will be included in their budget. Increasingly GP fundholders are questioning the value of traditional psychiatric out-patient appointments and, given the opportunity to fund their own psychology or community nursing services, may refer fewer patients to hospital. While this may be beneficial for some patients, there is a significant risk of inadequate treatment and an increased burden for carers. Specialist services could be reduced to caring for only the most chronically ill or disturbed patients. Fundholding GPs will also have the opportunity to refer patients to the mental illness service of their choice; where fundholders prefer to use the services of other districts, a direct reduction in budget for the local service will result. The effect of any such changes in referral patterns must be closely monitored.

Despite the move towards more community based psychiatric facilities, and several innovative schemes in primary care, little attention has been paid to the views of GPs on the provision of mental illness services. In a postal survey of 46 GPs, all of whom responded, Stansfeld (1991) found that the majority of GPs questioned wanted closer liaison with psychiatrists about out-patients but views on psychiatrists actually carrying out clinics in general practice were mixed.

Whatever the future of fundholding, primary care teams are becoming increasingly influential in the purchasing process. Psychiatrists would do well to actively seek the views of GPs on mental illness services and take full account of such information in the planning process.

(b) Providing care

The original 1987 review of the NHS was prompted by concern about levels of funding. Since the resulting reorganisation did not address these concerns, financial constraints on the service are likely to continue, whether providers are in a self governing trust or a directly managed unit. It remains to be seen whether contracts for specific services will prevent the financial difficulties of one directorate being passed on to others.

Self governing trusts

Self governing trusts are likely to be preoccupied with issues of efficiency and quality of services; psychiatrists will need to be clear about what they provide, why and how. These questions present a significant challenge but need not be seen as a threat. More worrying, if the market concept is extended, is the prospect that trusts may chose not to provide a service, or parts of a service, through financial considerations. The original White Paper (*Working for*

Patients) incorporated the concept of core services to be provided by each district regardless of the status of its hospitals. In recent political debate this concept appears to have dropped from view.

The separation of community and hospital trusts, as is happening in some districts, causes particular difficulties for psychiatry. However, where the whole mental illness directorate is incorporated within a community trust there may be advantages, particularly in relation to the autonomy of the service (Dick, 1991).

Trusts also have the power to negotiate their own terms and conditions of service with staff. Again the full implications of this have yet to emerge, but in principle where posts are sometimes difficult to fill, as for example in old age psychiatry, financial incentives could be applied. Conversely, posts in psychiatry may be viewed by trust managers as more expendable than consultant posts in other specialties.

The internal market

At present all service agreements between purchasers and providers are based on block contracts reflecting previous patterns of delivery, and health authorities have been encouraged to maintain a "steady state".

If and when money truly follows the patient, "successful" services should benefit. In the case of psychiatry, with its long-term patients and sometimes poor outcomes, "success" is likely to be defined more in terms of structure and process than true outcome. More debate is needed on the most appropriate measures of success, since these criteria will increasingly be used to justify decisions on purchasing services. In this as in other respects the workings of the internal market are difficult to apply to psychiatry. If hospital and community services are split into separate trusts, how will a "seamless service" be maintained? And how could a service in another district provide hospital care carefully coordinated with local authority and community services in a patient's own district? If competition between services does develop, it is difficult to see how this can result in anything but fragmentation of care for patients.

A further complication for mental illness services is the use of a patient's home address to decide which district should be charged for providing care. Particularly in inner city areas a large proportion of psychiatric patients have drifted from one area to another and have no fixed address (Fisher *et al*, 1991). These patients already experience difficulties registering with GPs and may in the future find health authorities unwilling to authorise hospital treatment.

The return of a Conservative government means that, like it or not, the NHS reforms are here to stay. While they undoubtedly present many difficulties for psychiatry, there are also new opportunities for the specialty to demonstrate its worth and in doing so argue for more resources. Standing on the side lines is no longer an option.

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