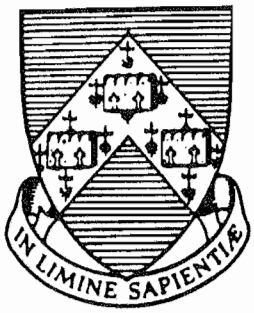

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Family Practitioner Committees and their Customers

by

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and
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March 1989

DISCUSSION PAPER 55

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ABSTRACT

This paper illustrates some of the ways in which the Family Practitioner Committees will have to change in order to bring about their transformation from the 'passive paying agency' into the 'active manager of customer interests' when the proposals from the recent White Paper, 'Working for Patients', become law.

We were asked to examine what was happening in the area of 'consumer relations' within the National Health Service by the Department of Health. Part of this work has involved our surveying all the Family Practitioner Committees in England and Wales. This paper present the results of our survey, examining some of the pioneering work carried out by a handful of FPCs to enhance consumer relations and highlighting the enormous amount of work that has yet to be done to ensure that providers and financiers really know what customers want from their local Health Service.

All 98 FPCs were written to for information about customer relations' initiatives and 60 replies were received. Of these only nine FPCs had carried out work in the area of customer relations, ten planned to do so and one had work in progress. The number of active FPCs varied notably by region, there was evidence of more work being done in the northern half of the country than in the south.

The responses indicated that very little work was being undertaken to test the quality of the service provided by contractors (e.g. GPs) to FPCs. Most of the work was either a public relations exercise or surveys of accessibility. The results appeared to have little or no impact upon the policy of the FPCs. If FPCs are to become active managers of primary care services, radical changes in their practices with regard to customer relations are essential and long overdue.

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I INTRODUCTION

The NHS has over 50 million customers, but until recently little attention has been paid to customer relations. In 1983, the Griffiths Report [1] recommended that the new general managers of the District Health Authorities should do so, but there were no specific proposals in the area of primary care. However, when the Family Practitioner Committees (FPCs) became independent health authorities on 1 April 1985 their remit included the now familiar clause "to be more responsive to public demands". The same point was made in the 1987 White Paper, on "Primary Health Care: An Agenda for Discussion".

> "The Government wants the public to be able to make an informed choice of good quality services which are sensitive and responsive to the needs of the patients, and to get better value for the large amounts of taxpayer's money invested in primary care. [2]

Since the Griffiths Report there has been a substantial increase in DHA activities: some have conducted consumer surveys; others have introduced programmes to improve customer relations. Their efforts have been reviewed in Carr-Hill, McIver and Dixon [3], on the basis of a postal survey of all District Health Authorities, supplemented by personal interviews with 42 of them.

The object of this paper is to report on a preliminary review of the FPCs entry into customer relations. What are primary care managers doing in order to "be more responsive to public demands"? We circulated every FPC asking for information.

II THE ROLE OF THE FAMILY PRACTITIONER COMMITTEE

In contrast to the District Health Authorities, whose doctors, dentists and opticians are directly salaried, the same professionals working in primary care are individually contracted with the Government to provide their services. A patient can choose which doctor, dentist, pharmacist or optician to use, so long as the provider is prepared to accept him or her as a patient. The doctor has a continuing contractual responsibility for the patients' medical needs and, in return, receives a basic fee whether or not the person seeks treatment. This basic capitation fee represents 45% of total income, the remainder coming from extra fees for additional services such as vaccinations and immunisations, night visits and the provision of maternity services.

In effect the medical practice has become a loosely regulated "small business" supervised by the FPCs. But, unlike its commercial counterpart these "businessmen" have job security and built in pensions: indeed, a retirement age, set at 70, was only introduced last year. Recently, however, the way they have been regulated has been changed.

Before 1st April 1980, the FPCs were seen as the "quartermasters" of primary care, responsible only for the administration of pay and rations. But with the FPC's new independence came new responsibilities. Whilst they have no direct control over the self employed professionals who serve their customers, they do have a "planning function" (never clearly specified) as well as the accountability to both the Department of Health and to the population they serve.

The FPCs have several roles in relation to the consumer. They have to ensure that there is adequate provision of primary care services, that the public know what services are available, and that the care provided is of the highest standard. They also have to assist the consumer in their choice of doctor and help those patients who wish to change their doctor. Finally, they have to liaise with the Community Health Councils who are, as their handbook says, "the patient's friend within the health service and the communities' watch-dog." [4]

The recent White Paper, 'Working for Patients' [5] has increased the FPCs obligation to the consumer. The Government proposes to enhance the value of the patient to the doctor and to make sure that the patient is, as the White Paper says, "free to choose and change their doctor without any hindrance at all". The capitation fee will be increased so that it forms 60% rather than the 45% of the doctors' income. The GPs will have control over larger budgets to buy health care services on behalf of their patients and will be allowed to advertise their services.

The FPCs will have a crucial role in monitoring the services provided by GPs. They will have to supply information and encouragement to any General Practice that wishes to control it's own budget. They will have sight of the financial audit of each practice, and they will be responsible for monitoring expenditure in relation to the budget. GPs will be subject to medical audit. Here the FPCs will establish Medical Audit Advisory Committees to lead, support and encourage local GPs to put the new system into operation. External peer reviews of GPs and their practices will be organised with the help of the FPCs who will have access to the general results of these new procedures.

These measures are intended to ensure that the FPC is in the best position to advise the patients not only about the range of services offered by the GPs, but, by implication, about the quality of those services also.

III METHODS OF ENQUIRY

This paper provides a comprehensive picture of what the FPCs in England and Wales were doing in the area of customer relations as at Summer of last year (1988).

We sent a letter to all FPCs in March 1988 asking for details of any initiatives to examine consumer relations over the previous 5 years. We then approached some of the FPCs, who had not replied by letter, on the telephone. We received answers from sixty FPCs.

These came from all regions and fall into four categories:-

(1) those that had not done any work in this area and made no indication of the likelihood that they would do in the future (40 replies).

(2) those that had already done some work in this area (9 replies).

(3) those that had work in progress (1 reply).

(4) those that had already set aside a budget to do some work (10 replies).

The replies highlighted some notable regional variations. None of the FPCs in Northern, Wessex or Oxford Regions or in Wales were doing anything. Of the 26 FPCs, out of 40, in the 5 Northern Regions who replied, 10 had done some work or were planning to do so. In the 5 South Eastern Regions, the corresponding number of "active" FPCs was 6 out of the 26 who replied. The breakdown by Region is shown in Table 1.

Table 1	Replied		Of those who replied		
	No	Yes	Work done	Work in progress	Work planned
Northern Regions					
Yorkshire		7	2		2
North Western	1	10	2		1
Mersey	2	3	1		1
Trent	5	3			1
Northern	6	3			
South Eastern Regions					
South East Thames	1	4	2		
North West Thames	3	4			1
South West Thames	1	4			1
North East Thames	4	2			1
East Anglia	2	1			1
Midland Regions					
West Midlands	5	6	2	1	
Oxford	2	2			
South Western Regions					
South Western	2	3			1
Wessex	2	2			
Wales	2	6			
Total	38	60	9	1	10

We found that many of the 40 "non-active" FPCs - those who said they were doing nothing - referred us to work by the Community Health Councils. This indicates that many FPCs believed that customer relations should be left to the CHCs.

IV WHAT FPCs ARE DOING

In some FPCs a consumer relations manager or patients relations officer has been appointed to take on the task of consumer satisfaction. They are given the task of dealing with complaints, giving advice, and acting as a source of general information to patients.

There are two major tasks:

(i) to inform the public about the services offered by FPCs;

(ii) to carry out surveys of patients to find out more about their specific needs for medical services.

1. Public Relations

One way for the FPCs to make contact with the public is to set up a mobile exhibition or to take stalls at local events or shopping arcades. For example, Sheffield FPC has hired a mobile van from the City Council. The van contains a display advertising the FPC services together with leaflets, which the public are invited to complete and return to the FPC. The questionnaires are made up of items of a factual nature, such as:

Have you got a medical card?
Is the address on your medical card correct?
Do you know how to change your doctor?

Unfortunately the public's response is poor, so the FPC's efforts in this field have little or no effect on policy decisions.

One FPC, Sandwell, did try a more direct approach. They designed some posters inviting the readers to "write their own prescription for health". The poster told the reader what the FPCs were responsible for and invited them to play a part in drawing up a strategic plan. The public were asked to comment on 14 issues concerning primary health care expressed in the form of straightforward questions:

1. Would you welcome more clinics giving advice on things like giving up smoking and losing weight?

2. Would you like to be able to get a regular health check?

3. Do you think there should be better training for the administrative and clerical staff who work in doctors' and dentists' surgeries?

4. Should family doctors do more minor surgery in their own premises?

5. Should doctors be allowed to advertise their services?

6. How can we make it easier to change doctors if you want to?

7. Are you happy with the system for complaining about doctors? If not, why?

8. What do you think of doctors' surgeries. In what ways could they be improved?

9. What information should be included in the leaflets doctors give about their services?

10. How could we improve child health care?

11. How would you like to see dentists' "out of hours" emergency arrangements improved?

12. Are dentists and chemists in the right places to meet local needs most effectively?

13. What do you think of the services and facilities offered by opticians?

14. What do you think of dentists' surgeries. In what ways could they be improved?

To cater for the diverse ethnic population in Sandwell, these posters and leaflets were translated into four languages: Urdu, Punjab, Guyeratic and Bengali. They were distributed to doctors, dentists, pharmacists, opticians, voluntary organisations and post offices. At the same time the FPC took space in a "health newspaper" that was delivered to 120,000 local households. Sandwell FPC also wrote to each of the four local professional committees and all the voluntary organisations in their area.

They had a mixed response. The FPC received replies from all the local professional committees. The replies contained constructive criticism which, it was claimed, was certainly taken into account in making up the strategic plan.

By contrast no response was received at all from the voluntary organisations.

More encouragingly, 16 members of the general public took the trouble to reply. Out of these, 6 dealt with hospital services - even though it

had been explained to the respondents that the FPCs were not responsible for hospitals.

As they felt disappointed at the response to their poster campaign Sandwell FPC changed their approach. They organised three open meetings, at different venues within their catchment area, on successive Wednesday evenings in November. These were advertised in the local press as well as in the "health newspaper" distributed to every household in the area. The FPC also sent out a leaflet giving details of the meetings in each and every letter that was sent out from their office during a period of two months up to the time that the meetings were to take place.

The meetings were even less successful than the posters. Only one person attended the first meeting; four people attended the second; two the third. The two people who attended the third meeting were retired professionals, members of Rotary International and the local Lions club. Their attendance had an unexpectedly beneficial consequence: an invitation to the FPC speaker to talk to their organisations, where they could guarantee a captive audience of about a hundred people on each occasion.

In the North of England, North Yorkshire FPC have also used leaflets and posters to develop a higher public profile. Their leaflet set out to tell the public who they were, what they did and how they did it. They also invited the reader to send in comments or complaints.

Once again, there was very little response. Even so, the FPC noticed that a number of people had asked about the availability of homoeopathic medicine. This led them to contact all doctors in North Yorkshire to find out if there were any who had an interest in homoeopathic medicine; whether they would be prepared to apply this under their NHS contracts; and whether

they would allow their names to go forward to members of the public on a special list of doctors interested in homoeopathic medicine.

More recently, North Yorkshire FPC has tried to raise it's public profile with a special display at York District Hospital. This was designed to coincide with the 40th anniversary of the NHS. The response was more encouraging, and subsequent displays are being held in other parts of the county. Visitors to these exhibitions are asked to complete a simple questionnaire. This asks for straightforward factual information: whether or not the visitor has a medical card and whether the address on the card is correct.

These two examples from Sandwell and North Yorkshire suggest that it is difficult to assess to what extent the FPCs interest in public relations had any practical effect. In North Yorkshire the FPC did instigate some changes of policy; but in Sandwell the FPCs efforts seem to have had little or no measurable effect.

2. Surveys of Accessibility

There have been several studies among local population of demand for specific medical services [6]. We focus here on surveys conducted by the FPCs.

Most of the survey work by the FPCs has been to find out whether a particular service was sufficiently provided in a local area. These have concentrated on dental services. The FPCs send a simple questionnaire to each household or to a selection of households requesting information about whether or not they would use that service, if one was available. The

response is generally low. What is uncertain, however, is whether a low response indicates a low demand. The fact that a household fails to answer a questionnaire does not necessarily mean that it's members do not perceive a need for the service in question. Here we might draw a parallel with local government. Electors often express strong opinions in private about the provision of local services; even though the very low turn-out at local elections might suggest that people were indifferent or apathetic.

Calderdale and Humberside FPCs have both carried out surveys of the demand for dental services. Each had the same aim, but the outcomes were different.

In 1986 Humberside wished to find out whether there was a demand for a permanent dentist in Gilberdyke. They sent a simple questionnaire to a hundred households. They asked the respondents' age, how many times they had visited the dentist in the last year, the distance from home to the dentist and whether they would use a dentist if one were available at Gilberdyke. The results showed that 45 of the 65 people who replied would use a local dentist. Accordingly it was decided that it was not necessary to provide a dentist at Gilberdyke, as so many people preferred to attend a dentist near to their place of work in Hull. This conclusion may have been wrong to ignore the time and travel costs of the respondents, especially those who did not work in Hull, but - with such a low response - a final assessment would have been very difficult.

The Calderdale study also wished to determine whether there was a need for a dentist in a particular isolated area. They sent a form with thirty questions to every household. The respondents were asked about the state of their teeth, how frequently and how far they travelled to the dentist and whether they would like to make any further comments. The results

showed that a part-time dentist would meet their requirements. Calderdale are at present seeking a dentist to fulfil this role.

Two more general surveys of demand were mentioned. A research student at Brighton Polytechnic conducted a study of the access to primary health care in Hollingdean on behalf of East Sussex FPC [7]. There had been claims in the Hollingdean area that facilities in primary health care were severely lacking. The study focused on the general medical, dental and pharmaceutical services. Here the question turned out to be one not so much of the provision of additional services, but of access to existing ones. The final conclusion was that most of the respondent's problems could be solved by a better bus service!

In the North-West of England, the local Faculty of the Royal College of General Practitioners set up a patient liaison group with the support of the CHCs and FPCs. The group commissioned a survey of patient's perceptions of General Practitioners across seven health districts in 1985 and 1986. The study looked at both the accessibility of the GPs and the quality of the service provided. Questions were asked about the appointment system, making the appointment, waiting time for the appointment and inside the surgery, access by telephone and home visits at night and during weekends. The study also looked at whether the patient could choose the doctor within the practice. The results showed a high level of dissatisfaction with appointment systems. Paradoxically, the patients with appointments waited only half as long as the patients using open access yet both groups appeared equally satisfied with the length of time they waited. Many more respondents wanted to be able to speak directly to the doctor on the telephone, believing they were not allowed to do so.

3. Surveys of the quality of service provided

Greenwich and Bexley FPC, with the help of a student from Thames Polytechnic have undertaken a survey of the elderly [9]. One of the main findings was that the elderly did not understand the system of financial assistance with optical and dental treatments, and the report therefore recommended that the payment system should be reformed or efforts should be made to increase public awareness of what it is all about. In view of the recent charges imposed on dental and optical check-ups, explaining the system of exemptions becomes even more important. Two further recommendations were that there should be quicker communications between the Hospital and GPs when a patient is discharged and an increase in the public awareness of the loneliness of the elderly as 70% of respondents did not have regular visitors. They are about to start another survey and are hoping to interview all people over 85 in their catchment area, some 6000.

Some of the other initiatives by Greenwich and Bexley have been to produce a calendar and posters for the doctors' premises; to encourage GPs to issue leaflets outlining their services; to investigate the use of health promotion videos in large surgeries. Some of these measures will have sponsorship.

Humberside FPC have employed a liaison officer to monitor the quality of care provided by the two deputising services used by them. They also conduct annual surveys of all patients who receive a night visit during a given week to ensure that there are no significant problems in the service provided. To date the surveys have reiterated the reports received from the liaison officer that the quality of service provided by the two deputising agencies is satisfactory and efficient.

Wakefield FPC carried out a survey in a local shopping centre as part of an exhibition. The questionnaire asked whether they had seen the exhibition, and whether they had a medical card. As the survey did not have any specific aims, the results were not remarkable. They are seeking professional advice before starting a second survey in January 1989.

Occasionally, the FPC has been a "passive" partner in a survey. Thus, in Wolverhampton the District Health Authority together with the Borough Council sponsored a GP consumer survey in GP surgeries. Fourteen surgeries were visited for one or two sessions at the end of March/beginning of April 1987: 387 people completed the questionnaire. This covered surgery facilities and helpfulness of ancillary staff; arranging an appointment; the consultation and the doctor; and the overall level of satisfaction. They reported many detailed findings; but, as found by Cartwright and Anderson (1987) it is still the younger generation who have the most difficulty and who complain the most. In Wolverhampton, most of those who were dissatisfied were the young women.

Berkshire FPC have joined with the CHC to fund a GP who is carrying out a survey into how people choose their GPs. They have also produced an information leaflet. This gives information on what the FPC is, what it does, and how to obtain services from the family doctor, dentist, pharmacist and optician. It also explains how to make a complaint.

As Norfolk FPC covers a very rural area, it is difficult for patients to have a choice of GP and they have a restricted access to dental or ophthalmic services. The FPC are now looking at the possibility of a common location for these services. They have conducted a survey with the local College of Higher Education to investigate the use of, and satisfaction with, the primary health care services, especially the general

practitioner service. They have also appointed a consumer relations manager.

Another (un-named) FPC that intended to do something, for which they had set aside a budget, worked closely with a research body, but were unable to persuade one of the local doctors to co-operate in the research. This project is being reviewed in six months time.

V LIAISON WITH THE COMMUNITY HEALTH COUNCILS

There is some liaison between the CHCs, and the FPCs. As part of the overall research into customer relations in the NHS, we interviewed fifteen CHCs about a whole range of issues connected to their assigned role of representing the public. More than half of the CHCs answered that their relations with the FPCs were very good, and that they worked alongside the FPCs and attended each other's meetings. One CHC reported that they were having discussions with the FPC about doing a joint survey of dental services. If a liaison between the CHC and FPC is established, in most cases it works well.

There are, however, some difficulties. One of the CHCs reported that the FPC was 'pretty remote due to lack of interest... they do not send an observer'. The CHC felt that this FPC had no sense of urgency.

The Government are aware of the need to develop a working relationship between the CHC and the FPC in 'Promoting Better Health'. It emphasises this point:-

"The Government will, therefore, positively encourage effective collaboration in FPC areas where it remains weak." [11]

The impressions given by the people interviewed were that if links can be established, and if the 'right' officer is found, then the dialogue between the two organisation becomes constructive and mutually beneficial. The consumer must in the long run benefit from this co-operation. Liaison between the two organisation should result in economies of scale in any work done in the area of consumer relations. The least it can achieve is to avoid the duplication of information gathering. It is cheaper to add an extra question to a survey than do a separate survey.

Where there was an existing relationship between the CHC and FPC, it was hoped by the CHC that this could be made stronger or at the very least that it would continue. Those CHCs that admitted to none or very little liaison all felt that it was important that some move towards this should be made.

Many of the FPCs who said that they were not doing anything themselves referred us to those CHCs who have incorporated questions relating to primary care in their research. The results of these surveys were mentioned as having an impact on the supply of general medical services by the FPCs. One particular FPC mentioned the dissatisfaction with the waiting time and the manner and attitude of the reception staff. This has resulted in the FPC drawing up a set of objectives and training courses for receptionists, as has been done elsewhere.

VI DISCUSSION

The Family Practitioners Committees (FPCs) play a major role in the provision of health care. Every person has contact with the primary sector at some stage in their lives. On an average working day, 3/4 million people see their family doctor and about the same number get prescriptions from their local pharmacist. In addition there are visits made to the dentist and the optician. However, despite the large numbers of people using the family doctor service, a Consumer's Association survey [12] found that less than one in five people had heard of the FPCs and that less than one in ten patients knew who represented their interests in the NHS. Eight out of ten did not know how to make a complaint.

In a study of health care needs in Wolverhampton [13] a sample of 415 people was taken from the Electoral Register and asked whether they knew of the FPC and the CHC. Table 2, below, shows that less than half knew of either of these bodies and less than a quarter knew what they did. More people knew of the FPC than the CHC; but only 21% knew the role of the FPC. Most of those that knew what the FPC did were in the upper socio-economic classes.

Table 1. How Well Known is the CHC & FPC

	CHC %	FPC %
Know of it	39	45
Knew what it did	14	21
Social Classes I & II	33	41
Social Classes IV & V	5	12
Total N=415		

Source: Wolverhampton: A Picture of Health

There have been suggestions that GPs should be given a more central role in deciding upon the use of the NHS [14]. Given the emphasis by Government on consumer participation and consumer rights, a greater number of surveys of consumer satisfaction, covering more ground, in primary care might have been expected. It is disconcerting to find that, after all, very little effort has been made to collect the consumer's opinion on any of the services that are offered. The work done has been about the sufficiency rather than the quality of the service.

But in order to be responsive to public demands and be effective managers, the FPC needs to know much more about the population it serves. Basic information about the characteristics of the population can be derived from the combination of Census Small Area Statistics and GPS age-sex registers. But more qualitative data about the kind of services people would like to be available and about the quality of the services currently offered can only be obtained from the (potential) customers themselves.

Some FPCs have included or are going to include proposals for surveys of consumers in their strategic plans. But so far, the few attempts that have been made have not always been successful. Given the known difficulties of carrying out surveys of consumers [3] and interpreting results [15], the FPCs will require a degree of help and encouragement, that only a sustained programme of development work made available to all of them can provide.

VII CONCLUSION

When the Health Service was founded forty years ago, not only the medical profession but also the Government looked on the 'patients' as a

passive recipient of services arranged and organised by experts who knew what was good for them. The best that the 'patient' could hope for was that, as a citizen, she had a right to medical treatment, just as she had a right to receive services from other agencies of the Welfare State. Little or nothing was done to change the day-to-day management of hospitals and clinics, even less to alter the essentially passive relationship of patients to their GPs. Although the patient could sometimes insist on a second opinion, the only effective remedy for dissatisfaction with the treatment meeted out to her was to opt out of the NHS into the private sector and for primary care this option was not available for most patients.

By the time that the NHS entered the second half of it's forty year life, the patient, once the passive recipient of treatment decided by other people, was being transmogrified into the 'consumer'. This was a reflection of what was happening outside the doctor's surgery and the out-patients' waiting room in the High Street where people were being encouraged to make informed choices about the quality and life-expectancy of goods which they bought in the shops.

If people could make informed decisions about which make of refrigerator or television set would best suit their needs, why should they not be encouraged to make similar choices and criticisms about the quality and efficiency of services such as gas, water and electricity? Indeed, if the consumer could criticise their local electricity board, why should they not also have something to say about their local hospital or health centre?

Even so, the 'consumer' of health services in the 1960s and 1970s was still expected to have many of the same passive characteristics of the

'patient' of the 1940s and 1950s. Just as the purchaser of a refrigerator of television set was not expected to have any say in the design and distribution of the product, so the 'consumer' of health services was not expected to play any significant part in decisions about what was provided, where and by whom. In this respect the health service has lagged behind the commercial sector in the use of market research. Makers of cars and washing machines spend millions of pounds to find out what their 'consumers' really want. But until now, as this survey has shown, the NHS has only just started to take a few fumbling steps to find out what people really want and how they react to what they get.

In other words, the 'consumer' has yet to emerge as a customer in the NHS. The NHS, like many other public and private services dominated by strong professional groups, whose members seek to organise their clients lives, has fallen behind the standard of services provided in the non-unionised sectors. In the case of public transport, the 'passenger' - a word which, like 'patient', implies passivity and non-participation - has given way to the 'customer', someone who, if he does not like what is on offer at the railway ticket office, has the choice of taking her purchasing power down to the bus station or airport. The White Paper, 'Working for Patients',[5] takes the doctor patient relationship one small step in this direction. Indeed, the allocation of budgets to GPs to buy hospital services for their patients reinforces the analogy with the world of commerce. Just as a customer buys from a retailer goods which are ordered from a wholesaler, so the Health Authority becomes a 'wholesaler' of health services to a 'retail network' of GPs. The successful operation of this system of internal markets, like any other system of wholesaling and retailing, requires market research to a depth and extent that no Health Authority or FPC has yet appreciated [3].

The FPCs can ensure by promotions, surveys and other methods that the patients know what to expect from the primary care services. In effect the FPC can act like an 'advertising agency', telling the customer what is available, where and at what cost. At the same time, they can raise peoples' expectations, just as advertisements for cars and holidays try to persuade customers to spend more for a better product which will lead to a better quality of life. Raising expectations will in turn ensure that the customer receives the services that they expect. Moreover in principle, these services will be self monitoring, their quality being measured by the amount of work and the number of customers which the suppliers - the hospital or the General Practice - can attract and retain.

Clearly the District Health Authorities led the way in the process of developing strategic plans for customer relations. By contrast the Regional Health Authorities appear to have made less progress. This is why the role of the FPCs is crucial. If they are to come under the direct control of the Regional Health Authorities, they must develop their plans now and not wait for directions from their new masters. The FPCs thus have a double burden: they must continue to develop their pioneering work in the field of customer relations, defending what they have achieved so far, and face the realities of what the customer really wants.

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