A NEW NHS ACT FOR 1996?

Papers prepared for a discussion meeting
held at Cumberland Lodge on 7th and 8th June 1984,
together with a summary of the discussion

Edited by George Teeling Smith

Office of Health Economics
12 Whitehall London SW1A 2DY

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Foreword

This booklet contains the background papers prepared for a discussion meeting at Cumberland Lodge in Windsor Great Park on 7 and 8 June 1984.

The idea for the meeting came from the late Lord Vaizey, who was Principal of St Catherine's Foundation at Cumberland Lodge. It followed on from the discussion in his recent book 'National Health'.

His belief, which is shared by the Office of Health Economics, was that the principles of the Beveridge Report need to be fundamentally re-appraised in the light of the changes in British society since the 1940s. It is not too soon to be looking at how Britain's National Health Service should be developed to cater for the situation which can be expected in the 1990s, half a century after the NHS was introduced. An NHS conceived to deal with the medical and social problems which existed in the 1930s and 1940s cannot be expected to cater for the problems of the 1990s.

As my own background paper explains, the arguments in favour of the solutions which have been discussed in the past – a reversion to 'private' care, or the introduction of competing insurance-based sources of finance – have not stood the test of time. Much more subtle and imaginative changes are required to meet fully the present and future health care expectations of the British public. And those expectations, in turn, need to be both more realistic and more critical than they have been so far.

These are some of the issues raised in these eight papers, and in the digest of the discussion of them which makes up the ninth chapter of this booklet. As this last chapter points out, the meeting at Cumberland Lodge can been seen as the start of a new phase of discussion about the future of health care in Britain.

Many of the ideas which it introduces would have been unthinkable a few years ago. The fact that a totally constructive and uninhibited discussion of these issues was possible is immensely encouraging for the prospect for a realistic and positive 'New NHS Act for 1996'.

The untimely death of Lord Vaizey since the meeting has been a sad blow to all of those of us who were present. However even without the continued benefit of his driving energy the discussion which he stimulated must be encouraged to continue.

George Teeling Smith

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The evolution of the 'NHS debate'

George Teeling Smith

In the 1960s 'The Great NHS Debate' concentrated on a single question: 'Was socialised medicine better or worse than private enterprise medical care?' Advocates of the success of Britain's NHS argued that the American pattern of private care suffered all the defects of a market system in respect of a welfare service. In particular they pointed to the 'poverty trap' which – even after the introduction of Medicare and Medicaid – left many of the less affluent members of society impoverished or even bankrupt as the result of health care costs. On the other hand, the detractors of the NHS pointed to the large scale emigration of British doctors to apparently greener pastures overseas, and to the obvious deficiencies in the bureaucratic British system.

When it was founded in 1962, the Office of Health Economics stood aloof from this debate. This was partly because of the overtly political basis of the discussion and partly because OHE even then could see that this particular debate was sterile. Clearly the problems of medical care in the 1960s did not arise primarily from the political system under which it was provided.

By the 1970s, this latter view came to be more generally accepted. Dick Crossman must be given the credit for being the first Labour Heath Minister to have openly acknowledged that Bevan's 'great triumph' had conspicuous shortcomings. Equally, serious students of the American scene acknowledged that there were massive problems from the failure to provide pre-paid health care for an important sector of the American population. Hence 'The Great Debate' shifted onto new ground.

In the 1970s it became fashionable to question the generally tax-funded basis of the NHS and to look enviously at the 'advantages' of the insurance based schemes under which more or less universal pre-paid health care was provided in the other European countries. These countries spent more on health, and avoided the most conspicuous feature of the British shortages – namely the 'queues' for hospital treatment for non-urgent surgical cases. However once again it was the role of OHE to point out that higher spending overseas was a consequence of greater affluence, rather than a specific result of the method of financing the health services. A more thoughtful examination of the situation in continental Europe indicated that there, too, there were major problems in medical care. Professional discontent had erupted under a number of different systems, just as it had done under the NHS in Britain.

Thus, by 1984, if neither private enterprise market-orientated health care nor insurance-based pre-paid systems could solve the problems of the NHS, it is clearly time to examine other avenues. What is still clear, however, is that the original concepts of the NHS, as constructed by Beveridge in the 1940s, are no longer relevant to the health care problems of the 1980s. This is not to say that the principle of a comprehensive pre-paid system of health care is not still essential. But in certain crucial respects the principles lying behind the 1946 NHS Act are now inappropriate.

First, and most immediately, it has become clear that Beveridge's idea that the demand for medical care would wither away was indeed a chimera. He believed that there was a fixed pool of illhealth, and that if treatment were made freely available to the population as a whole the size of this pool would be diminished. Hence he believed that the cost of the Health Service would be reduced after the initial backlog of illhealth had been eliminated. This was subsequently – and appropriately – described by Enoch Powell as 'a miscalculation of sublime proportions'.

More generally, however, there are at least seven other areas where the basis of the original NHS clearly needs to be rethought. This list of seven is by no means exhaustive, but it illustrates why the fundamental philosophy underlying the 1946 NHS Act needs to be reassessed.

These seven areas, each of which will be dealt with in turn, are as follows:

1. The NHS was planned to deal with acute disease.
2. It was to be primarily hospital based.
3. It was a development of the earlier 'poor law' or 'panel' health insurance schemes.
4. It was planned to be acceptable to a relatively non-affluent society.
5. It was assumed that NHS health care priorities would be self-selecting.
6. It was based on the relatively 'low-technology' medicine in the 1930s.
7. It assumed professional dedication to the cause of caring for the sick.

None of these seven concepts have stood the test of time over the intervening 36 years.

Planned for acute disease

In the 1930s and 1940s the major health problems in Britain were tuberculosis and childhood mortality from the infectious diseases, such as diphtheria and measles. The NHS was conceived as a way of tackling these – and other – problems amongst those who could not previously afford good medical care. Chronic sickness – such as rheumatoid arthritis – was seen as a much less pressing problem. Within a few years of the introduction of the NHS, these acute infections had been largely controlled by the introduction of antibiotics, antibacterials and vaccination. Britain faced an unexpectedly aging population with a preponderance of chronic disabilities. At the same time previously intractable problems such as mental illness became amenable to pharmacological treatment, and whole new vistas of effective therapeutic invention consequently opened up. The medical problems facing the NHS in 1984 are very far removed from those facing the medical profession in the 1940s. A health service planned largely to deal with acute and often rapidly fatal episodes of illhealth has found it hard to adapt to caring for the chronic problems of the 1980s.

More importantly, the NHS has largely ignored the priority of promoting positive health, and the task of detecting asymptomatic conditions such as moderate hypertension.

Hospital based

It was always assumed that the NHS would primarily be a hospital based service. This is reflected in the fact that at least 60 per cent of NHS expenditure has always been allocated to the hospitals. It was even more pungenty underlined by Lord Moran's infamous aphorism, that doctors who went into NHS general practice had 'fallen off the ladder' in their attempts to climb to eminence in the hospital service. The hospital orientation of the service was suggested again by the fact that the community opticians' service was originally entitled the '*supplementary* ophthalmic service'. It was implicit that in an ideal world everyone should be able to have their sight tests from a hospital ophthalmologist.

Thus it is only comparatively recently that it has been recognised that the majority of health care problems are more appropriately dealt with in the community rather than in hospital. The shift of resources out of hospital has only very slowly begun in the 1980s.

Based on the 'poor law' and the 'panel'

It was certainly the brave intention of Beveridge and Bevan that everyone should enjoy 'middle class medicine' under the NHS. However in practice – perhaps inevitably – the reality was much closer to an extension of the 1911 'panel' system of health insurance medicine rather than to a general availability of the 1930s standard of care provided for private patients.

In the 1930s, the panel patients queued up in dingy surroundings to be seen by the doctor, while private patients were welcomed into his dining room or sitting room to await their pre-arranged consultation. It was the dingy waiting room rather than the warm well-carpetted sitting room which was made available to the population as a whole in 1948. Although this may seem a trivial carping observation, there is little doubt that in the minds of the majority of the medical profession 'free' NHS treatment was all too often equated to what had previously been freely available to insured patients, and before that to those seeking charitable care.

Again it is only in the 1970s that surroundings – and perhaps attitudes – are beginning to change and to catch up with those applicable to private patients in the 1930s.

Conceived for a non-affluent society

The expectations of the majority of the British public in the 1940s were relatively modest. Few had yet experienced regular foreign holidays; few owned a car; and such comforts as central heating and fitted carpets were still in the future for most people. The NHS was introduced to match the modest expectations of the immediately post-war society.

By 1984, an average male in the South East of England can expect to earn £200 a week, or so. He probably takes two holidays abroad each year, and owns such luxuries as a video recorder. He is accustomed to eating out in a huge variety of restaurants, to which he will drive in a comparatively modern motor car.

It is questionable whether the provisions of the NHS have kept pace with the broader expectations of a generally affluent society in the 1980s.

Assumed priorities would be 'self-selecting'

In the prevailing attitude to health care problems of the 1930s and 1940s, it was naively assumed that it would always be obvious which were the most important health care priorities. The problem of allocating resources between the chronic sick and the acutely ill had not really arisen to any extent. It has already been pointed out that no effective treatment was generally available for chronic conditions; acute illness was seen as the obvious priority.

The structure and organisation of the 1948 NHS – and its various reorganisations – have still left it ill-equipped for the rational distribution of its scarce facilities. More fundamentally, the essentially political – rather than economic – nature of these decisions on allocation is often not yet appreciated either within the NHS or by the public at large. Few people recognise that the treatment of patient 'x' implicitly prevents patient 'y' from receiving necessary attention. There has never been any inbuilt mechanism in the NHS to make sure that such treatments are correctly allocated – or even to debate whether such allocation could ever be fair or rational.

Based on low-technology medicine

All of the problems which have been outlined so far are accentuated in the most dramatic way by the advances in medical technology since the 1940s. To quote only the most spectacular examples, brain surgery, micro-surgery of the nerves (allowing severed limbs to be re-attached), kidney, liver, bone marrow and heart transplants have all been introduced since 1948. Many of these advances have been made possible by pharmacology, for example advances in anaesthesia, muscle relaxation and immunosuppression. Pharmacological advances themselves have transformed medical care.

New diagnostic techniques, such as the CAT scanners, have made the identification of disease much more precise. The whole practice of medicine is rapidly approaching the status of an exact science rather than a mystical art. The hurtful gibe that general practice was no more than a 'cottage industry' is becoming increasingly inappropriate.

Assumed professional dedication

In the 1940s it was too easily taken for granted that the health care professionals – and nurses in particular – considered their work as a vocation rather than as a career. Bernard Shaw had identified the mercenary nature of some doctors thirty years earlier, but once again it was assumed that the majority of doctors were dedicated to the care of patients rather than to their own enrichment.

Thus general unionisation of health service workers during the 1960s has come as a nasty shock. It is a new challenge to Health Service management which is only now being recognised.

Conclusion

These seven bases for potential misconceptions in relation to the current NHS situation provide some background for the advancement of 'The Great NHS Debate' in 1984. In view of the extent of change in so many dimensions of the health care system, it is not surprising that an NHS which is still often based on thinking in the 1940s should be in difficulty in the 1980s.

The Royal Commission in retrospect

Alec Merrison

Taking together the title of this discussion meeting and the title of my own contribution – on neither of which had I any influence! – I will assume that what we are to talk about is whether one can see that it is likely that health care in this country will require by 1996 the sort of reform offered by legislation and whether what was learned from the work of the Royal Commission, which reported in 1979, and what we have learned since, offer any guide to such reform.

Let me start by reminding you of our terms of reference, which were:

'To consider in the interests both of the patients and of those who work in the National Health Service the best use and management of the financial and manpower resources of the National Health Service.'

Nothing, you will see, about the *provision* of resources though that did not stop us from slipping in a chapter on this; the issue was much too serious to be neglected, and in any case the distribution of resources is affected by the method by which they are provided. And, although I had been privately forbidden by Mrs. Castle to do so, we put in a chapter also on private practice; again, a topic too important to the NHS to pretend that it did not exist.

The Royal Commission was appointed against a background of a good deal of emotion – worry about lack of finance, about pay-beds, about industrial action (including striking by doctors), about the Heath government's re-organisation of the health services which had resulted in an absolutely byzantine system for its administration.

I do not believe that it would be very useful, and certainly not interesting, if I were simply to go through a check-list of the Royal Commission's recommendations and construct some sort of score-sheet. What I *will* do is simply to highlight some of the more important points we were worrying about which continue, for the most part, to be worrying.

As Sir Douglas Wass recently reminded us in his Reith lectures, one of the prime duties of a Royal Commission is exposition. Such a body is usually set up in response to a problem – even a crisis – and it is certainly incumbent upon it to give its own clear description of the problem, its nature and magnitude, quite apart from any solutions it offers. In this respect I believe the Royal Commission did pretty well. It gave an overall picture of the NHS and other bodies providing health care which certainly existed nowhere else and, curiously enough, it was a picture which seemed to be denied to most of our witnesses, however expert or professional they may have been in some particular aspect of the field.

Much the most disappointing aspect of the Royal Commission's report, at least to many of its readers was 'that the NHS is not suffering from a mortal disease susceptible only to heroic surgery'. I am afraid that there are many people who do really long for the 'our-hero-in-mighty-bound' sort of solution to large problems, and sadly they are rarely on offer. But to be told that not only is there not a crisis but that in addition there are no dramatic solutions is, I recognise, very flat. It was a great comfort to see in the recent and excellent OHE report by David Taylor that he comes to similar conclusions.

Can I remind you too of what the Commission called 'gradations of health care' which were:

'the care which a healthy person will exercise for himself so that he remains healthy;
the self-care which the slightly ill person will exercise which may involve medication and treatment;
the care provided by the person's family and by the health and personal social services outside hospital;
the care which can only be provided in hospital or other residential institution.'

The interesting thing about these categories is of course as the patient slips down them not only does he not get more uncomfortable but his treatment becomes dramatically more expensive. So one looks for sticks and carrots for both patients and providers of health care which will discourage the slide down these stages of care.

We made some recommendations which we thought would help in this problem, which I still think is one of the more critical facing any system of health care, but when we meet in Windsor I should like to discuss the matter a little more.

I still remain very much of the view that the excellent principle of 'delegation down, accountability up' is still not strongly enough observed in its first part and this too I see as a major area of necessary reform in the Health Service, even to the degree that I have in a recent lecture suggested that we perhaps now have outgrown the concept of a *national* health service.

Let me finish this short note with a quotation from a lecture I gave in 1979, words I believe to be still true.

The lessons to be learned

This is to some extent a personal view but I think it would be strongly supported by the Commissioners.

In terms of value for money and patient satisfaction the NHS is doing well. There is no evidence – indeed, all the evidence is the other way – that radically new schemes of financing would do better.

In terms of staff morale and renewal of buildings it is not doing well. The latter can be solved only by more money.

The 1973/4 re-organisation, although its *principles* were largely correct, led to a byzantine system of administration which must be simplified. The two major failings of the 1973/4 re-organisation were the lack of a 'district' level of authority and the failure to carry through the principle of 'delegation downwards, accountability up'.

Staff morale will improve with better administration and better industrial relations. These will not be more costly, indeed if carried through with determination they will save money.

It is not hard to find areas of the NHS where more money will be well spent. Nonetheless, the NHS can do better with what it has – but not overnight.

We have a good system of community care and this will be crucial in future.

The NHS lacks leadership at all levels. It is my view that to put this right is the Government's most urgent task in this field.

Changing patterns of disease

Nicholas Wells

In 1968 Sir John Butterfield wrote in his Rock Carling Fellowship review monograph entitled 'Priorities in Medicine':

> 'Since the National Health Service was based on the Beveridge Report which in turn was based on the old order of infectious disease, we have to examine this instrument in terms of the new challenge. For though we may have been very successful in dealing with disease in the past, there is no guarantee that the same instrument will serve for the future – and the first idea is that the medical planner may have to suggest a completely new solution'.

In these two sentences, Butterfield therefore pinpointed some 16 years ago an issue central to the agenda for the present meeting. In order to facilitate discussion, this paper traces the broad changes that have occurred in disease patterns since the inception of the National Health Service (NHS). It then identifies the major health care problems of the moment, some of which are clearly destined to become yet more burdensome in the years leading up to the 50th birthday of the NHS.

An assessment of changes in health over time is not however a straightforward exercise. An index constructed of a set of variables which in sum provide a measure of an individual's or a nation's health simply does not exist. Indeed, it is only relatively recently that the first tentative steps have been taken in the measurement of health status – and this in the much more limited context of gauging the efficacy of medical or surgical interventions rather than overall levels of well being. As an alternative morbidity data might be employed but these too present problems. Knowledge of the incidence and prevalence of specific diseases has frequently derived from once-off studies which by definition do not of course yield insight into changes in occurrence over time.

Traditional measures of morbidity suffer equally from a number of shortcomings. Hospital data, for example, are generally indicative of disease prevalence only above certain thresholds of severity. Statistics of sickness absence from work are of course irrelevant for large sections of the population; even among those of working age they disregard individuals whose impairments either prohibit their participation in the workforce or do not affect capacity for work but are nevertheless disabling in other contexts. Finally, the General Household Survey (GHS) furnishes up-to-date information about the broad occurrence of acute and long standing ill health in the community but it has only been running since 1970 and fails to elicit details about the underlying causes of self-reported morbidity.

Figure 1 **Crude mortality rates per 1,000 persons**

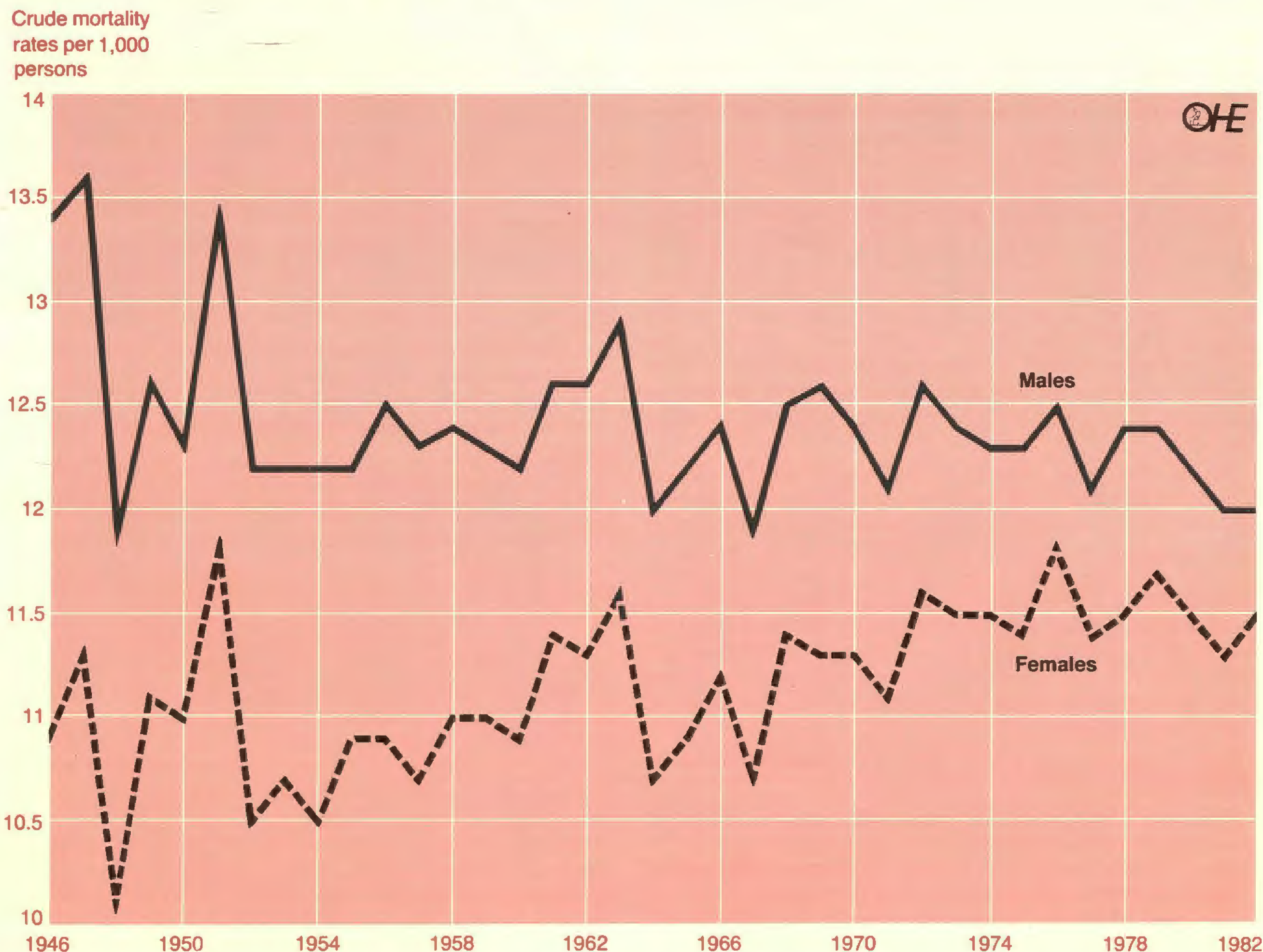

Figure 2 **Standard mortality ratios 1950–52=100**

Standardised
mortality ratios
1952=100

In view of the conceptual and practical difficulties involved in measuring health and sickness, this paper therefore employs mortality statistics to identify the broad changes in disease that have taken place since the late 1940s.

Mortality trends

Crude mortality data for the period 1948 to 1982 for England and Wales are presented in Figure 1 and suggest, at first sight, that there has been relatively little improvement over this period of time. However, account has to be taken of the important demographic changes that have taken place during these years – notably the increasing proportion of elderly people in the population – and this may be achieved by employing standardised mortality ratios. The latter, shown in Figure 2, reveal in fact that male mortality fell by 20 per cent during the 35 years, 1946/8 to 1980/82. For females, the corresponding improvement was 28 per cent.

More detailed analysis by age group, contained in Tables 1 and 2, indicates that the improvements in the standardised mortality ratios are principally a reflection of substantial reductions in mortality among persons below approximately 35 years of age. These developments, in turn, are a function of the decline in the significance of infectious disease as a cause of death.

The effect that the latter trend has had on mortality profiles is illustrated in Figure 3. Between 1946/48 and 1980/82, the crude death rate for infective and parasitic diseases in England and Wales fell from 677 to 44 per million population, generating a current annual 'saving' of more than 31,000 lives.

Within this broad disease grouping the most dramatic improvement has been shown by respiratory tuberculosis. Here the mortality rate has declined by 98 per cent over the same period. As a result, over 1980/82, there were on average 453 deaths from this cause each year compared with an estimated 22,760 fatalities that might have been expected in the absence of any change in the death rate.

Against this background accidental and non-accidental injuries and poisonings have become a prominant cause of death among children, adolescents and young adults. In 1982, events of this nature were responsible for 58 per cent of the 7,396 deaths among males aged between 5 and 34 years. For females in the same age group, such 'unnatural' causes accounted for 36 per cent of the 3,647 fatalities recorded in that year.

Among persons older than 35 years circulatory diseases and cancers have emerged as the principal causes of death. Thus in 1946/48 the former accounted for 33 per cent and the

Table 1 **Age specific male mortality per 1000 population, England and Wales 1946-80**

Quinquennium	*1-4*	*5-9*	*10-14*	*15-19*	*20-24*	*25-34*	*35-44*	*45-54*	*55-64*	*65-74*	*75-84*	*85+*
1946-50	1.90	0.88	0.69	1.33	1.75	1.92	3.23	8.55	22.4	51.6	119.0	241.6
1951-55	1.23	0.55	0.48	0.86	1.23	1.39	2.71	7.93	22.5	54.6	126.7	265.9
1956-60	0.99	0.49	0.40	0.88	1.12	1.17	2.45	7.35	21.9	53.7	122.7	239.2
1961-65	0.94	0.47	0.41	0.95	1.11	1.11	2.46	7.38	21.7	54.0	121.3	253.2
1966-70	0.87	0.43	0.39	0.96	0.97	1.02	2.38	7.18	21.0	55.3	115.9	254.2
1971-75	0.75	0.39	0.35	0.88	0.99	0.97	2.22	7.22	20.2	51.4	116.3	240.9
1976-80	0.59	0.32	0.29	0.87	0.93	0.94	2.01	6.73	18.9	48.8	112.5	237.1
% Change 1946-80	69	64	58	35	47	51	38	21	16	5	5	2

Source: OPCS

Table 2 **Age specific female mortality per 1000 population, England and Wales 1946-80**

Quinquennium	*1-4*	*5-9*	*10-14*	*15-19*	*20-24*	*25-34*	*35-44*	*45-54*	*55-64*	*65-74*	*75-84*	*85+*
1946-50	1.62	0.64	0.54	1.05	1.54	1.76	2.56	5.51	12.8	34.4	93.2	208.9
1951-55	1.04	0.39	0.34	0.50	0.70	1.09	2.11	4.89	11.8	33.1	92.4	222.0
1956-60	0.82	0.33	0.27	0.38	0.52	0.81	1.83	4.46	10.9	30.7	86.4	212.5
1961-65	0.78	0.32	0.25	0.38	0.47	0.73	1.78	4.43	10.6	29.8	83.6	206.7
1966-70	0.70	0.28	0.25	0.39	0.44	0.65	1.68	4.34	10.3	28.0	77.5	203.0
1971-75	0.61	0.27	0.21	0.39	0.43	0.57	1.56	4.37	10.2	26.5	75.4	193.5
1976-80	0.48	0.22	0.21	0.34	0.40	0.56	1.40	4.11	9.9	25.3	70.9	192.9
% Change 1946-80	70	66	61	68	74	68	45	25	23	26	24	8

Source: OPCS

latter for 17 per cent of all deaths over 35 years. By 1980/82 these proportions had become 50 per cent and 23 per cent respectively. To some extent these trends may be regarded as an inevitable aspect of an ageing population. They are nevertheless a major source of concern because of the volume of premature mortality to which circulatory diseases and cancers give rise. The Office of Population Censuses and Surveys has calculated, for example, that each year the toll of mortality among males from these two broad disease groupings results in 500,000 lost potential years of working life. Furthermore, in both instances, epidemiological investigation has yielded persuasive evidence that 'environmental' factors frequently underlie causation and that consequently many of these deaths are avoidable.

Health of the elderly

Meeting the health needs of the elderly is arguably the major problem currently facing the NHS. The data contained in Figure 4 are drawn from the General Household Survey* and demonstrate the sharp increases in the prevalence of chronic ill-health with age. Thus 54 per cent of males and 63 per cent of females over the age of 65 years report themselves to be suffering from long standing illness. Among those aged over 75 years and over the corresponding proportions rise to 60 and 70 per cent respectively and, as Figure 4 shows, the illnesses involved more often than not serve to limit activity. The General Household Survey also reveals that acute sickness is reported by the elderly half as often again as it is by persons under 65 years of age (16.1 per cent compared with 10.9 per cent).

The extent to which these levels of self-reported morbidity are translated into demands upon the health and personal social services is illustrated in Figure 5. One third of persons aged 65 and over in the 1981 GHS sample had seen a doctor in the month preceding interview. During this same time period six per cent had been visited by a district nurse or health visitor and nine per cent had used a home help service. Focusing on the hospital services, data from the Hospital Inpatient Enquiry for England and Wales show that persons aged 65 years and older accounted for 30 per cent of all discharges and deaths in 1981. However, because the mean length of hospital stay for this group was 24 days compared with 7 days for admissions of persons aged under 65 years, the elderly accounted for 60 per cent of total hospital bed days in 1981.

As a consequence of these morbidity and service usage profiles, hospital and community health current expenditure in 1980/81 per head for those aged 65-74 years was double the overall average of £160. For those aged 75 years and over per capita expenditure was almost five times greater.

It is against this background that demographic trends have given, and continue to give, rise to concern. In 1951 the population of England and Wales contained 4.825 million persons aged 65 years or older. By 1981 this figure had risen to 7.572 million and projections based on the latter year suggest that in 1996 there will be 8.054 million elderly people in the population. However, the importance of these demographic trends does not lie simply in the expansion of absolute numbers. Instead their significance is a function of changes in the dependency ratio and in the age structure of the elderly population itself.

Focusing on the former, available data indicate that in 1951 there were 6.06 persons aged 15-64 years for every individual aged 65 years or over. By 1981 this figure had fallen to 4.22 and it projected to decline to 4.03 in 1996. This trend has profound implications for service provision since it determines not only the financial limits to the supply of care, but also the extent to which the latter may be 'allocated' to relatives in the community.

The age structure of the elderly population itself is clearly important because of the significantly raised morbidity and service take up rates observed for the old elderly, that is those over the age of 75 years. The numbers of the latter group have risen from 1.568 million in 1951 to 2.926 million

*The General Household Survey excludes individuals in hospital or residing in institutional accommodation.

Figure 3 **Selected causes of death by age and sex, Britain 1951 and 1980**

Figure 4 **Percentage of persons reporting long standing illness, Britain, 1981**

Percent
70
60
50
40
30
20
10
0

OHE

Long standing
Limiting long standing

Males

Females

0–4 5–15 16–44 45–64 65–74 75+

0–4 5–15 16–44 45–64 65–74 75+

Age Groups

Figure 5 **Use of selected health and personal social services by elderly people, Britain 1981**

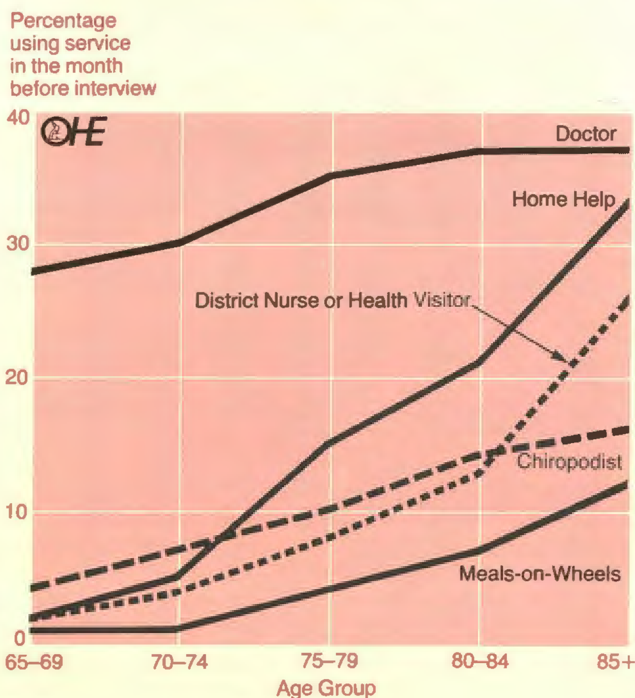

Figure 6 **Prevalence of reported long standing illness by socio-economic group, Britain 1981**

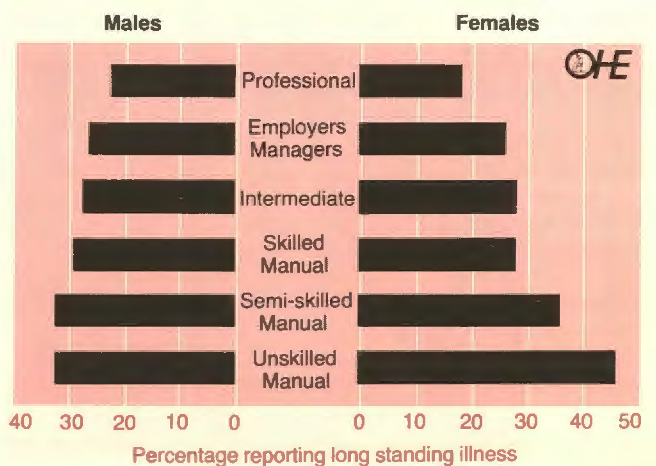

Table 3 **Male Standardised Mortality Radios by Social Class: England and Wales 1921-23/1970-72**

Social class	1921-23 (age 20-64)	1930-32 (age 20-64)	1949-53 (age 20-64)	1959-63 (age 15-64)	1970-72 (age 15-64)
I Professional occupations	82	90	86	76	77
II Managerial and lower professional occupations	94	94	92	81	81
III Skilled occupations	95	97	101	100	104
IV Partly skilled occupations	101	102	104	103	113
V Unskilled occupations	125	111	118	143	137

Source: Merrison 1979

in 1981 and will reach 3.626 million in 1996. Thus over this complete time span, during which the size of the elderly population as a whole will have increased by 67 per cent, the 'old elderly' will have increased their representation within this group from approximately one person in three to one in every two.

Social class disparities in health

Whilst concern at the increasing significance of preventable causes of death and the implications of an ageing population – if not the problems themselves – may be regarded as a relatively recent phenomenon, awareness of marked discrepancies in health status between different sections of the community is long standing. Table 3 shows standardised mortality ratios by social class for males of working age and indicates that in 1930/32, for example, the ratio for socio-economic group V exceeded that for group I by 23 per cent. Against this background the opening paragraph of the 1944 White Paper stated that the government:

> 'Want to ensure that in future every man and woman and child can rely on getting all the advice and treatment and care which they may need in matters of personal health; that what they get shall be the best medical and other facilities available; that their getting these shall not depend on whether they can pay for them, or any other factor irrelevant to the real need'.

Yet as the Royal Commission Report published in 1979 commented 'there is plenty of evidence to show that there are still striking differences in morbidity and mortality between social classes as defined by the Registrars General'. Data from the General Household Survey, for example, reveal that the proportion of males reporting long standing illness is 45 per cent greater in the unskilled manual group compared with the professional group (Figure 6). Furthermore, table 3 suggests that the disparities between social classes I/II and IV/V appear to have widened over time, although it should be emphasised that 'all social classes are healthier than they were thirty years ago and that the proportion of the population in the least well-off sections of the community has fallen' (Merrison 1979).

The explanations for these disparities have been the subject of extensive and as yet inconclusive debate. In this context, the working group on Inequalities in Health (1980) commented that 'too little work of a wide-ranging kind on the interrelationships between mortality or, even more, morbidity and social and economic as well as biological and clinical factors has been carried out'. Nevertheless, the authors 'were convinced that it is difficult to begin to explain the pattern of inequalities except by invoking material deprivation as a key concept'.

Discussion

If it is assumed that man possesses an inbuilt biological clock which sets an upper limit to the average duration of life of between 80 and 90 years (Fries 1980) then in broad terms it might be argued that society is now confronted by a two fold health target. The first objective is to reduce the number of persons who die prematurely. The second is to minimise the morbidity and disablement experienced by individuals, especially during the latter part of their lifetime. These goals are neatly encapsulated in Doll's (1983) expressed desire to 'die young as late as possible'.

The data contained in this paper suggest that effective disease prevention/health promotion strategies have a major role to play in achieving these objectives. In England and Wales, 22 per cent of the 581,861 fatalities recorded in 1982 involved persons who had yet to celebrate their 65th birthday – a milestone still 5 and 11 years below contemporary average life expectancies for males and females respectively. Together the 'preventables' of coronary heart disease and cancer of the lung coupled with injuries and poisonings accounted for 44 per cent of all deaths occurring under 65 years in 1982 (or 53 per cent for males alone). Against this background the Royal Commission on the National Health Service considered that the first of a series of objectives for the NHS should be 'to aim to encourage and assist individuals to remain healthy'. Yet, in spite of the 'preventive intentions' embodied within the NHS Acts, 'one of the more frequent comments about the NHS is that it is really a national illness service' (Godber 1975). In view of contemporary morbidity and mortality patterns, the Royal Commission therefore urged that the lack of emphasis placed in the past on the preventive role of the NHS 'must change if there are to be substantial improvements in health in the future'.

Prevention should not however be seen as a straightforward panacea. There are important issues to be resolved concerning, for example, resource requirements and the motivation of different sections of the community to act upon preventive advice. Focusing on the role of government, the British Medical Journal (1984) has commented that 'politicians must be persuaded that a responsible government should have a policy on health and be prepared to take account of that policy in its decisions'. Yet conflict abounds. For example, the Canterbury Report (1984) noted that 'the present operation of the European Economic Community Common Agricultural Policy in relation to dairy products and sugar is directly opposed to the food and health policy the United Kindgom should be aiming for'. And consideration must also be given to the more direct implications of 'preventive strategies' for the National Health Service. Tables 4 and 5 present data on contemporary general practice and general surgical workloads. They suggest that preventing the diseases which are responsible for today's high levels of premature mortality will do relatively little to reduce the real resource requirements of the NHS. Indeed, by facilitating the survival of greater numbers into old age, the opposite effect might result.

Disease prevention/health promotion is not of course the only issue confronting the NHS. With regard to the ageing population there has been a succession of reports in recent years detailing the inadequacy of care facilities. These deficiencies affect not only the elderly themselves and the relatives caring for them but also have important implications for the provision of health care to other groups in the population. In the context of social class inequalities in

Table 4 **The 10 disease categories (three digit aggregations within chapter) most commonly encountered in general practice, consultations in 1980 per 1,000 persons**

	No in 000s	*Consultation* rate/1,000 persons*
Neuroses and personality disorders (300-309)	35,065	627
Symptoms referrable to systems or organs (780-789)	26,012	465
Acute respiratory infection except influenza (460-466)	25,825	462
Arthritis and rheumatism except rheumatic fever (710-718)	22,962	410
Bronchitis, emphysema and asthma (490-493)	22,504	402
Hypertensive disease (400-404)	18,461	330
Other inflammatory conditions of skin and subcutaneous tissue (690-698)	11,749	210
Maternal and well baby care (Y60-Y69)	9,665	173
Diseases of ear and mastoid process (380-389)	9,598	172
Diseases of oesophagus, stomach, and duodenum (530-537)	9,372	168

*Total consultation rate is a measure of general practitioners workload and not of incidence as the same patients are repeatedly counted within the study period.
Source: Balarajan *et al.* 1983.

health, the 1981 General Household Survey has shown that 21 per cent of professional males aged 16-64 years report themselves to be suffering from long standing illness compared to 33 per cent among unskilled males of the same age. For females the gap is even wider – 20 per cent and 44 per cent respectively.

Finally there is evidence that insufficient use is being made of the fruits of technological advance. Coronary artery bypass grafting for example, is performed in the US six to eight times more frequently per head of population than it is in this country. And a recent BMJ leader discussing the management of kidney failure pointed out that the treatment rate in England in 1981 of 25.4 new patients per million population was less than that recorded for 16 other European countries (Wing 1983).

There are obvious dangers in attempting to draw general conclusions from specific examples such as those cited above. Nevertheless, it seems likely that there would be a consensus that disease prevention, the ageing population, inequalities in health and advancing technology are major issues of the moment to which the NHS must address itself.

Table 5 **Top 20 general surgical operations**

Operation	*No per 100,000*	*Total No in England and Wales*
Appendicectomy	143.5	70,480
Inguinal hernia repair	129.6	63,650
Benign breast disease (excision biopsy)	75.5	37,100
Cholecystectomy	73.9	36,310
All anal operations (including fissure, fistula, and haemorrhoids)	71.6	35,160
Cystosocopy with or without bladder diathermy*	62.3	30,620
Varicose veins	54.7	26,880
Malignant skin lesion (excluding melanoma)	51.6	25,330
Circumcision	44.6	21,920
Prostatectomy*	35.5	17,420
Mastectomy	29.9	14,670
Orchidopexy	23.6	11,580
Colectomy, total or partial	21.5	10,570
Rectal carcinoma, excision or diathermy	18.8	9,240
Thyroidectomy	17.3	8,500
Vagotomy	16.9	8,280
Hydrocele (aspiration or excision)	11.7	5,730
Femoral hernia repair	11.6	5,720
Amputation of leg for vascular disease	8.7	4,250
Defunctioning colostomy	8.0	3,940

*Excluding operations performed by whole time urologists.
Source: Allen-Mersh and Earlam 1983.

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New advances in therapy

Charles George

Problems with existing drug treatments include poor prescribing habits, inadequate communication with patients and imprecise targeting of the medicine. In addition, unwanted effects of treatment are common[1] and, in many instances, are preventable. One advance in therapy which can be expected by 1996 is the better use of currently available treatments. The improvements will result from several changes.

Implementation of some of the recommendations contained in the Greenfield Report[2] should help to promote safer, more appropriate prescribing. Nevertheless, better education of undergraduates and postgraduate doctors are by themselves insufficient to achieve this end. More attention needs to be paid to the needs of patients. Currently, some 62% of patients are dissatisfied with the information given about the treatments which they receive. The great majority (83%) would like to have more information[3]. Although many patients are aware of the names of their medicines and the purposes for which they are intended, knowledge of unwanted effects is very poor[3,4]. The situation can, however be improved by the use of information leaflets and other techniques. I anticipate that these will become commonplace by 1996.

Currently, the targeting of many drug treatments is inaccurate or too diffuse. Even 'topical' therapy such as timolol eye drops creates an overspill which can have systemic actions. Although we have seen the introduction of some improved methods of delivery, including the Ocusert system and transdermal administration of nitrates, further improvements in technology will occur. These should ensure better delivery of the medicine with the occurrence of fewer unwanted effects when these occur due to high systemic concentrations of the drug. Possibly the most specific forms of targeting of drugs will be in the shape of immune therapies. Already these have been used in the treatment of digitalis intoxication[5]. But, monoclonal antibodies directed at preventing or treating malignancy may well become an important remedy for cancer[6].

New treatments

Although acknowledging the fact that both musculoskeletal problems and digestive symptoms cause significant morbidity, they appear to me to have received disproportionate attention from pharmaceutical companies. The plethora of non-steroidal anti-inflammatory agents which are currently available have done comparatively little to improve upon ones which were available 10 years ago. Indeed, in the last 3 years we have seen the withdrawal of several NSAID's from the UK market because of serious unwanted effects. By contrast, major improvements have occurred in the symptomatic treatment of gastrointestinal disease. Nevertheless, modern anti-ulcer therapies, although effective in healing the majority of peptic ulcers, do not cure the underlying disorder which led to their development. I have little doubt that further advances in treatment will take place in both of these areas of medicine. However, in my view it is important that we concentrate our activities in those areas where disability is even more prevalent. According to the MRC, the most common problems afflict the cardiovascular and respiratory systems and affect the brain to cause mental illness.

It is possible that, as in previous times, serrendipitous discoveries of useful actions on these systems may occur – the introduction of lithium for manic depressive psychosis is an example of this type of discovery. However, it is much more likely that advances in the treatment of conditions will follow an improved understanding of normal physiology and how it is deranged in diseases which affect the heart, lungs and brain. For example, despite the high incidence of myocardial infarction and its terrifying consequences both in terms of mortality and morbidity, we are only just beginning to understand the events which herald the development of an infarction[7]. Only by the demonstration of thrombus within the coronary circulation and the antecedent splitting of atheromatous plaques do we have a logical reason to explore further the use of agents with an antithrombotic action.

Among the common conditions which afflict the respiratory tract are asthma and bronchitis. We recognise that allergens may provoke the acute release of inflammatory mediators from the sensitised human mast cell[8] and these processes can be controlled with several currently available treatments. However, chronic forms of airways obstruction have a more complex aetiology. We require detailed studies on the interactions between the mediators produced by activation of the lipoxygenase pathway with other systems, e.g. the autonomic nervous system, if we are to gain a clearer understanding of chronic bronchitis and severe asthma. Armed with such information new drug therapies can be sought using a more rational approach. At the same time more strenuous efforts could be made to limit exposure to some of the precipitating factors, e.g. stopping smoking. Finally, in the case of psychiatric illness, the complementary use of new imaging techniques to detect the distribution of gamma emitting, isotopically labelled agonist and antagonist substances in patients with various forms of mental illness, coupled with studies *in vitro*, will, I believe, yield important information. Already, studies performed *in vitro* on the binding of radioligands have shown the 'monoamine depletion theory' of depression to be wanting and have shed light on alternative mechanisms by which drugs such as mianserin produce their effects[9]. It is likely also that the use of nuclear magnetic resonance techniques will shed further light on metabolic abnormalities occurring *in vivo*[10]. Experimental studies are likely to contribute to our understanding of the normal and will allow the development of hypotheses to explain disease. Subsequently, this may lead to a more rational approach to development of new treatments rather than the existing, sometimes 'hit and miss' approach.

Post-marketing surveillance

Despite the limitations of the yellow card system[11] of adverse drug reaction reporting, there is little doubt that it will continue to play an important role in the detection of very rare unwanted effects from drug treatment. Nevertheless, alternative (but complementary) techniques have already shown their worth[12]. For example, 'prescription event monitoring' can detect problems which occur at a frequency of between 1:100 and 1:5000 patients studied. Once the prescription pricing bureaux are equipped with computerised information retrieval systems, it seems to me highly likely that event monitoring will become routine. Not only should this improve the recognition of unwanted effects (thus exposing fewer patients to the risk), but also it should allow a further reduction in pre-marketing requirements.

Generic prescribing

Generic prescribing has, in my view, several advantages[13] and generic substitution in the community may become a future reality. But, if it does occur, innovative companies must continue to expect a reasonable return on their

investment. Protection of their interests can be achieved by rationalising the pre-marketing requirements in terms of demonstration of safety and efficacy[14] and must be coupled with a realistic patent life which takes account of the legislative requirements imposed by the constituent members of the EEC and especially the FDA in America.

Hospital or community?

Recently, it has been suggested[15] that in hospitals, medicines are frequently used only to facilitate other procedures such as surgical operations, whereas in general practice they are often the central element in medical care. The fact that some 70% of GP consultations terminate with the issue of a prescription (for an average of 1.4 items) is consistent with this claim. In addition, I must agree that a great deal of such treatment currently provides only symptomatic relief for many diseases. In view of this I must also concede that future advances may equip family doctors to cure or prevent a wider range of disease than is at present possible. If so, there may be a shift in the main focus of health care activity further into the community, rather than institutionalised settings. But, I consider that the extent of this change will be small. Most infections are already treatable, but there is a future possibility of further preventive measures. The development of a vaccine to protect against the development of a cancer following infection with hepatitis B would be an advance. It is possible also that such treatment might be offered within the general practitioner's surgery. However, unless it were universally acceptable it might only be justified in patients who had contracted hepatitis B infection. Diagnosis of the latter would depend upon the hospital services. Similarly, the detection of many other diseases and their follow-up will necessitate the widespread use of hospital laboratory facilities and non-invasive imaging. It is unlikely that this will be available outside the setting of hospital.

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Developments in primary health care

Marshall Marinker

Introduction

Primary health care is a much larger concept than general practice. Nonetheless the two terms continue to be used as synonyms in the United Kingdom, because most of our primary health care is organised around the general practitioner and the so called 'practice population'. Exceptions include the school health service, occupational health services, and certain hospital based facilities – for example accident and emergency services and clinics for sexually transmitted diseases. Inevitably my use of the term 'primary health care' will be coloured throughout by the traditions of the U.K.

The present position of the Family Practitioner Services is excellently described in the appropriate section (pp 30-36) of 'Understanding the NHS in the 1980's' (OHE 1984), which is one of our source documents. This section should be read in association with what follows. In this paper I want to look at some historical perspectives; the background of change against which any plans which we make for primary care in a future NHS Act must be seen; the aims of primary care; some of the impediments to achieving these aims and some of the dilemmas which will face us. I conclude with a suggested new model.

Historical perspectives

General practice emerged in the mid 19th century at a time when apothecaries joined physicians and surgeons on one common medical register. The relationship between them was first territorial (there was an agreement that physicians and surgeons would only see patients who had been referred to them by general practitioners) and second educational (they shared a common basic training).

The territorial relationship resulted from hard bargaining and sometimes litigation between the various groups. It became enshrined in the arrangements made for the National Health Service in 1946.

This ensured a separation of function between primary care which remained domestic and generalist, and secondary care which was hospital based and has become increasingly specialist and technical.

The educational relationship showed much less reciprocity than the territorial one. For almost a century after the 1858 Medical Act it was possible to make the assumption that medical schools produced general practitioners. These student doctors were trained by hospital consultants and their senior staff. An educational hierarchy persisted, until the recent past, in which general practitioners looked to their hospital colleagues for life-long instruction.

Foucault[1] describing developments in medicine in 18th century Europe talks of 'la naissance de la clinique'. The term 'clinique' translates both as the location of practice and as the method of medical thought. Little has changed in this regard, since the 18th century. Both structurally and conceptually the medical school allies itself to the teaching hospital. However, the aim is no longer to produce a safe practitioner. In the 1980's there is a mandatory three year period of vocational training for future general practitioners, following the pre-registration year in hospital. Yet two of these three years training still take place in hospital posts.

There are now considerable pressures to re-examine both the territorial and the educational relationships which helped to form, and which stem from, the 1858 Medical Act, and which continue in contemporary practice and training. For example hospital clinicians and community physicians who express anxiety about the quality of care in general practice which is given to such groups as children, the mentally ill, diabetics, asthmatics, have advocated hospital outreach programmes to supplement, or even replace, general practice primary care. Already obstetrics has been almost completely hospitalised, and general practitioners effectively de-skilled over the past two decades. Others have suggested that at least in relation to the age of the patients for whom they care, general practitioners must specialise.

In the hospital there is a diminishing recruitment of generalists to the staff. Although many consultants may still be described as 'general' physicians or surgeons, most of them have special interests which come to dominate their contribution. The benefits of this specialisation are self-evident, the disbenefits, slighter and often unnoticed. The tasks of doctors in the hospital are now particulated by age (paediatricians and geriatricians): by organ (gynaecologists and dermatologists): by system (neurologists and endocrinologists) by technique (vascular surgeons and diagnostic radiologists) by disease (oncologists and diabeticians) by social stigma (venereologists and forensic psychiatrists): by biochemistry (immunologists and clinical geneticists). So specialised have many of these functions become that these clinicians no longer share common technical pre-occupations, and so no common language in which to communicate with one another.

Hospital medicine is likely to be characterised by the application of an increasingly sophisticated, expensive and narrowly specialised technology. It will be practiced by clinicians whose specialist training is no longer preceded by even the semblance of what Todd[2] called general professional training. If this specialist care is to be selective, efficient, effective and humane, the entry of patients into this secondary care system must be mediated by highly trained community based generalists. Further, the overwhelming majority of health care problems which patients bring to doctors do not require specialist care: indeed inappropriate specialist care can be not only costly, but unhealthy.

By a fortunate stroke of history we have developed a code of relationships between the different members of the medical profession, which is revealed as being infinitely more rational, clinically appropriate and humane than it was in the 19th century, when the bargains were finally struck. We have yet to build on this system, so as to ensure the quality of referral, its appropriateness and its cost-effectiveness.

Background of change

Plans for primary health care in a future National Health Service will need to take into account changes in society, demography, medical technology and specialisation, and the nature of medical problems with which the health caring professions will have to deal. It would be folly to make anything but the most tentative predictions.

The most radical *social change* may stem from the new information technology. Much will depend on general levels of prosperity, but it is already technically feasible for individuals to have access to a vast electronically mediated library. Moreover access to this library will be interactive, will permit problem solving, and will encourage individuals to take greater responsibility for their own health maintenance.

As far as primary health care is concerned, therefore, patients may be infinitely better informed and the consultation may start on quite a different basis from that with which we are now familiar. Patients will also have access to information which will allow them to audit the quality of the care they receive.

The development of robotics has already resulted in structural mass unemployment in manufacturing industries: the shift of these workers into service industries will be slow, and probably never complete. Although the new technologies promise increasing prosperity for everyone, many commentators suggest that for the forseeable future there will be greater disparities in the distribution of wealth than in the last few decades. These analysts suggest that increasingly disadvantaged sub-groups in our society will become disaffected and that considerable social turbulence is likely. We can predict that this would give rise to new psychosocial morbidities, a growing gap between the health of the affluent and the poor, and new problems in the delivery of primary health care, particularly in inner cities.

Already we have seen the relatively low level of primary health care in our inner cities. Tudor Hart[3] proposing an Inverse Care Law suggests that there is an inverse relationship between the measurable medical needs of a locality and the provision of health care services.

Even if we do not take such a pessimistic view of our social future we may do well to recall Toffler's[4] prediction that communities within one country or society are likely to be much more heterogeneous than in the past. The provision of primary health care in a new National Health Service may need to be much more flexible and responsive to local needs than are our present provisions.

The major *demographic change* will be the ageing of our population. If the response of primary health care continues to focus predominantly on the management of established physical and social handicap, the task is likely to overwhelm our resources. The present trend in general practice (still barely discernible) towards health education and anticipatory care, will nowhere be more crucial than in the case of the not yet elderly.

Changes in *medical technology* will develop apace. Although high technology begins in the laboratory and the specialist hospital department, it is often quickly translated into the sphere of general practice. Potent, specific and reliable drugs have transformed primary care and many conditions which formally required hospitalisation can now be effectively dealt with in the community. As a result the majority of infectious diseases can be managed outside the hospital and people with mental disease, who were previously confined in asylums, are returned to the community. As this process accelerates, there will be a need to increase all the resources of primary health care, including access to laboratories and other investigative facilities.

If anything, *medical specialisation* will increase. It has already progressed to the point where specialists find it difficult to relate their diagnosis and treatment to the patient as a whole. This can result in excessive diagnosis and management and in distorted judgements which are no less threatening because they are well intentioned. Logic suggests that, in the future, there will be an even greater need for high quality generalists. This role can now only be filled by general practitioners in the community. How medicine practiced in the specialist hospital unit is to be moderated by a generalist approach, remains an unsolved problem.

Lastly, the nature of *medical problems* will change and our understanding of current medical problems will change. Major morbidities ebb and flow over time in ways which remain difficult to explain, and difficult to predict. More than this, as medicine outside the hospital becomes more professionalised and more self-aware, doubt is thrown on much of the nosology which stems from the hospital (and increasingly specialist) experience. Shepherd[5] has commented on the inappropriateness of psychiatric language to describe the array of emotional illness encountered in the community. The same is true for physical disease. What is the name of the disease which causes countless women in early middle age to experience heavy menstrual loss, with no real evidence of pathological changes in the uterus, and no anaemia? What sort of treatment is the removal of the structurally normal uterus? How can we explain the subsequent improvement which these women experience in mood, function and sense of well being? The pharmaceutical industry may need to take increasing notice of general practice perceptions of health and illness in developing appropriate drugs for the future.

Aims

Doctors and other members of the primary health care team rarely sit down to discuss the question: 'What is the practice here to do?' The contract with Family Practitioner Committees is not explicitly helpful. When this question is pressed, two distinct classes of reply are given. The first is that the general practitioner intends to respond to the problems which patients bring. The second is that the practice intends to enhance the physical social and psychological well-being of the population which looks to the practice for care. The literature of general practice is full of good intentions, good advice, but only a modest amount of research, in relation to both of these approaches.

The Royal College of General Practitioners, has over the past 30 years, defined and redefined general practice as an independent clinical discipline. The declared aim of primary medical care in our society is described by the College as at once personal, family-orientated, continuous, preventive, local, and based on a multi-disciplinary team. Many of these intentions are in conflict with one another.

Personal and continuous health care is sometimes in conflict with current demands by health care professionals for a personal and continuous domestic and social life.

A family orientation while appearing to be both effective and humane, is in fact often characterised by conflicts of interest to which lawyers have traditionally been more sensitive than doctors.

The team approach, while offering a variety of personalities and roles, is inimical to personal care, and can result in what Balint[6] called 'the collusion of anonymity'.

The consultation which moves from a consideration of the problem which the patient brings, to a consideration of the doctor's beliefs about the patient's lifestyle (diet, exercise, smoking and so on), transforms both the intentions of the medical transaction and the doctor-patient relationship.

Preventive medicine is easier to practice in a population which is based on a geographical location, than in a population based on affiliation to a particular doctor or doctors. When health visitors changed their constituency from a group of streets to a group practice, it was proposed that the loss of geographical area of responsibility would be off-set by the advantages of team work. There are now doubts about the wisdom of this judgement. Yet if primary care were to be offered on the basis of a locality, and not on the basis of affiliation to a particular doctor, freedom of choice (both for doctors and patients) might be diminished. Since most practice would be based on groups, the loss of this freedom may be more illusory than real.

In 1982, recognising that continuing medical education for general practice would need to take the form of a perpetual performance review, the Royal College of General Practitioners published under the title *What Sort of Doctor?*[7] a

series of criteria which were listed under four main headings:

1 Accessibility
2 Clinical Competence
3 Communication
4 Professional Values

An example of these criteria (the section on Clinical Competence) is in the Appendix.

A system of practice visiting, which includes the analysis of randomly chosen video-taped consultations, is being developed, in order to assess the criteria. Though far less reliable than more conventional examination techniques, these methods of looking directly at the function of the doctor in the practice hold out the promise of a valid medical audit. There is as yet no regulatory intention, but the method is currently providing a framework for a growing programme of continuing medical education.

In 1983, the College, in what became known as the *Quality Initiative*, adopted the following policy:

1 each general practitioner should describe his current work and therefore should be able to say what services his practice provides for his patients;
2 each general practitioner should define specific objectives for the care of his patients and should monitor the extent to which those objectives are met.

Much attention is being paid to the development of specific objectives for the care of practice populations. For example

1 'The Practice will generate a case finding programme to detect hypertension in men and women between the ages of 35 and 65 years. The aim will be to achieve control at 100 mm Hg diastolic pressure. 70% of this population will be enrolled within the first year, and 95% within the first 5 years'.
2 'By their fifteenth birthday, all girls in the practice will be immune from rubella infection'.
3 All known diabetics in the practice will receive annual checks of vision, fundi occuli, peripheral circulation, weight and blood pressure, chest pain symptoms, and so on.

Needs

Over the past two or three decades much has been written about the appropriate organisation of primary health care in the NHS. What has been missing is a professional approach to management. Educational courses are now being developed (notably by the King's Fund) which invite members of the team to look at the management of self, of others, of resources, of time and so on. A prerequisite will be the development of shared goals for health care, and a commitment to innovate change, to take part and evaluate.

It will be essential that the tasks and roles of health care workers reflect clinical imperatives and the needs of the community. Most often they now reflect professional self-image, and the ambitions of professional institutions. The structures of primary health care – people, buildings and equipment should provide a maximum flexibility in order to achieve movements in directions which we cannot forsee. Planning for the group practice will demand the introduction and maintenance of a comprehensive information system. Locally, systems will need to be linked, in order to provide data for the planning of appropriate secondary care, at least at the level of the Family Practitioner Committee, and almost certainly regionally.

Impediments

There are a number of major impediments to change. Perhaps the strongest and most insidious is our present system of medical education. The National Health Service has an enormous investment in all three phases of medical education. For all sorts of reasons, not least that the National Health Service is the major employer of hospital staff, and virtually a monopolistic employer of general practitioners, it has seemed important to defend the independence of the universities and the colleges. Yet the relationship between the National Health Service, the universities and the colleges is a close and complex one, and likely to remain so. For example, while the NHS has given massive support to hospital based clinical teaching in the medical school, it has given scant support to the development of clinical teaching for medical students in the community. The disbenefit of this conjoint university and NHS indifference to the development of academic general practice in the medical school has done much to stunt the development of teaching and research which might have had far reaching effects on the efficiency and effectiveness of the NHS. For the future, time and resources for the perpetual training of primary health staff has to be brought within the framework of any future contract.

The assumption by health care workers of inflexible roles is another impediment. Particularly in nursing, specialisation has resulted in tangled lines of accountability and communication. Restrictive practices and boundary disputes have become a major problem. A nurse in the practice may usefully be employed not only in traditional home nursing (now the province of the *community nurse*), but also in treatment room procedures (now the province of the *practice nurse*). She may take on a specifically health education function (now the prerogative of the *health visitor*), and it is currently unthinkable that she might encroach too far on the territories of the *community psychiatric nurse* or the *occupational therapist*. There is currently almost no provision for the nurse to move into areas of clinical decision making: this contrasts with the United States where there has been a widespread, (though now failing) development of *nurse practitioners*.

Primary medical care in a new National Health Service may require a generic nurse, capable of undertaking all of the wide variety of primary care nursing functions. In this he or she would mirror the non-specialised generalist functions of the primary health doctor. The present relationships between doctors, nurses and others (including social workers) in so-called primary health care teams are impossibly muddled. Practice nurses are employed by the doctors in the practice, and have a clear accountability to them. Community nurses and health visitors have no such direct responsibility or lines of accountability. They relate to nursing bureaucracies who determine their goals, and decide on boundaries. Social workers, of course, have a totally different line of accountability and administration. Others relate elsewhere: for example clinical psychologists to Divisions of Psychiatry.

If the primary health care team (deprived by its structure of a leader) presents problems, so does the idea of the general practitioner partnership. This partnership which has the form and intentions of a business arrangement, is devoid of any explicit content related to the service which the group is to provide. It can impede change because change is geared to the rate of movement of the slowest, the least imaginative or the laziest member of the group.

Perhaps the most stultifying impediment to change is the security of the general practitioner. NHS general practice is a relatively well rewarded, non-competitive monopoly, and its practitioners enjoy virtual life-long tenure. Given these conditions, the wonder is not that so little has been achieved

in terms of improving quality, but that so many practices have done so well. Any future system must build into its structure some elements of competition, reward for attainment, and disincentive to poor work. The Report of the Review Body in May 1966 (colloquially known as 'The General Practitioners Charter') gave a great impetus to the development of group practice, purpose build premises and the employment of administrative and clerical staff.

One current difficulty illustrates the complexity of the impediments. The Royal College of General Practitioners now envisages that practices will produce brochures which set out in clear and unambiguous language what is available for their patients. These will include statements about accessability, plans for the continuity of care, availability of advice on contraception, well-women clinics, developmental assessment of infants, goals for immunisation and blood pressure detection and so on. Such brochures, which would be available not only to patients but to those who were considering joining a practice, are likely to gain common currency in a locality. The General Medical Council is likely soon to be asked how close this comes to advertising – so fiercely proscribed by conventional medical etiquette.

Dilemmas

If an independent contract is to provide the basis for primary health care in a 1996 NHS Act, the content of this contract will require close scrutiny. The lines of accountability will need to be made clear and the method of monitoring the contract agreed. Unless a quality-sensitive reward system is introduced, motivation for change, and improved performance, will continue to rely on professional good conscience alone. The latter has worked remarkably well, but perhaps not for the majority of general practices.

Rewards need not necessarily be entirely financial. They may include rewards of status and standing, and of opportunities for further education, teaching, and research. Currently the income of general practitioners is derived from three main sources. Basic practice allowances provide a salary component. Capitation reflects the size of the list. In addition there are payments for particular items of service. Each of these components is poorly related to performance. That component of reward which relies on basic allowances (for example location of practice, size of group, years of service and so on) is insensitive to current effort and performance. The component which relies on capitation, is similarly insensitive to the quality of care which each individual receives. Indeed the larger the population for which care is provided, the smaller the share of resources, particuarly time, that will be available to each individual.

It might seem that payment by item of service was most likely to reflect quality of care. But such payment is capable of generating clinical work which is geared to the attraction of fees, rather than to the solving of medical problems. Items of service may be rewarded if they are easily accountable (like cervical cytology), but not if there is no reliable way of checking (like the taking of blood pressures). Further, by selecting some items of service for additional payment, the rest of the items of service become in some way 'optional'. At a recent conference on child abuse, general practitioner representatives were heard to argue that attendance at such conferences about families in their practice, should attract an additional fee. Once a professional service becomes itemised like a grocers bill, it becomes difficult any longer to rely on the professional ethos as a means of calibrating appropriate clinical work of a decent quality. Donabedian [8] has pointed to the tenuous and often impossible to prove connection between the processes of medical care, and the quality of the outcomes.

Perhaps the most important question which faces us is this. Can a high quality primary health care service come about by incremental reforms of the present system, or do we not now need to consider the possibility of a radical new model? What follows should be read as notes towards the construction of a system. Others more knowledgeable and skilled than the writer, in health care organisation and the politics of the professions may be capable of modifying, adapting, negotiating and perhaps even translating into reality.

A new model

The 1946 National Health Service Act was based on hospital medicine. It is difficult to avoid the conclusion that in the minds of these early planners, the major role of primary health care was to act as a stopcock on the use of the hospital. For all the reasons adduced in the papers by George Teeling Smith and John Vaizey, which review some of the societal and medical changes since 1946, a National Health Service Act for 1996 should be based on a recognition of the central role in total health care provision, which could be played by primary health care teams.

Modern general practice stems from two distinct traditions. The first, described in many Victorian novels and in Cronin's Dr Findlay's Casebook, is most often found in relatively affluent rural areas, market towns and suburbs. The first NHS Act sought to graft this tradition onto another and more impoverished one: the perfunctory care by perfunctory men which characterised general practice in the industrial slums, and which is still extant. The relative success of this grafting is reflected in many surveys of consumer opinion.[9] But in the inner cities, this model of health care, like so many other social structures, has broken down.

In outlining a new model, I want first to define acceptable goals for a future primary care service, second to suggest some of the means of achieving them, and finally to make a plea for experimentation in the decade which will lead up to a new Act in 1996.

Future goals

We should aim for the universal provision of a high quality service which incorporates health education, prevention and the diagnosis and management of illness. The criteria for this high quality should reflect the views of the consumers and local traditions and needs, as well as our understanding of medical science and the management of health care. Attempts should be made to reconcile the desired goals of personal and continuing care, with the sometimes conflicting goals of freedom of choice by the patient. We should seek to address the conflict between a population based on a geographical area (which would simplify programmes of health education and disease prevention), and a population based on affiliation to a particular doctor or group (which permits greater flexibility of patient choice). The service must be cost effective, and capable of rapid adaptation. This adaptation may need to become quite radical if and when changes in medical science and social conditions accelerate.

In order to achieve these goals, it will be necessary to innovate and experiment. Both diversity and competition in the provision of primary health care will be a sine qua non. So will a significant shift in the proportion of limited resources from secondary to primary care.

Means

Diversity and competition could be achieved by encouraging private fee paying general practice to compete with the present NHS provision of care. This would certainly encourage innovation, and with a population much more affluent than that of the 1940s, for whom the first NHS was planned, it might become acceptable to the majority of people – particularly if there were demonstrable benefits in accessability to the doctor of choice, standards of premises and equipment, and a change in the attitude to the patient as client. However, it is argued that the underprivileged would suffer, that even though scarce central resources might be diverted to them, two classes of care would emerge. Broadly, the arguments divide on lines of political philosophy.

The very fact that there has been almost no growth in private medicine in general practice (it has remained at less than 1 per cent since the beginning of the present Health Service), suggests that there is a concensus in the country, for universal primary care, free at the time of consultation. This seems to have broad support on the right as well as the left of politics, and from the health caring professions themselves.

What is suggested, therefore, is the development of a diverse and competitive primary care which is centrally funded, and based on a system of rational health goals, incentives, penalties and sensitive accountability. This would not preclude the competitive development, subsequently, of some privately funded units based on a mixture of insurance and direct payment.

The franchise for the provision of primary health care would be offered by local communities to new groups of primary health care providers. In the first instance many of these units might be based on the personnel and premises of present day general practices. This would be a trend and not a pre-condition. Where current primary health care provision is notably failing, local communities would naturally wish to introduce totally new units. Existing groups would doubtless wish to negotiate for a two or three year period, initially, in order to reorganise so as to meet certain basic criteria.

We would need to decide on the optimum size of these units, with variations depending on local circumstances. Each unit would almost certainly need a practice manager with far greater expertise in health care management than is now either necessary or assumed by those who carry this title.

In its apotheosis all the members of this unit, doctors, nurses and other health care workers might become cooperative, and therefore profit sharing, partners. The managers, or groups of managers, might be the profit sharing partners, and all the health care workers salaried. There is an infinite variety of possible combinations and agreements into which those involved may wish to enter. Where, for ideological reasons, a local community would prefer to offer a salaried-service based unit, this would be possible. But it might well compete in the same locality with a differently structured and motivated group.

The contract between the community and the unit would, unlike the present general practitioners' contract, be very specific, and be armed with teeth. Health care targets concerned with accessibility, standards of record keeping, an appropriate environment for health care, health education programmes, anticipatory care, preventive medicine and rates of diagnosis and standards of monitoring of chronic conditions, could all be used as markers of quality.

It will be argued that the most important components of quality, such as compassion, respect for the patient as a unique individual, therapeutic listening and so on, will be not be measurable. The qualities which will be measured will emphasise the mechanistic face of modern medicine. This criticism cannot be avoided, but the measurable elements, however mechanistic, remain crucially important. Moreover, the immeasurable human qualities may well come to be reflected in patient preference and choice, which can become an important factor in future competitive practice.

The community would offer a franchise to a unit for a realistic period of time. First contracts might be for three years, and would be reviewed in the light of performance. Similarly the rewards would be linked not to basic allowances and capitation (which might nonetheless constitute a starting base for the calculation), but to measures of performance (as opposed to crude items of service). If a group proved highly successful in setting and meeting its targets, and popular with its community, the franchise might later be extended for a maximum of, say, seven years. The period of subsequent franchise (up to this maximum) would be part of the reward system.

Based on calculations which take into account the number of patients to be served, and the health care targets agreed, each of these units would receive an annual budget. The unit will become the budget holder. Built into the system, would be incentives for cost effectiveness, as well as high quality care.

Such units would need to operate from the sort of premises and with the sort of plant which is now mostly found in purpose built premises such as health centres and medical centres. Future provision of such premises and plant for primary health care units, as well as pump-priming funding may become available from a number of resources: local authorities, government agencies, insurance companies and banks. Any such system would require a sophisticated method of record keeping, not only in order to facilitate clinical problem solving, but so as to provide foolproof recall systems for preventive medicine, and the means of achieving a continuous performance review. A major advance in achieving both continuity of care, and patient participation in his or her own health care maintenance, would be the option of patient-held records, which would be universally offered.

Past experience suggests that patients will infrequently move between one unit and another, except on changing address. If the unit size were large enough, and a mechanism built in to allow patients within each unit maximum freedom of choice of doctor and nurse between one consultation and the next, it may well be that freedom of choice of unit would have to be limited. Ideally, however, there should always be a choice between two units. It is recognised that this will not hold in sparsely populated parts of the country.

The contracts envisaged here would be voluntarily entered into by the contractors and the community. The community would however need to have made available to it, expert guidance about the current state of the art in primary health care, including currently perceived priorities. Such guidance, which one could envisage being published annually, might come from a consortium of national bodies concerned with standards of medical and nursing care. A local community would therefore be able to judge its own aims, and its own performance, in relation to such national guidelines. Given the natural inventiveness of the professionals, and the enhancement of this which is

likely to come from the new incentives to work together, such national guidelines are more likely to follow than to lead local initiative.

Family Practitioner Committees are now developing in such a way[10] that by 1996 they may well be equipped to function as the commissioning agents for this new form of contract. A prerequisite for such an agency is the development of a computer based information system which must also provide a link between primary and secondary care.

One major consequence would be to evacuate patients from the present wasteful and ineffective out-patient clinics, and return them to general practice. Much of the present monitoring of chronic diseases in out-patient departments is carried out by junior staff who are not equipped to take the relevant decisions or to provide personal follow-up. These tasks must become the responsibility of the primary health care unit. Specialist opinion about difficult problems in primary care (the traditional function of the consultant), could take place at sessions held in the primary health care unit itself.

Admission to in-patients would take place directly from primary health care. For many procedures like herniorrhaphy and varicose vein surgery, there would be direct access to waiting lists, and not the present ritual of preliminary out-patient appointments. The abolition of out-patients would be matched by increasing availability of specialised diagnostic techniques (laboratory, x-ray and other) to general practitioners, and there may indeed be further scope for industrialising and automating these investigations.

Such primary health care units, taking on a broader remit, will undoubtedly generate the need for community hospitals, whose development would further reduce the pressure on district general hospitals. These community hospitals will provide an appropriate environment for patient care where the medical problems are technically within the scope of primary health care personnel, but where, for social reasons, patients require short term admission to a hospital bed.

Maynard's suggestion that the primary health care unit should be the budget holder not only for primary but also for secondary medical care, ushers in immense possibilities for appropriate use of resources and cost effectiveness. Not only would the cost effectiveness of general practice improve, but hospital clinicians would be motivated to rationalise their currently idiosyncratic use of hospital beds and expensive personnel and plant. Far from the rather simplistic model of primary care as a stopcock on secondary care, this new model would permit an entrepreneurial competitiveness in both primary and secondary care, in which both quality and value for money could be more easily achieved.

The next stage

What is outlined above should be read as a broad manifesto, rather than as a detailed proposal for change. Whether it is regarded as an accelerated form of incremental change in the health service, or as an upsetting revolution, will depend on the beliefs and philosophies of the reader. If the ideas appeal, and if the motivation is there, the organisational difficulties can be constructively tackled. I do not underestimate the likely resistance which will be expressed by those organisations whose task it is to defend the general practitioner's terms and conditions of service. Similar reservations may be expressed by those currently concerned with the professional organisation of nursing. Attitudes however may change quite quickly, once it is seen that the rewards will rapidly come to outweigh the penalties of practising in a way which is accountable both for quality of work, and economy of resources.

What is proposed, therefore, is a decade of experimentation. In order to try out the model which I have suggested here, we may need to see how far our present regulations can be stretched, in order to provide a minimum requirement for such experiments. I suspect that present regulations cannot be so stretched. To take only one example, the function of doctors and nurses as independent contractors, working together in a profit sharing partnership presents formidable challenges to established professional organisations, and perhaps also to establish rules or professional etiquette.

It seems reasonable to speculate that there will be many general practitioners, nurses and other health care workers, not least from among the younger members of the professions, keen to experiment in this sort of way. In order to provide minimal arrangements for such experiments, it may be necessary to establish something analogous to the present 'enterprise zones', for the National Health Service. The inner cities provide obvious examples, but the experiment should also be carried out in a variety of other localities. If central funds are to be found for health care research, what higher priority could there be than the evaluation of alternative forms of health care, appropriate to the next half century?

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APPENDIX

Criteria for General Practice Performance

Clinical Competence

From 'What Sort of Doctor?', RCGP, September 1981

CLINICAL COMPETENCE

History-taking

The doctor consistently gives evidence of his ability to take a relevant history. He appears to be listening to what his patient says and is able to respond to the verbal and non-verbal cues which he is given. He constructs his questions logically and puts them clearly. He uses the medical record both to verify and to amplify the history.

The doctor persistently fails to elicit a relevant history. He gives evidence of not hearing what his patient is saying, or of actively preventing the patient from communicating. He cannot follow up the verbal and non-verbal cues which the patient gives, or he actively pursues aspects of the patient's history which seem to have no relevance to the problem presented. He fails to verify points in the history by reference to the medical record, or fails to use the medical record itself as a source of further information about past events.

Physical examination

The doctor consistently makes an appropriate physical examination based on the history. His examinations are skilled and carried out with obvious consideration for the patient. His examinations are more often concerned with clinical problem-solving than with ritual behaviour.

The doctor fails to make an appropriate physical examination based on the history. His examinations are cursory and are in other ways technically inadequate. He gives evidence of making so-called 'full physical examinations' which seem in no way part of the problem-solving approach.

Defining the problem

The doctor's definition of the patient's problem is clearly based on the evidence presented. He does not make a habit of naming a disease, where there is no reasonable criteria for such a diagnosis. He consistently relates physical, social and psychological factors.

The doctor's definition of the patient's problems, his 'diagnoses', are unsupported by the evidence that he has collected, or by a reasonable interpretation of the probabilities that exist. In formulating these problems, he persistently fails to relate physical, social and psychological factors.

Seeking further information

The doctor's search for further information is clearly rooted in the clinical work which precedes it, or can be supported by a reasonable interpretation of probabilities. He tries to understand how the patient sees the problem.

The doctor's search for further information by investigation cannot be supported either by the clinical work which precedes it, or by a statement of reasonable probabilities. He is not interested in how the patient sees the problem.

Use of resources

He refers appropriately to other members of the primary health care team and to the hospital services, including consultants.

He either fails appropriately to refer the patient to other members of the primary health care team, or he does so inappropriately. Similarly his referrals to hospital are either unsupported by the preceding clinical work, or fail to occur when they should.

Explanation to the patient

His explanations are both informative and clearly expressed; and where appropriate he explains both the likely causes of the problem and the likely course of coming events.

He fails adequately to explain his understanding of the patient's problems, including, where appropriate, the causes of the problems and the likely course of events.

Management

He involves the patient in decisions on management. He gives clear and concise advice about management, including life-style, diet, work, drug therapy and so on.

He does not involve the patient in decision-making. He fails to give clear advice about management, including life-style, diet, work, drug therapy and so on.

Prescribing

His use of drugs is appropriate. He has a disciplined and logical approach.

His use of drugs is inappropriate. He gives no evidence of a disciplined approach.

Preventive medicine

He consistently gives evidence of a willingness and ability to give both opportunistic and anticipatory care.

He fails to give appropriate opportunistic or anticipatory care.

Continuing care

The doctor, wherever appropriate, demonstrates his ability to make plans for the adequate follow-up of the patient. He goes out of his way to take personal responsibility for the continuing care of his patient, and imparts a sense of that continuity to the patient when this is appropriate.

The doctor persistently fails to make plans for the adequate follow-up of the patient. He gives scant evidence of taking personal responsibility for clinical problems, or for ensuring that the patient has a sense of continuing care, when this might be appropriate.

The pharmaceutical industry

Brian Cromie

Attitudes

The keynote of attitudes between the pharmaceutical industry (PI) and NHS is conflict. Not just between the two but within the view of each for the other.

The PI cannot decide if it is part of the professional health-care team or a maker of goods for a consumer, from which the best price must be obtained by the most commercial of methods.

The NHS cannot decide if it wants a thriving industry, which researches improved therapies or a base supplier of medicines at the cheapest possible price.

The wide variation between these conflicting attitudes underlines the dilemma of a free-enterprise industry inventing and producing medicines that have to be paid for by the tax-payer via a socialized health-service.

Profitability

The PI has to attract risk capital and produce a profit after covering costs and internal investment in order to survive. This is a commercial situation and demands commercial responses. Normally this would involve maximising profit by appropriate pricing and promotional policies.

However, the PI operates in an environment which criticises any profit (from illness) and doubly so for medicines, which are paid by the State and appear to compete for funds with doctors and nurses.

It is, perhaps, unfortunate that few people appreciate how short the current boom in pharmaceuticals really is. They criticise the high profits of pharmaceutical companies but this could be a temporary cycle. In the 1950s, the PI was relatively small and not particularly profitable. The era of discoveries produced new medicines and high profits due to widespread usage of patented products for thirty years but that phase is passing; the majority of companies now depend on sales of older products under severe competitive pressures with just the odd startling break-through and the PI is already beginning to shrink.

Perhaps I can illustrate this conflict in attitudes by reference to four topics, from which suggestions for a better future might follow:

1 Pricing

a) NHS: The Government acknowledges a dual role. It wants to support the positive balance of trade (currently £600m.) produced by the industry, by allowing pricing levels which reflect the export prices that give this balance of trade.

It also wants to limit the cost of drugs to the NHS to a reasonable level.

It sets out to achieve this dual role of helping export prices and having reasonable drug costs for the NHS by means of the Pharmaceutical Price Regulating Scheme (PPRS).

This is a complicated scheme by which the NHS, as the monopoly purchaser, allows a level of notional profit after certain levels of cost for research, promotion, etc.

This attitude of allowing higher local prices, so that the country gains from their export equivalents, seems reasonable until the logic is completely turned on its head by introducing a 2½ per cent price cut and by encouraging 'parallel' imports from countries where there is no sponsorship of exports and research and by pushing doctors to prescribe generically, thus threatening the research-based medicines.

The Government's attitude is also conflicting in that it wants to encourage patients to be treated under the Family Practitioners Service (FPS) and then suggests cash limits, which would limit the use of medicines needed. Such limits can only direct patients back to the more expensive hospital service.

b) The PI, as a profit-based industry, should aim to maximize prices and, from these, profits. However, the 27 years of the PPRS (originally VPRS) have conditioned the industry, so that it now only seeks to survive for a medium- or long-term future within the scheme. The industry agonizes within the formula of the PPRS, recognizing that prices must be at a level to produce the maximum 'notional' profit after incurring the 'allowed' level of costs but that much of the 'notional' profit might have to be used up to research and sell, so that the business is continued.

Having found the optimum price to comply with Government requirements (via PPRS) and to survive, companies may well find their prices are not competitive with similar products, are publicly criticized for being higher than generics with no research overheads or threatened by parallel imports from other countries.

There is also the problem that a profit-based pricing policy tends to reward a me-too drug as much as a break-through and does not provide the incentive for more basic R & D.

c) Summary: The DHSS is confused over its pricing aims and acts in diametrically opposed directions and the PI is confused by an increasingly contrived and artificial PPRS that is being over-ridden by direct price cuts and parallel imports.

2 Promotion

Promotion under the PPRS includes all mailings, advertisements and all the field force and their back-up services.

a) NHS: It is appreciated that there are unusual aspects in pharmaceutical promotion. The manufacturer informs/persuades a doctor, who is an independent contractor to the NHS and he prescribes for patients, while the cost is covered in full by the NHS.

This is an uneasy relationship between the doctor, who should be free to prescribe what he thinks is necessary for his individual patient, the manufacturer who supplies the medicine and the NHS which pays. In addition to this uneasy relationship, the DHSS has differing views on promotion. It probably recognises the efficiency of the current methods whereby doctors, at least, are aware of new medicines within 6-9 months of their introduction, as opposed to new surgical advances, which take up to 12 years to percolate down to GP level for the selection of appropriate patients.

Despite the efficiency, the DHSS tries to limit promotion at every turn. It tends to encourage publicity against all promotion, it endorses a negative Code and it 'allows' a level of promotional spending under the PPRS, which is tied to sales, so that large companies have more funds for promotion than they need and the smaller companies are not allowed to spend enough to guarantee national coverage of the information about their medicines.

The DHSS joins with part of the medical profession in saying that it wants a higher quality of pharmaceutical promotion and then does absolutely nothing to foster such an improvement. In fact, the quantitative restriction could have the reverse effect.

b) The PI looks at promotion in a different way. It knows that there is no substitute for the trained representative, who has three roles:

i) inform doctors and back-up that information with the resources of the Company
ii) collect information on clinical experience, which is passed back to the Company
iii) follow-up adverse reaction reports and remind doctors to send in yellow cards, where appropriate.

The PI also knows that doctors are human and information has to be presented in a straight forward and sometimes colourful way to obtain understanding.

The conflict for a commercial industry is that extreme methods of persuasion might maximize sales but that such methods would contravene the Code of Practice and the accepted professional mores in the health care area. The occasional, well-publicised excess demonstrates the conflict and the tendency of some companies to move beyond accepted limits towards commercial extremes.

c) Summary: The DHSS is basically antagonistic to promotion and has introduced discriminatory quantitative limits, while the PI recognizes the vital importance of effective promotion with varying responses to the mutually agreed Code of Practice.

3 Research

a) The NHS wants to have effective medicines and to encourage what is recognized as high-risk research. This is a declared part of their original PPRS but is now under severe challenge by their own policies.

Firstly by virtually abolishing the higher-price concept by allowing parallel imports of cheaper medicines from countries that do not have a research-sponsoring idea.

Secondly the DHSS actively promotes generic prescribing and has even given nodding acknowledgement to the possibility of generic substitution at some time in the future.

The problem for future research does not just lie in the very high risk and very high cost (£50-100m. per NCE) but in the long time taken to develop a new medicine and the short residual patent-life after licensing. A survey by the Centre for Medicine Research (Fig. 1) shows that the average NCE receives its product licence with about 8 years of effective patent-life left and this could be down to 5 years by 1990.

Economists estimate that an average of 19 years of world-wide sales are needed to recover R & D investment. Accordingly, it is worth while continuing research, if sales continue on the strength of the brand-name after the end of the patent but it will no longer be worth investing in pharmaceutical research, if generic usage makes the patent-life the total selling life.

To be fair, there is an understanding by the DHSS of the need to restore pharmaceutical patent-life but that is in the hands of the European Convention and the Department of Trade, so the Health Ministries feel powerless. In addition, governments tend to think in four-year terms, while research deals in 10-15 year projects!

b) The PI has been fairly slow to appreciate the danger to its very foundations by the erosion of patent-life and is only now beginning to make appropriate noises. In the US, they are ahead of us and 1984 will be the second attempt in two years to get some restoration of pharmaceutical patent-life but the UK has been apathetic in comparison.

The PI must recognize that the erosion of patent-life threatens continued investment in R & D. It also puts enormous pressure on the quality of research.

Society appears to want the PI to undertake more basic research and to conduct unending safety tests. In contrast, the rush to get a product licensed while it has still some

Figure 1 **New Chemical Entities (NCE's) in the UK**

Source: CMR October 1983

residual patent-life forces companies to undertake the minimum statutory safety tests and also discourages research into new areas, where animal tests and the like have not been fully established and where the development of the new product will take longer.

If the PI had a guaranteed patent-life after licensing, it could afford to look into less well-worn paths of R & D and conduct safety tests in an unhurried way to the benefit of all.

c) Summary: DHSS policies on parallel importation and the use of generic products are in conflict with their declared sponsorship of pharmaceutical research. Unless the PI manages to get some restoration of patent-life, there will be no incentive to invest in R & D and the cycle of innovation, which started in the 1950's, will not last to the end of the century.

4 Image

Many of the difficulties that have arisen between the PI and the NHS and the attitudes one to another, stem from poor public images.

a) The NHS had an excellent public image, which has become a bit tarnished at the edges, due to unequal levels of care, publicized waiting lists, industrial disputes, lowered staff morale and the gradual public realization that the NHS can only give 'care for all' up to the level of its cash limits; it is no longer an open-ended commitment.

In looking for scapegoats for their shortcomings, it is easy for the NHS to point to the unpopular drug industry and talk about costly medicines taking money from nurses, hospitals and patients. Some Ministers of Health have defended the industry as the major innovative source of improved medicines, but the image lingers on.

b) The PI now accepts that it has neglected the public relations activities needed to improve its image but it has left it somewhat late and the damage has been done.

Every medicine has a balance of benefit to risk and, if properly used, will help most patients but that help cannot be guaranteed any more than a surgical operation can guarantee success. This message should have been driven into the minds of doctors, politicians and public, together with the excellent record of innovation.

Perhaps it is not too late but years of inaction, failing to defend publicized adverse effects and conducting occasional excessive promotional practices have made it an uphill task.

c) Summary: The poor public image of the PI has had a major impact on attitudes between PI and NHS. Improvement of this lies largely in the hands of the PI, which should act, if it wants to prevent further damage.

Conclusion

There is no easy answer to the items listed.

The NHS must decide if it really wants to encourage an innovative PI and use their improved medicines to the optimum effect in primary care or go for a cheap-drug policy with no further research and no economic advantage, as has happened in Canada.

The PI is in such a punch-drunk state at the moment, that it tends to concentrate on the latest immediate threat (currently parallel importation) and cannot get round to the steps needed to guard its long-term future. However, for the record, I would like to repeat a six-point plan which would put the industry on the right lines:

1 Restoration of Patent-Life; probably to 15 years from product licence, similar to US.

2 Parallel Importation; work with DHSS and PSNC to ensure no lowering of standards for patients with imported material and no 'wind-fall profits' for pharmacists.

3 Original Pack Dispensing; individual patient packs for all medicines reduce errors, allow patient information leaflets, make patients familiar with the manufacturers of the medicines that help them and give pharmacists more time to advise patients on their treatment.

4 Promotional Code; obtain awareness and co-operation of medical profession in forcing a tight code concentrating on information and not on entertaining and the like.

5 PPRS Review; complete review of an out-dated, discriminatory system which has been overtaken by events, such as parallel imports and which reduces quantity, but probably also the quality, of promotion.

6 PR Campaign; long-term attempt to improve the environment for the PI by an active informational/ educational campaign with regional and central effort to doctors, MP's and public.

An NHS administration for the future?

John Vaizey

Though the 1946 National Health Service Act has been amended most of its major structures remain largely unaltered. Most treatment is free or heavily subsidised at point of service. Most facilities are owned and operated by the NHS. The hospital service is the centre of the NHS.

It is evident that in forty years the medical problems with which medicine deals have radically altered, and that the change will be no less great in the following years. The social and economic environment has also altered and will continue to do so.

A central fact of the medical situation in the next forty years is that the *volume of treatable cases* will increase. Each case will prove initially (on average) to be expensive to treat, and then less expensive. Therefore the total volume will rise, and will be compounded of expensive cases and those where costs are falling. It is a matter of judgment as to whether total expenditure on health care will rise faster than g.n.p. per capita. Judging from other countries and the speed of medical advances the answer is almost certainly 'yes'.

There are reasons why more medical care will be borne by private expenditure. Much dentistry and optical services are now privatised, and (effectively) so is a proportion of pharmaceutical prescriptions. To this must be added a whole range of quasi-medical activities – diet, exercise, group therapy – which double up with medical care as well as privately provided medical treatment. These are all growth areas of the medical care trade.

It follows that even if the NHS remains the dominant mode of providing medical services, it will be buttressed by substantial private provision, arising from the growth of the scope of 'medical care', and the costs per unit of treatment.

Obviously a central question is whether or not the main structure of the NHS will continue to rest on public finance in its present form. To this no adequate answer can be given. But a reasonable assumption would be that public finance will be supplemented in some form or other, at some time or other, from the growing affluence of individuals (clearly, too, one section of opinion will wish to go considerably further than this cautious statement).

In what respects would a new administration structure tend to differ from that which exists? First, ultimate responsibility to Parliament is unlikely to be relinquished, though there is now ample precedent for a quango – the Regional Boards being one approximation to a model and the Manpower Services Commission another to which Parliament cannot question directly.

Next, the Griffiths report has identified the need for adequate management of the units within the NHS.

The obvious principal lack is adequate cost control and budgeting of units, and of medical procedures within those units.

The expected development of existing trends would be for growing autonomy of the Regions and of the Districts. This autonomy can only be gained and preserved if the pressure for 'efficiency' – a many-faceted concept – is derived from tight managerial budgeting. Therefore, if the process of devolution of detailed control from the centre to the periphery is to be accelerated then it must follow a sustained and serious attempt at careful costing and budgeting at District level, and in units like hospitals and health centres (or group practices) within Districts. If such costing procedures are developed then the orthodox process of managerial control through finance rather than regulations – about manpower, or authorising clinical procedures – can be developed as well.

The process of devolution to the smallest possible unit will remove the necessity for detailed managerial control and co-ordination. Large parts of the present administrative structure will thus become redundant and this process will be accelerated by the progressive adoption of new communication processes using micro-circuitry of all kinds.

Thus far, however, the procedures which are being adopted are administrative and require little if any adaptation to the legislative framework. It cannot be too strongly emphasised that such administrative changes will represent in themselves a series of major developments.

But a further series of changes will require legislation. Though they are proposed here baldly, they are of course merely items on an agenda for extended discussion.

1 Is it to be the function of DHSS to organise a comprehensive system of medical care, or is it to be to provide a framework, a monitoring process, and to channel public funds? This is a central issue because at present in principle, the DHSS (through its Regional and District bodies principally) is the *providing* authority.

It can be argued that the principal function of a Department is not to *provide* but to arrange for a flexibility of response to a rapidly changing situation.

2 Is it to be the case that local units, including hospitals, general practioner groups and other local units, are to be the building blocks of a health care system? How far are these units to be self governing, subject mainly to financial control (through a budgetary process), and monitoring? If this is to be the case – and it can only be so if modern managerial and budgetary techniques are adopted – then the autonomous local units will require:

a) acceptable procedures for government and management (such as those recommended by Griffiths),

b) adequate procedures for budgeting, on the basis of case loads,

c) this in turn will rely upon the development of adequate procedures for determining appropriate unit costs.

3 Given this development towards local autonomy within a context of financial rather than administrative controls, there are of course hosts of administrative and other matters which would require detailed consideration. For example, general practitioners could hardly continue as independent contractors with FPCs, unless the FPC itself became a unit. It is not to dismiss such problems lightly to say that they are subsidiary to the main issue, namely whether allocation of resources is to be a centralised bureaucratic procedure (as in Defence), or a pseudo-market procedure (as in a commercial concern). The bulk of opinion among economists whether of the right or the left, would regard the market simulation as more efficient.

4 On the assumption that much of the concept of the dispersal of decision-making power is broadly acceptable, there remain many questions of principle, each in themselves sufficient for a major paper.

a) The present professional domination of the NHS is one of the characteristics that has led to its popularity, since doctors are perceived as 'goodies'. There is no pressure, for example, for the NHS to be put into the hands of local government. But the role of the professions is being increasingly questioned and the vexed questions of 'democratic responsibility' and of 'consumer participation' are also at issue. The doctrine of Ministerial responsibility is plainly not an adequate response to those sorts of matters.

b) The question of capital requirements is separate from the resolution of the mode of paying running costs. Some of the most difficult political issues concern the opening and closing of hospitals. In principle, if different bodies – trade

unions, county councils, businesses – were able to open hospitals (or other health care units), for which current expenditure can be reimbursed by the accounting procedures discussed above the problems would diminish. In other words, much capital allocation is unnecessary unless it is publicly provided. The issue here of course is whether capital costs are reimbursed on an amortised basis.

c) If payment is by unit of service a major step is possible in blurring private and public boundaries. If there is a major issue of limitations of public finance, this is a step to be desired. If not, not.

d) National pay and conditions negotiations are now out of favour. A process of 'unitisation' would enable local negotiations to take place. It may be noted that it is asserted (but unproven) that this process has led to the cost inflations in local insurance based services like the United States and Federal Germany.

Is it intended that the great bureaucratic creation should carry on, expanding a bit, but never enough to meet soaring demands for health care and modern high technology medicine? Or is it to be squeezed and cut about by crude Treasury pressures?

Or can it be reformed and reshaped so as to meet efficiently the radically changing, growing and increasingly diverse requirements for health services in a modern society, and to do so in a way which draws on both public and private finance?

Advances in modern medicine are changing people's expectations, demands and needs. The role of hospitals in routine care is diminishing and that of the GP and his or her supporting group – the primary health care team – vastly expanding. The emphasis on preventive medicine as a major element in the system of health care is growing, as is the need for resources in this area.

The common element in all this is the prospect of a massive and continuing expenditure on medical care. Everything takes us inexorably that way. The hospitals, even if they have fewer routine customers, will be spending far more on treating successfully the 'killers' like cancer and cardiac illness. The doctors at the primary care end will be facing an explosion in demand for the new medicines and therapies which the second pharmacological revolution is making available, and will be expected to have more and more equipment, information and health facilities right beside them on the spot, as the computer moves into every surgery. And people will anyway be wanting to spend far more on keeping fit and healthy, and demanding a far greater diversity of provision as the health care possibilities multiply.

Right across the path of these developments towards much greater expenditure and much greater diversity lies the dear old NHS. By being tax-financed it guarantees that the resources will never be adequate to catch up with the rising demand for health and medical care. And by being of its nature bureaucratic and rigid it guarantees that uniformity rather than diversity and innovation will prevail.

So what on earth do we do? Against this background of growth the one percent real increase for the health services allowed in current government expenditure plans looks quite puny. Yet even this is going to place enormous strains on budgetary strategy and could well crowd out tax cuts or force reductions in other vital programmes – a fact which the drier amongst the Government's uneasy backbench supporters have not hesitated to point out.

Here are a few topics for discussion.

First, on the organisational side, both hospitals and local primary health care centres should become virtually autonomous and receive their finance, both current and capital, through a mixture of payments per item of service (based on standard costing) and per capita. The administrative superstructure would thus be much reduced.

Second, on the financing side, where this payment is for the treatment of illness and the major serious diseases it should still come from taxation (and thus be free at the point of service) but this main source should be supplemented by a variety of others. It might well be argued that those above a certain income should be charged for consultations and routine care, and that insurance schemes should be encouraged to develop further,

Preventive health care should be more and more financed direct by the clients – which seems reasonable when one considers the fortunes already being paid out on aerobic classes, sports kit and the whole 'keep fit' business.

In short, the problem is to harness affluence to the provision of constantly changing and developing health care needs without overburdening the exchequer.

The patient and the NHS

Polly Toynbee

The founding of the NHS provided an enviable model for other countries. It was an astonishingly radical departure, giving rich and poor the same access to health care, lifting the burden of worry about paying for treatment. Indeed, people were so pleased and so grateful that they have been willing over the years to be treated as charity cases – a whole nation of charity cases with few rights (which ignorance and awe inhibit them from exerting), few choices, scant information and very little chance to complain.

As charity cases, British patients have been willing to put up with long waits, dilapidated hospitals and surgeries, and a lack of consumer choice they would not easily tolerate in most other aspects of their lives.

Before considering the changes needed in the NHS, let us look at the way services are currently provided, from the consumer's point of view. I shall, no doubt, be grossly unfair and exaggerate enormously to get across my point, nevertheless, this is, I believe, the essential truth of the matter.

Hypothetical patient John goes to see his local GP. He telephones and is told there is no possibility of an appointment for a week. He does not know, because of course the receptionist does not tell him, that if he were to put his foot down and insist it was urgent, he would be squeezed in at the end of surgery after a long wait – maybe two hours. Perhaps the week's wait for an appointment is a test of the seriousness of his complaint.

In any case (unlike most NHS patients), John does not much like his doctor. He is unfriendly and never seems to remember him from one visit to another. He lives miles away, at the posh end of town, and locums fill in for him at night. But John's friend tried to change doctor and couldn't find another one to take him on, partly out of professional etiquette, partly out of suspicion that anyone with the cheek to wish to change must be a trouble-maker.

When his appointment finally comes round, he still has a long wait. Emergencies have been squeezed in, or the surgery is simply unrealistically booked. But like all patients he is used to it, and philosophical. It is an appurtenance of power to be perpetually so over-worked and in demand that no single person dares call upon more than a fraction of your time or attention. It would be quite unfair to blame over-worked doctors for the fact they have too many patients, but over the years this situation has created in them an aura of unapproachibility. John expects to wait to see the doctor because of course the doctor's time is very much more precious than his own. In other words, the doctor is a very much more important person than he is. The longer the wait, the more John feels this to be the case. What's more, as he looks round the waiting room, he thinks there are people there much sicker than he, maybe some with cancer, who knows? (It is an NHS maxim that there is always someone worse off than you are, so what are you complaining about?)

By the time the buzzer summons him into the doctor's office he feels a bit jittery. He has a lot to say in a short time. He mustn't use up more than his allotted 5½ minutes, the average GP consultation time. All those sick people outside want their turn too. The doctor glances at the untidy heap of notes in John's file (not on computer), and just manages to take in information about John's last two visits, but no more.

John presents himself badly. He says the least important things first, he forgets half his symptoms. The doctor's questions don't seem to relate to what he wants to tell him. The doctor gives no clue that he knows more about him than his name, even after all these years.

However, the doctor makes a fair diagnosis, and decides to refer John to a consultant. He knows a couple of specialists in this field personally, but not many, in his area. Crucially, he does not know which hospitals have the longest waiting lists because he has no computer linked to the hospital waiting lists. He does not turn to John and say 'Which hospital would you prefer to be referred to? A small local one, who could probably manage your case perfectly well, or a big high-tech hospital far away, who would provide the most specialised treatment?' He certainly does not say to John, 'I know one consultant who is a charming and kind man, loved by his patients, or you could choose one who is an absolute beast but certainly far more advanced in the technology of his field. Which would you prefer?'

What he says is, 'I'm sending you to Mr X at St Swithins. Here's a letter.' The letter is firmly sealed and John has no idea what it says. It might be 'This man is a nuisance, but just to get him off my back, old boy, would you mind seeing him?' Or it could say, 'This chap's a terminal case, I'm afraid, no hope at all, but perhaps you'd just take a look at him?'

John telephones the hospital to make an appointment. A brusque receptionist says he'll have to wait three months for a first appointment. John wonders if his GP knew that. He does not insist on a more prompt appointment because he does not know that he would probably get one if he did. He is not one of those patients who knows how to operate the system, how to get to the best hospital, and how to lean on people to get prompt treatment.

Three months later the day comes. First he queues at the front enquiry desk, then he is sent to queue at the relevant outpatient department desk. Then he starts the real waiting. He chats with some of the regulars. One explains that this doctor (like one I know at St Thomas's) starts bookings at 8.30 but only arrives himself from the wards at 9.30, guaranteed over-booking to ensure everyone waits at least an hour, without allowing for extra emergencies slotted in, or some appointments taking longer. This doctor ensures that he is never himself kept waiting for even a second by the non-arrivals of some irresponsible patients, by grossly overbooking and ensuring all his patients wait at least an hour and a half. But John is used to it, like all the others.

He does consider making a mild protest about the waiting when he gets into the surgery, but the consultant and his ten medical students look too formidable. Anyway, it would waste some of his precious time, and worse, turn this all-important man against him, and maybe get 'trouble-maker' on his notes. The consultant is jovial, but treats him like an imbecilic child. Then he turns to his students and fires machine-gun questions at them, terrifying not only them, but also John. On examination he seems to pay no attention to John's own comments, as if he weren't really there at all.

John, he pronounces, will have to come in for a small operation – nothing urgent, nothing to worry about. 'When?' asks John, worried about his work and his holiday plans. That the consultant cannot tell him – maybe in three months, maybe six months, or could be at short notice if someone drops out. Lucky he doesn't need a hip replacement, because those waiting lists last years and years, he jokes, jovial again.

To be generous, let us say John arrives in the hospital three months later. He fills out a lot of incomprehensible but vital forms on arrival, hangs around, and eventually goes up to the ward. As soon as he gets there, a nurse descends on him and tells him to pop off his things, pop into his night clothes, and just pop into bed. He feels silly in bed, and realises he is put there for the neatness and efficiency of the running of the ward. He is patient in bed number 3, and deprived of his clothes, and his outside identity, he is now hospital property. He has lost all control over his existence, and

obedience is all that is expected. He has never slept in a large public room before and he does not like other people's noises.

He knows at once, instinctively, that to ask too many questions, let along make demands, will get him branded by the nurses as 'difficult', and then things will get worse. He would like to have a telephone, to talk to his family and friends, and not feel so cut off. But the telephone trolley is hard to come by, and anyway there is no privacy at all for conversation.

He falls unwillingly into the hospital routine – awake at six am, sleep at 9 pm. A flotilla of passing medical personnel troup by, and some of them come and ask him questions and give him conflicting information. He cannot distinguish between junior and senior doctors. Although the consultant's name is over his bed, he does not see him again. Some nurses are tart, and he is disturbed at how they treat some patients. Others are charming and friendly – but few of them seem to regard him as a real person, with a family, job and a position in the world outside.

The operation day arrives. No-one has told him exactly, step-by-step, what to expect, and each event is a little alarming in its way. 'Just a teeny jab', 'Just wheeling you along to theatres', 'Just waiting in this room', 'Just a wee mask over your nose . . .'. Each voice has a new face.

When he comes round he does not know if it is day or night, or several days have passed. No-one tells him much once they are satisfied he has come round. Once the pain sets in, he has a lot of trouble getting pain-killers and sleeping pills. Some nurses say yes, others say no. One or two offer them when he needs them, most need asking many times, so the pain takes a real grip. Pain control is clearly not regarded as real medicine in this place. Sleepless nights are terrible. People groan, an old man dies, and he cannot get used to the public life of the ward.

He develops a minor infection, which causes more pain, and keeps him in hospital a lot longer than planned. A rumour from the ward gossip says there is concern over a high post-operative infection rate and one ward was closed for a while. But he daren't ask. One stroppy nurse drops the same hint, and says it is all because of privatisation of the cleaning services. His wife makes an enquiry of a passing doctor. Always better for a relative to be the 'difficult' one, leaving the patient safely playing the angel. She is told firmly by the doctor she sees (she has no idea of his rank) that this is quite normal, often happens, part of the risk of operating. They wonder about it, but can get no further.

After he leaves hospital, having missed a long time off work they decide to go and talk to the hospital administrator to find out about this infection. But they get the same reply from him. John asks if he could please see his medical notes, as that would put his mind at rest? No, out of the question. Not permitted. So, they give up. They are given form 8315271, which tells them how to continue with their complaint, but having seen the doctors' letters to the administrator on John's case, in which they say 'routine', 'normal' and so on, they realise they are up against a complete wall of silence and there is no point in pursuing it. They have absolutely no information of any kind, only a hunch that might be utterly mistaken and unfair.

Back at home, life is not easy for John and his wife Edith. His old mother who has been living with them for many years has become increasingly incapacitated. Edith has had to give up her job to care for her mother-in-law, who is now very deaf, mostly wheelchair bound, and doubly incontinent. On top of that she is now severely demented, and wakes up and screams at them at all hours of the night. Their children can't bring friends home as she is too embarrassing, and the family no longer go on outings. They decide, very reasonably, that they can no longer cope. Edith has strained her back with the lifting, and the family rows are getting bad.

They take the old lady yet again to the geriatric outpatients' at St Swithins (though, in fact, the geriatric beds are all in St Gertrude's, an old work-house that still looks like one). The geriatrician is a kind man – at least kind with old people – but tough with their relatives. He has no alternative.

'I have no beds. We've had cuts – ten thousand geriatric beds have been cut since 1979 despite the number of elderly growing by 2 per cent a year. What can I do? You are both fit and well, and perfectly capable of caring for her. What's more, it would certainly be better for her to stay at home, in the community and surely you want what's best for your mother?'

John and Edith feel guilty, but things are bad at home. They beg and beseech. They say they can't go on. 'Well,' says the doctor, 'I could take her in for a few weeks occasionally to give you a rest. But not for another six months at least.' Reluctantly they agree.

They do not know that if they were brave enough to leave the old lady there and walk away, refusing to take her home, if they had the nerve to suffer the opprobrium heaped on them, they could just walk out. The authorities would be obliged to take her in. They do not know that, and if they did, being good people, they couldn't bear to do it. So they wheel her home, and fear for the future of their family life. They read in the papers that this government extolls the virtues of 'care in the community' and that it condemns the callous selfish society we live in, where we don't even care for our old folks. The government says nothing about the fact that there are now a smaller proportion of old people in care than there were at the turn of the century, nor that only 6% find places in institutions while 23% are looked after by relatives.

However, extraordinary though it may seem, along with a great majority of the population, when John and Edith are asked by opinion pollsters what they think of the NHS, they are still, on the whole, reasonably satisfied. They rate doctors at the top of the 'Good People' scale. They think they get pretty good treatment 'Best in the world' they say, though they haven't been abroad yet. When asked what changes they would like, they find it hard to think of any. After all, they are charity cases, and, of course, deeply grateful.

How can we begin to change the nature of the relationship between the patient and the NHS? If private practice has any value, it is that it shows us what can be done to give patients dignity, privacy, independence, and freedom of choice. From small to important matters, the difference between private and state practice is colossal. The very same consultant who keeps his NHS patients waiting hours, and intimidates them when he interviews them, will leap to his feet and usher a private patient into his consulting room, help him off with his coat, and give him time to catch his breath, and order his thoughts for a far more lengthy interview. For this is his valued client who might take his illness elsewhere. This is no charity case who has no choice, who has to take what he is given.

The aim of the NHS in the next decade should be to give to its patients what private practice offers its clients. For one thing, if it does not, even without a government like this one actively urging on the private sector, more people will take to private medicine and a seriously divisive two-tier system

will enter into our health care, which will become harder and harder to eradicate. For one of the wonders of the NHS has been that it has been embraced by almost everyone satisfactorily, with only a tiny minority opting out. But since we spend a smaller proportion of our GNP on health than most other civilised countries, we are bound to continue to see our Victorian infrastructures deteriorate, and our services and treatments fall further behind an expectation of care which grows with each generation.

Those who can afford it, will be attracted by the bright new clinics of the private sector, by the private rooms, by civil doctors, the lack of waiting, and definite dates for hospital admittance. Even if private medicine cannot cope with the serious and long-term sick, it could mop up a large sector of medicine. Though I strongly believe people should have the right to spend their money, if they wish, in private medicine, I fear for the future of the NHS as we have known it at its best, if the private sector is allowed to grow much beyond its present size, encouraged by the inadequacy of NHS provision. It would mean a spiralling downwards of NHS standards, and many people finding themselves paying more than they could afford on health insurance.

In primary care, I see no reason why the patient should not be entirely free to take his custom where he pleases. The system of registration with one GP has far more to do with capitation fees and administration than with patient care. Alas, most GPs are not, and cannot be Dr Finlays, closely bound with the local community, intimate in their knowledge of each patient and his family. Desperately overworked, they hurry through their lists of captive patients.

In inner cities the problems are acute, with few GPs living in the areas where they work, and many being long beyond a reasonable retirement age. They should be directly employed by the state in these problem areas, with strict terms of service. Also, they could do with more assistance – which need not be expensive. Already in 60 surgeries around the country, trained Marriage Guidance Councillors and others take on the counselling work, the social and emotional problems of those who need more time than a doctor can give. Patients find such counselling, linked to their doctor far more helpful and acceptable than in other situations – and doctors have found them a great asset.

Patients should also have a choice in the hospitals they attend, and a choice in consultants. It is sad that small local hospitals are being closed (though of course some of them are beyond repair and utterly unsuitable) when often they could be used to take in patients from the big general hospitals a few days after operations, to care for patients at lower cost, near to their own homes and communities.

Life in the hospital ward is certainly not what it was before Salmon. It seems sad that the best nurses are hurried out of nursing into administration for which they have little training. Figures of real authority are missing from the ward, nurses who could stand up to doctors on patients' behalf – even if they were sometimes gorgons. The only way to get the nurses back into nursing, is to give them better job and training opportunities to move up into more paramedical specialities. Practitioner-nurses are certainly a step in the right direction. Already they can be midwives and specialised intensive care nurses. But there are plenty of other specialities they could learn, if doctors were not so jealous of their own expertise. Certainly the move towards a new nursing process, ideas for giving each patient a particular nurse who will take time to care for them, talk and listen to them, may help humanise the wards.

Privacy is also essential, for those who want it. Wards should no longer look like barracks, and the norm should be for people to have rooms of their own.

The hospice movement has pioneered new ways of caring for patients, that should be extended to all people, not just the dying. Nurses treat their charges with real consideration. Families are encouraged to stay as long as possible, and to do as much of the caring as they can. (Children's wards now do this, and there is no reason why other wards should not do the same.) Treatment is agreed mutually between patient, family and medics. Nurses are given far more authority, and are listened to by doctors, because they actually know and talk to patients. Control of pain should be given a high priority, since hospices have developed immensely successful pain treatments without rendering people semi-conscious. It is a skill that should and could belong to the nurses (under doctors' guidance), who are the best ones to monitor a patient's pain levels.

The advantage of involving the patient's family as much as possible, is that it breaks the absolute authority of the hospital. That is why staff hated it so much at first in children's wards, where the mother clearly was the most important person. Once the patient has a strong intermediary, he is more likely to receive the treatment he needs, and to understand exactly what is happening to him. The doctor is likely to treat him with greater respect and to involve him more in the treatment and the decisions to be made.

The training of doctors is a pretty dismal and Victorian affair, by any human standards. The wonder is that so many of them come out of it reasonably well. Medical students are bullied and tormented by consultants, who remember being bullied and tormented themselves. The whole thing is like some antiquated public school, with fagging all the way up the line, until you become, Oh Glory! A prefect! You put up with the terrible life because you know so well all about the good things that come to prefects. Prefects feel they've earned every penny, every privilege, because they've been treated so badly in their time. Someone, somewhere has to call a stop to this nonsense, this absurd mystique. Someone too has to have more power in the hospitals to curb the absolute and unaccountable power of consultants.

Junior doctors, working eighty and more hours a week are exhausted, and exploited. If they didn't know they were going to be prefects they wouldn't put up with it for a moment. It cannot be a good way to treat patients. It must lead to errors. It cannot be a good way to learn, in a state of sleepless exhaustion. There are strict laws for the number of hours lorry drivers can drive – what about hospital doctors? They often have many lives in their hands.

The insecurity and uncertainty of their lives, the constant moving on every six months is hardly conducive to consistent care of their patients. But the rigid structure of the training forces them on. In the meantime, of course, it forces most women doctors out. If they cannot stay the course, avoid having babies until they are 35, then they never make it to consultant. Part time jobs, or even jobs with a civilised 40 hour week are scarcely available on this perilous ladder to the top, even in those specialities like obstetrics and gynaecology where women are actually in demand by patients (only 13% of gynaecologists are women).

Very little time in doctors' training is given to treating their patients as people. As they get bundled along the line from one part of the body to another, students learn from the extraordinarily strict hierarchy of their profession, that the patients tend to come at the bottom of the heap, followed closely by nurses. The information that is being given them throughout this ritual induction is so powerful, so magical

that it endows all doctors with an aura of great authority. We look up to them because they can save us all. The information they have is jealously guarded. Secrecy is an important part of their mystique.

That is one reason why it is so important that patients who ask should have the right to see any medical files on them they want – unless the doctor can show excellent reasons why not. Their body and their history belongs to themselves, and not to doctors. While doctors guard that information, the patient will always be at a severe disadvantage. Open records may inhibit doctors from writing certain personal things in a patient's notes, but that may be no bad thing. It only takes one doctor to suggest, long ago, that someone is troublesome, for it to blot all future medical encounters. Or worse, it only takes some allusion to mental disorder, however far in the past, for the patient to be discredited on future consultations.

One way or another, the National Health Service has always been profoundly undemocratic. Enormous patronage rests in the hands of the minister, and at the same time the doctors themselves manage to rule the roost, because their clinical judgements are sacrosanct. Though their judgement on one patient in their own field may be crucial, that does not mean that doctors are the best people in committees to make administrative decisions on medical priorities. The glamorous and the powerful within the profession often win out over the more socially useful but less dashing, like the geriatricians.

Exactly what form of democracy would best suit the health service is beyond my remit in this paper, but a strong element of direct election should be included in RHAs, DHAs and CHCs. Already the politically appointed members of these are often virtually mandated by their parties. At least elections would bring some of the issues out into the open. There are precedents for this, since Poor Law Boards and Education Boards used to be directly elected at the turn of the century. There is, in any case, no avoiding the fact that health is a highly political matter. Appointing people, often by the colour of their politics, or by direct choice of a minister is just as political, but less democratic. Open discussion of health priorities could only benefit the health service, and patients' feeling of participation in it.

Complaints and grievance procedures are daunting, and hard to find out about. All patients should be clearly informed of their rights, and given the relevant addresses to complain to. The Ombudsman needs to have greater powers. The fact that he cannot call upon evidence that infringes on any doctor's medical judgement makes it impossible for him to pursue many of the complaints he receives. It is hard enough to get doctors to give evidence against one another, but the Ombudsman at least ought to be able to make such a thing easier, where necessary. Doctors' fears of American-style 'defensive medicine' – so often given as a reason for not giving patients greater rights – is largely unfounded in English law, where our system of damages is so different.

However, placing too much emphasis on rights is to miss the point. Rights for patients can only deliver a small part of the service they need. What patients want is a caring, responsive service with a human face, flexible in its provision, willing to suit their needs, rather than always expecting them to fit in with its routines and systems.

In this paper, I have been given the pleasurable task of outlining what I believe the patient wants and deserves, without having to consider costs, nor, in detail, the problems of changing an enormous bureaucracy to make it more responsive to the people it is supposed to serve. Perhaps at a time like this, when we may be hard put to hold on to what we have, there is something cavalier about recommending reform and expansion in the service. But I honestly believe that unless we start putting a higher proportion of our GNP into the NHS soon, and most certainly not a lower proportion, there is a serious danger that increasing numbers of the better-off will abandon the NHS and take to private practice. This government may be short-sighted enough to think that in the short run, this will be cheaper. But in the long run, judging by the American experience, it is likely to end up a lot more expensive for everyone – with a far higher proportion of our income going on a health system that delivers less – with no cost-control on the hands of either the government or the private insurance companies.

Unless the needs and wishes of the patients are catered for soon, I fear that many of them will start voting with their feet, and will abandon a service that until now they have in the main admired and even loved, warts and all.

Some issues from the discussion

George Teeling Smith

The most conspicuous impression to emerge from the discussion was the unanimity among those present that the major developments in the system of British health care which can be expected over the next twenty years should take place around the broad framework of the NHS. Despite the varied political and disciplinary backgrounds of those present, there was no division of opinion over this issue on Party Political or other lines. There was a consensus that the principle of publicly funded medical care, freely available for all, should be maintained. It was also agreed that the source of funding was irrelevant, and that although the present tax-funded basis for the NHS might be modified, there seemed to be no case for scrapping it.

However, against this surprisingly clear consensus on basic principles, a very large number of different topics were raised in the course of the discussion. Hence the present summary is a statement of issues which were raised which need to be developed and discussed in the years ahead. The Cumberland Lodge meeting was, in this sense, the beginning of a new phase in 'The Great NHS Debate'. There is now widespread acceptance that the 1946 NHS Act has been overtaken by events.

Health as a commodity?

One of the most basic issues to be raised was the question of whether 'health' can be regarded as an economic commodity in the same way as food, clothing, housing or entertainment. Many people felt health was essentially 'different'. They echoed the view of Professor Dennis Lees' critics in the 1950s, when they told him that as an economist he could not study health – it was not an economic subject! Understandably, those with a background in health economics at Cumberland Lodge in 1984 tended to take a different view. They believed that health per se is an economic good. The more good health you enjoy the better off you are.

To support this view, it is possible to draw an analogy with housing and education. Someone living in better housing or someone who is better educated is 'richer' in a very real sense than their less privileged counterparts. Furthermore, the question of whether health is a commodity is not just a semantic or theoretical question. It is fundamental to the issue of whether it is possible to use market principles to ensure an optimum distribution of good health.

Some interesting analogies were drawn on this point. For example, in provision of care for the mentally handicapped it was suggested that private charities should be encouraged and given government funds to compete with the NHS providers. This would be analogous to the role of the Housing Associations in the provision of accommodation. They use public funds, and compete both with local authority housing and the private sector. It was generally agreed that the Housing Associations had filled an important gap in the housing market. Could the mental health charities do the same for the mentally handicapped?

In considering the role of the market in health care generally, however, the usual objection was raised that the customer/consumer/patient cannot judge the quality of the care which he is receiving. This view was strongly challenged, and it was pointed out that for many consumer goods it is equally difficult for the customer to decide what is the quality, and hence the value, of the items which he is purchasing. One thing is certain. In the free democratic economic system of the Western World, there are very few market shortages of the type which characterise parts of the NHS. There is, for example, no shortage of clothes in Marks and Spencer; although, of course, it was pointed out that not everyone can afford to buy the goods on offer. This is the other major objection to falling back on purely market principles in the provision of health care. Those most in need are least able to pay.

Rising expectations

Another background issue which was much discussed was the rising expectations of the public in respect of their health and their medical care. At the most superficial level this means that they expect nicely carpeted waiting rooms in general practice, and colour TV sets in the hospital wards. On the technical side, they expect heart surgery and hip replacements, for example, which would have been undreamt of in the 1950s. All these expectations have added dramatically to the cost of the Health Service, and can be expected to continue to do so in the future.

However, the general view was that patients' expectations in Britain were still too low rather than too high. They accepted shabby hospitals, and were too easily persuaded that particular treatments would not benefit them, when in fact if the doctors were more honest they would say that the treatments simply could not be afforded under the NHS. For example, coronary artery bypass operations are performed between six and eight times more frequently in the United States than in Britain. One question, of course, is whether the Americans do too many; however, it was agreed that in this and other areas there is a real shortfall below reasonable levels of provision in Britain.

Could the present NHS be adequate?

One lone voice at Cumberland Lodge argued that if only health care could be restricted to meeting proven needs, the existing NHS, within its present budget, could provide all that was required. However there was little support for this view. The evidence of inadequacies and the growing expectations for the future indicated that substantial new money was required.

One proposal was that these additional funds could be raised by 'ear-marked' taxes; it was thought that taxpayers as a whole would be willing to pay more provided they knew that the extra burden was going to improve the NHS. There have been government hints in the past that the present administration might be thinking along these lines.

However, a more fundamental issue was whether it would be desirable in the 1990s even to try to meet all demands for medical care from within a tax funded service. Should some forms of medical care not be increasingly provided outside the NHS, like some ophthalmic and dental services at present? There was a strong view that when at least 75 per cent of the population are generally affluent, if not actually wealthy, they should be encouraged to buy privately, usually through private insurance, some of the less urgent types of medical treatment.

This would bring in substantial additional revenue for medical care, and enable the NHS to concentrate more of its resources on improving the provisions for the 25 per cent of the less affluent or relatively impoverished members of the public. This raised the issue of the relationship between the publicly and privately funded services, and the spectre of 'two standards of care'. In general it was felt that if private health services remained less than 10 per cent of the total – which seemed a probable immediate ceiling anyway – there was no threat to the quality of care within the NHS. In addition, the role of private care in providing an effective

bench-mark for the quality and efficiency of the services which should be expected in the public sector was emphasised. In any case, 'catastrophe' or very long-term medical care will usually be provided under the NHS even for the very wealthiest in the population.

Competition versus control

A great deal of discussion centred on the role of competition in improving the quality and efficiency within the NHS. Although competitive sources of funding (i.e. multiple insurance funds) were agreed to be irrelevant, this was by no means the case in respect of a multiplicity of providers. This is the theme which Lord Vaizey argued in his book 'National Health'. If some form of effective competition could be introduced between different parts of the Health Service it could introduce the best features of a market system. Just because health care is centrally funded it does not mean that it has to be centrally provided. Few specific ideas were put forward as to how multiple competing sources of provision might be introduced in practice, but the theme of competition is picked up again later when the role of the general practitioner is discussed.

Turning to a more philosophical issue, there was some debate as to whether competitive forces could regulate the provision of health care in the best interests of the patient, or whether stronger statutory controls were required. This was one of the few areas where individuals' ideological principles crept into the discussion. Some favoured a free market situation, with only the minimum of necessary constraints; others believed that even existing regulation of the medical profession had proved ineffective in protecting the public, and much stronger external restrictions would be desirable. Predictably, the advocates of a market solution pointed to the failure of existing regulations as evidence in favour of their own position!

The importance of evaluation

In the past the shibboleth of 'clinical freedom' has tended to dominate the discussion of doctors' activities. It is of course essential that doctors should maintain their professional independence, but it was generally agreed that they now need to take broad economic considerations into account alongside individual clinical judgement. They can no longer provide only what they believe to be best for the patient actually facing them, but must take into account how their use of scarce resources will affect the wellbeing of the community as a whole. In order to do this, the keynote is effective evaluation of the outcome of various medical and surgical procedures.

One question which arose again in this context was whether or not patients are themselves good judges of the quality of the care which they receive. The conventional wisdom is that patients cannot judge between the success of alternative therapies. This was strongly challenged during the discussion. Many people felt that patients' ability to appreciate the quality of care had greatly increased in recent years, and that their opinion of whether they had been well treated was an important factor to take into account. In other words, market forces in the conventional sense need not be nearly so ineffective in medical care as many people argued. However, this is a complex subject; despite the better education and scientific understanding among the population as a whole, no-one claimed that the patient 'always knew best'.

In fact, as will be discussed below, it was agreed that the central figure in evaluation of medical care should be the general practitioner. He should be the professional adviser to the patient, nevertheless accepting the restraints mentioned above, in that he must also try to allocate scarce resources for the optimum overall benefit of the community as a whole.

In particular, there was considerable discussion of the new techniques of evaluation of the outcome of medical care in terms of the quality of life. Such concepts as the 'Quality Adjusted Life Year' were mentioned. In general, it was felt that no rational allocation of health care resources – whether by market forces or bureaucratic controls – would be possible until systematic schemes of evaluation had been worked out. The present emphasis on 'performance indicators' concentrated on measuring inputs rather than outcomes of medical care.

Geriatrics

One particularly difficult area which received a great deal of attention was geriatric care. It was felt by many that this was an important field where the private sector could be even further developed. Already many people rely on private care in their old age, and there is a strong inter-relationship between NHS funding and private provision for many of the frail elderly. That is, the NHS contracts with private homes to care for NHS patients.

Certainly the problem of old age will become greater during the remainder of this century, with an increasing number of over 85s. There is a possibility of a breakthrough, for example, in the prevention of senile dementia which would greatly reduce the burden of dependency. However, in general, it was agreed that plans would need to be developed for the more sympathetic care of the elderly.

One consideration which should be taken into account is the growth of private home ownership. It was pointed out that when the old people need to go into residential care, they will often at the same time release considerable personal capital from the sale of their house or flat. This can be used at least partly to finance the provision of congenial geriatric accommodation.

Therapeutic innovation

Another area sparking off a lively debate covered the prospects from therapeutic innovation over the next twenty years. In general, there was surprising pessimism. The pharmaceutical industry feels that it is being harshly treated by governments, particularly in Europe, and that this may slow down its rate of pharmacological progress. It was questioned whether a cut-back in pharmaceutical profits necessarily resulted in the curtailment of desirable research; in general, however, the more fundamental and speculative the area of research, the less likely it is to be financed by companies in difficult economic conditions. Hence there is a tendency for a company to concentrate more on less desirable 'me-too' types of innovation if it is struggling to maintain an acceptable level of profitability. Major breakthroughs become less likely if profits are restricted.

Overall, even given the rather better prospects of innovation from the United States and Japan, it was felt unlikely that there would be a transformation in the patterns of therapy during the rest of this century. Good progress is likely against the cancers and viral diseases; transplants will become easier and safer; and other steady progress can be expected. However, a revolution such as occurred with the control of tuberculosis and the other bacterial diseases may be less likely than the optimists expect.

One probable development is that more evidence from cost-benefit analysis will be required for new therapies in the future. Britain is one of the world leaders in this field of evaluation, and continued consumerist pressure is likely to demand formal evidence that therapeutic innovations justify their cost to the community or the patient. Similarly, the recent escalating expectations in respect of safety are unlikely to diminish. It is now unacceptable for a medicine to have a risk of the order of one fatality in 50,000 cases treated – a level of risk which was automatically accepted thirty years ago. It was pointed out in discussion that the avoidance of risks at this low level presents almost insuperable problems in the evaluation of a new medicine. And risks two orders of magnitude greater are still routinely accepted for surgery. It was agreed that the public urgently needed to be educated on the subject of risk assessment and risk acceptance.

Developments in general practice

The most important and most interesting part of the discussion dealt with the future role of the General Practitioner. It was pointed out that the central position of the GP in health care in Britain was in a sense a historical accident, and one which had brought great benefit in the whole organisation of medicine in this country.

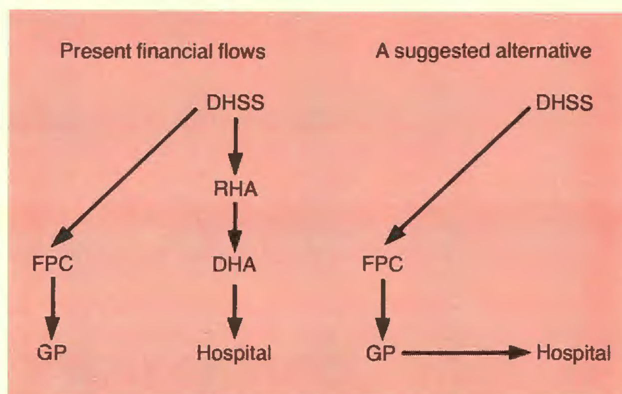
For the future, it was predicted that General Practice would become even more important. Already more highly qualified doctors were preferring to work in the community rather than in hospitals, and the education of doctors was paying more attention to the role of the General Practitioner.

However, there will need to be changes if General Practitioners are to exploit to the full their potential role in improving the quality of care in Britain. First, it was emphasised that the General Practitioners' contract must be made more meaningful. At present, it was largely a description of how they should be paid; it devoted too little attention to what their objectives should be.

In connection with their contract, there was some suggestion that General Practitioners should in future be salaried employees of the NHS. Provided they did not have indefinite tenure, they could lose their practice if they became inefficient or lazy. However this concept of control by the threat of a 'stick' to beat the bad doctors gained much less favour than the alternative. This argued that they should be rewarded by a variety of financial incentives to encourage good performance; in other words, a series of 'carrots' to promote higher standards. It was, of course, agreed that it is essential that realistic and meaningful measures of performance should be developed if the rewards are to go to the right doctors.

Several criteria for the assessment of the quality of practice were put forward. For example, the proportion of the patients in the practice who had received the appropriate vaccinations could be one measure. The degree of preventive medicine practised could be another: as one extreme, could a GP be rewarded if he had a low proportion of smokers among his patients? Certainly practices which routinely screened for hypertension should be appropriately rewarded. This raised a more speculative issue. Could practice remuneration be linked to measures such as mortality? If patients died of strokes, for example, because they were undetected hypertensives, the practice clearly deserved less reward than if such deaths had been prevented. Finally, could practice remuneration eventually be linked to the 'quality of life' as well as to the survival of patients? We would have described this as a '1984 concept', if 1984 had not already arrived.

Figure 1 The GP as a budget-holder



All of this, of course, assumes that the principle of the 'practice team' will continue and perhaps develop. It also assumes that the quality of practice will continue to improve. There was general confidence that this is likely to be achieved in the next 20 years.

The general practitioner as a 'budget holder'

Within the discussions on general practice another speculative and fascinating idea emerged. This was that the GP should in a very real sense become a 'Budget Holder' for the whole of the health service. That is, funds for health care should be channelled through the General Practitioner instead of being distributed downwards from the DHSS, through Regional and District Authorities. The idea is illustrated in Figure 1.

This does not mean that the General Practitioner and his Team would actually handle the funds, and keep any surplus saved by reduced utilisation of hospitals. However, they would *control* the flow of funds to hospitals. Metaphorically, when a General Practitioner referred a patient to hospital the latter would arrive with a bag of NHS gold round his neck to pay for his treatment. This would effectively give the General Practitioners control of the hospital budgets. Thus hospitals which were successful in attracting referrals from general practice would increase their budgets and grow. This success might be based, for example, on the fact that they had short waiting lists, or that they had good patient facilities, or that their surgical mortality record was particularly favourable. The element of market forces – controlled by the GP – which this introduces was extremely attractive to a number of those at Cumberland Lodge. Good hospitals would flourish, while bad hospitals would dwindle away, exactly as happens in the market place with manufacturers and distributors of clothes or food or with the providers of entertainment. The General Practitioners would have an incentive to refer patients to hospitals economically because their own remuneration could be indirectly but inversely related to the hospital costs which they incurred.

Of course it was pointed out that there were difficulties. For example, GPs must be prevented from always choosing a cheap hospital or from failing to refer patients at all because they would then be running a particularly 'economical' practice, and would be rewarded accordingly. This is one of the criticisms of the American Health Maintenance Organisations, which operate on a similar principle. Then there is the question of whether different hospitals should in fact be encouraged to quote different prices for the same

operation, further to stimulate the market forces in the system. Under Medicare and Medicaid in the United States they have tended to move in the opposite direction, with fixed prices for reimbursement of hospitals depending on the 'Diagnostic Related Group' (DRG) for which the patient is admitted.

However, in response to these difficulties, it was pointed out that the discussion was not supposed to be advancing solutions to be applied in 1985 or 1986. The intention was to concentrate on 1996. The sort of far-reaching principles implied by making the GP the 'Budget Holder' might indeed be developed into something practical over the next twelve years.

One possible corollary which was discussed was that – as at present – General Practitioners might guide some patients into the private sector within this arrangement. In this case the patients could either 'take NHS funds with them' – thus being a debit against the practice NHS budget – or they could pay privately (or more often from private insurance). Thus a practice in Harrow-on-the-Hill might encourage a large proportion of patients to pay privately for private treatment, and, therefore, release funds which could ultimately be used in improving the quality of care in Hackney. The Harrow Practitioners would be rewarded for running an economical practice; the Hackney Practitioners would be rewarded by being able to do more for their underprivileged patients.

The patient as a 'client' or 'customer'

One of the undoubted failings of the present NHS is that a large proportion of patients treat it as if they were receiving some form of charity. They are, in a sense, unreasonably grateful for what they receive. They are uncritical. The discussion emphasised that the patient must see himself as a 'client' rather than a 'supplicant'. Indeed several people went further and suggested that the right attitude for the patient is the one of a 'customer'. Even though he is not paying at the time, he has just as much right to expect good service from the NHS as he has from Marks and Spencer. Indeed it was suggested that patients should pay their doctor, to underline their status as customers, but this was generally rejected as impractical. Those most in need are least able to find the cash to pay for treatment, and any system of exemptions from a general payment for services becomes too cumbersome and uneconomic.

The other question about the 'patient as a customer' brought the discussion back to the recurrent theme of the patient's ability to judge the quality of the medical care which he was receiving. Once again the consensus was that the patient is surprisingly competent at judging whether he is getting 'good value for money' even though he is not paying. Nevertheless, a more critical consumer attitude is something which still needs to be encouraged under the NHS, as one of the ways of raising its standards and reducing its shortcomings.

There was considerable strength of feeling that it should be made easier than at present to change one's GP. The idea that General Practices should produce brochures to describe the quality of care they will provide under the NHS is a valuable step in this connection.

Education for medical practice

Once again there was unanimity that medical education needed to adapt further to the changes in medical practice since the 1940s. It is often still too authoritarian. It is based too little on the principles of epidemiology and the evaluation of outcome of procedures. It contains too little health economics. It still does not put sufficient emphasis on the central role of General Practice in the provision of health care.

Some of the newer and some of the more imaginative medical schools have already gone a long way towards catering for the needs of medical students in the 1980s and 1990s. Others, however, still have a very long way to go.

Experiments in provision of medical care

Another recurrent theme was the need for experiments in the patterns of provision of care. Competition, diversity, market forces, incentives and evaluation were all ideas which had run through the discussion. Not surprisingly, no one clear pattern of health care for the future had emerged. However, the desirability of experimenting with different systems on a Regional or District basis was generally agreed. Much more flexibility is needed within the framework of the NHS.

Much has already been achieved, as, for example, David Taylor's book on 'Understanding the NHS in the 1980s' had emphasised. However this should not mask the continuing deficiencies of the NHS. As the background papers and the discussion have emphasised, it has failed to adapt to the affluence and to the expectations of the 1980s. There is a real need for a new approach to the NHS by the mid 1990s.

However, there was consensus on yet another point. The changes over the next twenty years should be achieved by evolution rather than revolution. It is by no means denigratory to say that progress in health care should be achieved by continuing to tinker with the existing structure, rather than trying radically to dismantle and to reconstruct it.

The future

The Cumberland Lodge meeting was recognised as a small step forward in the continuing NHS Debate. It was not expected to reach firm conclusions. However there is no doubt that it helped to establish a framework within which future discussions can develop. It raised many issues which those concerned with the future of health care in Britain would do well to ponder.

The Office of Health Economics is greatly indebted to all those who took part in the discussion for helping to advance in a thoroughly constructive way the debate about how Britain's NHS can indeed once again be established as an envy of the world by the late 1990s.

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