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The Personal Health Services

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*A Perspective of
The General Medical
&
The Pharmaceutical Services*

Office of Health Economics

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The Personal Health Services

BEHIND the planning of the National Health Service lay the proposition that everyone should be entitled to the services of a personal physician. For the first time a scheme of publicly provided medical care embodied this concept.

The general practitioner is responsible for all aspects of the medical care of his patients, treating them as people rather than as cases. His function is to co-ordinate his own services with those of others, calling upon them as he interprets his patients' needs.

The National Health Service is organised in three parts: the Hospital and Specialist Services, administered in the main by 15 Regional Hospital Boards in England and Wales;* the General Medical, Dental, Pharmaceutical and Supplementary Ophthalmic Services, which are the concern of 138 Executive Councils; and the Local Health Authority Services which are provided by 146 Local Health Authorities. The General Medical Service, providing personal medical care for the individual, has a central position in this structure.

The work and the development of the General Medical and the Pharmaceutical Services are closely related. The foundation of the National Health Service coincided with a period which saw great advances in medicine, which have profoundly affected the work of the general practitioner. This change is important when evaluating expenditure on the services and for the attempt to assess the trends which may affect the future shape of general practice.

* Teaching hospitals are independently administered by 41 Boards of Governors.

There are 20,325 general practitioners operating in about 11,100 practices in England and Wales and approximately 15,800 chemist's shops dispensing 196m. prescriptions on 136m. separate forms (1962). The size of a general practitioner's list averages 2,300 patients, and he may see as many as 1,500 in any one year, many on several occasions. The number of patients seen on a full working day averages 32—about 22 in the surgery and ten at home. This gives a national total of 650,000 patients seen per full working day, with 200,000 visits to patients' homes. The combined cost of the General Medical and the Pharmaceutical Services works out at just over $2\frac{1}{4}d.$ a day per head of the population (1961).

This study is an attempt to put the costs of these services into perspective and to discuss some of their underlying trends. It does not attempt to discuss in detail the structure or the special problems of these services, nor to describe the highly complex mechanisms used to determine the amounts spent. It aims to present a picture in broad outline.

The General Medical or general practitioners' service and the Pharmaceutical Services account for the major part of Executive Councils' expenditure. The general practitioner receives his income from the Councils largely according to the number of patients he has on his lists—a capitation fee. Dispensing chemists are reimbursed according to the ingredient cost of the drugs plus a fee for dispensing. Payment for the other services of the Executive Councils, the Dental and Ophthalmic services, are based on a predetermined scale of costs for specific treatments. Of all the Executive Councils' services, only the general practitioner is paid on a capitation basis and not according to the amount of work done.

General Medical and Pharmaceutical Services Expenditure

THE cost of the General Medical Services for the United Kingdom rose from £47m. in 1949 to nearly £90m. in 1961 (*Fig. 1*). The proportion of National Health Service expenditure devoted to the general medical services has fallen slowly since the early years of the Service. In 1953, it amounted to 11·2 per cent of the total bill for the Health Service: by 1961 the proportion had fallen to 9·1 per cent (*Fig. 2*). The cost of the Pharmaceutical Services rose rapidly during the first three years of the National Health Service—from £37m. in 1949 to £55m. in 1952. Since then, the rise in expenditure has been less rapid, reaching £100m. in 1961 (*Fig. 1*). The Pharmaceutical Services' share of the total National Health Services expenditure rose from 7·9 per cent to 10·6 per cent in the first three years of the service. Since 1952, the Pharmaceutical Services' share of National Health Service expenditure has remained practically constant: the proportion was 10·3 per cent in 1961 (*Fig. 2*).*

Neither the General Medical nor the Pharmaceutical Services has been an exceptional cause of the increased cost of the National Health Service during the past decade. The proportion taken by the General Medical Service has declined, whilst the increase in the cost of the Pharmaceutical Service has no

* Expenditure on the general medical services has been adjusted to include for the appropriate year any arrears of remuneration subsequently granted, particularly the Danckwerts' award of 1952 and the later Pilkington award, 1962. (*Memorandum on . . . remuneration of General Practitioners in the National Health Service* (1952) Cmd. 8599. *Royal Commission on Doctors' and Dentists' Remuneration 1957-60* (1960) Cmd. 939.)

Expenditure on the pharmaceutical services is the gross amount including the charges collected directly from patients. These now cover about one quarter of the total cost of prescriptions.

more than kept pace with the total rise. The Hospital and Specialist Services in contrast have enlarged their substantial share of expenditure, and in absolute terms account for nearly two-thirds of the total rise in the Health Service bill.¹

The shares of national income taken by the General Medical and by the Pharmaceutical Services have remained almost constant since 1951. The proportion devoted to General Medical Services has declined slightly from 0.44 per cent (or 8s. 10d. for every £100) in 1951 to 0.41 per cent (or 8s. 3d. for every £100) in 1961 (*Fig. 2*). The share of national income taken by the Pharmaceutical Services has risen slightly from about the same level as the General Medical Services in 1951 to 0.47 per cent (9s. 4d. for every £100) in 1961 (*Fig. 2*).

Expenditure per head of the population on the General Medical Services increased from nearly 19s. in 1949 to almost 34s. in 1961. Allowing for the falling value of money, however, this represents an increase of 14 per cent since the start of the National Health Service (*Fig. 3*). Expenditure on Pharmaceutical Services per head of the population rose rapidly between 1949 and 1951—from nearly 15s. in 1949 to just under 21s. in 1951. The rise since 1951 has been slower—in 1961, expenditure per head of the population on the Pharmaceutical Services amounted to slightly more than 38s. (*Fig. 3*). Again, allowing for changes in the value of money this represents an increase of 30 per cent between 1951 and 1961.

Growth in The General Medical Service

The number of general practitioners under the National Health Service in England and Wales has risen from 17,300 in 1952 to 20,300 in 1962 (*Fig. 4*).^{*} The rise, in relation to the total population, was most rapid between 1952 and 1956 bringing a sharp reduction in the average size of lists, from 2,430 in 1952 to 2,270 in 1956. The average remained steady until 1958, but since then has risen slowly. Between 1952 and 1958, the

^{*} The number of doctors is the number of principals providing unrestricted services under the National Health Service. If assistants are included, the increase in numbers is not so great as, particularly since 1956, the increase in principals has in part been at the expense of a decrease in assistants.

Fig. 1.

Expenditure on the National Health Service and on the General Medical and Pharmaceutical Services, 1949-61 (including Local Authorities' expenditure). United Kingdom.

Sources: Central Statistical Office. National Income and Expenditure, 1962. Annual Abstract of Statistics, 1962.

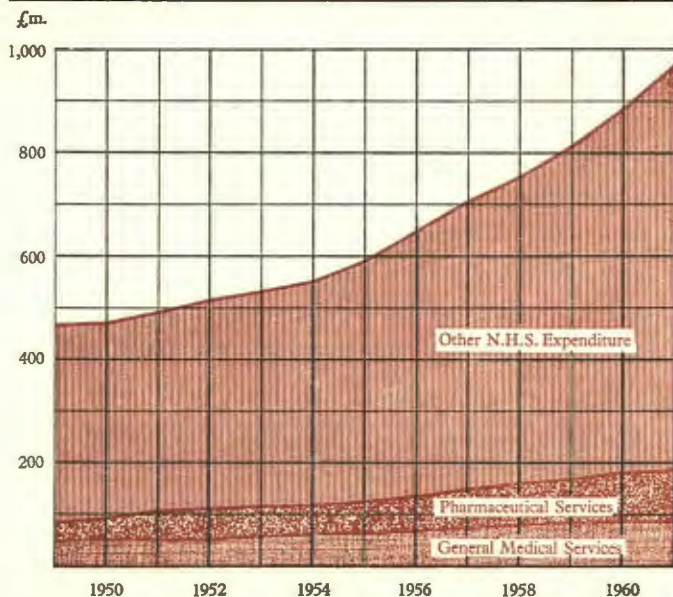


Fig. 2.

General Medical and Pharmaceutical Services as a proportion total of National Health Service expenditure and as a proportion of national income. United Kingdom, 1949-61.

Source: Vide Fig. 1.

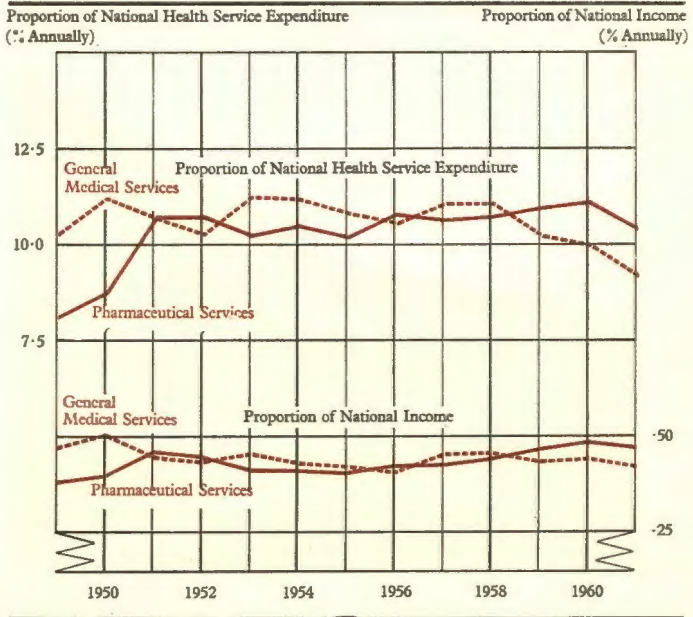


Fig. 3.

Expenditure on General Medical and Pharmaceutical Services per head of the population at actual and constant prices. United Kingdom, 1949-61.

Source: Vide Fig. 1.

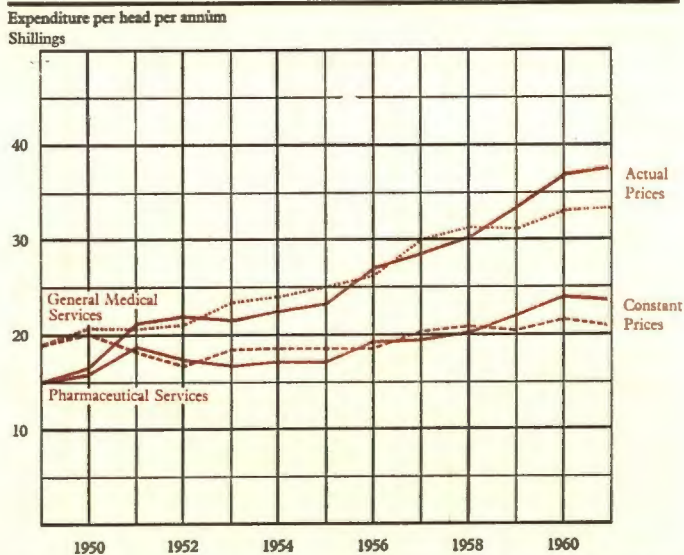
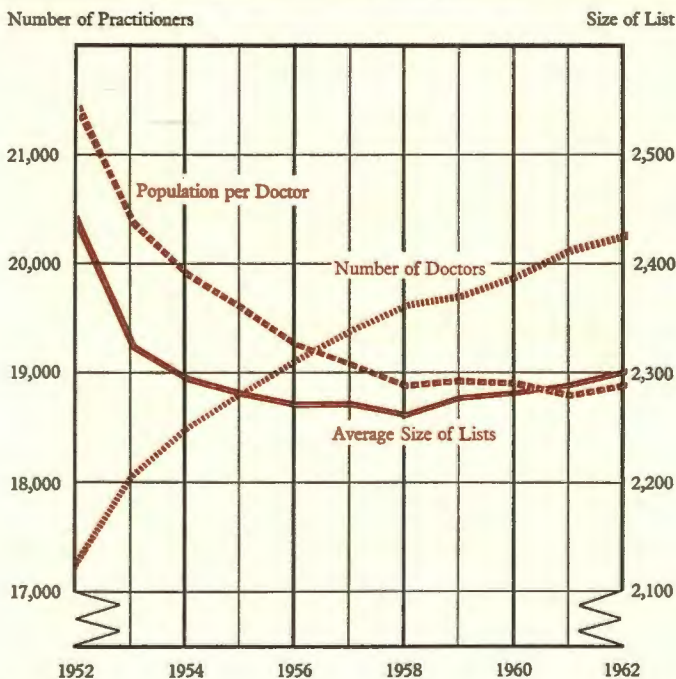


Fig. 4.

Number of practitioners, providing unrestricted service, and average size of lists and total population per Doctor. England and Wales. 1952-62.

Source: Ministry of Health Annual Reports. (Various Years.)



number of doctors increased more rapidly than total U.K. population; since 1958, the increase in doctors has just kept pace with the increase in population. The rise in the average size of doctors' lists is therefore most probably the result of inflation of lists by duplication—patients remaining on lists after moving away from an area (*Fig. 4*).*

Alongside the increase in numbers has gone a more even distribution of doctors. A shortage of doctors in many parts of the country, particularly the industrial north of England was one of the first important problems confronting the National Health Service. An adjustment came about concurrently with the increase of doctors entering the service in the years up to 1956. Since the mid-1950's, however, there has been less progress in obtaining a better balance in the distribution of doctors (*Fig. 5*).

A third important feature of general practice since the start of the National Health Service has been the slow but steady decline of the single doctor practice and the growth of group partnerships. In 1952, 43 per cent of the doctors were in single-handed practices; within ten years, the proportion has fallen to 27 per cent. Between 1952 and 1958, the trend was away from single-handed to the two-partner practices; since 1958, the movement has been towards the larger groups of four, five or even more doctors serving in one practice (*Fig. 6*). Group practice allows a doctor greater freedom in planning his work, and spreads overhead costs over a larger number, consequently making it possible to provide better facilities.

The Work-load

The number of doctors, the size of doctors' lists, the distribution of doctors throughout the country and the sizes of practices are only one side of the picture. The patient, his habits and attitudes, the use he makes of his doctor can also shape the quality and development of general practice.

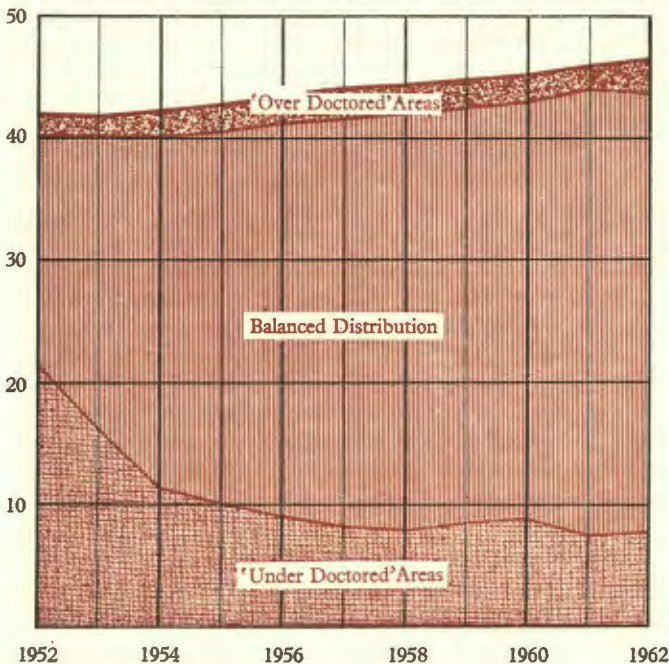
* The only alternative explanation of the larger rise in the average size of doctors' lists besides inflation by duplication, is a shift of patients from private practice to the National Health Service. As the number of private patients was reputed to be small in 1958, this explanation seems hardly likely.

Fig. 5.

Distribution of practitioners. Number of patients living in "Under Doctored" and "Over Doctored" areas. England and Wales. 1952-62.

Source: Ministry of Health Annual Reports.

Millions of Patients



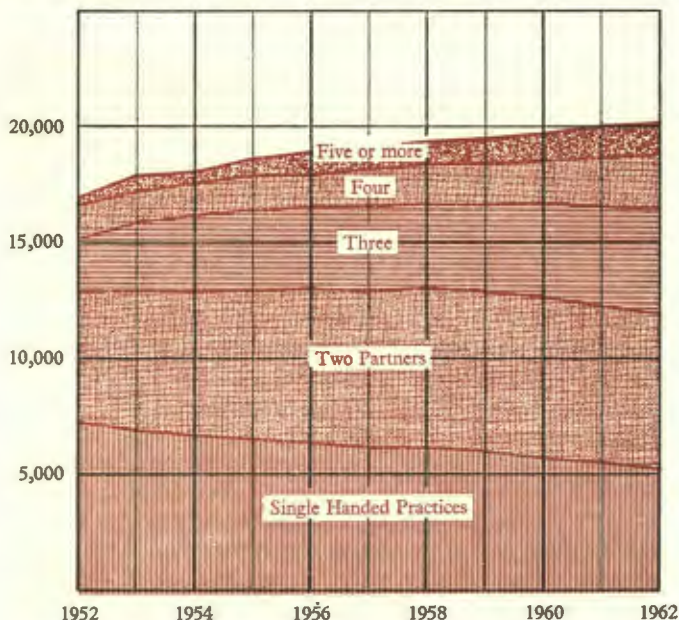
Note: "Over Doctored" Areas are equated with Restricted Areas.
"Under Doctored" Areas are equated with the Designated Areas.
Areas with Balanced distribution are equated with Open and Intermediate.

Fig. 6.

Number of practitioners by numbers of partners per practice.
England and Wales. 1952-62.

Source: Ministry of Health Annual Reports. (Various Years.)

Number of Practitioners



There are no regular and systematic statistics concerning the number and frequency of patients seen in general practice as there are for the Hospital and the Specialist Services. Published sample studies produce conflicting results.² Conclusions about the work-load must, therefore, be speculative.

Has the work-load—the number of consultations—been rising or falling? The start of the National Health Service saw a significant rise especially amongst women and children who had not previously been covered by the National Health Insurance scheme. The estimated increase for 1948-49 over 1947-48 was 13 per cent.³ Patients' behaviour at the start of the service might, however, be exceptional.

Titmus⁴ has reviewed published evidence on changes in the work-load between the 1930's and the early 1950's. He concludes that "on average and contrary to public belief, demand has not increased under the National Health Service and may indeed have fallen". In comparing the work-load of the individual general practitioner under the Health Service with that in the 1930's, account must be taken of the decline in the number of patients per doctor, their better geographical distribution, a decline in night visits, the growth of rota systems and a decrease in the number of statutory certificates.

There has, in addition, been an expansion in the local health services which might relieve the general practitioner of part of the work-load in caring for ante-natal, infant, child and aged patients.

Against this, however, there are grounds for suggesting that there is a tendency for the number of consultations to rise. Firstly, with the increase in the population there has come a change in its age composition. A larger number of persons are living their normal span of active life and into old age. With the increased birth-rate, and the substantial reductions in infant and child mortality, the proportion of children has risen. The need for medical attention is greatest at the extremes of life. However, although the effect of this changing age composition of the population is real, its effect should not be over-exaggerated.*

There may be other less obvious factors in operation. As each new generation has reached maturity over the past half century or even longer, they have found better and more freely

available medical services open to them than to their parents. Habits people form at the start of their adult life are often carried with them into old age. Those now over 65 years formed their views about consulting the doctor in the context of the medical services which existed in the years of the First World War. Those now in their 40's developed their habits of consulting the doctor during the years of the Second World War. People in their early 30's have enjoyed the National Health Service from the start of their adult life. Each new generation might be more ready to consult a doctor than their parents.

Morbidity statistics are consistent with this notion. Consultation rates for ill-defined conditions and symptoms such as aches, rashes, cough or debility tend to be higher among the young and middle-aged than for the elderly.⁵ It might be that this is the true pattern of morbidity. But equally possibly, the pattern could in part be a reflection of the different use of medical services by different generations.

The Changing Pattern of General Practice

Apart from any changes in the volume of work undertaken by the general practitioner, there has been a change in its nature. This trend reaches back over a long period, and is an aspect of the dramatic improvement in health seen during recent decades—the result of advances in social conditions, public health, immunisation and environmental control and more specifically modern chemotherapy. The diseases of childhood reflect this change most clearly. A doctor in one year may see as many as 74 per cent of his child patients: a greater percentage than any other age group.⁶ The treatment of many childhood illnesses in general practice has been radically changed by the advent of the sulphonamides and the antibiotics.

* In the decade from 1951, the proportion aged 65 years and over increased from 11·0 per cent to 11·9 per cent while the proportion of those under 15 years, rose from only 22·1 per cent to 22·7 per cent. Allowing for the higher consultation rates of children and the aged, this small percentage change in the age composition of the population does not dramatically increase the number of consultations. Logan gives a consultation rate of 6,194 per thousand population for persons aged over 65 years, which compares with 3,120 for those aged between 15 and 44 years. If the proportion of aged is increased from 11·0 per cent to 11·9 per cent it raises the average number of consultations by only 0·6 per cent. (Logan, W. P. D. and Cushion, A. A. *Morbidity Statistics from General Practice. Vol. 1 (General)*. General Register Office. 1958.)

The most obvious changes are in the infectious diseases. Their incidence is diminished and where they do occur treatment can be specific and effective. A doctor rarely meets a case of diphtheria. This is vastly different from the days when every sore throat had to be swabbed in order to exclude the disease. Measles is still one of the most common infections a doctor has to deal with. The average case, however, requires his attendance on only two or three occasions: the disease has been robbed of many dangerous complications.

There has been a steady fall in the number of cases of whooping cough diagnosed and the disease is far more mild than formerly. The *sequelae* of the disease are no longer so dangerous. The number of consultations per case is certainly less than 25 years ago when the disease often dragged on leaving an aftermath of chronic cough, pneumonia, and bronchial complications. The same is true of scarlet fever. The disease is now rarely treated in hospitals, yet even so the calls on the general practitioner average less than four attendances. A doctor now rarely comes across a case of congenital syphilis. Fewer cases of rheumatic fever occur in childhood while scabies and tuberculosis may now be classed among the rare childhood diseases. The picture has also changed with the minor complaints. Impetigo and the many other skin conditions diagnosed as eczema and dermatitis now yield rapidly to treatment.

Among the most common conditions a doctor sees among his child patients are *otitis media* and alimentary infections. 25 years ago mastoiditis was among the common causes of childhood death or morbidity, involving long drawn out surgery. The toll of child life from diarrhoea and vomiting a decade or so earlier was substantial. Again for all these conditions, the advent of sulphonamides and antibiotics entirely changed the outlook for the patient and the work-load of the general practitioner.

The Pharmaceutical Services

The changed pattern of childhood illness illustrates how closely the work of the general practitioner and the work of the pharmaceutical services are tied.

The Pharmaceutical Services came into being on a rising tide of drug discovery and development. By any method of measurement, the pace of drug research and development during the past two decades has been impressive. Yule Bogue has calculated that "70 per cent of today's prescriptions could not have been written in 1935, and even 45 per cent of today's prescriptions could not have been filled as recently as five years ago, because the drugs did not exist".⁷ A U.S. Senate Committee attempted to list the major drug discoveries during the past 100 years: 80 per cent of the discoveries were made after 1935—over half of the discoveries (54 per cent) had been made since 1948, the year which saw the start of the Pharmaceutical Service.⁸ The range of effective drugs has, therefore, radically altered in the past 15 years. When comparisons are made between the start of the Health Service and now, like is not being compared with like.

The number of prescriptions per head of the population rose by 12½ per cent during the first three years of the National Health Service—from 4.6 to 5.2 per annum (*Fig. 7*). The frequency fluctuated around this level until 1956, since when the number of prescriptions per head of the population has fallen. The figure in 1962, 4.2, is the lowest recorded since the start of the National Health Service.

Martin has suggested that prescribing frequency depends chiefly on three factors—a general regional one, which is associated with climatic conditions, ill health and local customs.⁹ He concluded that "prescription frequency was best described as being part of a response to ill health, the nature of the response being determined also by local attitudes and expectations as to appropriate behaviour of doctor and patient when illness occurred".

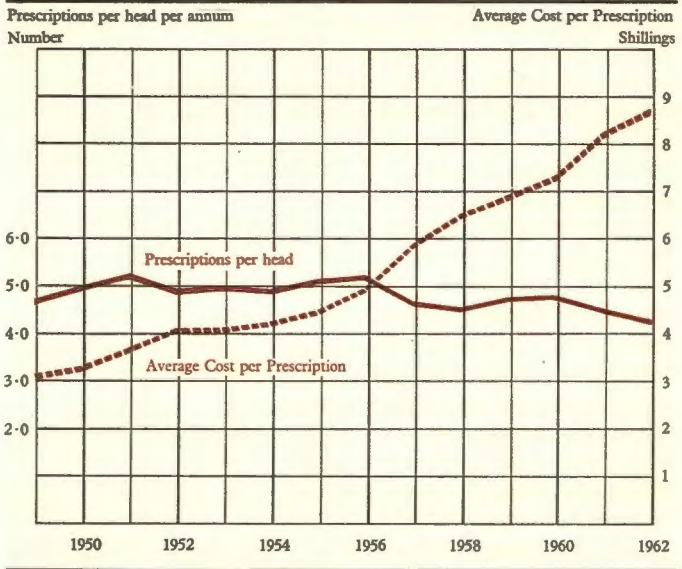
The most important factor causing changes in prescribing frequency from year to year has been the imposition of prescription charges. The Government first took power to impose a charge in 1949, but it was not until 1952 that a shilling charge for all drugs dispensed from one prescription form was imposed.* In 1956 the charge was increased by

* Higher charges are imposed for items apart from drugs, such as elastic hosiery which are supplied under the Pharmaceutical Services.

Fig. 7.

Number of prescriptions per head of the population per annum, and average cost per prescription. England and Wales. 1949-62.

Source: Ministry of Health Annual Reports. (Various Years.)



requiring a shilling for each item dispensed, rather than for each prescription form. In 1961 the charge was doubled.

By 1962 the revenue raised by prescription charges amounted to nearly one quarter of the total cost of the pharmaceutical services (*Fig. 8*). Prescription charges are the least popular part of the National Health Service. More than half the population consider them unfair. Prescription charges, however, have not stopped people consulting their doctors¹⁰—but clearly they affect the doctor's pattern of prescribing.

The Guillebaud Committee found that about one-third of the rise in the cost of pharmaceutical services during the years between 1949 and 1952 could be attributed to increased quantities of drugs prescribed^{11, 12}. The Hinchliffe Committee investigating the services in 1959 concluded that doctors appear to have reacted to the imposition of the new charges by prescribing less frequently but ordering larger quantities¹³. The doubling of the charge in 1960 had a similar effect, and also led to fewer of the cheaper prescriptions being dispensed¹⁴. However, these factors are not the most important contribution to the rise in average costs per prescription since the start of the Health Service.

The average total cost of a prescription has risen from 3s. 0d. in 1949 to 8s. 8d. in 1962 (*Fig. 7*). The rise was proportionately greatest between 1954 and 1958. The Hinchliffe Committee concluded that "the coincidence of the introduction of a free and comprehensive health service for all and the discovery and large scale production of valuable but expensive drugs has been the main factor contributing to the rise in the cost of prescriptions"¹⁵. Many of the more important new drugs were released for general use between late 1954 and the beginning of 1957.* In 1962 the ingredient cost of prescriptions for antibiotics was estimated to have amounted to almost one quarter of the total for all prescriptions¹⁶—most of these antibiotics were not available through the pharmaceutical service only ten years ago.

* Chloramphenicol was first released for general prescription in 1951. Chlortetracycline (Aureomycin) and oxytetracycline (Terramycin) were generally released in November 1954; tetracycline in May 1955. Prednisone and prednisolone became available on prescription after February 1957. More recently, the range of psychotropic drugs have been released for general practice.

Fig. 8.

Total expenditure on Pharmaceutical Services and amounts raised by prescription charges. United Kingdom. 1949-61.

Source: Vide Fig. 1.

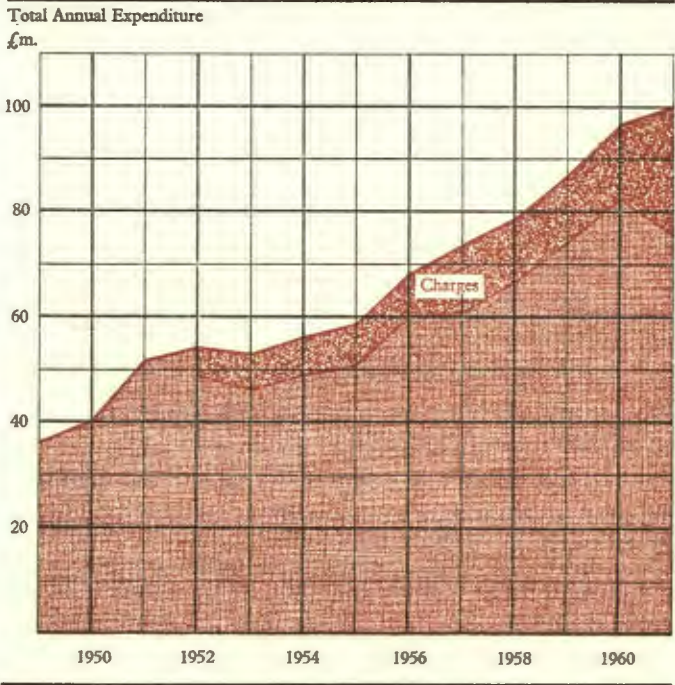
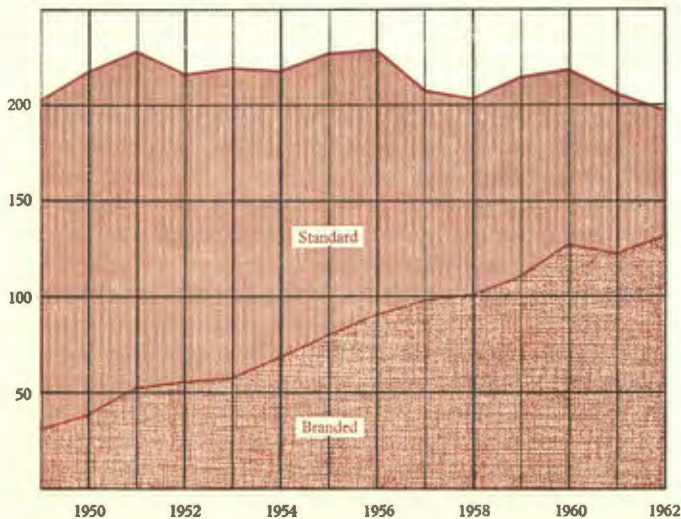


Fig. 9.

Total number of prescriptions and estimated number of prescriptions for branded products. England and Wales. 1949-62.

Source: Ministry of Health Annual Reports. (Various Years.)

Millions



Note: includes standard preparations available only in branded form from 1960.

Closely allied with the introduction of new drugs has been an increase in prescribing branded or proprietary products (*Fig. 9*). The growth of branded products represents a shift in the focus of production from the traditional retail dispensary to scientifically controlled large-scale industrial organisations. The growth of brand names is a feature in many other fields of production, which has changed their pattern of manufacture and distribution over the past 50 years. In this sense, the growth of brand names in the pharmaceutical service represents a stage of industrial development, postponed until after the scientific and chemotherapeutic revolution which brought the modern pharmaceutical industry into being. The development of brand names by a drug house is part of the attempt to secure continuity of market and so ensure continuity of revenue and profit leading to industrial growth. It enables expenditure on research and technical development to be undertaken with greater chance that such investment will be rewarded if the research is successful. It also protects the consumer since quality control is an integral part of the production of branded products.

The price of a branded drug carries a part of the overheads inherent in large-scale industrial organisation—research, development, quality control and sales promotion. When a drug is available both under a brand name and in an unbranded form, the latter tends to be cheaper. This price differential has caused concern to the Committee of Public Accounts and the Ministry of Health. The Ministry have circulated all general practitioners with a list of frequently prescribed branded products and their unbranded equivalents, showing comparative prices. It has been estimated that the cost of the Pharmaceutical Service could be reduced by approximately one per cent if all doctors prescribed drugs under their generic names instead of brand names.¹⁷

Future Trends

THE advent of the Health Service in one respect greatly enhanced the general practitioner's freedom to serve his patients according to their medical needs—particularly in treating women and children, the old, the disabled and chronically ill and the middle-income groups. This greater freedom to treat patients without regard to their economic resources came at a critical period in the history of medicine. Modern chemotherapy enlarged the potential sphere of the general practitioner's work. He could treat many diseases previously treated only in hospital.¹⁸ Taylor has pointed out that "today the practitioner in the gloomiest slum practice can treat pneumonia more effectively than the most eminent specialist was able to do before the war".¹⁹

Yet at the same time as the scope of general practice was enlarged advances in medical science led to the development of new specialist skills. Hospitals and specialist services take a greater share of the work. The organisation of the General Medical Services lacks incentive for the general practitioner to carry out minor surgery or to conduct pathological investigations. Some patients may have come to expect to be referred to a consultant almost as a matter of course. Indeed the fear is occasionally expressed that the general practitioner is in danger of becoming little more than a subordinate medical auxiliary.*

The financial organisation of the Health Service too has tended to make the hospital the centre of gravity towards

* In July 1962 a survey of the attitudes of general practitioners was carried out by Research Services Ltd. The majority (79 per cent) thought that the National Health Service was working reasonably well, although this did not rule out suggestions for improvement, chief of which were dealing with "red tape", need for more co-

which patient care has moved. The hospital service has been able to attract an increasing share of expenditure on medical care. Also, although a small number of hospital beds and diagnostic facilities have now been made available for general practitioners' patients, on the whole organisation of the National Health Service has tended from the beginning to isolate the general practitioner from the workings of the hospitals.

The great improvements in health following the medical advances of the past 30 years have revealed a submerged layer of chronic disease. In women from their early 20's until their late 60's, the dominant killer is cancer. Coronary heart disease is now the principal cause of death for all men over the age of 25 years. Logan (R. F. L.) has argued that the changed pattern of illness in general practice has stressed the importance of pre-symptomatic detection. He has suggested that it is now more than an academic question in severe hypertension, diabetes or in several other diseases²⁰. The ready availability of medical care under the National Health Service also makes it possible to tackle many conditions and complaints which exist sub-clinically. Butterfield and Sharp's survey of diabetes in Bedford revealed the extent of sub-clinical symptoms for only one disease²¹. Maddison has

ordination, reduction in the number of patients and more consideration from patients. During the interviews the doctors were also asked the following question and their answers are indicated in the table.

"It is sometimes said that there is a danger of general practitioners becoming little more than subordinate medical auxiliaries. Do you agree that this is a real danger or not?"

<i>All informants</i> (base for percentages)	Total	Under 45 years	45 years and over
	per cent	per cent	per cent
Agree strongly	31	22	40
Agree	28	31	24
Disagree	29	32	26
Disagree strongly	11	13	10
Don't know	1	2	—
Total	100	100	100

The combination of broad acceptance of and satisfaction with the National Health Service and this positive reaction to the suggestion that the general practitioners' position may be eroded may indicated an acute awareness of change rather than a resignation to decay.

“verified the existence of the vast amount of disability which exists in older people much of which is remediable and preventable”. He concluded that: “There is a great need for preventive medical services for older people to prevent the disabilities from becoming worse and to try to prevent them ever happening at all”.²²

The emergence of a new pattern of disease which it is vital to detect in the silent stage, and the existence of large areas of sub-clinical ill health—which may slowly emerge as a chronic condition—stress rather than diminish the importance and the role of the general practitioner. Continuity of medical care and responsibility is the distinctive feature of general practice—the major feature distinguishing it from hospital medicine. The general practitioner is responsible for the total and continuous medical care of his patients, while the hospital exists for the treatment of specific conditions or cases. The general practitioner is a personal and confidential physician in health as well as in illness. In this role he can hold the key position in dealing with the emerging pattern of disease.

Consideration of the precursors of disease is the essence of preventive medicine. Originally, preventive medicine was principally concerned with the elimination of epidemic and parasitic diseases in the population as a whole: it was concerned with the mass rather than the individual. The now almost forgotten Peckham experiment was the first systematic attempt to extend the principle of preventive medicine to the individual as a logical complement and extension of public health measures.*

The National Health Service has done little to develop personal preventive medicine. The failure is surprising, particularly as prevention was the dominant idea of those who originally formulated the National Health Service. The paradox may be explained by the coincidence that the appreciation of the possibilities of personal preventive medicine reached its height at the same time that the greatest therapeutic

* The Peckham experiment originated from the Pioneer Health Centre founded in 1926. The main phase lasted from 1935 until the outbreak of the war. The experiment defies concise description; it was a venture in “the practice of health” as distinct from the practice of medicine. The centre was in essence a family health club, providing members with periodic health overhauls. (Vide, Pearse and Crocker, *The Peckham Experiment*, Allen & Unwin 1943.)

advances in medicine occurred. When the scene was set for the expansion of preventive medicine, it became possible to cure many diseases once they developed. The ability of the medical profession to cure a disease like tuberculosis by chemotherapy appeared to rob programmes of prevention of their urgency.

Yet, the modern pattern of disease and the importance of its detection during the silent stages justifies as great an emphasis on prevention as formerly. How efficiently are the General Medical Services organised towards individual preventive care? How far can the organisation of the General Medical Services be improved to extend the sphere of preventive medicine? What is needed is essentially an improvement in the facilities readily available to the general practitioner.

The relationship between the general practitioner's work and the work load of hospitals is particularly important. But are factors affecting reference to hospitals adequately understood? Fry referred 40 patients per thousand to hospitals,²³ while Scott *et al* reported a reference rate of 108 per thousand.²⁴ In 1962 there were 7.22m. new outpatients from a population of 46.82m. patients, which would give a reference rate from all general practitioners of up to 150 per thousand.*

Discussion about the cost of the General Medical Services has concentrated mainly on the problem of doctors' personal income. The cost of the Service involves more than this: it includes an allowance for the expenses incurred by the general practitioner in running his practice. The amount a doctor spends on his practice may go far to deciding the scope and quality of his service. The system of financing the General Medical Services places the general practitioner at a disadvantage compared to his colleague in a hospital. The general practitioner must buy medical equipment, surgery fittings and furniture out of the income allotted to him. Clearly the scope and the quality of the general practitioner's work cannot be extended without greater costs. Such costs have perhaps in the past been considered too much in terms

* The simple average works out to 154 per thousand, but from this figure must be deducted an unknown amount to allow for out-patient attendance without previous consultation with a doctor, e.g. accidents and "walk-ins".

of historical numbers and averages, rather than in relation to the changing task.

The appraisal of expenditure on the General Medical Services has not been related closely to the question of the scope, quality and task of the general practitioner. The capitation system is a survival of the health insurance schemes devised by insurance companies towards the end of the nineteenth century. It was a departure from the traditional professional basis of payment for consultations, and this departure was fiercely criticised at the time. The capitation method of payment was a convenience for the insurance companies to help assess their financial risks. Their payments to "contract doctors" could simply be equated with the premiums charged to the policy holders. The Lloyd George Health Insurance Act, which operated through approved insurance societies, consolidated the capitation payment system. By the time the National Health Service was founded the capitation fee had become a normal method of remuneration.

The question of payment is only one part of the larger issue concerning the organisation of the General Medical Services. The National Health Service aimed at providing everybody with a personal physician—a concept formerly confined for the most part to private practice. But how effectively was this implemented? The organisation of the National Health Service was in the main a broadening and an extension of existing health insurance schemes. In paying the doctor, and in matters touching the relationship of doctor and patient, the National Health Service adopted the character of the Panel system. It did not take over the best features of private practice and consolidate for everybody the traditional features implied in the concept of a personal physician.

The General Medical Services are vital to the efficiency of the National Health Service and to the health of the nation. It is through the general practitioner that the majority of patients make their initial contact with the different services which comprise the National Health Service. The scope of his work, the decisions he takes and his ability to co-ordinate the other services will go a long way to decide the efficiency of the whole. The great therapeutic advances of the past

25 years have changed the nature of his task. However, despite his importance not enough is known about the way he works. The question of defining the future role and shaping the services of the personal physician is one of the major tasks facing those concerned with the development of the National Health Service.

Cover: The picture is taken from the front of a 19th century popular song—*Doctor Compus Menis*—and is reproduced by courtesy of The Wellcome Trust. Dr. F. N. L. Poynter, PH.D., F.R.S.L., F.L.A., Director of the Wellcome Historical Medical Library, writing in *Medical Care* said of it: "The practitioner in the industrial areas of big cities at the end of the 19th century was still very much a tradesman, and got most of his living from dispensing the medicines which he prescribed. Like the doctor in this picture, he often gave his advice free and his consulting room or office was often a chemist's shop".

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