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THE QUEEN MOTHER FELLOWSHIP

General practice and primary health care

1940s–1980s

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Dr Fry, the son of a general practitioner, was educated at Whitgift Middle School, Croydon and graduated from Guy's Hospital Medical School, London in 1944. He started in his single-handed practice in Beckenham, Kent in 1947. A strong believer in roles of a general practitioner as a personal and family doctor he has served his patients and their families continually for over forty years.

Since the 1950s he has carried out some seminal studies in his practice, mapping out the content, nature, and outcome of the common diseases and disorders in the community and has authored many papers and books. He is currently consultant editor of the journal *Update*.

Dr Fry was a founder member of the College of General Practitioners and has served on its Council for over thirty years. He has twice been President of the section of General Practice of the Royal Society of Medicine and more recently a visiting professor at the University of Oxford. He was Consultant in General Practice to the British Army.

Dr Fry has been a member of various committees of the Medical Research Council and an elected member and Treasurer of the General Medical Council since 1970. Internationally he was a consultant to the World Health Organisation and a visiting fellow of the Milbank Memorial Fund.

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PREFACE

Forty years of the National Health Service (NHS) is a good point at which to look back on the development of primary health care services, mainly general medical practice, during this time and to consider what may lie ahead.

I am in the increasingly unusual situation of having started in my general practice in July 1947, a year before the NHS began and having experienced conditions before and since. It has been an exciting and significant period for British general practice, which has been transformed from a cottage industry to a well organised and confident branch of the medical profession.

My aim in this monograph is to discuss and describe aspects of that transformation from the viewpoint of a general practitioner and to suggest issues for consideration in relation to further changes that can be foreseen.

I start by considering what general practice is then examine its fascinating history, always intricately interwoven with contemporary social and political events. Examination of the evolution of general practice as we know it in the NHS has to begin some two centuries ago because its roots and origins are evident so far back.

It is remarkable how much factual information there is on many aspects of general practice. Using these data, profiles are offered of the type and volume of work in general practice, of the general practitioners themselves and of the diseases and situations encountered. The increased importance of general practice education and training, communications, publications, and research are each touched upon, and reference is made to some of the organisations involved in the evolution of general practice. I am happy to acknowledge that the Nuffield Provincial Hospitals Trust is one of the bodies which has exercised constructive initiative in this field.

Each nation develops its own health care system rooted in

historical, cultural, and economic factors. The NHS is no exception, for in many ways it simply built upon and extended arrangements introduced in the early years of this century. This degree of determination does not mean however that we cannot learn from other countries and they from us. Contrasts and comparisons are instructive.

Finally, study of the past and recent history of British general practice should provide signposts for the future. The more prescient of our grandparents might reasonably have predicted general practice in a national health service. Notwithstanding the accelerating pace of change we should also try to forecast the trends and patterns of general practice for the next generations.

The production of this monograph truly has been a labour of love. It has enabled me to put together a picture of general practice during my own professional lifetime. It has enabled me to recall events and to discover facts I had not previously known. I hope that those who read this monograph will be as interested and as excited as I have been in collecting data and constructing the work. It has given me a clearer understanding of where we have been and where we are going.

I thank my fellow trustees for the opportunity and challenge.

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WHAT IS GENERAL PRACTICE AND PRIMARY HEALTH CARE?

GENERAL PRACTICE, PRIMARY HEALTH CARE, FAMILY MEDIcine, or first contact professional care, whatever names we give it, is the oldest form of medical care. In Britain we have had reasonably well defined general practitioners over 200 years (see chapter 2). The concept has recently been rediscovered by the World Health Organisation and is being updated for the 21st century (see chapter 9).

The reasons for this renewed interest and concern are quite simply, the hope or belief of governments and other funders that better general practice/primary health care may provide a cheaper and potentially more effective form of care than hospital and highly specialised services. General practice has always served as a screen and protector of expensive hospital services. The referral system of the British National Health Service where patients can normally only enter the hospital system through their general practitioner has a particularly strong filtering effect. Its attractions are all the greater since with escalating costs the organisation and management of health and medical care is no longer seen as a matter which can be left to patients and the medical profession. Governments are therefore seeking efficient, effective and economic systems based more on primary care, which is seen as having the potential ability to act also to prevent disease and promote better health.

There is another factor. There is some evidence of unease about the kind of care that can be given in large hospitals with their inevitable emphasis on automated and highly technological treatment or impersonal long-stay care. I

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believe that the public is seeking a return to the basics of good general practice. By this I mean a friendly personal and family physician providing individual care over many years, acting as a guide through potentially frightening modern medical technology, and serving the local community as one of its health promoters and disease preventers.

I am in no doubt that general practice is a special and distinct field of work that encompasses all the criteria of a 'speciality'. It has:

its specific roles and functions;

its own special skills, techniques and organisation;

its own core of scientific knowledge based upon research and experiment;

its own special training for new entrants;

its own arrangements for continuing medical education;

its own philosophies and body of published works(1).

LEVELS OF CARE

In every comprehensive system of health care four distinct levels can be distinguished(2).

The first level of care is *self-care* within a family unit of up to perhaps ten persons and commonly embracing three generations. It is at this level that the majority of minor and chronic disorders in all communities are managed without recourse to professional care. Direct responsibility for health maintenance is also carried by individuals and family units. This is an important level of care because the more effective self-care is the less will be the need for professional care. The relative lack of research on this topic is regrettable.

The second level is *primary professional care* within a locality or neighbourhood. This 'first contact' care provides easily available access to a trained 'primary health care worker' who may be a general medical practitioner but need not be. It can be a practice nurse, medical assistant, independent nurse practitioner or midwife, social worker,

osteopath, chiropractor, or similar worker. The Accident and Emergency Departments of hospitals also fill this role. Even if he wished the general practitioner can no longer expect to claim the whole patient in every case; the patient's freedom of choice has to be respected in this as in other matters.

The population base for this level of care is now about 2000 patients for each NHS principal, commonly aggregated so some 10,000–20,000 for large group practices of 5–10 partners. The administrative level in the NHS in England and Wales is the Family Practitioner Committee (FPC) and each of which is typically responsible for 100–200 NHS general practitioners.

Third in the level of care is that of *secondary (general specialist) care.* This can be equated with the District General Hospital serving a population of about 250,000 people (higher in a densely populated area and less with sparse population). Patients in the NHS may be referred to general surgeons, general physicians (internists), and a wide range of other general specialists including radiologists and pathologists. *Tertiary (super-specialist) care*, the fourth of the levels, is provided by Regional units serving populations of 1–5 million. Examples are neurology and neurosurgery, cardiothoracic medicine and surgery, renal dialysis and transplant units, etc.

SPECIAL FEATURES AND ROLES OF GENERAL PRACTICE

Within this setting special features and roles devolve upon general practice. A key feature is that it provides sufficiently prompt direct access to the general practitioner, or to a responsible fully qualified colleague or deputy at all times. Where necessary the GP acts as the portal of entry to hospital specialist services, but the main volume of work consists of first-contact care involving diagnosis and assessment of the patient's presenting problems. These often take the form of vague ill-defined symptoms. Long-term care and continuing personal care within the community are desir-

able features so that good doctor-patient relations can be built up.

On average each GP cares for a relatively small and stable population of 2000 registered patients on his own list and with a total of about 10,000 persons in a typical group practice. Given such populations, doctors and patients become well-known to one another. Chapter 4 discusses the morbidity and mortality to be expected.

The GP has to know how to co-ordinate and manipulate available medical and social services for his patients' needs; he gets to know who and what service are useful and helpful. Such knowledge is increasingly important as care becomes more comprehensive and is recognised as including—prevention of disease, promotion of health, comfort and relief, when cure is not possible, and, rehabilitation as and where necessary.

DIFFERENCES BETWEEN HOSPITAL AND GENERAL PRACTICE

It has been estimated that general practitioners are consulted in only a quarter of all episodes of illness, in the other three-quarters self-care is adequate. In turn the general practitioner is able to deal with 9 out of 10 of all cases in which he is consulted and in only 1 in 10 is the patient referred to a hospital specialist(2).

Whereas patients in the NHS have direct access to their GP, they can only consult a specialist through referral. This gate-keeping role of general practice entails a process of selection and ensures that the spectrum of disease encountered will be very different. This difference is compounded by the very different sizes of populations served by GPs, District general hospitals and Regional super-specialist units. Thus, whereas a GP may diagnose 2–3 cases of acute appendicitis a year, the District General Hospital will perform over 300 appendicectomies. The GP may diagnose 7 new cancers each year and the various hospital departments will care for over 700 new cancers. (See also chapter 5). Conditions which are frequently seen in a Regional

super-specialist unit will be uncommon at the District General Hospital and very rare in general practice.

Care given in acute hospitals inevitably is transient and episodic with constant emphasis on reducing the duration of in-patient stay. In contrast care in general practice is long-term and continuous. The hospital staff see only an instant-snapshot picture of the patient and the disease as it affects him. The general practitioner is privileged to see a continuing life-long picture of his patient and his disease experiences. General practice therefore offers unique opportunities for long-term observations and studies of disease and of the processes of health.

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2

THE BACKGROUND OF BRITISH GENERAL PRACTICE

1750 TO 1948

THERE MUST HAVE BEEN 'PRIMARY HEALTH CARE WORKERS' ever since the human race began to live as families and communities, for nothing seems more basic to human needs than a 'healer-of-first-contact' with some skills and knowledge to whom the sick and injured can turn to for assistance and succour. The earliest stages in Britain are shrouded in the mists of history but Loudon(1) gives an account of the earliest 'general practitioners' from the eighteenth century onwards.

Between 1750 and 1850, primary care was provided by a motley collection of non-professional irregulars who might include the local priest, parish clerk, the lady of the manor, 'wise women' who delivered babies, and grocers, spicers, and quacks.

The first true general practitioners were surgeon-apothecaries but it was not until the 1815 Apothecaries Act that surgeon-apothecaries were fully accepted.

By 1850 there was much work for these general practitioners. They worked single-handed from their own homes and dispensed and sold their own medicines which relieved and comforted but rarely cured. Patients feared hospitals, not without reason, and refused to be admitted. Measles, whooping cough, and scarlet fever were rife with an appreciable mortality. There were three or four young persons dying from tuberculosis in each practice, rheumatic fever was prevalent, leading to serious cardiac complications. A successful GP's reputation was built on domiciliary

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maternity work and by 1900 he might be dealing with 100 home deliveries a year, with assistance only from the family.

NATIONAL HEALTH INSURANCE

GPs derived their income from fees for work done. There was no health or medical insurance though Poor Laws required that arrangements be made for dispensing and supplying medicines for the sick poor. In the second half of the 19th-century informal local sick clubs and friendly societies began with medical benefits provided to members as part of their schemes. However by 1900 only 13 per cent of the whole population and less than one half of manual workers were covered for basic medical care. Wives, children, and elderly were usually excluded(2).

A Liberal government was elected in 1905 with promises to improve health provision for workers, the poor, and the needy. David Lloyd George, the Chancellor of the Exchequer piloted the National Health Insurance (NHI) Act through Parliament in 1911 (at this time the average annual income of a GP was £500)(3). Originally designed to cover all insured workers and their dependants, violent opposition from the British Medical Association meant that dependants were excluded from health insurance.

The NHI Act was important because it established principles and conditions of service which were carried forward substantially unchanged into the National Health Service in 1948(4). These included freedom of choice for insured patients in selecting a GP with whom to register for care, no full-time salaried service, payment by a capitation fee for each registered panel patient, and the service contract to be between the GP and a Local Insurance Committee to provide an agreed range and standard of medical services.

1920S AND 1930S

After the First World War one of the first actions of the first Minister of Health, Dr Christopher Addison, was to appoint

a Consultative Council on Medical and Allied Services under the chairmanship of Sir Bertrand Dawson (later Lord Dawson of Penn). The interim 'Dawson Report' (there was never to be a final report) proposed primary health centres for care in the community and secondary health centres, equivalent to District General Hospitals. Such ideas were fifty years ahead of their time and were not followed up.

However, momentum continued for a 'General Medical Service for the Nation' through two versions of a BMA plan in 1929 and 1938. This encouraged a GP for everyone and strict enforcement of the system of referral of patients by GPs to hospital specialists.

1939–1945: THE SECOND WORLD WAR

General practice was not exempt from the social disruption of the Second World War. Many general practitioners were conscripted into the services; those left behind had to look after their own patients and those of absent colleagues, as well as being involved in treating casualties and other war-time duties. It was a strained and stressful time that nevertheless was fruitful for the future. A viable system of medical care continued to function amazingly well, with improvements in most health indices in spite of, or in part because of, stringent food rationing.

The 'nationalisation' of all Local Authority and voluntary hospitals into the Emergency Medical Service was important for the future NHS. A system of controlled regional organisation and administration. This came at an opportune time for the voluntary hospitals since many were on the verge of bankruptcy in the pre-war period.

It is amazing that during a war for survival and at a point of near defeat for Britain far reaching plans were produced for the future. The concept of a 'Welfare State' was mooted by Archbishop William Temple, early in the war. Then in 1942 Sir William Beveridge produced his famous report. This included recommendations for 'Comprehensive Health and Rehabilitation Services for Prevention and Care of Disease', in effect a National Health Service available to all. The report was an instant best-seller.

Its main weaknesses, in hindsight, were that it underestimated the costs of comprehensive health care and overestimated the prospects for prevention of disease and abolition of social inequalities. Sir William assumed that a National Health Service would reduce the prevalence of disease and therefore costs of care would come down. How wrong he was! (but what would the cost of not having an NHS have been?)

Although now overshadowed by the Beveridge Report in 1942 the joint report by the BMA and the Royal Colleges had also proposed a national health service. Under this proposal 90 per cent of the population were to be compulsorily medically insured and 10 per cent (the wealthy) to be private patients. Capitation payments plus extra fees for special services were to be the bases of remuneration, and group practice with teams of attached staff the model.

PLANNING FOR THE NHS

Detailed planning for what eventually became the National Health Service Act (1946) began in 1943 when Henry Willink (Conservative) became Minister of Health. In response to the Beveridge Report he published in February 1944 a White Paper on a 'National Health Service'. It proposed the creation of a comprehensive health service for all citizens in which patients and doctors would be free to take part or not as they wished; under control by Parliament, by elected local government authorities; and detailed provision for the profession's views to be taken into account. Responsibility for primary and preventive services (including general practice) was to be vested in the local authorities, and general practitioners were to have the choice of being paid by capitation fees or by salary. Health centres were to be built by local authorities and general practitioners working in them would be salaried.

The proposal that general practice should be a local authority responsibility was fiercely opposed by the British Medical Association and the Government undertook to reconsider the proposals. However, Mr Willink had no

chance to enact any proposals. In 1945 a Labour government was elected with an overwhelming majority. Aneurin Bevan became Minister of Health and worked to implement the Labour Party's election manifesto promises for a National Health Service as the keystone of a Welfare State began at once.

There followed a period of intricate negotiations between Bevan and the medical profession. Doctors, like the public, were generally in favour of the principles of a NHS, but they were very much against some of the details of their proposed contracts and pay. They feared the loss of their independence, excessive bureaucratic control, and the arrangements for negotiating their remuneration.

At first most of the medical profession was united against joining the NHS on the Government's terms but Bevan showed great political astuteness. He divided the BMA, who mainly represented general practitioners, from the Royal Colleges, who fought for specialists. He appeased the Colleges by agreeing to allow specialists to retain their private practice and levels of salary more favourable than general practitioners could expect from their NHS contract.

The general practitioners were ably led by Dr Charles Hill, (later Lord Hill of Luton) secretary of the BMA and well known as the war-time BBC Radio Doctor. Three plebiscites among GPs in 1947 and 1948 reported substantial majorities against entering the NHS. But in the third plebiscite, held after the specialists had reached agreement with the Government, the majority was much lower and it was clear that the tide had turned in Bevan's favour. Finally after a face-saving compromise, 86 per cent of all GPs joined the NHS on the appointed day, 5 July 1948, and over the next 6 months the proportion had risen to 95 per cent(5,6).

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THE NHS: 5 JULY 1948 AND AFTER

THERE WERE NO CELEBRATIONS, NO BANDS OR PUBLIC processions, and a few preliminary special pronouncements on 5 July 1948. It was a fine summer's day and I had been in my practice single handed for exactly one year.

In preparation, for weeks before the appointed day the public had been asked to 'register' with a general practitioner of their choice. This was done by completing small brown EC 1 cards ('EC' denoting Executive Council then, and for the next three years the local administrative body for general practice and now the Family Practitioner Committee, FPC). The permitted maximum number of patients for a principal in general practice was 4500. Within a few weeks I had over 3000 registered NHS patients.

What were the changes and differences in my practice after 5 July 1948? I worked from the same premises as before with the same arrangements for consultations and home visits for the same patients and with the same part-time staff, my wife.

Nevertheless, there were great differences. No longer did my patients have to pay or feel inhibited from seeking any help because of cost nor did I have to worry how much to charge and whether I would be paid. No longer did my wife and I have to spend midnight hours sending out monthly accounts, of which 1 in 5 were never paid. No longer did I have to dispense medicines or worry whether the patient could afford the more expensive ones, I merely wrote a 'free' NHS prescription for what I thought was appropriate. No longer was there any distinction between 'private

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patients' and the less privileged 'panel patients' for all NHS patients carried the same annual capitation fee. It was real democracy at work.

I was an independent contractor in the NHS free to work and practise as I thought appropriate, within the terms of my contract, and I received a regular quarterly cheque from the Executive Council. Having bought my practice in 1947 with a large overdraft I was pleased to be compensated by the NHS for my loss of the right to sell it. I was able to continue to work as a hospital clinical assistant, but was now paid for the sessions.

In my Beckenham practice there was no immediate change in the nature or volume of work. However, nationally, the first effect of the NHS was of mass euphoria, the second was of massive demands of hitherto unmet social and medical needs. There was a rush for 'free' spectacles, dentures, and hearing aids, and the work of hospitals and general practitioners increased. As Richard Titmuss(1) put it well:

> the NHS inherited the debts of a decade of sacrifice and neglect, financial poverty and disorganisation. Simultaneously it had to meet, with access to medical care no longer dependent on the means of the patient, an immense pent-up demand for treatment.

Amazingly, the new NHS coped with these demands reasonably well because of the tolerance and goodwill of public and profession alike.

Yet it soon became clear that a huge medical industry had been taken over as a going concern but with no administrative and organisational arrangements to promote effectiveness, efficiency, and economy.

In general practice there was lack of local leadership and unity. There were no new ideas on methods and services. In particular there were no arrangements to promote good liaison and collaboration between general practice, hospitals, and local authority services. There were few attempts to collect facts and data on which future planning could be based and no immediate resources or funds to encourage experiments. As a result, it was not long before the early

heady days of the summer of 1948 changed into a cooler atmosphere.

THE 1950S

The early euphoria in the NHS was short lived. The 1950's became a period of criticism and counter-attack on many aspects of general practice.

1950: The Collings Report. On 25 March 1950 the *Lancet* devoted 28 of its valuable pages to the 'Collings Report'(2). Dr Joe Collings was an Australian who had practised in New Zealand and with a Harvard fellowship visited 55 practices selected at random. His report on his visits was damning.

Some of his observations were hair-raising—practices with minute consulting rooms with no chair for the patient and no couch for any examination; queues extending 200 yards waiting to see the GP; a practice of four principals and an assistant seeing 500 patients a day and proud of it; waiting rooms where patients had to stand for hours before being seen for five minutes.

Collings considered that within the NHS there was no planning for general practice and few incentives for good practice. The absence of goals and achievement were matched by an absence of professional and administrative checks, standards, and controls. He recommended a pattern of group practice from state owned premises as the model for the future.

Collings' report was received with shocked anger by GPs and others. It was criticised as unrepresentative, statistically unsound, highly personalised, and not validated. Nevertheless, Collings stunned the conscience of general practice and had considerable influence, particularly as it led to two counter reports from Stephen Hadfield(3) and Stephen Taylor(4).

1953: The Hadfield Report. In 1950 Dr Stephen Hadfield, an Assistant Secretary in the BMA, was 'encouraged' to carry out an extensive survey of general practice, presumably to try to refute Collings's allegations of bad practice. In 1950–2 he visited and surveyed 188 GP principals selected

at random. It was a grand exercise, and his report in 1953 is a fine historical record of general practice in the 1950s(3).

Using his own subjective criteria he reported that of the practices visited 44 per cent were 'good'; 44 per cent 'adequate'; 7 per cent 'inadequate'; and in 5 per cent 'no assessment was made'. The difference from Collings's observations is remarkable and it can only be assumed that these two honest observers had visited very different sets of practices.

An interesting side-note is that Dr Hadfield found that in 1950–2 the average waiting time for an NHS out-patient appointment was 2–3 weeks and for a non-urgent admission it was six months.

1954: 'Good General Practice'. In 1951 the Nuffield Provincial Hospitals Trust supported Dr Stephen Taylor (later Lord Taylor of Harlow) in an unusual exercise. Guided by a steering committee his remit was 'to identify, describe and analyse general practice at its best'. Thirty 'good general practices' were selected and he spent 1–5 days in each one observing, recording, and discussing.

His report *Good General Practice*(6) is a classic that should be re-read by young GPs now. Beautifully written, it does not describe each practice, but deals with the factors that make for good practice such as premises, staff, records, organisation, minor surgery and investigations, and hospital work, and he sets out goals to be achieved by others.

All the 30 practices were considered 'very satisfactory'. Taylor considered that the ideal size of a group was 4–5 GPs; that a list size of 2000–3000 for each principal was appropriate; that NHS records (old style) 'were ideal for their purposes'; that the capitation fee was 'an imaginative social instrument'; and that rota schemes between general practices had been one of the major advances.

Characteristically he detailed his own list of the personal qualities of 'the good GP' and 'the GP to be avoided'. The good GP is intelligent, practical and dexterous, energetic and capable of working for long hours, in good physical and mental health, a fast worker who deals with one case at a time, steady in temperament with a sense of humour, and

has a love for his fellow men. The GP to be avoided is stupid, smarmy, pompous and bad tempered, obstinate, refuses to admit mistakes, skimps work, and shows emotional instability with querulous self-pity and abuse of patients and society.

In subsequent years there were many reports covering the same areas of general practice. Most of these produced very similar recommendations which only after many years were introduced into everyday practice.

One produced in 1954 under the auspices of the Central Health Services Council (the Government's own advisory body on the NHS)(5) under chairmanship of Sir Henry Cohen (later Lord Cohen of Birkenhead) strongly emphasised that general practice was essential and could not be replaced by 'congeries of specialists'. It recommended that there should be more group practice but not necessarily from health centres, more ancillary staff, appointment systems for patients, opportunities for GPs to work in hospitals, and for medical students to receive teaching in general practice.

General practitioners had entered the NHS on the basis of average levels of remuneration related to calculations of the net income of pre-war GPs and their estimated practice expenses. These figures, adjusted by a 'betterment' factor to reflect the change in money values up to 1946, provided an NHS remuneration pool to be shared among GPs. Critical differences of interpretation rapidly emerged between the government and the profession, and in 1951 there was an agreed reference to adjudication.

Mr Justice Danckwerts was appointed as adjudicator, and his award in 1952 substantially increased the 'betterment' factor to 100 per cent for 1950–51 and (equally importantly for the profession) decided that the size of the remuneration pool should vary according to the number of GPs and not according to the total number of NHS patients. The Danckwerts award and some related changes in the way in which remuneration was distributed considerably eased relationships for a number of years.

In 1956, however, the profession once again felt that the government had abused its near-monopoly position to hold

down doctors' remuneration unfairly: the government for its part claimed that economic circumstances made it imperative to restrain public expenditure. From this sharp divergence of views there emerged agreement in 1957 to set up a Royal Commission on Doctors' and Dentists' Remuneration chaired by Sir Harry Pilkington. The Royal Commission reported in 1960(6). Apart from recommending substantial increases for all NHS doctors, it recommended the regular review of remuneration by an authoritative review body. The first report of the independent review body established on that basis was made to the Prime Minister in 1963.

THE 1960S

This decade was not a happy one for the NHS in general but, nevertheless, it saw a turning point, the Charter for General Practice. It was a time of general dissatisfaction over conditions and low levels of pay compared with other Western countries. There was considerable medical emigration to North America and Australasia. This resulted in a temporary shortage of GPs, larger list sizes, more work, and frustration. General practice had a low image among new graduates who showed a preference for careers in hospital medicine. Matters reached the point of a serious threat of mass resignation of GPs from the NHS. Yet towards the end of the decade, morale had been boosted with enthusiastic expectations for the future.

During this period numerous reports on general practice helped to crystallise thoughts and define needs and actions. While it is impossible to do justice to these in short compass, it is helpful to give an indication of their range and nature.

1960: 'The Personal Doctor'. Sir Theodore Fox, the editor of the *Lancet*, wrote an important paper on 'The Personal Doctor and his relations to the hospital'(7), stimulated by a tour of American group practices. He made a strong plea for the personal doctor in medicine and particularly in general practice. He concluded that 'the independent practitioner (GP) outside the hospital will survive as a personal doctor or not at all.'

1962: The Porritt Report. In 1958 the British Medical Association was instrumental in setting up a *Medical Services Review Committee* to review the NHS after 10 years(8). The chairman was Sir Arthur Porritt (later Lord Porritt of Hampstead), then President of the Royal College of Surgeons, and there were nominees from the Colleges and the BMA with a high representation of 'young doctors'. (I was one of them).

It met regularly for over four years and its recommendations on general practice were practical and constructive. Group practice was favoured and teamwork with nurses, health visitors, midwives, social workers, psychiatric workers, and probation officers was considered necessary for good care. Appointment systems, direct GP access to radiology and pathology investigations, and GP wards for general medical and maternity cases were all commended. GPs were encouraged to develop special interests and skills. Deputising services were approved but the need for supervision and control was recognised. Postgraduate education should be extended and improved and there should be incentives built into the remuneration structure to encourage better care.

1963: The Gillie Report. Annis Gillie (later Dame Annis Gillie and President of the Royal College of General Practitioners) chaired a Sub-Committee of the Standing Medical Advisory Committee of the Central Health Services Council on 'The Field of Work of the Family Doctor'(9). The intention was to look forward and forecast trends over the next 10–15 years. The recommendations were very general and overlapped those of the Porritt Committee, but a forceful criticism related to the lack of data on most aspects of general practice. There were pleas for general application of scientific medicine to general practice and to medico-social problems; for more experimentation and research; for departments of general practice in all medical schools; for mandatory vocational training, and expansion of continuing education in post-graduate medical centres; and for easier and more exchanges of personnel between general practice, hospital, and public health services.

THE CHARTER FOR GENERAL PRACTICE, 1965

Many GPs were in sympathy with the views expressed with such regularity by these high-level committees, but very deeply frustrated by the lack of any actions to implement their recommendations. Moreover, there were successive instances of failure on the part of the government to give full effect to recommendations for increased remuneration made by the independent Review Body, or to modify some of the contractural obligations which GPs regarded as unreasonable.

By 1964 mass resignation from the NHS was seriously considered and undated letters of resignation were called for by the BMA.

By a most fortunate coincidence, four key leaders came together to achieve a momentous negotiated agreement. Kenneth Robinson (now Sir Kenneth Robinson) was the new Labour Minister of Health. As the son of a general practitioner he knew the problems of general practice. Ronald Gibson (now Sir Ronald Gibson), a GP from Winchester and a pioneer of progressive practice, was chairman of the BMA Representative Body. James Cameron (now Sir James Cameron) a sound sensible middle of the road GP from Wallington, Surrey, was chairman of the General Medical Services Committee. Sir George Godber was Chief Medical Officer at the Ministry and brought the exercise to fulfillment.

Over a few weeks in the summer of 1965 a *Charter for General Practice* was generally agreed and a joint report published(10). (The speed with which it was possible to achieve results demonstrates what can be done by a 'non-committee').

The Charter was the basis for a completely new contract which substantially modified the long-standing capitation fee system of payment. Basic practice allowances supplemented capitation fees in all save the smallest practices, and additional fees were paid to GPs who accepted responsibility for patients outside ordinary hours or who responded to requests for visits in unsocial hours. Direct reimbursement

of 70 per cent of the cost of employing ancillary staff and 100 per cent of the agreed rent and rates or practice premises was conceded. Financial inducements were introduced for group practices of three or more doctors, for work in under-doctored areas, and for undertaking continuing education. New or improved fees were agreed for a number of items of service. Medical certification procedures were modified to ease the burden on GPs and the responsibilities of deputies for their actions clarified.

In addition to the contractual changes, legislation was introduced to create a General Practice Finance Corporation as a source of loans for new or improved practice premises, since many traditional lenders had shown themselves reluctant to make advances on such buildings. And there was a clear commitment to encourage the creation of Departments of General Practice in all medical schools.

Thus in one leap general practice moved into a new era. It was up to GPs themselves to use the opportunities. This they did to the full. Group practice grew, many more staff were employed, better premises were built, and working conditions improved.

THE ROYAL COMMISSION ON MEDICAL EDUCATION, 1968

The Report of the Royal Commission (the Todd Report)(11) finally effected the major changes in education recommended by the Cohen, Porritt, and Gillie Reports and by the Charter. It recognised general practice as a specialty with its own educational requirements at all stages of medical education from the undergraduate through to general professional training, special mandatory vocational training, and then continuing learning. It was not until 1982 that it was finally found possible to introduce a three-year mandatory vocational training programme for all entrants to general practice.

THE 1970S

The turbulence of the 1960s gave way to a quieter gradual progression into the new world of general practice made possible by the implementation of the Charter. Much of the attention of the Government and the BMA was transferred to the drafting and enacting of legislation which altered the administrative structure of the NHS from April 1974. Now Family Practitioner Committees (FPCs) replaced Executive Councils, they were separate from new Health Authorities which assumed responsibilities for services previously provided by Hospital Boards and Medical Officers of Health of Local Authorities. Community Health Councils were established to represent users of health services.

However, the decade did not pass without yet more Commissions and Committees reporting. Three warrant mention.

In 1971, there was published under the auspices of the Central Health Services Council what became known as the Harvard Davis Report(12) on the 'organisation of group practice'. Recommendations included proposals for group practices of varying sizes, serving up to 30,000, but with groups of 5–6 GPs seen as the basic unit. Much wider roles and duties were proposed for practice nurses and 'nursing units' in the larger practice premises for in-patient care by GPs were seen as a possibility, just as they had been in the Dawson Report of 1920. It was recommended that consultants should hold clinics in such practice premises and that GPs should be encouraged to develop special clinical and associated interests.

The Committee on Child Care Services produced in 1976 a report *Fit for the Future*(13) commonly known as the Court Report after its chairman, Professor Donald Court. Its proposals were designed to foster an integrated service for children and their families. One of its recommendations proved too drastic for general practitioners to accept at that time.

The Court Report suggested that there should be *General Practitioner Paediatricians* (GPP) in each group practice, specially trained to organise care for all the children in the

practice. In a group practice of 12,000–15,000 persons one GPP might have responsibility for 3000 children or more.

The post would entail carrying out child development and preventive surveillance in the practice, working paid sessions for the local Health Authority, arranging relevant education for the practice team and for parents, and acting as the link between practice, community, and hospital services. Logically this might be considered a progressive implementation of the Porritt, Gillie, Todd, and Harvard Davis reports, but the idea of GP 'specialoids' always has been somewhat of an anthema to GPs (see chapter 9), and the proposals for GPPs were not acceptable. Now in 1988 most of the other recommendations of the Court Report have been implemented and even the principle of the GPP is coming in.

Thirty-years after the creation of the NHS the government set up a Royal Commission on the NHS, under the chairmanship of Sir Alec Merrison, vice-chancellor of Bristol University, 'to consider in the interests 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'. The Commission reported in 1979(14).

The background to the Commission's appointment was concern over the NHS. The re-organisation introduced in 1974 had given rise to difficulties and there had been a series of industrial disputes involving strikes by junior hospital doctors and dentists, ambulancemen, and ancillary staff. There was anger among hospital consultants over phasing out of private beds in NHS hospitals, and among all groups of staff about the effects of the cold climate of national economic decline and restraint.

After three years and 35 meetings, and at a cost of almost £1m the Commissioners acknowledged that they had 'no blinding revelations' to transform the NHS, which they considered had achieved much and compared very favourably with other national health systems. Whilst they offered many comments on general practice, most were on familiar themes, including more health centres in inner cities and more attention to incentives and trial of a salaried service for the GPs there to promote teamwork and higher

standards in general practice. Signs of the new times were recommendations for a fixed retirement age for GPs, better training for receptionists, more power to Community Health Councils, and vigorous attempts to secure value for all the money spent on the NHS.

THE 1980S

It is too early yet to take a coherent view of the 1980s but certain new trends have emerged.

The Royal College of General Practitioners has entered medical politics in a subtle but powerful way (see chapter 8). It now has about one-half of all GPs as Fellows, Members and Associates. It launched a 'quality initiative' in 1985 and has published a series of papers including evidence and comments to the Merrison Commission, on the Green Paper of 1986, and the White Paper of 1987 in which the government set out proposals for changes in primary care. The College is regularly consulted by the DHSS and seems to have the ear of the Secretary of State.

The BMA has been forceful in giving its opinions on various issues and in negotiating conditions of service and pay, and reacted to the introduction of restrictions on NHS prescribing.

A new influence has been the *House of Commons Select Committee on Social Services* which scrutinises the whole range of work of the DHSS. For example, its first report for 1987(15) had 62 recommendations for the government. These covered alternative ways of paying the GP including incentives for special tasks in prevention and health promotion; means of evaluating and checking the quality of practices and individual GPs to ensure better value for money; the case for annual reports by NHS practices with provision for more information for the public on the range of services provided by practices; the need for more GPs and team members to care for our ageing population; the roles and responsibilities of nurses in primary care; better co-ordination of District services for patients; and support for patient/consumer groups.

However, it must be noted that Select Committees have

no executive powers and the government often rejects their recommendations.

In 1986 the government published the long awaited discussion paper entitled *Primary Health Care: an agenda for discussion*(16). This proved an anti-climax. It was not the comprehensive review that Ministerial statements has foreshadowed, it offered no detailed analysis, and few references. For general practice its main themes were greater responsiveness to the wishes and needs of the public, possible changes in remuneration to assist in control of costs, and enhanced standards to improve efficiency with a suggestion for 'good practice allowances' based on objective criteria.

Following extensive public and professional debate, the government produced its policy proposals in the White Paper *Promoting Better Health*(17) and incorporated many of these without delay in a Health and Medicines Bill which is expected to pass into legislation in 1988.

The White Paper and the Bill may be regarded as the most important documents on general practice since the Charter of 1966, but like its predecessor the Green Paper, the White Paper showed no evidence of critical analysis of published or commissioned research data. Essentially it represented the government's terms for negotiations with the profession, and displayed a definite shift towards greater recognition of consumers' views and rights and away from any over-domination by general practitioners.

It therefore laid emphasis on better availability of and accessibility to their GPs, i.e. a move against excessive use of deputising services to be curbed; more information being made available on practice facilities and staff through published leaflets, and fuller statements on the doctors' qualifications and experience; better choice and easier change of doctor; easier complaints procedures; and in general, greater responsiveness to the public's views of the NHS. Equally, it envisaged better standards in general practice through a wider range of services being made available to patients, including attention to special at-risk groups and to children, GPs would be encouraged to carry out minor surgery on their patients and to use computers to

provide data on which to base better care, such as prescribing and referrals to hospital. The proposed 'good general practice allowance' was dropped because of the profession's views that it would be divisive and unworkable.

The government continued to make clear its view that the promotion of health and prevention of disease should be encouraged by including attention to these in normal GP consultations, particularly to discourage smoking, and in a variety of other ways. Higher rates of immunisation and of cytology screening would be sought and clinics provided for persons with high blood pressure and diabetes.

The White Paper shows to the full the government's wish to secure better value for taxpayers money. It proposes both more patients and a higher minimum number of hours worked; encouragement of women doctors to work in general practice as part-timers through job sharing; a revised scheme for reimbursement of postgraduate training for GPs; and introduction of cash-limited FPC budgets for reimbursements or practice expenditure on staff and premises. Family Practitioner Committees (FPCs) would have greater powers of planning, control, and direction of primary care services, and GPs would be obliged to retire at no later than age 70.

The White Paper has many untidy loose ends which will be negotiated and its full implications will not be seen until the 1990s. It does, however, offer general practice opportunities to put itself into a better shape for the needs of the future. Failure to achieve agreed objectives set by the government may produce more radical and undesirable changes through enforced inspections, controls, and directives.

What is desperately necessary even at this late stage after forty years of the NHS is a better system of data availability on all aspects of primary health care, including assessment and evaluation of the effectiveness, efficiency, and cost benefits of much of the work of GPs and other members of the primary care teams. Most of the recommendations in the White Paper have not been based on any hard and reliable objective evidence, but rather on soft beliefs handed down by armchair philosophers.

STEPPING STONES: 1950–88

Consideration of the many reports since 1950 shows a build-up of change that reached its climax in the radical proposals of the 1987 White Paper. From the 1950s, through to the 1970s, they tended to present re-formulations of familiar recommendations. Starting with the Cohen Report of 1950(5) which accepted the essential place of general practice, there followed a series that concentrated on improving practice conditions, i.e. group practice and premises, teamwork and delegation, better hospital facilities, development of special interests, training, and continuing education. There was little in these reports about the patient or the providers, the government.

A change was apparent in the Merrison Report (1979)(14), with its proposals for better standards and quality of care, better value for money, and more power to Community Health Councils. The House of Commons Select Committee on Social Services (1987)(15), the Green Paper (1986)(16) and the White Paper (1987)(17) have gone much further in tilting the balance towards the patient and the government. The emphasis now is on patients' services, wants and needs, better access to and availability of services, more information on the services actually provided, easier change of doctor, simpler complaints procedures and, in general, more attention to the views of the public. GPs will be expected to meet set standards of care and accept checks and controls. Securing value for money and cost containment within cash limits will be new roles for the Family Practitioner Committees.

The negotiations over the White Paper's proposals and all that may flow from there are certain to be interesting and productive. Recommendations for better general practice are only likely to succeed if they relate to *money*, that is, financial incentives for the GP, to *easing of work*, with appointment systems, deputising services, group and teamwork, and to *real benefits for patients*, with preventive measures and increased access to services. The enshrining of such changes in the formal terms of service of GPs so that

they have contractual status will, in the future, as in the past, be the most effective way of achieving positive results.

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4

CHANGING TRENDS IN SOCIETY

SOCIAL CHANGES HAVE CONSIDERABLE EFFECTS ON THE health of a community through patterns of behaviour, mores, and attitudes. Social changes also influence the ways in which general practice is organised and carried out. It is therefore important to consider some of the more significant changes and to note their possible effect and influence.

Only those who are now upwards of 50 years-old can consciously remember social conditions in the immediate post Second World War period. The price of victory had been enormous in loss of life, loss of wealth and resources, and loss of an empire.

Rationing of food and many other goods continued long after hostilities ended and there were shortages of almost everything as reconstruction got under way. But there was also an intense spirit of common goodwill and expectation for a better future, with a remarkable national consensus that we were becoming a new society with a new Welfare State; and the NHS was created in the period of fundamental optimism.

This chapter quantifies some of the major changes in demography and prosperity which have transformed Britain since the inception of the NHS. It makes no attempt to weigh current levels of national cohesiveness and self-confidence against those demonstrated in 1946.

POPULATION

The population of the UK is growing slowly but significant changes are taking place (Table 1). A low birth-rate means

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TABLE 1. *UK population 1901–2001 in millions.*(1)

Population in millions	*1901*	*1931*	*1961*	*1971*	*1981*	*1991*	*2001 estimated*
Total	38·2	46·1	52·9	56·9	56·5	57·5	59·0
aged 60–74	2·4	4·4	6·8	8·0	8·1	7·9	7·6
aged 75 and over	0·5	1·0	2·2	2·7	3·3	4·0	4·4

there are fewer children and with longer life expectancy (now 72 years for men and 78 for women) there are more elderly, especially the very old (over 75s)(1).

These factors mean that the population will become older with fewer people of working age available to care for the elderly. General practice has to prepare for such changes and consequent problems.

DEATHS

An annual death rate of 11·7 per 1000 population (Table 2) means that there will be some 23 deaths in a typical practice of 2000 persons. Of these, one-fifth (4–5) of deaths will take place at home, two-thirds(15) in hospital, one in a hospice and two 'elsewhere', e.g. in a public place, nursing home. Dying, therefore, tends overwhelmingly to be away from the home with those general practitioners who do not have access to long-stay hospital beds relatively uninvolved in the process of terminal care. In 1948 the situation was very different with more than one-half of deaths occurring at home.

TABLE 2. *Deaths and births per 1000 in UK 1951–86*(1)

	1951	*1961*	*1971*	*1981*	*1986*
Deaths per 1000 population	12·0	12·0	11·7	11·7	11·7
Births per 1000 population	15·9	17·9	16·1	13·0	13·3

BIRTHS

The birth-rate now is well below the peak of the 1960s (Table 2). The consequences have been seen in school closures and, as noted, a smaller cohort of young people will have to care for more old people in the next two generations. The nursing profession has already expressed concern about its ability to recruit sufficient recruits from the reduced pool of school leavers.

A general practitioner with 2000 patients at the present levels can expect 26 maternity cases a year requiring shared care with the local obstetric unit. Practically all births take place in hospital. The same number (26) of new babies will need paediatric care, surveillance, and immunisations.

One in five of all births now is illegitimate but in two-thirds of these the birth is registered in joint names of parents, suggesting a stable relationship(1).

MARRIAGE AND DIVORCE

Although marriage is still popular it is also less stable. The total of 394,000 marriages in 1986 was little different from the 397,000 in 1961, but whereas 86 per cent were first marriages in 1961, by 1986 the rate was 64 per cent(1). Remarriages of the divorced were nine per cent of all marriages in 1961, and 33 per cent in 1986.

The divorce-rate went up six–fold between 1961 and 1986 from 27,000 in 1961 (2·1 persons divorcing per 1000 married people) to 168,000 in 1986 (12·9 per 1000)(1). At this rate it may be that one in three of marriages will end in divorce.

Relating this to a general practitioner with 2000 patients means that there can be five divorces a year in his practice with all the consequent emotional and social problems affecting the couples, their new partners, and any children.

FAMILY PLANNING AND BIRTH CONTROL

Family planning advice and treatment is now freely provided by general practitioners and clinics, though it is worth

TABLE 3. *Methods of contraception in UK by women aged 18–44.*(2) (by percentage)

Method	*1970*	*1976*	*1983*
Pill	19	29	28
IUD	5	6	6
Condom	18	14	13
Cap	2	2	1
Withdrawal	14	5	4
Safe period	5	1	1
Other	3	1	1
Sterilisation	4	13	22*
Total per cent using contraception	70%	71%	76%

(*31% in 1984)

recalling that only in 1968 was scope of NHS legislation widened to enable family planning to be offered on social as opposed to health grounds. Only in 1974 did the legislation embrace treatment, such as vasectomy and sterilisation, on general social grounds rather than medical need.

In 1983, 76 per cent of all women between the ages of 18–44 were using some form of regular birth control(2). The methods used (Table 3) show a remarkable increase in popularity of sterilisation.

The general practitioner is mainly involved in supervising women taking the contraceptive pill and in advising on and arranging sterilisation. Some practitioners will also fit intrauterine devices and diaphragm caps.

The NHS contract specifically remunerates GPs for their family planning responsibilities and on grounds of social policy prescription fees are not charged to women for supplies of contraceptives.

CONCEPTIONS OUTSIDE MARRIAGE

Another index of sexual mores in the community is the proportion of conceptions outside marriage and the percentage of these ending in legal abortion. Table 4 shows that in spite of free availability of family planning, about one in

TABLE 4. *Conceptions outside marriage (% of all births) and percentage of those ending in a legal abortion in 1984.*(3)

Age	*% outside marriage*	*% ending in a legal abortion*
15–19	83	33
20–34	25	13
35 and over	21	30

four of all conceptions is outside marriage with around one in five ending in legal abortion.

The general practitioner often becomes involved in supporting and helping the woman during and after the pregnancy whatever its outcome.

LEGAL ABORTION

The Abortion Act of 1967 permitted the termination of pregnancy in a defined range of circumstances and the effect was to make this safer and easier. The number of terminations is increasing each year (Table 5) and more are being carried out in private hospitals and clinics (at an average cost of £200) rather than in NHS hospitals. Sixty-two per cent of all legal abortions are carried out on unmarried women, married women account for 27 per cent and those widowed, divorced, or separated for 11 per cent.

A general practitioner may expect 5–6 women each year in his practice requiring counselling and help in arranging a legal abortion.

TABLE 5. *Legal abortions in UK 1969–86 (in thousands).*(1)

	1969	*1971*	*1981*	*1986*
Place of abortion (thousands)				
NHS hospitals	37	60	70	77
Private hospitals and clinics	16	41	68	80
Total	53	101	138	157*

*Another 35,000 were carried out on women with overseas residence

Given the availability of a free family planning service, it must be a matter of concern that so many unwanted pregnancies have continued to occur and appear to be increasing in number.

SEXUALLY TRANSMITTED DISEASES

AIDS, of which over 1000 cases have been recorded in the UK, commands media attention. In terms of numbers, however, it is insignificant in comparison with attendances for new cases of other sexually transmitted diseases at hospital clinics.

In 1971, there were 338,000 attendances (men 213,000 and women 125,000); by 1985, the numbers had risen to 658,000 attendances (men 366,000 and women 292,000)(4). The great majority (over 90 per cent) of attendances were for less serious 'non-specific genital infection', 'other conditions requiring treatment' and 'other conditions *not* requiring treatment'. The reasons for the large attendance are not that specific sexually transmitted diseases such as syphilis and gonorrhoea have increased, but rather that it has become more acceptable to attend a 'special clinic' for many symptoms that cause anxiety, and for many minor conditions that were previously managed by general practitioners. It is wrong to conclude that there has been a true increase of sexually transmitted diseases in the community, but it is of significance that so many patients choose to attend clinics rather than seek advice from their general practitioners.

SOME SOCIAL TRENDS AFFECTING WOMEN

The roles of women over the period 1946–1988 changed considerably. We have been through a period of emancipation, and greater opportunities (almost one-half of medical students now are women), yet still there are inequalities that show no signs of resolution.

Table 6 shows that there are now more women in paid employment, especially married women; fewer children per

TABLE 6. *Social trends affecting women.*(5)

UK	*1931*	*1951*	*1981*	*1985*
WOMEN				
% all women (16 and over) at paid work	34	35	48	49
% married women at paid work	10	22	49	52
(% men 16 and over at work)	(91)	(88)	(76)	(74)
Average number of children per woman (16–44)	3·0 (est.)	2·16 (1961 = 2·78)	1·79	1·78
Illegitimate births (% of all births)	5	5	13	19
DIVORCES per 1000 marrieds	less than 2	3	12	13
ONE PARENT FAMILIES (% all families with dependent children)	N.A.	4	14	16

woman; but more illegitimate births; more divorces and more single parent (mother) families.

Women may have been released from housework and enabled far more than ever before to follow activities outside the home, but at the same time the stability of the family has suffered. It must be a matter of opinion how far these developments are causally related. What is clear is that general practitioners often become involved in the difficult consequences for their patients.

THE ECONOMY

Table 7 shows the growth of the economy from 1951 to 1985 in real terms (at 1980 prices). The gross domestic product (GDP) more than doubled and the average income per head for men in employment rose by the same extent.

Another illuminating comparison of personal wealth and resources is to measure how long a married man on average hourly male earnings has to work to pay for selected commodities and services. Table 8 shows that contrary to the

TABLE 7. *Growth in economy in Gross Domestic Product (GDP) and average annual income for a working man (1951–85).*(3)

	1951	*1966*	*1981*	*1985*
GDP Index (1981=100)	49	74	100	110
Average annual income for working man (at 1980 prices)	£2226	£3138	£4037	£4465

common belief that most goods are more expensive, everything is relatively cheaper, apart from cigarettes, which are unchanged. Health educators naturally despair at the halving on this index of the costs of spirits.

Our standards of living have also improved in other ways. Now two-thirds of all houses are owner-occupied compared with one in three in 1951. In 1951, less than 10 per cent of houses had central heating, now it is over 70 per cent. Almost everyone has a TV set and one-third possess a video. Most homes have refrigerators, washing machines, and deep freezers, though still relatively few have a dishwasher. Most

TABLE 8. *Length of work time to pay for selected goods and services, 1971 and 1986.*(1)

Commodity/Service	*1971*	*1986*
	hours/minutes	
Large white loaf (sliced)	9 min	7 min
1 lb rump steak	54 min	45 min
12 eggs	22 min	14 min
100 g coffee (instant)	22 min	22 min
1 pint beer	13 min	12 min
1 bottle whisky	4 h. 17 min	2 h. 04 min
20 cigarettes	22 min	22 min
Weekly gas bill	55 min	1 h. 15 min
Weekly electricity bill	1 h. 04 min	1 h. 03 min
Weekly phone bill	50 min	37 min
Gallon petrol	33 min	26 min
Car licence	39 h. 59 min	25 h. 38 min
Colour TV licence	19 h. 40 min	14 h. 52 min

have a telephone and a car and one-third of professional households have a home computer.

Table 9 shows how widespread the ownership of consumer durables has become.

TABLE 9. *Distribution of Consumer Durables and other facilities in 1985 (percentages of households).*(1)

Consumer Durable	*% households*
TV	99%
(Colour TV)	(85%)
Video	31%
(professional class)	(40%)
(unskilled manual)	(30%)
Washing machine	81%
Refrigerator	95%
Deep-freeze	66%
Dishwasher	6%
(professional class)	(23%)
(unskilled manual)	(10%)
Home computer	13%
(professional class)	(33%)
(unskilled manual)	(5%)
Phone	81%
Car	62%
Holiday abroad	33%
(manual workers with holiday of more than 3 weeks)	(100%)

CRIME AND VIOLENCE

A less satisfactory social trend has been the increasing extent of recorded crime and violence, many more incidents are unreported. Notified offences increased five-fold from 1951 (15 per 1000 population) to 1985 (70 per 1000). In 1971 there were 1·91 million offences and in 1985 there were 8·12 million, with theft, burglary, criminal damage and violence the most prevalent. The police 'clear up' rate was only 35 per cent. In 1961 there were 32,600 (31,500 men and 1100 women) in prison and by 1985, the figure had risen to 53,000 (men 51,800 and women 1700).

SOCIAL PATHOLOGY

A useful way of relating some of the social problems noted to a typical average NHS general practitioner with 2000 patients is to show how many of his patients may be affected by such problems in a typical year as is attempted in table 10. It must be recognised, however, that such figures conceal as much as they reveal and averages frequently obscure great disparities of behaviour.

TABLE 10. *Social pathology in a general practice population of 2,000.*(6)

Situation	*Numbers in a practice of 2000 patients*
Poverty and handicap	
Supplementary allowance	175
Unemployed	120
Attendance, mobility invalidity allowances	60
Marriage, divorce, births	
Marriages	12
Divorces	5
Illegitimate births	5
Legal abortions	5
Single parent families	40
Smoking, alcohol, drugs	
Smokers	450
Heavy drinkers	300
Illicit drugs	7 (estimate)
Crime	
Burglaries	36
Personal violence	5
Sexual offence	1
Positive breath test (drunken driver)	4
Children in care	4
Persons in prison	2
Juvenile delinquents	10

IMPLICATIONS FOR GENERAL PRACTICE

The most important impact of all these social changes for general practice has been that we now have a well-informed and educated society. For those in employment it is also relatively affluent and comfortable though the concept of full employment assumed by Sir William Beveridge (Chapter 2) no longer forms part of government policy.

In 1988, higher standards of care and service are expected and indeed demanded than in 1948. There is more concern with health promotion and use of leisure time. People know their rights and are more ready to complain.

General practice has, of course, changed to reflect these social changes but it needs to develop a closer and more collaborative relationship with patients through better communications, information, and patient participation. Shared efforts may improve conditions for all, whereas an approach whch envisages the general practitioner primarily as a provider of care to largely passive patients seems bound to fail in modern circumstances.

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5

GENERAL PRACTICE: TRENDS AND DATA

PART 1. TRENDS

THERE HAVE BEEN MANY CHANGES SINCE 1948, AND SOME significant absences of change. The changes have been in altered attitudes of the public and of general practitioners, in practice structure and organisation, in financial incentives and methods of remuneration, and in the controls exercised by government through the Family Practitioner Committee. Among the things which have not changed are the one-to-one personal doctor–patient relationship and the high British rates of consultation and prescribing.

WHAT SORT OF GENERAL PRACTITIONER?

There are many more GPs in 1988 (33,000) as there were in 1948 (20,000). The present day GP is likely to be younger, aged in the 40s; more likely to be a woman, now one in five of all GPs, compared with one in twenty in 1948; and quite likely to be an 'overseas doctor' (qualified overseas), about one in four.

The present day GP will have selected general practice as a positive first career choice rather than being a frustrated would-be hospital specialist who went into general practice reluctantly.

He is far better trained than his predecessors, and since 1982 becomes a principal only after a three-year mandatory training period following the pre-registration year.

The present day GP is most likely to work in a group practice. Only one in ten of all GPs are single-handed

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practitioners, and over one-third now work in groups of five or more. In these large group practices there may be difficulties of affiliation by patients. It is not unusual for patients who move and seek to register with a new doctor not to know the name and address of their previous general practitioner.

The present day GP is still a generalist who thinks of himself or herself as a personal and family doctor. There were suggestions by non-GPs, such as the late Professor Thomas McKeown, Professor of Social Medicine at University of Birmingham, and Professor Donald Court, Professor of Child Health at Newcastle, that general practitioners should develop specialist skills and care for distinct groups of the population. Thus, in large group practices, there would be individual GPs recognised by their colleagues as having a special interest in paediatrics, geriatrics, or other fields. This was an attempt to create 'specialoids' such as exist where general practice on the British model is relatively rare as in USA and USSR. There were experiments in Hengrove, Bristol, in the 1950s where Dr Norman Cook ran a NHS practice for children only, and a more ambitious scheme at Livingston New Town in Scotland, where the GPs also had linked specialist appointments at local hospital departments. There has been no spread of such ideas. However, it is common for women doctors to undertake a considerable part of the care of children and women in the larger group practices.

It is not usual for the present day GP to live on the practice premises, which are unlikely to be purpose-built or adapted, rather than part of a doctor's home. Indeed, not only do doctors not usually live on the practice premises, but often they reside some miles away and commute to the practice area, rather than being fully integrated in the local community.

The Royal College of General Practitioners Report(1) on *What sort of doctor* set out four criteria for 'good general practice–1985 model:

clinical competence;	ability to communicate;
accessibility;	professional values.

These are different from the more homely characteristics set out by Stephen Taylor (1954) in his report *Good General Practice* referred to in Chapter 3.

Professor Astrid Nicklebye Heiberg(2) from Oslo has a similar collection of basic requirements for the 21st century. 'A doctor should be knowledgeable, capable of assigning priorities, skilful, dedicated, trustworthy, available, a good listener, a good teacher, a good leader, a good health promoter, and a life-long student and researcher.' Truly a paragon.

WHAT SORT OF PRACTICE?

With the trend towards group practice came larger premises. From shared rooms in the doctor's house, the norm became purpose-built or adapted and improved premises. The transformations were remarkable.

These changes were parts of political swings and roundabouts. Aneurin Bevan and his Labour followers believed in the 1950s that large purpose-built health centres of the kind advocated in the 1920s by the Dawson Report would be the pattern of the future. They were to be built by local authorities and rented to local practices. Conservative policies were different. They believed in owner-occupied group practice premises.

Paradoxically the impetus towards purpose-built or improved adapted premises was fostered by the Labour Minister of Health, Kenneth Robinson, and his Charter for General Practice is described in Chapter 3. This set up the General Practice Finance Corporation and the rent and rate reimbursement schemes to provide financial incentives for improved general practice premises. It has been a great success.

The story of *health centres* is an important one(3,4,5). The first health centre was an enormous one at Swindon, built in 1892 by the Great Western Railway Medical Fund Society and there was a showpiece Dawson-type Pioneer Health Centre at Peckham, S.E. London, in 1926. Some of the early NHS health centres were extravagantly large, such as the William Budd at Bristol, the John Scott at Woodberry Down in North London, and Sighthill in Edinburgh. There were

smaller experimental health centres associated with hospitals at Livingston, Scotland and Hythe, Southampton, with a new town in Harlow, and with a medical school in Manchester and Edinburgh.

By 1988 there are more than 1200 NHS health centres. Most were planned and built in the 1960s and 1970s and many are in need of change and renovation. The Conservative policy in the 1980s has been not to go ahead with new health centre building in England and Wales, though in Scotland the tendency for GPs to work from health centres has continued.

Health centres demonstrated the feasibility of centralised primary care health services for large populations, but on the whole they must be considered a non-success. In many, friction developed between practices, between GPs and local authorities, and between GPs and nurses and other staff who were not employed by the GPs. One reason was that the general practitioners were not prepared or trained for the changes associated with the move. In many cases it proved merely a re-housing exercise with little influence on the kind of medicine practised.

Group practice premises owned and developed by GPs themselves appear to be happier and more effective. They fit in better with the philosophy of the GP as an independent contractor in the NHS.

With larger group practices and health centres came the concept of the *primary health care team.* This also was prompted by the Charter of 1965 and led to the attachment of local authority health visitors, district nurses and midwives to general practice in the 1970s. Practice nurses (nurses employed by the general practitioners as distinct from attached nurses employed by health authorities) have been a feature of the 1980s. The difference is that the practice nurse is under the authority and direction of the practice and generally does what the GPs wish to have done, whereas the attached nurse as an employee of the health authority, who has to give effect to her authority's priorities and her activities require its approval. There is now more delegation and sharing of traditional GP work with practice nurses(6,7).

Practice teams have grown in large sizes. There are often 5–10 'other workers' to each GP in the practice, so there are more than 50 practice units with 50–100 members in the team.

As Jefferys and Sachs(5) comment on present day group practice:

> 'the model GP unit (has) evolved from a unicellular form of organisation to a complex multi-occupational work team (needing) harmony to work in small groups with freedom to select staff in GP-owned premises with useful work for all in innovative exercises and with no antagonsisms.

In the past the family doctor was also a family man. When the practice was part of this house the family inevitably was intimately involved. The doctor's wife was the original 'dragon-at-the-gate' protecting her husband and acting as a first contact. The children, once they were old enough, also played their parts in answering the phone, running messages, delivering bottles of medicine, and listening to table talk about their father's daily and night-time work.

Now it is very different. Living away from the practice, the home phone rarely rings on practice matters, phone calls are mostly dealt with by the practice receptionists or deputising services. As a consequence, the doctor's wife is only remotely involved in the work of the practice. She may see her husband less often than when he worked from home and the children are less likely to follow their father into the medical profession.

The role of the *GP's wife* provides a nice social history over the past 40 years. Just as the neophyte GP was untrained for his job, so was his wife. It was a much more formidable undertaking then than it is now. The GP's wife was expected to be a housewife, a mother, a receptionist, a nurse, a dispenser, as well as a tender, loving companion. Amazingly most wives coped and loved it all and there were very few divorces. It is a shame that no monument has been erected to the GP's wife of the past to commemorate her many unsung contributions.

Nor was she a recognised worker for the NHS. She was

ignored in 1948 and she remainded without due recognition in the 1965 Charter when direct reimbursement of employed staff was introduced. Wives and other members of the family were, and still are, positively discriminated against by exclusion from any forms of direct reimbursement because of the government's fears that the sums paid might not be related sufficiently closely to work done for the NHS.

Another great difference is the background occupation of the GP's wife. Forty years ago young male doctors tended to marry nurses and this helped them to run their practice. Now young male medical students tend to marry young female medical students and there are many practices with husband and wife principals. There are also many women GPs whose husbands are not medically qualified: a great change from the past.

Private general practice, outside the NHS, now is rare. It exists in the centre of London, and in a few other places, but probably it represents only 1–2 per cent of all primary medical care in the UK.

In 1948, the change from private to NHS general practice took some time to adjust to and in the 1950s there was a size-able number of elderly people who 'did not believe in a free NHS' and who insisted in paying their doctors, probably also elderly, as they had done before. Once these two elderly groups disappeared, then so did most of private general practice.

There was an attempt in the 1960s by BUPA to introduce a private GP insurance scheme outside the NHS, but it failed because it became too costly both for BUPA and for subscribers.

There was an episode in the mid-1960s when 15 Birmingham GPs resigned from the NHS in disgust over their conditions of contract. This was just prior to the Charter agreement. They set up in private practice, but this did not survive.

Work outside the practice. General practice is now, and has always been, a part-time occupation for many GPs. Before the NHS, many GPs were associated with, and worked in, local hospitals in honorary capacities. The introduction of

the NHS in 1948 changed this situation at a stroke. Hospitals became the exclusive province of salaried specialists with almost total exclusion of GPs.

There have been changes. Gradually there has been a re-entry of GPs into recognised paid hospital appointments as clinical assistants and in the hospital practitioner grade. About one-quarter of all GPs hold such hospital appointments.

There still are a few GP hospitals which escaped closure in the 1960s and 1970s and which are staffed by local GPs in collaboration with visiting specialists. They provide a good service to the local community and a fine system of continuing medical education for the GPs.

The drastic shutting-out of GPs from hospitals in 1948 was one of the worst features of the NHS. It was the result of pressure by the Royal Colleges of Surgeons and of Physicians who struck this bargain with Aneurin Bevan as their price for agreeing to enter the NHS. It was a step that pushed general practice back in status and esteem for at least 20 years. Closer collaboration and working together would have resulted in a more satisfying system of medical care.

In addition to hospital work, there are many other outside activitives which are likely to take up part of a GP's time—occupational health service; regular medical examinations for insurance and other purposes; contributing to the undergraduate education of medical students; vocational training programmes for trainee GPs; and serving on many, many committees such as Local Medical Committees, District Health Authorities, BMA Committees, and RCGP Faculty Boards.

WHAT SORT OF SERVICE?

The service provided by GPs reflects their contract with the NHS, the public's wants and practitioners' own interpretations of what is necessary and appropriate. This has led to problems and difficulties in the past and is likely to do so in the future.

The *GP's contract* as an independent contractor requires

that he should provide all necessary care for persons who are registered with him. This is open to broad interpretation on which the patient's and the doctor's viewpoints may differ and can, though surprisingly rarely, lead to complaints about refusal to visit, waiting time, failure to refer, incompetent care and rudeness by staff as well as the doctor.

The *patients' wants* are relatively simple. They want readily available and accessible personal care by doctors and their staff and want them to be interested, concerned, friendly, and understanding, and ready to become involved and supportive in dealing competently, if not always successfully, with their problems.

The *GP* is seeking interesting and challenging work of the kind for which he has been trained, without too many frustrations and irritations, in good premises, with colleagues and staff in whom he has confidence, and with good working conditions, adequate time for family and leisure and, of course, with a good income.

In many ways the changes over recent years have meant that the services provided have become more efficient and more organised, but also more complex and more controlled. Bigger, and sometimes more distant practice units with more staff have meant patients having to negotiate more barriers to 'see their own doctor'. Appointments have to be made for 5–10 minute consultations, often two or more days ahead; it is difficult to speak to the GP on the telephone; home visits are more difficult to obtain; travel by public transport is less easy and car parking more awkward. In large practices first-contact care may be from the practice nurse, or the health visitor, or the social worker, or the GP, or the trainee or partners.

Continuous care has always been a part of general practice. In 1948 the single-handed general practitioner met this obligation by being on-call every night and every weekend. It was in the 1950s that inter-practice rivalries ceased and rotas allowing reasonable periods off-duty began to form.

In the 1960's *deputising services* started. The story of deputising services is instructive(3). Two South African doctors conceived the idea in 1956 and introduced a service in South London with the support of the then popular

national weekly illustrated *Picture Post.* Similar schemes already existed in Copenhagen and Stockholm. Their Emergency Call Service at first was considered 'undesirable' by the British Medical Association (BMA) and a bitter battle ensued between them. Needless to say, the concept of switching over at night and at weekends to a deputising service proved very attractive with GPs. By 1965, two-thirds of GPs in London were subscribers and deputising services were being planned in most large cities. By 1969 the BMA changed its views and recognised deputising services as 'filling a definite medical need' and then set out to create a scheme of its own.

'Deputising' is now part of British general practice. Wherever it is available, the great majority of GPs use it to some extent and there is no good evidence that it has been detrimental to general practice. Organisational faults and poor communications between visiting deputising doctors and GPs can cause problems, and for these and other reasons Family Practitioner Committees now satisfy themselves that the standard of service offered is satisfactory.

WHAT SORT OF ORGANISATON?

The evolution has been noted of general practice from the single-handed GP living on-the-shop through to a cottage industry and now into a collection of small businesses. Along with this has come increasing concern with finance and profits. There are now two free GP magazines dealing specifically with money matters and GP newspapers carry sections on business affairs. GPs are targets for investment groups and others who seek their money. This should not be surprising because the gross turnover of a large group of 15–20 GPs can be over £1m a year. To cope with these amounts, the practice must act like any other company with a board, a managing director, and financial advisers. It cannot be long before insider or outsider entrepreneurs devise new devices to increase profits perhaps by establishing larger companies controlling a number of large group practices and sharing costs and expenses. Takeover bids for practices may not be that far away.

The basic equipment of general practice has not changed much over the years. British general practitioners have had a few incentives to undertake minor surgery and have been excluded from any more major surgery. Perhaps the most significant new tool has been the Wright peak-flow meter to assess respiratory function. Computers are recent innovations. In countries with billing systems they have become essential for the business side of practice, but in the NHS there has been no such pressing need. Computer enthusiasts have reported on their use for complementing the age-sex register with the ability to pick out quickly patients needing immunisations and screening procedures, they have been used to facilitate repeat prescribing, and they are being promoted by market research firms recruiting GPs in the surveillance of new drugs and their complications. There are no signs yet that computers will take over clinical recording and replace standard medical records.

Larger practices use standard new office machines and it may be that some practices will follow the USA in using desk top auto-analysers for processing pathological specimens (blood and urine). However, without some financial inducements from the NHS these will not be taken up widely.

RELATIONS WITH OTHERS

The growth of practice size and other changes in medicine and society have meant changes in relations within and without general practice. Arrangements now have to be made to ensure good communications and understanding among all members of the enlarged practice team and sometimes this is not given the high priority that it demands.

Unfortunately contacts between GPs and consultants and junior hospital staff tend not to be close now that few general practitioners have a role in the work of the hospital. There may be meetings at the postgraduate centre or on other professional occasions, but the usual contacts are by letter and telephone only. General practitioners and consultants may correspond for many years without ever meeting face-to-face. It is sad that the domiciliary consultation which aimed at bringing consultant and GP together at the

patient's bedside at home has become a domiciliary visit by the consultant alone.

A major frustration in GP–hospital relations has been the increasingly long waiting times for admissions and out-patient appointments. It is not uncommon now for a routine out-patient appointment wait to run into months and for admission of a non-urgent case to extend into years.

Good personal doctor–patient relations are the key to good practice. Consumerism has created many representative groupings of patients, some of which have created less than good relations with general practice. This is a pity because both patients and doctors share the same ideals of care and service and should be able to develop local procedures with all practices working together with representatives of patients on friendly terms. The present situation where some Community Health Councils pride themselves on acting as vigilantes against general practice has not been conducive to better care.

PART 2: DATA

Good health care demands a constant supply of reliable data and facts so that planning decisions can be soundly based. This is particularly so in general practice which works as small units in relatively professional isolation.

Although there is no single source for general practice information there are a number of regular publications which provide some of the necessary material. The following are of particular value: the annual DHSS *Health and Personal Social Service Statistics*; the annual *Social Trends* by Central Statistical Office; annual *General Household Survey* by OPCS: and occasional *Morbidity Statistics* from General Practice by OPCS (all published by HMSO). The corresponding bodies in Scotland, Wales, and N. Ireland also provide regular information or general practice. *The Compendia of Health Statistics* by the Office of Health Economics bring together much of this data in an attractive format.

TABLE 1. *NHS Manpower (1986) (whole time equivalents)*(8)

	Hospitals					*General Practice*		
NHS Staff in 1986	Medical and Dental	Nurses and Midwives	Professional and Technical	Admin. and Clerical	Domestic and Ancillary	GPs	Others (est.)	Total
Numbers	43799	514962	88872	128567	221429	32847	60000	1090476
%	4%	47%	8%	11%	22%	3%	5%	100%

TABLE 2. *Percentage of Doctors in NHS (1986)*(8)

	Hospital		*General Practice*		*Totals*
	Consultants	Other and junior hospital doctors	Principals	Trainees and Assistants	
Number	17520	26279	30305	2542	76646
%	23%	34%	40%	3%	100%

NHS MANPOWER

With a relatively static population of about 56·5 million the staff working in the NHS went up by about 15 per cent from 1975 to 1985 to just over one million, or 1-in-50 of the population. It is one of the largest employers in the country (Table 1), though strictly no-one is employed by the NHS as such but only by one of the authorities created by legislation, as Regional and District Health Authorities and FPCs.

It is of political relevance to note that doctors comprise only 7 per cent of NHS manpower and nurses almost one-half.

MEDICAL MANPOWER

In 1986 the number of doctors in the NHS was 76,646 (Table 2). The total number of registered medical practitioners on the General Medical Council's *Principal List* (UK) in 1986 was 125,168. The difference is made up by doctors who work outside the NHS or are retired or not working for other reasons. There were almost twice as many GP principals as hospital consultants, expressed as whole-time equivalents, but many consultants have part-time contracts.

These numbers of consultants and general practitioners allow some theoretical speculations on replacement numbers of consultants and GP principals in the NHS.

Assuming that the average age of a consultant at appointment is 37 and retirement is at 65, excluding deaths and early retirements, etc., the annual replacement number is 626. For GP principals assuming appointment at 30 and retirements at 65, the replacement number is 856.

Each year about 4000 medical students graduate. Although some will emigrate, some will work outside the NHS, some will work part-time and provision has to be made for a slow increase in senior medical manpower, there seems to be an excess of medical students to meet our needs.

GENERAL PRACTITIONERS

Since 1948 the numbers of GP principals have increased at 1·3 per cent per year and for the past 10 years at almost 2 per cent per year. There were approximately 20,000 GP principals in 1948 for a population of 49·4 million and in 1988 an estimated 31,500 GP principals for 56·5 million. (Table 3).

TABLE 3. *NHS GP principals in 1948 and 1988 and per population (various sources).)*

	1948	*1988*
Population	49·4 million	56·5 million
GP principals	20000	31500 (est.)
GP per population	1:2470	1:1794

LIST SIZE

For various reasons the average list size derived from NHS sources does not equal the population divided by total number of GPs, it is always greater. This reflects a variety of factors, including delay or failure in notifying deaths, emigration, and population movement to the NHS Central Register. It is worth noting that GPs collectively gain no financial benefit from this, since the level of inflation is known and allowed for in the calculation of target levels of pay.

Table 4 shows the average list size of GP principals in the various parts of the UK from 1951 to 1986. The high list size of 1966 was related to the low status and morale in general practice at that time, described in Chapter 3.

The average list size has always tended to be highest in England lowest in Scotland and Northern Ireland. Within England there have been constant regional variations with lowest list sizes in the South-West, and highest in Midlands and North-West(9).

TABLE 4. *Average list sizes of GP principals 1951 to 1986.*(8)

	1951	*1956*	*1966*	*1976*	*1986*
UK	2498	2225	2400	2301	1977
England	2570	2270	2461	2365	2032
Wales	2295	2002	2231	2193	1888
Scotland	2197	1990	2095	1939	1644
N. Ireland	1798	1885	2011	2105	1840

A GP PROFILE

The average GP in 1988 is likely to be a male in his 40s who has had a recognised vocational training, but the proportion of female GPs is increasing. In 1948 only 5 per cent of GPs were women, now it is 20 per cent and by 2000 AD it will be about 55 per cent (over 40 per cent of GP trainees now are women). (Table 5).

TABLE 5. *Percentages of NHS male and female GP principals, 1948–2000.*

	1948	*1968*	*1978*	*1988*	*2000* (est.)
Male	95	90	86	80	45
Female	5	10	14	20	55

THE CONTENT OF GENERAL PRACTICE

The nature of general practice is such that most of the clinical work will be with minor conditions (60 per cent) and chronic disease (33 per cent) and only 7 per cent with more acute major life-threatening situations.

As numerical representation of the content of general practice, Tables 6–9 show the numbers likely to consult a GP with 2000 patients(9).

TABLE 6. *Persons consulting annually for minor conditions per 2000.*(9)

Minor Conditions	*Annual persons consulting per 2000*
'Coughs and colds'	400
Hay fever	40
Ear Wax	50
Backache	100
'Fibrositis'	70
Minor anxiety/depression	100
Cystitis	50
Minor gynaecological problems	110
Acute 'D and V'	70
Dyspepsia/constipation	40
Skin infections	100
Eczema	60
Acne	15

TABLE 7. *Persons consulting annually for chronic conditions per 2000.*(9)

Chronic Conditions	*Annual persons consulting per 2000*
Asthma	35
Chronic bronchitis	20
Rheumatoid arthritis	10
Other arthritis	50
Chronic psychiatric	55
Peptic ulcer	12
Cataract	5
High blood pressure	80
Cardiac (various)	45
Strokes (old)	12
Migraine	30
Diabetes	15
Epilepsy	7
Parkinsonism	3
Multiple Sclerosis	2

TABLE 8. *Persons consulting annually for acute major conditions per 2000.*(9)

Acute Major	*Annual persons consulting per 2000*
All cancers (new 7)	15
Acute myocardial infarction	10
Acute strokes	5
Acute appendicitis	3
Acute pneumonia/bronchitis	20
Suicide	1 in 5 years
New cancers	
Lung	2
Breast	2
Gut	1
Stomach	1 in 3 years
Cervix	1 in 5 years
Brain	1 in 10 years
Thyroid	1 in 20 years

Table 9 shows the large number of patients who now attend for reasons other than illness, including for preventive measures.

TABLE 9. *Persons attending annually for reasons other than illness per 2000.*(9)

Reason for attendance	*Annual persons per 2000*
Family planning	110
Immunisation	100
Cervical cytology	50
Antenatal/Postnatal	40
Others	100

HOW MUCH WORK DOES THE GP DO?

In any year around 70 per cent of the population consult their GP and the average number of consultations per person per year is 4. A GP with 2000 patients can therefore expect some 8000 consultations a year, 154 per week, or 30 per working day (5 days a week). (Table 10).

TABLE 10. *A GP's work profile.*(9)

Daily	*Number*
Consultations per day At two consulting sessions	26
Home visits per day On one round	4
Night visit (11 pm–7 am) (on call 1 night per week for a group of 5)	1 per week
Out of hours weekend on call 1 in 5 (for group of 5 GPs)	10 per weekend on call
Clinic (Antenatal, children, cervical cytology etc.)	1 or 2 per week

At 8·25 minutes per consultation and 24 minutes per home visit the GP will be in contact with patients for 5 hours 15 minutes a day(9). In addition he will be involved in practice administration, paperwork, discussions with colleagues and teaching and learning. All these add up to more than an 8 hours day.

HOW IS GENERAL PRACTICE ORGANISED?

There have been two major trends, towards larger partnership groups of GPs and larger practice teams.

Group practice. Table 11 shows that the change from 1952 to 1986 has been remarkable with decline of single handed practice and growth of larger groups.

THE PRIMARY CARE TEAM

Comparison of 1958 and 1988 is revealing (Table 12)—from one doctor and his wife in 1948 the average size practice now has a team of 30 and the largest practices may have teams of 100 or more.

TABLE 11. *Size of NHS practice (groups) 1952, 1970, and 1986 (in percentages).*(9)

Type of practice	*1952*	*1970*	*1986*
Single handed	43	21	11
Groups (partnerships)			
×2	33	25	16
×3	15	27	21
×4	6	16	19
×5	2	7	15
×6 and more	1	4	18
	100	100	100

TABLE 12. *Primary care team size— 1948 and 1988 models*

	1948	*1988*
GPs	1	4+1 trainee
Staff		
Employed	1 wife	20
Attached	NIL	5
Total	2	30

A GP is likely to prescribe at two out of three consultations, often more than one item. The mean number of prescription items per person per year is 7. In 1949 it was 4·5. The average cost of each item is now *£5*, whereas in 1949 it was *16 pence*. Therefore the annual prescribing cost per person is *£35* and in 1949 was *72 pence*. The annual prescribing cost per GP with 2000 patients will be *£70,000* (and an estimated *£80,000* in 1988). It was *£750* in 1949. (Table 13).

TABLE 13. *Annual average prescribing data in 1949 and 1986*

	Prescription items per person	*Cost per item*	*Prescription cost per person*	*Prescription cost per GP*
1986	7	£5	£35	£70,000*
1949 (at 1949 prices*)	4.5	16 pence	72 pence	£750

(*Estimated £80.000 in 1988) (10)

The top categories of drugs prescribed in 1986 were for central nervous system (including psychotropics, analgesics, and anti-convulsants) (21 per cent of all prescriptions); cardiovascular (17 per cent); antibiotics (12 per cent); and respiratory (11 per cent).

UTILISATION OF HOSPITALS

The general practitioner is, because of the referral system, normally, the gate-keeper to the hospital service. Hospitals are by far the most expensive part of the NHS accounting for two-kinds of the total budget. General medical services represent only 7 per cent and GP prescribing 11 per cent(8). Through referrals to hospitals the GP exercises an important influence on costs. Although in only about one in ten of GP consultations is there a referral to hospital, about one-third of the population receives some hospital care every year.

In 1986 the percentages of the population who used NHS hospitals were:

13 per cent were admitted to hospital (in 1967 it was 10 per cent);

18 per cent were newly referred to an out-patient clinic (in 1967 it was 15 per cent);

22 per cent attended an accident–emergency department (in 1967 it was 15 per cent)(8).

Translating these rates to a general practice list of 2000 patients, in a year 260 will be admitted to hospital, 360 newly referred to an out-patient clinic, and 440 attend an accident–emergency department. Some of these will be using more than one facility, i.e. the same person may have attended accident–emergency, out-patients, and also have been admitted to a bed.

COSTS

How much does this cost the NHS? Although it is difficult to make precise costings, an attempt has to be made. In 1988 the NHS will cost £22b, or £390 per person. A breakdown

of this figure of £390 into spending on each part of the NHS(8) shows that:

Per Person	
£226	will be spent on hospitals
£ 29	will be spent on general practice
£ 40	will be spent on GP prescribing
£ 25	will be spent on community health services
£ 17	will be spent on general dental services
£ 3	will be spent on ophthalmic services
£ 50	will be spent on others such as administration, ambulance, research, public health.
£390	

Translating these costs to a GP with 2000 patients his practice will cost:

Per GP	
£ 58.000	for remuneration and expenses
£ 80.000	for prescribing
£138.000	

As noted the GP is responsible for some of the hospital costs through his referrals and use of open access diagnostic facilities. In estimating these amounts it has to be appreciated that it now costs £100 per day for an in-patient in an acute general hospital (average stay is 5 days); that each new referral to an out-patient clinic costs £25 (a re-attendance £15); that an accident-emergency attendance costs £17; and a GP radiology investigation averages £25; and a pathology investigation £10.(9)

The total hospital costs per 2000 persons in 1988 will be a staggering £452.000. It has been estimated that at a minimum the GP is directly responsible for £84.000 of this annually.(9)

Therefore a GP with 2000 patients may be regarded as costing the NHS:

£ 58.000	for general medical services
£ 80.000	for prescribing
£ 84.000	for hospital referrals etc.
£222.000	

This estimate, though crude and approximate, shows the order of magnitude that could be required per GP if practice budgets were to be considered. It would mean over £1m for a partnership of five. The day may come when accounting procedures are created to allocate NHS resources on some basis, but there would also have to be sophisticated measurements of the outcomes of treatment if effectiveness rather then simple economy were to prevail.

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6

EDUCATION AND COMMUNICATIONS

THE PILLARS OF THE ACADEMIC CLINICAL DISCIPLINE ARE care and practice based on sound education, communication, and research.

The aims for general practice must be: to *teach* present and future general practitioners on the nature and needs of their special field; to undertake *research and study* in order to provide fundamental knowledge for teaching and practice; to practise good care based on sound teaching and research; and to ensure good *communications* within the profession.

Education and communications are considered in this chapter and research in Chapter 7.

BEFORE 1948

Before the NHS the basic undergraduate medical education was aimed at producing a young doctor who could either go straight into general practice (as my father had done in about 1925) or could start on a specialist career and years of low paid or even unpaid hospital jobs.

Most would-be general practitioners did organise their own unsupervised 'do-it-themselves' vocational training. They worked in a few hospital jobs and then sought out an assistantship-with-a-view for a year or longer before buying themselves into a practice.

Continuing medical education chiefly consisted of reading the *BMJ* and the *Practitioner*, but because of the pressures of

References for this chapter begin on p. 69

work on single handed practices, many consulting rooms were littered with rolled-up medical journals waiting to be opened but mostly never read. In some districts however there were attempts at organising continuing professional education.

In the provinces local medical societies of long standing held regular meetings with visiting lecturers and some local divisions of the British Medical Association also were active in arranging clinical meetings.

Probably the best and most practical way of keeping up to date was through working (unpaid) in local GP hospitals and mixing with honorary (unpaid) consultants in caring for one's own patients. Unfortunately such opportunities were not universal and almost non-existent in the large city hospitals.

AFTER 1948

UNDERGRADUATE EDUCATION

The first intrusions of general practitioners into any contacts with medical students were by Dr Will Pickles, of Aysgarth, who lectured, when invited, on his 'Epidemiology in Country Practice'(1) and Dr Geoffrey Barber(2) who was invited once a year to give a talk to clinical students at his old teaching hospital, St Mary's, London, on the contents of his doctor's bag which led on to stories about patients and practice.

The first formal teaching on general practice was at Edinburgh in 1948–9 where the old Cowgate dispensary (for local poor) became a GP teaching unit in the University Department of Public Health. Dr Richard Scott was its director and he became the first Professor of General Practice in 1963,(3,4). This led to voluntary electives for medical students who wished to see something of general practice. The first English general practice was established in Manchester in 1966 with Dr Pat Byrne as the first Professor.

Following the Cohen, Gillie, and Porritt Reports (see Chapter 3) the General Medical Council (GMC), in its 1967

'recommendations' encouraged medical schools to include general practice in their curricula. The Todd Royal Commission on Medical Education in 1968 (Chapter 2) reinforced this and within a short time most medical schools had set up departments of general practice. Now there are independent departments in all medical schools. The GMC was very influential in this development, as is clear from its 1977 report *Basic Medical Education in the British Isles: General Medical Council Survey*(5).

How have these departments of general practice fared? The answer must be 'less than well', as noted in The Mackenzie Report(6), yet in spite of problems of status, money, and facilities, they have achieved much. Primarily their tasks were to set up modules of teaching for undergraduates. This they have done well with student attachments in general practices and regular teaching in the practice associated with the department.

VOCATIONAL TRAINING

As noted in Chapter 3, the introduction of the NHS in 1948 put an end to the buying and selling of practices. The NHS had power to select, approve, and appoint GP principals. This degree of authority meant it was possible to introduce rules and conditions including vocational training. From the outset there was provision for the status of a 'trainee-assistant'. This allowed GPs who were approved as trainers to engage trainees who were paid for by the NHS: in addition the trainer received a personal training allowance. Such an unsupervised system was wide open to abuse.

The Todd Report (1968) recommendations led to a new system of vocational training. The Royal Commission recognised general practice as a specialty in its own right and suggested a 6-year period of specific vocational training:

1 year pre-registration appointments;

3 years of vocational (general professional) training;

2 years as an 'assistant principal' before recognition as a full NHS principal (this was not accepted by the profession).

The profession then showed its bent for bureaucratic elaboration. At the apex are now the Central (and Scottish) Councils for Postgraduate Medical Education with a Joint Committee of Postgraduate Training in General Practice (1975). Each Region has Postgraduate Advisers in general practice. Each District has Course Organisers. Now there are approximately 2500 trainers and 2000 GP trainees with the total cost of vocational training running at over £50m a year.

It is surprising that there has been no independent evaluation to assess the organisation and measure outcomes. The RCGP(7) in a small study did however find that vocational trainees had a better knowledge of general practice and the highest pass marks of any group in the MRCGP examination.

CONTINUING MEDICAL EDUCATION

Members of a learned profession must accept their own responsibility for continuous self-learning and regular 'brain-dusting' as suggested by Sir William Osler 80 years ago(8). For doctors this is a requirement from the time they enter medical school until they retire or expire. The habits for self-learning and up-dating must be inculcated early and maintained conscientiously. Time should be set aside every working day for this purpose by reading, researching, writing, discussing, and by constant questioning and analysis of what is being done and with what outcome.

Self-learning is a private and an individual discipline. Its basic ingredients traditionally are reading and writing. Recent new tools such as tapes, videos, and computers are refinements only.

There are other methods of continuing professional education through tutorials, lectures, small groupwork, courses, and conferences. There are many opportunities both nationally and internationally for all these activities, taken up by academics and others. Again, there have been no reliable studies to measure the cost-benefits of such exercises, which is surprising since their cost is high.

POSTGRADUATE MEDICAL CENTRES

A landmark was the 1961 Christ Church Conference organised by the Nuffield Provincial Hospitals Trust. Leaders of the profession were brought together in Oxford on a cold December week-end and invited to identify priorities for immediate improvements in professional education. Under the less than gentle guidance of the chairman, Sir George Pickering, it was agreed that the major need was for a Postgraduate Medical Centre (PGC) in every District, prototypes existed in Stoke and Exeter.

The Trustees responded at once with a scheme of interest-free loans to build postgraduate medical centres. There are now postgraduate medical centres in every District.

DEPARTMENTS OF GENERAL PRACTICE

In USA University Departments of Family Medicine have been active in promoting continuing medical education. This has not been the case in the UK(4). This is a pity and a missed opportunity. There would be no better way for the Departments to promote relations with local GPs than through programmes of continuing education rather than the occasional lecture or course.

INCENTIVES: THE SECTION 63 STORY

One outcome of the Charter for general practice was the passage of the Health Services and Public Health Act, 1968, Section 63 of which allowed the Health Departments to provide or arrange with others, usually universities, to provide lectures and meetings for GPs. In addition to reimbursing the GPs' expenses the seniority payments which were part of the new arrangements were not to be paid unless the GP attended at least 12 hours of approved courses a year. Attendances went up and stayed up until the link with seniority payments was dropped and Section 63 allowances were drastically cut in 1977(9). Now it is less easy to obtain Section 63 approval for a course or full reimbursement of GPs' expenses, meetings now often rely on subsidies from pharmaceutical companies.

COURSES FOR TEACHERS

The increase in vocational training and continuing education for GPs meant there was a need for well trained teachers. The Nuffield Provincial Hospitals Trust granted the RCGP funds in 1973 for three courses for teachers. 100 GPs participated and have been influential nationally and locally(10).

GP PUBLICATIONS

In 1947 when I started in general practice there were three accepted and long established journals for the GP, namely, the *British Medical Journal* (*BMJ*), provided to all members of the BMA, the *Lancet* (weekly) and the *Practitioner* (monthly). My practice library consisted of my student textbooks and some volumes written by specialists for GPs. There were no books for GPs by GPs.

Soon remarkable changes began to occur and now in 1988 I receive some 24 'free' journals a month and there are well over 200 books written by GPs for GPs (Margaret Hammond, personal communication). Relatively little of the flood of informative material comes from official sources, but the four publications produced, or paid for, by DHSS warrant mention, *Prescribers Journal, Drug and Therapeutics Bulletin, British National Formulary* and *Health Trends.*

GP NEWSPAPERS AND JOURNALS

The 1960s saw the inception of free controlled circulation publications, journals and newspapers, to be sent without charge and without request to all GPs. The costs of such publications to be met by extensive advertising by pharmaceutical companies. There are 20 of these 'free' publications. In addition there are many occasional publications of high quality produced and published directly by the pharmaceutical companies.

Overwhelmed by more than 2000 pages of potential reading each month the GP has to become a highly selective reader and scanner.

WHY SO MANY 'FREE' JOURNALS?

Free medical journals and newspapers are a world wide phenomenon. They exist wherever there is a good market for products available on prescription: most prescriptions are written by GPs and most of the advertising is aimed at GPs. In Italy, France, and West Germany there are even daily medical newspapers filled with advertisements.

In UK the standards of these publications have always been high with attention to ethics and scientific accuracy. They provide the GP readers with a wealth of news, feature articles, clinical reviews, correspondence, and information on organisation and the NHS. In general GPs derive much of their knowledge of new drugs from such vehicles for advertising rather than from data sheets prepared under the auspices of the Medicines Commission and the Committee for the Safety of Medicines.

HOW ARE THEY FINANCED?

For many years there were no quantitative restrictions on promotion and advertising by pharmaceutical companies. Since the NHS has to meet the cost of the great majority of drugs prescribed in the UK the scale of promotional activities gave rise to criticism. In 1977 the Health Departments arrived at an agreement with the pharmaceutical industry to restrict spending on costs of sales promotion to 10 per cent of each company's turnover. In 1983 the Departments imposed a further cut. The present rate is 9 per cent.

In 1987 the total NHS drug bill was £1700m and £153m (9 per cent) was spent on information to general practitioners. This £153m was divided up as shown in Table 1.

In addition the pharmaceutical industry spends £10m a year on non-promotional medical symposia.

The roles of the 3000 drug representatives must be recognised. About 2000 are allocated to general practice, (i.e. 1 to 15 GPs) and they are a source of information as well as assisting in promoting local educational meetings. They also act as a two-way link between prescribers and the

TABLE 1. *Estimated spending by pharmaceutical companies on information to GPs.* (Professor George Teeling-Smith, 1988 personal communication)

	£million	*per cent*
drug representatives	78	51
advertising in GP medical journals	28	18
literature	18	12
administration and others	29	19
	£153	100

industry, for example, in reporting early adverse reactions to drugs. There are formal channels for such reports through the 'Yellow card' scheme organised by the Committee on the Safety of Medicines.

The 'free' GP journals in 1987 were financed through the £28m advertising and another £18m was spent on literature produced by the pharmaceutical companies themselves. These amounts represented £1500 per GP in 1987 or 2 per cent of his £70.000 annual prescribing costs.

LEARNING THROUGH WRITING

The growth of a substantial medical press has resulted in the discovery and encouragement of new writers and authors from the ranks of general practice. Writing about their own field of work, particularly if based on study and research is a fine way of learning. There are now many regular GP contributors to these publications and increasing numbers who produce books.

The General Practitioner Writers Association was formed in 1986 to 'foster the skills and interests of its members and to improve standards of writing for, from, or about general practice'. Its register for 1987–8 lists the names of 209 members.

RCGP PUBLICATIONS

The RCGP has an active publication section with its monthly *Journal,* books and a range of other material. Margaret

Hammond in her 25 years as Librarian at RCGP has kept up with the increasing bibliography of general practice. Her section on general practice in 'Information Services in the Medical Sciences' listed all books by GPs from 1952–82(12).

In addition she has produced two special series for RCGP. *New Reading* has appeared annually since 1973 and lists books, reports, articles, and papers by and for GPs and cross-referenced by subject and author. The other is *Research Intelligence* (started in 1968) which lists GP research in progress under subject and researcher. Volume 15 has 173 entries. Both these publications are sponsored by pharmaceutical companies.

Through Professor Denis Pereira Gray the *College's other publishing activities* have grown, including Occasional Papers (now up to number 40), Policy Statements, information folders, Reports from General Practice, and books. And it is evidence of the extent of GP research and writing are the 150 *MD theses* deposited in the College Library.

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7

RESEARCH

GENERAL

FOUR OFT QUOTED GIANTS OF GP RESEARCH ARE JENNER, Mackenzie, Budd, and Pickles. Edward Jenner in Gloucestershire introduced vaccination against smallpox. William Budd in Devon confirmed typhoid as an infectious disease. James Mackenzie stepped from general practice in Burnley to consultant cardiology in Harley Street and then back to practice at St Andrews, and made contributions to both fields. Will Pickles epitomised the kindly country doctor who recorded at leisure his patients' histories and was able to demonstrate the epidemiological opportunities in general practice.

Nevertheless before 1946 general practice was a place for doctors to work and grind away until they had no more to give. It was not itself recognised as worthy of serious study but seen as a minor field with minor ailments for minor doctors. Very occasionally an unusual individual produced some original work and was rewarded by an MD.

The NHS changed such unworthy beliefs. Shut out of hospitals by their specialist colleagues, general practitioners began to consider, examine, and undertake research into general practice, its work, nature, content, and management. Suddenly the potential was recognised and now hundreds of original research papers from general practice are published each year.

The NHS created the opportunities for GP research in a number of ways. It provided each practice with a known recorded population at risk; it provided opportunities for long-term observation of patients suffering from diseases

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and of diseases affecting patients; it offered a morbidity spectrum of chronic and minor disease not available in hospitals; it allowed opportunities to study the effects of social, family, and personal and environmental factors on disease; it allowed patients who were well-known to their doctors to participate and co-operate in research; and it offered opportunities to study healthy persons and the nature of health.

Although research is important and necessary for general practice it will always be a minority interest for the few. As in other fields of medicine not all doctors want to do it, can do it, or should do it. Nevertheless, it is right to encourage general practitioners to become involved and not to be frightened off by false images and impressions of what is research.

Research requires some fundamental personal characteristics namely, a nagging curiosity that asks questions and seeks out answers, the ability to organise thoughts and ideas and put them into practice; obsessional attention to detail in the collection of data; persistence and endurance, not being put off by circumstances and people; and willingness to apply findings and impose self-critical checks.

Research in general practice is different in kind from sophisticated professional research. It does *not* require large units, staff, space, and resources. It does *not* need a lot of funding. It does *not* always require high statistical expertise by the GP, though such advice should be obtained from experts when indicted. It does *not* require elaborate data processors and computers.

The creation of the College of General Practitioners provided a meeting point and stimulus for like minds and particularly embryonic research minds. For me it provided contact and friendship with Ian Watson, Robin Pinsent, Donald Crombie, Tev Eimerl, Ekke Kuenssberg, and Arthur Watts, all pioneering GP researchers brought together through the College. There was unstinted encouragement and support from outside general practice by experts from many fields of research.

WHAT SORT OF RESEARCH

The range of GP research now is very wide as the regular annual RCGP publications reveal but it is useful to try to distinguish some of the main themes.

One division is into 'interventionist' and 'non-interventionist' research. The latter is largely observational recording and analysis without the patient being directly involved or put to any risk or trouble. Interventionist research does require patient participation as in clinical trials or experiments.

Examples of non-invervention research are:

Morbidity recording. The best have been the three National Morbidity Surveys carried out by the General Register Office in 1950–1 and then by its successor the Office of Population Censuses and Surveys (OPCS) in 1970–2 and 1980–1(1). In these some 150 GP volunteers from 50 practices recorded all doctor-patient face-to-face consultations over a year. These surveys provide a picture of the content and volume of work in general practice and demonstrate the feasibility of national research and of close successful collaboration between the RCGP and DHSS.

Work of general practice. We know more about the diversity, content, and volume of work in general practice than of any other field of medicine. Individual practitioners and practices have published annual and longer analyses of their work(2). These show wide differences in all indices and practices. The variables include the amount of work done, the diagnostic content, prescribing rates and costs, referrals to hospital, night visiting and activity rates in screening, immunisation, and maternity work. (Bromley Local Medical Committee 1984 unpublished)(3).

Natural history of disease. A privilege of general practice is the opportunity to study the long-term course of disease over many years. Probably because of its relative youth, general practice research has not yet contributed much in

this important field. I have found it most educational to observe that there are chararacteristic courses of common respiratory disorders in children, of duodenal ulcer, asthma, migraine, hypertension, and other conditions (see pages 82–3)(4). It is important that we are fully aware of the likely *natural* course of a disease before we produce an *unnatural* course through therapeutic actions that may not always be necessary or beneficial.

Prescribing. Since up to two out of three GP consultations involve a prescription and since each British citizen, on average, is prescribed seven items a year, research into GP prescribing is important. However, not very much has been carried out to discover why there are such great differences between regions, practices and practitioners, in volume and costs. There is much market research on by the drug companies, but since this is for their own purposes, very little is published(5). The Health Departments produce detailed analyses of prescribing statistics but seem to use these mainly to identify and query doctors whose costs are significantly higher than the average of their area.

Plotting disease. Because they see the whole spectrum of disease there are opportunities for GPs to plot all the varieties and grades of common diseases and in this way add to the selective views available to specialist hospital colleagues.

Intervention research studies have been less numerous, but paradoxically have involved more GP participants. Some of these were widely based, such as the Oral Contraception Study, at Manchester, and the MRC trial of treatment of hypertension. Many are more modest in scale, including private clinical trials carried out for drug companies, and may be based on the interests of a single practice. The range has included preventive care, biofeed-back and holistic techniques, the role of nurses in practice, appointment systems, use of diagnostic facilities, hospital referrals and the use of deputising services.

WHO HAS RESEARCHED AND WHERE?

The list of GP researchers is long, and some deserve specification. Ian Watson followed Will Pickles in defining new viral conditions, in his rural Surrey practice at Peaslake. Robin Pinsent and Donald Crombie in Birmingham carried out early community studies on diabetes and established the RCGP's Research Unit. Ian Gregg has done some fundamental work on asthma, Edgar Hope Simpson revealed the nature of herpes zoster. Michael D'Souza has reported on the epidemiology of hay fever and other allergies.

Each *department of general practice* has built up its own character and activities. There are many examples, Professor David Morrell, at St Thomas's Hospital, London, and his team have carried out basic studies on common disorders using patient diaries. Professor Brian Jarman at St Mary's Hospital, London, has carried out a major socio-medical study in inner cities. Professor David Metcalfe at Manchester has carried out major operational studies on general practice in his area with results that upset some local doctors. Godfrey Fowler, at Oxford, has demonstrated the value of facilitators and of self-check audits in improving care in practice. Professor John Howie, Edinburgh, has examined diagonistic interpretations and the cost effectiveness of certain practice procedures. Professor John Bain at Southampton is involved in basic clinical research in diabetes, asthma, and other common respiratory and gastrointestinal disorders. Professor Idris Williams, Nottingham, has researched into care of the elderly and Professor Robert Harvard Davis and his successor, Nigel Stott, into the opportunities of the consultation. Professor Robin Fraser, Leicester, has demonstrated the value of collaborative studies with his Local Medical Committees. Such studies demonstrate that good practical research can be carried out in spite of shortages of resources and lack of time.

From outside general practice academic units have discovered the rich sources of material to be unearthed there. In collaboration with GPs, Professor Michael Shepherd, Institute of Psychiatry, London, defined the common psychiatric syndromes in general practice. At the Department

of Surgery, Nottingham University, trials are going on to develop methods for early diagnosis of large bowel cancers. The assistance of GPs is now recognised as vital not only for clinical trials, but also for long-term drug surveillance.

THE ROLE OF THE ROYAL COLLEGE OF GENERAL PRACTITIONERS

After its initial active leadership in detailed research the Royal College of General Practitioners (RCGP) now leaves research largely to it four reseach units and its individual members.

Of the four RCGP research units, that in Birmingham, the records unit, under direction of Donald Crombie helped to organise the three National Morbidity Surveys (see page 72) and it has a cohort of recording practices that provide regular reports on prevalence of disease. In Manchester, the oral contraception unit, under the direction of Clifford Kay, has organised most successfully many years of observational study involving several thousand practitioners who report on the health of their patients using oral contraceptives. Its reports have received international acclaim. In Swansea, the empidemic observation unit, under W. O. Williams, carried out studies on the epidemiology of whooping cough, its complications and prevention; and in Leigh, Lancashire, Maurice Stone has for many years carried out unique biochemical studies among his patients into ischaemic heart disease and its prevention.

FROM MY OWN PRACTICE

An example of research in general practice is my own experience. However, any attempt to compress 40 years (1947–87) of general practice into a few pages has to start with some personal and biographical notes.

EARLY YEARS

My memories of general practice go back over 60 years. My father was a single handed GP in Selhurst, Croydon. He had a very busy practice and we lived on the premises.

It was inevitable that we children became involved in the happenings of the practice. We overheard table talk between our parents. We took messages, we delivered medicines to patients and ran other errands, we heard the door bells ring at night, and listened to our father go out and come back, and we were introduced to patients and to specialists who came on a domiciliary consultation. We became aware of the hardships, the joys, the failures, and the successes of a good general practitioner.

I went to Whitgift Middle School, Croydon, and then on to Guy's Hospital Medical School during the war years, 1940–44. I qualified at 21, and did 3 years service in hospitals.

ENTRY INTO PRACTICE

I was destined to become a surgeon and gained my FRCS, Eng. in 1947. However, a young family and post-war uncertainties over a career in surgery led to a decision to follow in the footsteps of my father and three uncles and to become a general practitioner.

The usual method of entry into general practice in the pre-NHS time was to buy a single handed practice. An established (since 1925) practice in Beckenham was for sale. The asking price of a practice was '1½ years income', that is one-and-one-half of gross reliably accounted income of the past year.

Thus, on 1 July 1947, at the age of 25 years I moved in with a young wife, a son of 16 months, and a daughter of 6 weeks.

I was an over-confident young doctor who had just obtained the FRCS, Eng. and who believed that his Guy's training and his hospital service experience were more than adequate for single handed general practice.

How wrong I was, and what painful anxieties I, and my patients, suffered. In fact I was untrained, unsure, uneasy and unfamiliar with the work.

There were no books *by* general practitioners to turn to, rather books *for* GPs written by eminent specialists who were sure that they knew what the GPs should know.

I asked myself—'what was I doing, how and why, for what and for whom?' The answers could only come through a process of self-learning by recording my work and by analysing the findings. I had no knowledge of epidemiology or statistics, and computers had not been invented. Naively, I developed easy, simple, rapid, and cheap ways of recording my data which could also be capable of analysis.

The records consisted of:

regular *clinical* notes;

day sheets which recorded all patient contacts by name, age, sex, diagnosis and referral;

a *disease register*, where names of patients diagnosed with important specific diseases were entered and then transferred to cards and indexed under the disease;

an *age-sex register* of all patients in the practice providing the denominator for calculations of rates;

hand sorted *punched cards* (Cope-Chat) were also used for some years.

Recording of data took less than a minute of each consultation, but analysis took many hours.

THE PRACTICE

The *practice* was started by Dr Alan Marsh in 1925. He stayed till 1943, succeeded by Dr Benjamin Mushin until 1947.

Beckenham was first recorded over one thousand years ago as a small hamlet. My neighbourhood, Elmers End is old but was largely developed as suburbia in the late 1920s and 1930s. It is now part of the London Borough of Bromley, with a stable population mainly of social classes 2, 3, and 4. There is a core of patients who have been in the practice since 1947 and on occasions I have had four generations in my consulting room at one time—great grandmother, grandmother, mother, and baby.

Doctors. I worked single handed from 1947 to 1960, when I was joined by my partner, Dr John B. Dillane (retired in 1988). From 1970 to 1987 we had a series of part-time

assistants and in 1987 a third partner, Dr Paul A. Dunachie and then Dr. Jan Wagstyl.

Staff. Apart from my wife I had no ancillary staff until 1954. Now we have five part-time receptionists and attached health visitors, district nurses, and a midwife.

Premises. Are a separate suite in my house, where I still live.

40 YEARS OF DATA/FACTS

The range of data that can be collected from a general practice is truly remarkable and the implications and applications from the data are amazing. I shall restrict my examples to the two fields of '*work*' and of some of the '*clinical content*' in the practice.

It has to be emphasised that the data is from a single practice and should be considered as an illustration of the scope for potential fact finding rather than in providing definitive answers.

WORK

Volume. Work in a practice can be measured by *annual patient consultation rates,* i.e. the total number of face-to-face consultations divided by the registered population of the practice. There is, of course, other 'work' in the practice such as the telephone, correspondence, and reports and 'repeat prescriptions' (prescriptions requested by patients who do not need to be seen by the doctor).

The workload of the practice was reported in 1986(6).

Table 1 shows the size of the practice and the annual patient consultation rates.

This set of data is unique in the timescale recorded. Facts of note are that:

total consultation rates have fallen by one-third from 1950 to 1987;

surgery consultations fell by 25 per cent;

home visits fell by 87 per cent;

TABLE 1. *Annual patient consultation rates and referrals to hospital, x-ray and pathology per patient(1950–87)*

	1950	*1955*	*1960*	*1965*	*1970*	*1975*	*1980*	*1985*	*1986*	*1987*
Population	4200	5551	6801	8001	8609	8776	8620	8650	8600	8550
Surgery consultations	2·7	2·69	3·04	2·44	2·27	2·11	2·08	2·14	2·01	2·10
Home visits	0·64	0·53	0·67	0·38	0·13	0·10	0·08	0·08	0·07	0·08
Total Patient Consultations	3·34	3·22	3·71	2·82	2·40	2·21	2·16	2·22	2·08	2·18
Hospital referrals	0·10	0·09	0·06	0·06	0·05	0·04	0·06	0·08	0·05	0·06
X-Ray Referrals	0·07	0·06	0·08	0·06	0·06	0·06	0·04	0·08	0·06	0·07
Pathology Referrals	0·05	0·06	0·06	0·06	0·07	0·06	0·08	0·04	0·05	0·06

notable were the highest patient consultation rates from 1950–70 and constant low rates since 1970;

highest referrals to hospitals in the earliest years (1950–55) and then constant rates since then;

referrals to x-ray and pathology departments (there has always been full direct access to these departments) have remained almost unchanged.

It is possible to express workload in a simpler way. Table 2 gives my own average daily numbers of consultations between 1950 and 1980, for similar numbers of patients for whom I was responsible.

TABLE 2. *Average daily consultations (by J.F.) 1950–80.*

	Surgery Consultations	*Home Visits*	*Daily Total*
1950	56	12	68
1960	54	8	62
1970	42	2	44
1980	41	2	43
% fall 1950–1980	27%	83%	37%

Who comes?. Annual patient consultation rates can be broken down into a number of different groups:

Age. as expected, it is the young and old who consult most.(7)

Sex. females have higher consultation rates at all ages, except in infancy, when baby boys are brought by their mothers more frequently than baby girls.(7)

Individuals. three groups can be defined:

High consulters: the 'fat envelopes'—some suffer from recognised chronic diseases but some have no recognised physical disorders and are vulnerable individuals whom the GP has to support and assist through their troubled lives;

Average consulters: the 'normal' patients;

Low consulters: patients who may not consult for 5, 10, or 20 years.

Twenty years ago Neil Kessel (now Professor of Psychiatry at University of Manchester) surveyed 100 of my patients who had not consulted me for at least 10 years and compared them with a control group. In brief, he found that they were no 'healthier' than controls for minor illnesses; the main difference was that they were much more self-reliant individuals who had lower opinions of doctors(8).

Families: there are also family patterns of consultation that tend to be shared by members of a family—high, average, and low consulters. The influence appears to be the mother and her mother and her grandmother.

CLINICAL CONTENT

To illustrate some of the opportunities of observational research in general practice, I shall refer to some findings from my practice, again with the proviso that they are from a single practice in a specific part of England. Nevertheless, the observations may stimulate others to compare their own data.

To return to some personal experiences. Once I had collected practice data for a couple of years I realised that it may be of interest to others and I produced reports. Here I want to express my thanks and appreciation to Sir George Godber and the late Sir Max Rosenheim who encouraged me, and to the late Dr. Hugh Clegg, Editor of the *British Medical Journal*, who published my papers.

The first were general reports on one-year and then five-year analyses of work in my practice. Soon I realised that many diseases seen in general practice had a different prevalence and course than those noted in hospital practice and that there were new dimensions that a general practitioner could add to clinical knowledge and understanding(9–10).

THE NATURAL HISTORY OF DISEASE: THE TEMPORAL DIMENSION

As a medical student I was stimulated by my teacher, Professor John A. Ryle to recognise the importance of the

natural history of common diseases. His book on *The Natural History of Disease* is a classic(11). Ryle was a superb general physician and clinical observer, he was Physician to Guy's Hospital, then Regius Professor of Physic at Cambridge and finally the first Professor of Social Medicine at Oxford.

It was in my first years in general practice I realised that the picture of disease in a hospital ward gave an instant snapshot picture, whereas in general practice it was possible to see a long-term video or movie view. Since, by definition, a feature of general practice is long-term and continuing care of individuals and families with disease, the opportunity is offered to study a temporal dimension of disease.

I have noted five patterns of natural history of disease, that apply to most common diseases:

'Once and forever'
Once present the condition will persist until death, e.g. cystic fibrosis and other congenital disorders and acquired conditions, such as an amputated part.

'Disorders that children outgrow'
Many children have conditions which they "outgrow" naturally and without treatment, e.g. the catarrhal child syndrome, non-retractible foreskin, strawberry naevi, knock knees and umbilical hernia.

'Disorders of ageing'
As we live longer as our bodies age and degenerate, and we become prone, for example, to cancers, osteoarthritis, coronary artery disease, high blood pressure, chronic bronchitis, cataracts, deafness, strokes, and diabetes.

'Come and then go'
Some conditions commence in early or mid-adult life; there follows a period of clinical activity for 5, 10, or even

20 years; and then symptoms tend to diminish and disappear.
Such a course occurs in migraine, acute back syndrome, asthma, hay fever, duodenal ulcer, anxiety-depression, urinary tract infections in women, tennis elbow, and other soft tissue rheumatism.

'Young and old'
To complete the picture there are a few diagnoses most prevalent in the young and the elderly, e.g. acute wheezy chests, herniae, hydrocele, and constipation.

Disease is never static and during my 40 years in practice there have been ups and downs in frequency of conditions and diagnoses:

Less prevalent are: chronic bronchitis, duodenal ulcer, appendicitis, rheumatic fever, acute nephritis, and infections such as tuberculosis, poliomyelitis, scarlet fever, whooping cough and measles.

More prevalent: consultations for preventive care such as antenatal care, child welfare and immunisation, and cervical cytology. Insurance medical examinations have increased and so have consultations for rheumatological disorders, skin diseases, high blood pressure, diabetes, asthma, angina, gout, urogenital infections (in women), and alcohol and drug abuse.

With a population that has included an increasing proportion of elderly (more than 15 per cent of over 65s), there has been more care needed for their problems, but the majority of my elderly patients are at home, healthy, and contented.

SOME PERSONAL COMMENTS

Every GP during his/her professional lifetime accumulates portmanteaux of experience and facts that will be lost unless

recorded, analysed, and reported. These collections should serve as a memorial to his patients and a repayment to his professional colleagues for years of joys, challenges, and opportunities that medicine offers.

Here I offer my own contribution based on 40 years of just such recording and analysis. Each practice is a distinctive unit and my personal observations must serve as a stimulus for others to confirm or refute.

I have found it possible to provide care for a relatively large population (personal list of 5000) because of a low annual consultation rate of around 2. The outcomes of my care are comparable to those of other GPs and it is justifiable to consider experiments and trials into different forms of primary care to test whether we might be able to manage with fewer GPs and more nurses and other paramedical workers.

A feature of my practice has been the remarkably steady low rates of annual consultations, of referrals to hospitals and for radiological and pathological investigations. Patient consultation rates ranged from high, average, low, and non-attenders. It is likely that these variations have been related more to personal patient (and doctor) habits and customs than to pathologies.

My 40 years of clinical care have passed through periods of constant professional changes in fashion, advances and withdrawals in therapeutics and management. It is essential for a clinician always to be self-critical and self-analytical. As examples of my own uncertainty, I pose some questions:

how necessary and on what indications are tonsillectomy, adenoidectomy, grommets, and antibiotics for children with common respiratory disorders?

do *all* mild/moderate hypertensives need anti-hypertensive drugs?

because duodenal ulcers tend to heal naturally when and for how long should expensive H_2 antagonists be prescribed?

is the British low rate for surgery in angina incorrect?

in children all that wheezes is *not* asthma, many acute wheezy chests are due to infection and require antibiotics, is this right?

The long-term dimension for care and observation in general practice can be used to study the natural history of common diseases. I have noted five patterns of natural history. This knowledge has been immensely helpful in planning patient care.

During my years in practice, I have been guided by three dicta from the past:

Common diseases commonly occur,
rare diseases rarely happen'

SAM WASS, Surgeon, Guy's Hospital (1940s)

'To cure sometimes,
To relieve often,
To comfort always'
(I would add—
To prevent hopefully!)

AMBROSE PARÉ, Military Field Surgeon
(17th century)

'From inability to leave well alone,
From too much zeal for what is new and contempt for what is old,
From putting knowledge before wisdom, service before art, cleverness before commonsense,
From treating patients as cases,
And, from making the care of a disease more grievous than its endurance.
Good Lord deliver us.'

SIR ROBERT HUTCHISON, Physician, the London Hospital
(early 20th century)

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8

ORGANISATIONS
OPPORTUNITIES MISSED AND REGAINED

DURING THE PAST 40 YEARS MANY ORGANISATIONS, national and local, small and large, well known and little known, have been closely involved in the development of general practice. A detailed history of their influence requires another book. Therefore, my comments will be general and limited to bodies of which I can speak from my own experience.

NATIONAL ORGANISATIONS

MINISTRY OF HEALTH, LATER DEPARTMENT OF HEALTH AND SOCIAL SECURITY (DHSS)

The task of running the National Health Service (NHS) has been enormous and difficult. Parliament is directly responsible for the NHS and therefore a government Minster has to be in overall charge. Originally this was a Minister of Health, but since Health and Social Security were combined to form the Department of Health and Social Security, political primacy has been with the Secretary of State for Social Services, an influential member of the Cabinet. Health has other Cabinet Ministers also, since the territorial Secretaries of State for Scotland, Wales, and Northern Ireland all have responsibilities for health matters under their own jurisdiction. Now (1988) the two have been divided again into Health and Social Security.

Ministerial appointments to DHSS seem to have been stepping stones to nowhere. None achieved high and supreme office, though some, such as Mr Enoch Powell, appeared capable of doing so. Most Ministers and Secretaries of State have not stayed in their position very long and most certainly not long enough to be clearly identified with the introduction of major changes in primary health care. An exception to this, and the Minister who was most involved and concerned with general practice, was Kenneth Robinson. It was he who took office at the nadir of general practice and it was he who pushed through the Charter in 1965–6 (see Chapter 3).

Second in importance to the Ministers have been the Chief Medical Officers (CMOs), permanent medical civil servants advising the Minister. Of the four CMOs since 1948, Sir George Godber was the best friend of general practice in the 1950s to the 1970s. It was fortunate that he was there to advise Kenneth Robinson in negotiations with GMSC representatives. In Scotland, Sir John Brotherston and Sir John Reid were influential in keeping Scottish general practice in the forefront and in preserving a number of distinctive features of the Scottish health services.

Within the NHS general practice has always been considered by Ministers and civil servants as an important part of the service with problems of administration, management, and control quite different from those of the much more expensive hospital and specialist services. That is hardly surprising, for general practitioners are not directly employed by the NHS at all, but are in contract to provide services. The details of the contracts, involving pay and conditions, have been and are under constant negotiation by the General Medical Services Committee (GMSC) of the BMA and the Health Departments, and both sides provide exhaustive submissions of evidence to the independent Pay Review Body each year.

As independent contractors, GPs have been relatively free to practise as they choose with the result that it has been impossible for DHSS to control expenditure by limiting budgets (though for many years the operation of a remuneration 'pool' meant that a large element of costs was

completely pre-determined). This open-ended situation has been particularly expensive in prescribing by GPs, with wide ranges between practices and individual GPs (see Chapter 5) and in 1986, the government intervened to exclude a range of medicines from prescribing by GPs. Other means of controlling the drugs bill are constantly being sought.

With the doubling of NHS manpower from half million in 1948 to 1 million in 1988, leadership by the DHSS has been extremely difficult, not least because increases in medical and nursing manpower have usually been presented as signs of progress. The central administration has been seen as remote and unconcerned by GPs, the Family Practitioner Committee (FPC) as a big brother, and DHSS's local agent, the Regional Medical Officer (RMO), as a little brother and a threatening snooper. In the future there will have to be better leadership and morale through better communications and better local co-operation between GPs, FPCs and RMOs.

BRITISH MEDICAL ASSOCIATION (BMA)

The BMA has a membership of around 70 per cent of all general practitioners. It is recognised by the profession as its craft (trade) union with powers to negotiate with DHSS doing so for general practice through the General Medical Services Committee (GMSC). The GMSC is elected by GPs and has served them well. On the surface it may appear to be slow and less than ready to introduce new concepts until they have been tried, tested, costed, debated, approved, and accepted by most 'ordinary GPs', but within it there is constant activity and preparation for the future. It has been fortunate to discover and develop such fine GP politicians as Sir James Cameron, Sir Ronald Gibson, Ekke Kuenssberg, Tony Keable-Elliott, John Marks, and Michael Wilson.

The BMA is a strong, tough, and influential body and now financially sound. It has had three most effective secretaries, Charles Hill, Derek Stevenson, and John Havard.

Unfortunately whilst the central organisation has become strong, locally many BMA divisions have tended to wither from disuse. Its educational roles have been largely taken

over by postgraduate centres. Its local medico-political activities tend to lie dormant unless and until crises concerning pay and conditions occur in negotiations with DHSS.

ROYAL COLLEGE OF GENERAL PRACTITIONERS

The College of General Practitioners was founded in 1952 by a unique group of GPs under the leadership of John Hunt and George Abercrombie as an act of faith in the future of general practice. It brought together like minded pioneers who set out to organise general practice, to study it and to create an appropriate education system and a training programme. It was to be a non-political body working in harmony with the BMA and other Colleges.

By 1988 its membership of 15,000 represents about one-half of all GP principals. Its membership examination (MRCGP) generally is considered an end-stage of the three year mandatory vocational training, and so it introduces upwards of 1000 new members each year. With such a growth-rate the College (now a Royal College) is securing increasing political recognition, particularly by the DHSS. Recent examples have been the influence of the College on the recommendations of the DHSS Green and White Papers on the future of primary health care and in the deliberations of the House of Commons Select Committee on social services.

The College has become the pace-setter of new ideas and new challenges for general practice, whereas the BMA and GMSC have frequently given the impression of being reluctant to change the status quo and then only after lengthy negotiations on conditions and pay. Although efforts have been made by office holders in both organisations, College and BMA, to act in unison, at times this has been difficult.

THE GENERAL MEDICAL COUNCIL (GMC)

The changing influence of the GMC on general practice has been truly remarkable. Until the mid 1960s, the GMC was a sleepy, statutory body merely carrying out its allotted tasks of ensuring that medical schools educate all future doctors (and GPs) in a proper manner, on criteria set down by the GMC. Once registered, the young doctors were free to follow their careers out of sight and unhindered, provided that they behaved themselves and kept themselves on the Medical Register.

In 1967, during the presidency of Lord Cohen, a set of 'recommendations' to medical schools included one that all medical students should receive some instruction and teaching on general practice. Following the Merrison Committee's suggestions, the Council, in the 1980s, was able to extend its jurisdiction to postgraduate education, including general practice. This it is planning to do through the Colleges and Joint Committees for Postgraduate Training.

Other changes have been a doubling of the size of GMC now with a majority of elected members (including 13 GPs) and many more lay members appointed by the Privy Council. It is therefore more representative of the profession and at the same time more conscious of the general public interest in the ways in which the medical profession regulates itself.

The GMC through its Standards Committee has become intimately involved in current ethical issues, such as confidentiality and contraception for minors. Much of its disciplinary work is concerned with possible serious professional misconduct and, recently, with allegations of incompetence against NHS GPs. The Health Committee can now deal with sick doctors (GPs) for their own good and the good of their patients without the doctors having to be subjected to the disciplinary procedure. The GMC is also involved with the European Economic Community (EEC) in negotiating common requirements for education and training in general practice and other professional disciplines.

LOCAL ORGANISATIONS

FAMILY PRACTITIONER COMMITTEES

The original administrative bodies for general practice in the NHS were Executive Councils, direct descendants of pre-NHS Insurance Committees. In their turn they have now been translated into Family Practitioner Committees (FPCs).

Until recently FPCs were under the control of Area/District Health Authorities. Now they are more autonomous directly under DHSS itself. With this change in status have come more opportunities to influence general practice. Before FPCs were only concerned with GPs' contracts, the complex system of paying the GP and in dealing with patients' complaints. Since 1970s, they have been involved in advising and assisting GPs on improving and rebuilding their premises.

Now the FPCs are seen by DHSS as important in shaping the 'new general practice'. Already many FPCs have their populations computerised and should be able to provide data on a whole range of issues and items. They have begun to improve the cervical cytology programme through computerisation of records enabling them to send regular lists of women due for tests. They are able to provide GPs with age and sex registers of all their patients and already have data on immunisation rates in children, and can identify those who have been missed.

It will require considerable sensitivity and finesse for FPCs to collaborate with GPs to achieve local improvements in quality of services for the public. GPs have long regarded their FPCs as cold, distant, and threatening bureaucratic administrations. It is now necessary for FPCs to work closely and harmoniously with Local Medical Committees and others to plan for the future.

LOCAL MEDICAL COMMITTEES

In each FPC area there is a Local Medical Committee (LMC). The LMC is made up of GPs elected by their

colleagues and of representatives from hospital and community services. It is financed through a voluntary levy on local GPs and it has a paid secretary.

Potentially LMCs are important in the development of general practice and community care. With GPs independent and isolated, the LMC is the only local professional body available to represent a general practice. The BMA and RCGP cannot act in this way because they are not representative of *all* GPs in a locality.

Mutual antagonisms and suspicions between LMCs and FPCs should be shed and they should come together in fact-finding exercises that pinpoint problems and lead to improvements.

POSTGRADUATE MEDICAL CENTRES

In Chapter 6 I referred to the initiative of the Nuffield Provincial Hospitals Trust in convening a conference at Christ Church, Oxford which concluded that there was an urgent need for a postgraduate medical centre at each main District General Hospital. Such a centre would provide a meeting place for lectures, groups, and other forms of learning; include a library and canteen and a lecture theatre. The Trust made available loans matching local monies, and now there is a postgraduate medical centre in every District. The movement coincided with an explosive growth of planned vocational training and postgraduate education in all specialties, including general practice. Unfortunately all the promises and expectations of the Christ Church conference have not materialised. The resources provided have almost everywhere been used traditionally and unimaginatively for separate meetings for hospital doctors, for GP trainees, and for GPs, with lectures, group discussions, and films or videos, usually provided by pharmaceutical companies.

It is sad that new ideas and activities, such as studies and research into local problems, have not taken root. Closer co-operation between all members of the greater medical profession should have been promoted, yet in many centres nurses and others are rigidly excluded. Proper utilisation of the centres could provide bases for health education of the

public as well as the profession and offer facilities for health promotion through the organisation of preventive efforts in and by the community.

REGIONAL MEDICAL OFFICERS

Regional Medical Officers (RMOs) existed in recognisable form in the pre-NHS national health insurance system. They are all former GPs who are employed by DHSS. One of their functions is to visit all GPs occasionally. On their visits they are concerned with the prescribing rates and costs of the GP, and it these are significantly above average, to discuss ways of reducing them. They check dangerous drug registers and enquire on local problems and difficulties. Unfortunately they are looked upon as agents of the Establishment seeking to maintain the status quo. With a different style and approach the RMO could act as an important liaison person between GPs on the periphery and the regional and central administration.

OTHERS

OFFICE OF HEALTH ECONOMICS (OHE)

In 1962 the pharmaceutical industry funded a small independent unit, the OHE, to analyse data on health and disease and to publish occasional reports. Under the direction of Professor George Teeling-Smith, OHE has produced valuable series of analytical papers, reports and compendia of health and statistics by experts.

ROYAL ARMY MEDICAL CORPS

It may be wondered what has the army to do with general practice? Not a lot before the 1960s, but a great deal now.

In the 1960s the British Army, and other armies too, had great problems in providing care for the families of servicemen who were billetted overseas. The families expected to receive care up to NHS standards to which they had become accustomed back home.

There were no army medical officers who had been trained or were experienced in family care. The wives complained by writing to their Members of Parliament. Questions were asked in the House of Commons and these were a potent activator. The British Army decided it needed medical officers who were also trained in general practice.

A Department of General Practice was set up under a Director (now a brigadier) and general practices were established to provide primary and family care everywhere in the UK as well as overseas. A vocational training programme was created and approved by the Joint Committee for Postgraduate Training in General Practice. There were army teaching practices, trainers, and trainees.

Now after 25 years, general practice is the most popular first choice of army medical cadets. Vocational trainees have a higher than average pass rate in the MRCGP examination and the Millbank MRCGP Course is one of the most popular. The first army Professor of General Practice, Lt. Col. Tommy Bouchier-Hayes has been appointed.

THE KEPPEL CLUB

From 1952–77 the Keppel Club was a unique organisation that had a quiet but profound influence on the NHS. The Keppel Club was started in 1952 by John Brotherston (later the Chief Medical Officer of the Scottish Home and Health Department) and some of his fellow lecturers at the London School of Hygiene, in Keppel Street, (hence the name). Other members included GPs, hospital specialists, economists, sociologists, occupational physicians, public health doctors, and NHS administrators. There were monthly evening meetings with about 10–20 members. A short introductory paper was followed by animated discussion.

The influence of the Keppel Club was through cross-fertilisation of the receptive minds of a group of wide ranging body of professionals who worked for change within the NHS.

GP RESEARCH CLUB AND OTHERS

In April 1969, a course on 'Research methods' was held at the Royal College of General Practitioners. As a consequence a *GP Research Club* was created. It is a self selected group of more than 100 members. Meetings are twice a year, rotating at various university departments of general practice. They provide GPs with opportunities to present short papers on research from their own practices. The club has continued for almost 20 years and has stimulated ideas and advice during a period of substantial growth of research in general practice.

More recently there have been formed *interest groups* for GPs in gastroenterology and in rheumatology. A *Balint Club* has existed for 20 years for GPs and others interested in the psychotherapeutic methods of the late Michael Balint.

THE NUFFIELD PROVINCIAL HOSPITALS TRUST AND GENERAL PRACTICE

Lord Nuffield (then William Morris, and founder of Morris Motors) set up the Nuffield Provincial Hospitals Trust in 1939 to do what the King Edward VII Hospital Fund was achieving for London.

When the Trust became active after the Second World War, it became clear that care of the sick involved much more than hospitals and whilst retaining 'Hospitals' in its title, it extended its remit to include support of all health services. 'Provincial' was also interpreted broadly. If a study had wider national significance then it could be funded even if its base was in London.

During the past 40 years the policies of the Trust have been to anticipate trends likely to lead to improvements in services and to support worthy projects and individuals whose experiments and demonstrations will stimulate others to follow. During my time as a Trustee the Trust has had but three chairmen, Sir Geoffrey Gibbs and Sir Edgar Williams, and Sir Maurice Shock and three secretaries, Leslie Farrer-Brown, Gordon McLachlan, and Michael Ashley-Miller. All

have actively sought to encourage projects related to general practice and over 100 have received financial support.

The topics covered have reflected an open-minded and progressive approach. For example, the Trust was interested in supporting health centres with special and novel aims, including centres linked to the growth of university departments of general practice, centres in New Towns and diagnostic health centres. The interface between GPs and hospitals was studied in a variety of ways, relating for example, to patterns of referral to out-patient departments, access to diagnostic facilities, and the quality of care in GP hospitals. Numerous projects to improve vocational training, to study undergraduate and postgraduate medical education, and to promote better general practice have been supported over the years. The research work of the Royal College of GPs has been considerably helped, and there has been particular recent support for work related to the care of the elderly and the handicapped in the community.

COMMENTS

Although I have referred to only a few of the many organisations involved in general practice, the qualification for inclusion being the highly personal one that I have had some contact with them in the course of my professional life. It will be evident that great resources of goodwill are brought to bear on the provision and improvement of primary health care services. It is equally evident that there is a lack of close co-operation between many of these bodies, which go their own ways with little awareness of or interest in what others are doing.

Although intrinsically NHS general practice is independent, and its independence is to be cherished, in the future a high priority must be a more co-ordinated and better led system.

9

THE WORLD SCENE

OVER THE PAST FORTY YEARS WE HAVE NOT BEEN ALONE IN facing up to the new demands, needs, and increasing costs of health care. Such problems have been shared with every other developed country, and in all systems of care the place and role of primary health care have been under close scrutiny. Some of the past events in the international health scene, particularly as they relate to primary health care need to be noted and appreciated in planning for the future.

CHANGE AND COUNTERCHANGE

The 1950s and 1960s demonstrated in Sweden, and to a lesser extent in USA, the adverse effects of neglecting or nearly destroying the primary (general practice) level of health care in a national system.

These were times of rapid post-war biomedical and technological advances with shifts of resource funding to the hospital sector claiming an increased share of resources. It was believed that the old fashioned GP/personal doctor was unnecessary in a new scientific age of medicine. The results were startling. In Sweden, first-class new large district hospitals were built and staffed with almost all of the new medical graduates, leading to an immediate shortage of national medical manpower. This had to be met by encouraging immigration of doctors from neighbouring Scandinavian and other countries. The protective ring of primary care in the community was removed and the point of professional first-contact was shifted into the new large hospitals. Instead of minor and chronic disorders being

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treated in the community, these patients flocked directly to the hospitals. I recall a large space in the out-patient area of a new hospital crowded with more than 50 persons waiting to see the ear, nose, and throat specialist, most with common problems such as ear ache, ear wax, sore throat, and nasal allergies, all of whom I and my GP colleagues could manage in our practices without referral to hospital.

Removal of the general practitioner was associated with difficulties of access by patients to services, increasing fragmentation and depersonalisation of care, decline of comprehensive management, and mounting costs without any measurable health benefits.

Nevertheless, the Swedish health record is one of the best in the world demonstrating that the actual system of care and how it is provided is of less consequence than the fine social conditions that prevail.

The extent of the swing away from general practice varied in different countries. In USA in 1930, four out of five of all physicians in private practice were general practitioners, by the 1970s it had dropped to one in five. In Sweden the proportion must have fallen to less than one in ten. However, in health systems where traditionally general practice was strong the swings away from it were less dramatic. In Australia the proportions never fell below one GP to one specialist and in the Britsh NHS the proportion of general practitioners to specialists has remained constant at two GPs to one consultant. Likewise in Canada, Denmark, and the Netherlands, general practice held firm(1).

However, the progressive weakening of professional status by the primary care sector in the 1950s led to dissatisfaction and complaints from consumers, the patients, and to worries over escalating costs amongst government and other funders. A reaction occurred in the 1960s, with a timid rediscovery and renaissance of general practice that soon became a bold resurgence.

General practitioners got together and raised themselves up through their own efforts. Professional groupings led to creation of national colleges and academies to represent their specialty. In national medico-political associations, the voices of general practitioners became stronger and more influential.

In 1947 was founded the American Academy of General Practice (now of Family Practice), followed in 1952 by the British College of General Practitioners (now Royal). The British College opened its membership to general practitioners from Australia, New Zealand, South Africa, and other Commonwealth countries.

WONCA

In the 1960s an international movement began and 'WONCA' was formed in 1972, the World Organisation of National Colleges and Academies of Family Medicine/General Practice. There are now over 30 national corporate members. Its objectives are 'to promote and monitor high standards through education and research; to foster communication and understanding; to represent the academic and research activities to other world organisations; and to stimulate the development of the educational and research activities by general practitioners/family physicians.'

WONCA's overall influence so far has not been great. It holds a world conference every three years in different cities, the last one in 1986 in London, to provide opportunities to meet colleagues from other countries, and for research and other reports to be presented.

WORLD HEALTH ORGANISATION (WHO)

The World Health Organisation (WHO) is one of the special agencies within the United Nations (UN) and is the supreme co-ordinating authority for all aspects of international health.

WHO's interest and involvement in general practice and primary health care have mirrored the downs and ups already noted. In the 1950s it had little interest in general practice. In the 1960s there was an awakening of interest. In 1963 the WHO Expert Committee on General Practice(2) expounded the case for general practice and recommended a series of studies and experiments in the field. There were no apparent actions on this report but the seed-corn had been sown.

The 1970s were a period of rediscovery and promotion by WHO of primary health care. The new Director General, Dr Halfdan Mahler, re-orientated the work of WHO towards an acknowledging the importance of primary health care in promoting health. He enunciated a programme of 'Health for All by the year 2000' (HFA:2000). Although this ambitious and ambiguous title was concerned mostly with developing countries where rural population often had little or no access to any health services, the principles also applied to developed nations. The focus was centred on primary health care and how it could best be achieved.

In 1978 WHO and UNICEF organised a conference on primary health care at Alma-Ata, in the Soviet Union. The Declaration of Alma-Ata(3) re-affirmed health as a fundamental human right and stressed the continuing inequalities internationally and within countries in health care planning and provision. There was emphasis on primary health care as the key component towards progress(4).

Alma-Ata has challenged us all to review honestly our own patterns of primary health care and ask questions such as—

who can do what best and how?

what should be the respective roles and responsibilities of government, doctors, nurses and other health personnel and of individuals and families?

how should promotion of health, prevention of disease and care of the sick be financed and motivated?

So far the response of the UK and other developed countries to the Alma-Ata Declaration has been largely an ominous silence. It appears that another large expensive international conference and a brave declaration have come and gone with only minor flutterings in the dovecotes of the DHSS, the BMA, and the RCGP. Dr Mahler must be hoping that after his term as Director General is finished that his successor will continue to fight for 'HFA:2000' with primary health care as the key to success.

SYSTEMS OF PRIMARY HEALTH CARE

Primary health care in all countries exhibits certain broadly similar characteristics but there are also differences in detail in structure, organisation, and practice, even between countries of like social and economic development. National systems of health care usually develop their characteristic forms and patterns through processes of *slow evolution* rather than through *radical revolution.* (The NHS is a good example: see chapters 2 and 3).

Since a national health care system represents a background of years, decades, or even centuries of development, influenced by history, religion, and economics amongst other factors, there can never be a standard off-the-peg 'best buy' system suited to all national requirements. For these reasons a neat classification of health systems is difficult, but they can be divided into:

a free market system usually with no obligation to have health insurance and minimal intrusion from health insurers and funders (although intrusions are growing in order to try to control costs) as in USA and Japan;

free market system with considerable involvement of health insurance funds as in France and West Germany;

a *national health system under government control* offering comprehensive care but with considerable professional freedom as in UK, Denmark, and Netherlands.

a *comprehensive socialist system* with complete government control as in USSR, Eastern Europe, Cuba, and China;

a *variety of 'no system' systems* in many developing countries with some services for those in cities who can afford to pay for them and ad hoc facilities for the poor in rural areas.

The *processes* of primary health care are influenced considerably by how the doctor or other primary health worker is paid. The nature of the incentives offered can be directly related to the rates of surgical procedures carried out at primary level, to high or low consultation rates, to the extent of involvement in hospital work by general practitioners (where facilities exist), and to other services which

carry a right to payment(5,6). The differences resulting from such factors are of interest to doctors whose levels of incomes may be greatly affected by the system in which they work, and to economists since they appear to alter the proportion of GNP devoted to health.

Yet the *outcomes* in broadly similar developed countries, as measured by traditional mortality and morbidity statistics, are not very different. It seems to make much less difference to the patient than might be expected under which system care is provided. Certainly the system makes a big difference to the rates of income of practitioners.

FLOW OF CARE

In any system of health care progression beyond first-contact-professional care depends on the accepted national procedures. In the *UK* and some other European countries there is a single main portal of entry into the national health system, the general practitioner, who decides on referral to a specialist at a hospital out-patient department or arranges admission to hospital.

In the *USA*, with its more pluralistic system of independence and free enterprise by contrast individuals and families often have no general practitioner or family doctor. Alternatively they may choose to consult a first-contact practitioner who deals only with specific fields of medicine, a 'specialoid'. Thus a patient may decide that the appropriate one to consult is a paediatrician, internist, obstetrician-gynaecologist, psychiatrist, surgeon, or whatever. These 'specialoids' may have hospital privileges and act as the secondary level of care by giving treatment in hospital, or may refer the patient to a specialist.

In *USSR* the family is cared for at the local policlinic with geographical allocation of patients to a 'uchastok' (neighbourhood) primary practitioner specifically for children, for adults, for obstetrics-gynaecology, and in large policlinics for psychiatric disorders and for rheumatological problems. These practitioners can refer patients to specialists who also work in the policlinic. If hospitalisation is necessary another set of specialists take over.

In a *developing country* the situation may be stark. First-contact care is often provided by non-physician primary health care workers, ('barefoot doctors'), if at all, with limited resources and many miles away from medical facilities and with poor transport. Nevertheless, it is remarkable how some countries have organised effective health care programmes under such circumstances(7–10).

WORLD SCENE: PRESENT STATE AND FUTURE NEEDS

Primary health care is now recognised as having an essential role in health care everywhere. The WHO and national health systems have set it the important task of maximising the amount of care given outside hospitals, since hospital care, in addition to its great cost, may not meet the real needs of the community. These are great expectations, but possibly unrealistic, which still require to be tested by research to assess whether care can be provided by services in the community as well as and more cheaply than in hospitals. There is also an urgent need to produce realistic general structural and organisational models of primary health care based on international comparative studies; 'guidelines for good care' could help with the common problems and situations encountered by primary care workers.

Such work requires active experiments, trials, and assessments, including cost-benefit analyses. These should be carried out under the aegis of WHO which alone has the prestige to co-ordinate an international programme on the required scale. In each participating country support from government, independent trusts and foundations, would be essential.

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10

AT THE CROSSROADS OF TIME:

FUTURE HOPES, QUALMS AND DILEMMAS

OUR FUTURE IS ROOTED IN OUR PAST AND IS PREDICTABLE from the present. This applies in primary health care and general practice as much as in other areas of professional and social endeavour. There are some signposts that point towards future trends.

WHAT'S TO BE DONE?

In chapter 1 a case was made for general practice/primary health care as an inescapable component in our National Health Service, and in every other health system. The nature and content of work will be that generated by roughly the present ratio of 2000 persons per GP, scaled up as appropriate by the realities of group practice. The work can be expected to comprise clinical, social, preventive, and health promotional activities (chapter 5).

Until recently most emphasis has been on the clinical content of the workload, with minor problems making up 60 per cent, chronic disease 30 per cent and acute major situations 10 per cent (see chapter 5).

General practice mostly is, and should be, concerned with 'bread and butter medicine' and with the common disorders that commonly occur: these require a generalist rather than a specialist approach, but nevertheless demand sharp clinical acumen.

Likewise, the common social problems are undramatic, with housing problems, care of elderly relatives, family and

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marital difficulties, and lack of money predominating. Health promotion and disease prevention now occupy more of the GPs time. Here the approach has to be aimed at both the individual and the neighbourhood, using general, personal and family opportunities rather than sophisticated techniques.

There is therefore no shortage of possible work. The dilemmas are deciding what really needs to be done and what is or is not useful.

In other words, how should priorities be decided and by whom? In general practice as elsewhere in the health care system it is the art of the almost impossible to match wants, needs, and resources.

Another current dilemma is how to achieve equity in an unequal society. There have always been inequalities in health and disease. The report on *Health and Life Style*(1) provides the most recent evidence that significant differences still exist between different parts of the country and different social groups in most of the health indices measured. Forty-years of comprehensive, free at the point of use, health service may have contributed to greatly improved health statistics, but the gap between the top and the bottom groups has not narrowed appreciably.

'Community Care' is the watchword of our present political masters. It implies that general practice and other primary care services should almost as a matter of faith take on new roles and new tasks. There has not yet been much attention to the question whether it will be helpful and cost effective to adopt this course. It may be more expensive to push long-stay chronic handicapped patients out of hospital into the community: more worrying it may also prove not to be in the interests of patients(2).

WHO MIGHT DO IT?

It must not be assumed that the general practitioner as we know him is the most important professional in primary health care, though he is certainly the most expensive. A GP now costs some £100.000 to educate in medical school, for five years, and then to train, for four more years. Once in

practice he is responsible for £200,000 a year of NHS expenditure (see chapter 5).

There is evidence that much of the traditional work of a GP can be done as effectively, efficiently, and more economically by other less expensively trained primary care workers. Practice nurses and primary care health workers in USA, USSR, and developing countries have demonstrated how this can be done. This does not mean that the GP does not have an important place, only that we should consider how much of the present day work of general practice can be delegated or shared with non-medical colleagues and, if so, whether the numbers of GPs might be reduced?

Consideration should also be given to a more imaginative development of the primary care team ideal. For example, it would be possible to divide primary care work into three divisions, each with their own roles and working where possible from the same premises, to provide teams collaborating closely in aspects of neighborhood care, namely:

CLINICAL CARE;

SOCIAL CARE;

HEALTH PROMOTION AND DISEASE PREVENTION.

Another question for the future has to be whether we want to establish the GP as a personal doctor or to replace him with ad hoc 'practice doctors' without long-term continuity of personal relationship? Where patients see almost at random any partner in a large group practice the personal relationship is already quite different from that built up in a single-handed or small group practice. Yet another question. Should we strive to maintain the generalist nature of practice or should we create a collection of neo-specialoids in the larger group practices, each with their 'special interest'? If so, this would have implications for the basis on which patients are accepted onto a doctor's list, and the obligations of the doctor in terms of his NHS contract.

HOW SHOULD IT BE DONE?

Because the personal nature of medical care includes as much art as well as science, measurements of quality are

difficult. Nevertheless, if we are to make the best use of available resources we must attempt to quantify quality.

As a corollary, one of the joys of general practice is the opportunity to adapt care to the individual patient. Reliance on specialist research reports has to be tempered by one's own knowledge and experience of the patient, often over many years, and by an understanding of disease as it exists and occurs in general practice. A sensitive appreciation of local specialist skills and their availability may also influence decisions on care.

There is a lack of reliable trials under general practice conditions of treatments for the common diseases of general practice. In the main, it is specialists who carry out trials and experiments: they do so on their own case material which is often very different from that seen in general practice. For example, high blood pressure in general practice is chiefly of the mild to moderate variety. Although there have been well planned short-term studies, longer studies of high blood pressure are necessary to determine the natural history and outcome. In my own practice I have found that intensive treatment of high blood pressure in the elderly is unhelpful; that more than one-half of children with acute otitis media recover without antibiotics; that the majority of children with hyper-reactive acute wheezy chests do not become adult asthmatics. I question the excessive use of H_2 antagonists for ulcer and non-ulcer dyspepsia, since most such symptoms respond to simpler and cheaper measures and resolve with time(3).

Unsubstantiated heavy-handed public health education through the media creates anxiety, difficulty, and waste. The annual promotion of wide scale immunisation against influenza is of questionable benefit. Routine health checks of the elderly population tend to reveal 'normal abnormalities' which may be best left alone. The huge expense of our extensive cervical cytology programme has not reduced mortality from cervical cancer appreciably, and the proposed national mammographic screening for breast cancer appears to be based on some questionable data. These examples are offered to emphasise the need for stricter trials and experiments before scarce national resources

of money and skilled manpower are irretrievably committed.

There are other examples closer to general practice. Health Centres were a fine idea, on paper. They were introduced with much political fanfare as the pattern of the future. They have not been a great success. Not that their concept or the buildings were wrong, but because there were no adequate preparations beforehand. It was a rehousing exercise without much attention as to how their occupants would work better together and what improved services they would provide (see chapters 3 and 5).

There has been much recording of quantitative data such as consultation and home visiting rates, length of the consultation, and availability and accessibility of the GP.

But it has not been possible to assess convincingly the relationship between quality or care and high or low consultation and home visiting rates or a specific length of consultation or appointment systems or deputising services. There is evident need for research and experiments in primary health care to assess current and future trends to challenge assumptions and to develop performance indicators and guidelines.

HOW TO ADMINISTER WELL, AND GIVE BETTER VALUE FOR MONEY?

It is clear from the 1987 White Paper and current legislation that government plans for general practice will aim to secure better value for money, better service for patients, and more patient participation. The difficulties for the NHS are how to direct and control the expenditure and organisation of GPs who are 'independent contractors' responding very largely to demands initiated by ordinary members of the public.

Budgets for practices: It could be that annual or five-year budgets might be allocated to practices to meet targets agreed between the practices and the NHS. Built into these budgets might be performance indicators measuring preventive procedures as immunisation, screening, and health education. Allowances would have to be made for special

factors such as inner city conditions, high proportions of elderly, and other local social, economic, or geographical conditions having a bearing on health or the provision of services. If the practice should underspend the budget and provide good care, the surplus could be spent on improvements. Overspending with no good reasons would have to be met out of practice reserves.

Information and data on practice work: Practices may be expected to keep records and produce regular information on services provided, on how to obtain them, and on any special features of the practice. Annual reports of work and achievements of the practice based on collected data might be a condition of the budget allocation or withholding of some remuneration.

Board of Management: Practices might be expected to create Boards of Management. Each Board to include representatives from staff, patients, and health authority.

Practice Finance: In the larger NHS practices annual turnovers already exceed £1m. If account is taken of the national cost of drugs prescribed and hospital services utilised, GPs naturally seek to maximise their incomes and minimise costs, with business managers and financial consultants as key advisers. At present, however, the most lucrative practices may not be the most effective and efficient from the standpoint of the NHS. As part of a move towards practice budgets, efficiency, and profits should be closely related and with this would come business methods and gadgets to control income and expenditure most effectively.

Mergers and Take-overs: General practice has become potential big business, ready for entrepreneurs to move in and revolutionise the system. With the Conservative government's attraction to privatisation and innovation, as seen in the suggestion of 'health shops' in the Green Paper of 1986, all options are possible and should be considered and tested.

Practice mergers may create controlling companies interested in competitive primary health care with high quality

facilities and services, combining clinical, social, preventive, and health promotional care, including screening and fitness facilities. GPs could be partner/shareholders. A more radical event which would be likely to attract the attention of the Monopolies and Mergers Commission might be a take-over of regional, or even national, primary care services by large financial conglomerates. Here GPs might lose their independence and become 'salaried partners' possibly with shared percentages of the profits.

Such moves could be made feasible in the context of our NHS in which GPs are private independent contractors. In fact, they are already taking place with general dental practices being bought up and merged with larger groupings, and in ophthalmic practice where large companies are buying up smaller businesses, though the fee-for-service basis of payment for these services is different from NHS general medical services. Schemes such as these exist, and are growing in USA, and there are few reasons whey they could not exist here if business organisations become convinced that good profits could be made through favourable agreements with NHS to provide better primary care services with guaranteed savings on hospital services.

HOW TO ACHIEVE CHANGES?

Changes are possible through agreement between government and the medical profession. They can be as radical or as benign as the government and the profession wish. Given the prime objectives of better value for money and better services with better use of resources, it need not be difficult to achieve agreed changes through alterations of systems of remuneration. As the 1965 Charter for general practice showed, where the will exists there is nothing sacrosanct in our methods of paying GPs by capitation fees, extra fees for specified services, reimbursements, and other complex ingredients.

Given that the total cost of primary care services is 20 per cent of the annual £20b budget of the NHS, it would be an intriguing challenge to invite plans for a scheme to provide a first class national primary health care system for £4000m a

year. The major problem would not be in finding new ideas, but of convincing government, public, and profession of their viability and practical benefits.

The providers would, of course, have to guarantee first-rate care on to an agreed standard. This would include good premises with full facilities; adequately trained personnel for team care; services to include clinical care, preventive care, health promotion, prescribing, and arrangements for joint care with local hospitals. Quality checks and controls would be based on collected data and audits. Annual reports would be published. There would be public representation on local management. Provision for research and development would be made at each unit with local regional and national links for such activities. General practitioners would be on long-term contracts and there would be a negotiated remuneration package.

FUTURE HOPES AND NEEDS

This has been an opportune time to carry out a review of general practice over the past 40 years and a chance to consider the future. The past has caught up with the NHS. Some of its basic philosophies are being challenged and found to be in need of change.

Beveridge believed that a national health service would improve health and reduce costs. Bevan's social philosophy was for a 'free' service without any specified responsibilities by receivers.

Although we have a relatively cheap health service, at 6 per cent of GNP, there are those who believe that public funding through taxation has reached its limit. If that is really so, then suggested alternatives have to be considered urgently. Although on the whole the public loves the NHS, radical alternatives cannot be excluded if they can offer better services easily obtained and with no payment at time of service.

THE INSOLUBLE EQUATION EXAMINED

The awful and inescapable truth is that wants are greater than needs which are greater than resources.

Wants for health care are in effect infinite: the people seek more and better services and the health professions seek more and better facilities, equipment, and conditions.

Needs of health care are imprecise: objectives, goals, and priorities have never been defined and agreed.

Resources are restricted and what is spent on health may mean an equal or greater benefit forgone in some other field; unless extra monies are to come out of taxation then consideration must be given to better use of available resources, to drastic cuts in services or to alternative sources of funding. Something is likely to give politically, for an ageing population and the progress of medicine create more financial pressure. Under the present government radical alternatives are being seriously considered.

GENERAL PRACTICE

With negotiations taking place between the DHSS, GMSC, and RCGP on the White Paper, the future is being shaped now. It need not be doubted that all want the best quality of general practice, and that the question is how it is to be achieved.

The **System** for primary care can be changed and all options must be considered on the lines touched upon earlier, subject to the over-riding need to ensure fully comprehensive services.

Realistic objectives and goals have to be set through agreement between public, profession, and government. Such objectives have to be based on reasonably attainable priorities.

Methods have to include reliable data and experiments and trials to assess quality and to take note of the large differences between practitioners in work rates and

content, prescribing rates and costs and hospital referral rates.

Outcome measures are all important in assessing the methods employed and **costs** must be included.

WHAT MAY HAPPEN— AN AGENDA FOR THE FUTURE?

Crystal ball gazing is a relatively safe pastime, particularly if the time scale is long and memories short. Personal forecasts may be permissible for the next five years, 10 years and 15 years.

next 5 years will be a period of tinkering with the present system based on the 1987 White Paper. At the same time, given strong leadership, there will be serious consideration of radical changes. Ideally this should be initiated by the BMA and RCGP, with initiative and support from independent bodies such as the Trust and the King's Fund.

10 years hence, the new proposals will be tried and tested.

15 years hence (less given goodwill) the new scheme will be introduced nationally.

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FINALE

British general practice has a long history of continuing progress and advancement. It has had a secure place within the NHS, but it will have to adapt and change for the future.

Its foundations are sound. General pracitioners are well trained and prepared. Recent trends involving team care and the emphasis on preventive and anticipatory care are welcome.

The current problems are concerned with the NHS as a whole, and include both inadequate funding of hospitals, and the relatively small independent units through which primary health care is provided.

Now is the time for professional leadership and planning for the future. Now is the opportunity for an independent body such as the Trust to bring together representatives from the health professions, the public, the DHSS, and for the private health industry and academia to produce plans for the future. The agenda should be such that working groups might report back on special issues quickly and with firm and practical recommendations.