Health Care, Health Promotion and the Future General Practice

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1

INTRODUCTION

Good health is a valued personal attribute in all human communities, even though 'health' may mean different things to different individuals or groups. It is also widely accepted—in principle if not in practice—that it is better to avoid illness than to have to suffer either its symptoms or the possible unwanted effects of medical and surgical treatments. Calls for 'a health service, not a sickness service' have therefore established a degree of popular support, perhaps especially amongst those sections of the population not in immediate need of cure or care.

Amongst governmental agencies, the concept of an approach to the public's health which might prove both politically acceptable and, in cash terms, relatively inexpensive should have an understandable attraction. In reality, of course, the long-term consequence of enhanced health promotion and disease prevention may only be to delay costly treatment needs to later in the average citizen's life-span. Yet, both common sense and welfare economics support the logic of trying to ensure good health for as many people as possible for as long as possible.

Until recently progress in Britain towards the establishment of an overtly 'health promotion/health gain' oriented culture within the NHS has been limited. Despite the lead given by the World Health Organisation through initiatives like the Alma Ata declaration (WHO 1978) and its *Global Strategy for Health by the year 2000* (WHO 1981), the Department of Health during the 1980s appeared to be resistant to the idea of setting clear targets for health improvement in the population.

This might partly have been due to a reaction amongst British health sector leaders and their advisers against what could initially have been seen as 'vapid sloganising'. Nevertheless, highly visible, confrontational disputes involving issues such as the publication of the *Black Report* on inequalities in health (Black 1980) and, later in the same decade, the disbandment

of the Health Education Council helped to create an atmosphere of concern and some distrust relating to health promotion policy.

Some observers feared that lobbies like those defending tobacco product manufacturers and traders had developed an undue influence over government decision making. Many deplored the continued lack of effective co-operation between the separate departments of state on matters like transport, agriculture and food policy and health, despite initiatives such as the 1970s *Joint Approach to Social Policy* programme. And critics of the medical and other health professions argued that they too were failing positively to promote healthier ways of life. The concern was that sectional economic and allied interests in acute treatment provision, coupled with a desire to maintain maximum degrees of professional autonomy, have been placed before the public's overall interest in the provision of effective, efficient, services for maintaining positive physical and mental well-being.

However, this situation began to change significantly at the start of the 1990s. The introduction, through the *Working for Patients* reforms, of the purchaser/provider divide has enabled all health service hospitals and community units to become, in effect, 'independent NHS contractors'. This in turn may allow health authorities to take a more strategic view of resource allocation for 'health gain' in the community. Unified local commissioning will, it is hoped, permit NHS policies and objectives to be set in an atmosphere relatively free from any distorting influence associated with the vested interests of service suppliers, and in a manner sensitive to consumer requirements.

The publication of the *Health of the Nation* green and white papers (Secretaries of State 1991, 1992) clarified government's view of the types of performance improvement it wishes the new NHS structure to deliver. There is no logical reason to deny the inherent desirability of achieving the targets detailed in Box 1.1. In a sense they can be seen as overt measures of public health 'profitability' in the more market-like NHS of the 1990s.

At around the same time as the *Working for Patients* changes were first introduced, new general medical and dental practitioners' contracts came into effect. These laid greater

Box 1.1 Health of the Nation Main Targets

Coronary heart disease and stroke

To reduce death rates for both CHD and stroke in people under 65 by at least 40% by the year 2000 (Baseline 1990)

To reduce the death rate for CHD in people aged 65–74 by at least 30% by the year 2000 (Baseline 1990)

To reduce the death rate for stroke in people aged 65–74 by at least 40% by the year 2000 (Baseline 1990)

Cancers

To reduce the death rate for breast cancer in the population invited for screening by at least 25% by the year 2000 (Baseline 1990)

To reduce the incidence of invasive cervical cancer by at least 20% by the year 2000 (Baseline 1986)

To reduce the death rate for lung cancer under the age of 75 by at least 30% in men and by at least 15% in women by 2010 (Baseline 1990)

To halt the year-on-year increase in the incidence of skin cancer by 2005

Mental illness

To improve significantly the health and social functioning of mentally ill people

To reduce the overall suicide rate by at least 15% by the year 2000 (Baseline 1990)

To reduce the suicide rate of severely mentally ill people by at least 33% by the year 2000 (Baseline 1990)

HIV/AIDS and sexual health

To reduce the incidence of gonorrhoea by at least 20% by 1995 (Baseline 1990), as an indicator of HIV/AIDS trends

To reduce by at least 50% the rate of conceptions amongst the under 16s by the year 2000 (Baseline 1989)

Accidents

To reduce the death rate for accidents among children aged under 15 by at least 33% by 2005 (Baseline 1990)

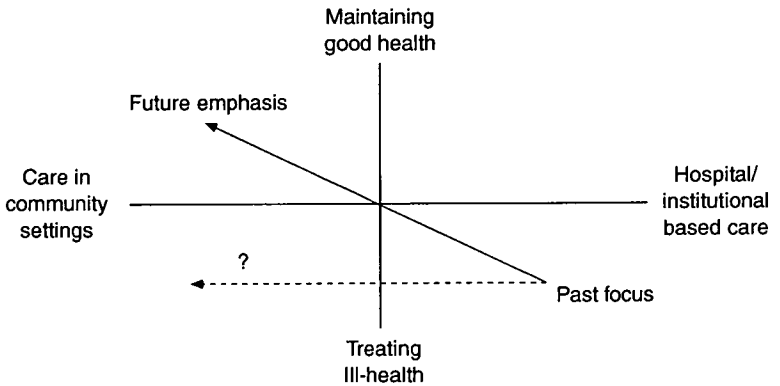
To reduce the death rate for accidents among young people aged 15–24 by at least 25% by 2005 (Baseline 1990)

To reduce the death rate for accidents among people aged 65 and over by at least 33% by 2005 (Baseline 1990)

emphasis on health promotion within the family practitioner, or 'traditional' independent contractor, sector of the NHS. This can be seen as part of a long term process aimed at integrating public health responsibilities into the primary care system (Charlton *et al.* 1994). Such trends, particularly when allied with the apparently successful introduction of GP fundholding (Robinson and LeGrand 1994) in 'the new NHS', promise an increasingly central role for general practice. But the financial and other consequences of the new contract created considerable friction between the government and family health services professionals, which in turn led to the further revisions in service arrangements described later in this book.

Overall, health promotion remains a politically contentious, volatile, area of policy debate within health care. Examples of the sort of question still fully to be answered in relation to national strategy in this area include:

- **'is the balance of responsibility for achieving better health weighted appropriately between individuals and the community/body politic?'** William Waldegrave, in his introduction to the 1991 *Health of the Nation* green paper, warned that debate about national health issues has been bedeviled by extremists taking either 'it's all up to government' or 'it's all up to individuals' lines. This is true. But it should also be recognised that many aspects of the state's responsibility to protect and inform its citizens—and their rights, responsibilities and requirements to control their own lives—are complex, and present important and as yet unresolved problems. The protracted debate on issues relating to tobacco product promotion illustrates this fact well. Interventions in the area of sex education and the heated discussion related to diet, cardiovascular disease risk and social class also highlight the political sensitivities which may be touched on by health promotion;
- **'can interventions like screening programmes and education about disease risks do more harm than good by raising public anxiety levels for relatively little overall health gain?'** The answer is 'yes', at least in some circumstances. And generally it is true to say that little is as yet known of the effects of increased 'health hazard awareness promotion' on the young, or indeed people of any age. The amount of personal reassurance individuals may need from professionals like GPs if they are to live comfortably in an environment in which there are frequent risk/disease warnings may well be greater than is as yet appreciated;
- **'might current health promotion policies place too much emphasis on disease avoidance, and too little on the value of encouraging a sense of well-being and/or coming to terms and coping with illness or disability?'** There is again an obvious possibility that this could happen, in the same way that health promotion propaganda could in theory at least draw attention away from the need to fund treatment and care



With a shift of resources away from traditional hospital care towards health promotion and non-institutional services the quality of support for seriously ill people living in community settings will need careful monitoring

Figure 1.1 Policy direction

adequately—see Figure 1.1. There is also a risk of creating and/or maintaining an artificial and harmful divide between health care and social care;

- **'will pursuit of simple, measurable, targets such as those set in *The Health of the Nation* stimulate changes in the NHS which could damage its ability to generate more complex, difficult to quantify, but nonetheless valued outputs?'** If the effect of concentrating efforts on meeting targets such as those set in the *Health of the Nation* programme and the Patient's Charter initiative were to reduce service providers' ability to address issues of more true importance to those using and ultimately paying for the health service, the result would be counter-productive. For instance, even if it were to become technically more efficient at promoting 'health gain' the NHS could be thought to be failing in an important aspect of its role if it were to become unable to assure all sections of the population that it offers them adequate access to good quality acute health care. If, for example, relatively affluent individuals (who on occasions may particularly value their personal relationship with their family doctor) come to fear that they and their families will not get standards of NHS service they believe they require then they may choose to pay for health care privately, but at the same time become less willing to make the tax (transfer) payments necessary for the NHS effectively to support those most in need;
- **'to what extent is there a possibility that increased emphasis on health promotion and primary care's integration with other NHS services will change the nature of this country's unique general medical care system in an unintended, and damaging, manner?'** This is one of the most important questions underlying in this book. Enhanced health promotion

effort in relation to activities of proven effectiveness is of course a valuable goal. But politically-driven changes in health care delivery may not always be based on good science, and so may harm both patients and the service they rely on. The side effects of ill-informed health promotion can be just as dangerous as those of other forms of medicine, and there is also a real danger that current attempts to improve general practice could ultimately undermine relationships between practice based professionals and their patients. Although this risk has at times been exaggerated, and the potential advantages and achievability of a better managed and co-ordinated NHS primary care system still are commonly underestimated, any hazard to what is arguably this country's most unique health care asset deserves serious attention.

Against these background questions the next two chapters of this book examine the broad demographic development of, and associated health challenges facing, British society. Particular attention is paid to the controversy surrounding social class-related differences in morbidity and mortality, and the opportunities which exist for reducing them.

The fourth and fifth chapters provide a description of the changing structure of the NHS and the position of general medical practitioners and practices within it. The motors driving decision making in the health sector are also briefly considered. Chapters six and seven discuss health promotion and screening in general practice in detail, together with concepts and models of health and health promotion and the nature and significance of the government's recently instituted *Health of the Nation* programme. Finally, the two closing chapters examine some key issues in primary health care today, and how the future general practice might look and function in the early years of the twenty-first century.

The approach taken aims to bridge between thinking in clinical medicine and 'hard science' disciplines such as, for example, neuropharmacology, and that of other areas, including public health medicine, health economics and medical sociology. It is based on the conviction that failure to develop further broadly balanced, evidence based, understandings of care needs would limit markedly the future potential of primary health service providers to contribute to the well-being of their patients. Health promotion and acute treatment standards are both threatened by conflicts between one-sided advocates of 'social' as opposed to 'biomedical' models of illness.

The main aim of this book is to review the determinants of health and ill-health in the community, and the role that general practice based professionals can play in reducing current levels of distress and disease. It also considers aspects of the recent NHS reforms and their likely impact on the structures, processes and eventual outcomes of primary care in Britain, identifying areas of both opportunity and threat to the public interest.

Alongside these goals another important objective is to establish the reasons why a clear appreciation of each individual service user's personal care requirements, in his or her order of priority, is an essential component of all good quality—genuinely effective—care. This is not to say, of course, that there is no proper place for the exercise of professional, managerial or political judgement and authority to protect the health of members of the public. But at the same time control over individual choice and freedom needs itself to be very carefully controlled if it is not to have perverse results. In short, despite 'market failures' deriving from inadequate consumer knowledge and other distorting factors, patients are more often than is often understood the best judges of their own best interests. In a sense, all care is self-care, in that service users have to elect to seek and then to follow, or not to follow, professional advice.

The more patients and service providers can in partnership make soundly based decisions in relation to the often difficult behaviourial and therapeutic choices to be made in respect to health, the more likely it is that the 'new NHS market' will work well. Seen from this perspective, general medical practitioners and their colleagues in primary care are well placed to help facilitate informed demand for many forms of secondary of tertiary provision, as well as directly to provide treatment and anticipatory care themselves. Despite the fears of some observers that the pressures created by the changes of the 1990s may undermine the quality of patient/practitioner relationships—at worst reducing practices to little more than anonymous walk-in treatment centres—this book looks forward to a 'primary care driven health service', with personal care provided through general practices playing an even more valuable role in the NHS of the future.

2

FROM DEMOGRAPHIC TRANSITION TO CARE TRANSITION

2.1 Past and present

The challenges facing the British health care system today are in many important respects unique in the country's history. Never before, for example, has the population been threatened with HIV/AIDS; never before have there been such large numbers of people living on into old age; and never before has such a complex range of screening techniques and therapeutic options been available to health care professionals and consumers.

However, this is not to say that the past behaviour, experiences and aspirations of the British population are irrelevant to the present health status of the community. Many of the problems, attitudes and values relevant to health are rooted in the conditions of the nineteenth century and before. This chapter therefore begins with a brief outline of the demographic and social basis of developments in health care, before moving on to consider more recent trends, the overall impact of demographic change on changing needs for health care, and the implications for general practice.

2.2 The origins of population ageing

'Demographic transition' refers to the process by which populations move from an undeveloped structure to a developed one. In an undeveloped population, fertility is high and relatively stable. It is approximately balanced by mortality which is high and sometimes catastrophically fluctuating. In a developed population low, stable, mortality is approximately balanced by low, if somewhat more variable, fertility. During demographic transition, which in Britain's case took over a century to achieve, rapid population growth occurs (as fertility remains high while mortality drops). Pre-transition communities

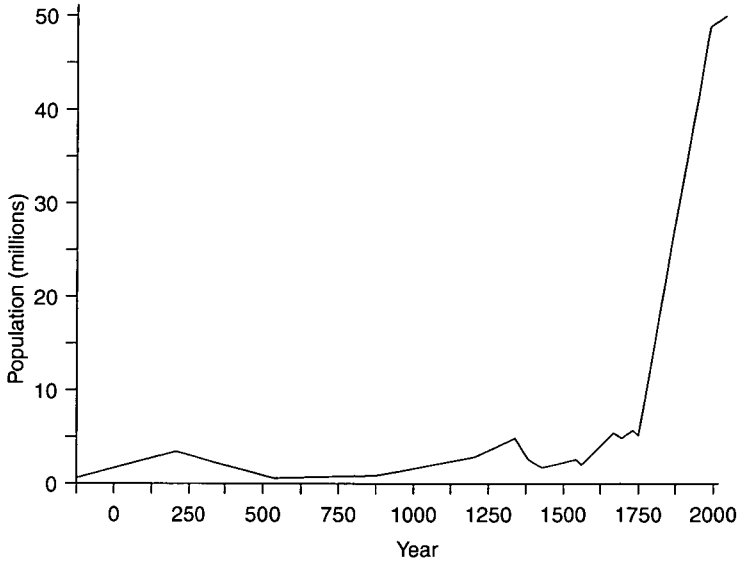
have low average life expectancies and a relative small proportion of elderly people, whereas post-transitional communities develop relatively large proportions of elderly people, and longer average lifespans. These are functions both of reduced numbers of premature deaths and, more importantly to date, reduced birth rates. As the number of children born in the average family drops to around replacement level and most individuals live on to old age the relative size of each age group will naturally tend to equalise.

Conventional thinking suggests that simple economic incentives act as the main motors of transition. For example, poor rural farming families benefit from having many children to help on the land, with those who live into adulthood also having a long-term role to play in supporting their parents in old age. By contrast, town or city dwellers with formal employment and access to organised pension schemes have less incentive to have large families, particularly when they are confident that their children have a good chance of survival into adulthood.

More sophisticated explanations of demographic change place greater emphasis on cultural factors such as those influencing the lives of women. Social developments may change both the personal costs and the overall benefits of child rearing. Relevant phenomena include variations in the intensity of the average mother/child relationship, and increases in the opportunity women have to find personally fulfilling careers outside the home.

As demographic development proceeds through the strata of any given society there may be a form of 'virtuous cycle', in which the life of each member of the smaller family unit is valued more and more highly. This has important implications for health related topics such as class related inequalities in health (see Chapter 3), the traditional role of women as carers, and the sometimes demanding attitudes of today's relatively healthy 'consumers' towards of primary health care services.

The data presented in Figures 2.1 and 2.2 illustrate the process of demographic transition in England and Wales. For almost two millennia the population ranged from under a million to peaks of perhaps as high as 5–6 million in the later Roman era, the early fourteenth century (before the onset of the plague) and the eighteenth century. It then began rapidly



Note: After 1801 data refer to England and Wales, before 1801 to England only. Before 1541.data are highly conjectural.

Figure 2.1 England's population growth. Source: Coleman and Salt (1992)

to expand, reaching 8–9 million in 1801, 30 million in 1901, and about 48 million by 1991. Average life expectancy at birth has risen from around 35 years in the period 1750–1800 to just over 40 years in 1850, almost 50 years in 1900, and around 75 years today.

2.3 Controlled reproduction and the care of the elderly

Similar increases in average life expectancy and population size are now taking place in many areas of Asia, Africa and Latin America. However, it would be wrong to conclude from such observations that the process of demographic change experienced in Britain was exactly like that going on in much of the developing world today. To do so may mis-state and misunderstand some of the key problems currently facing many of the nations of Africa, Asia and Latin America. It could also distort comprehension of British society, and the challenges it now faces.

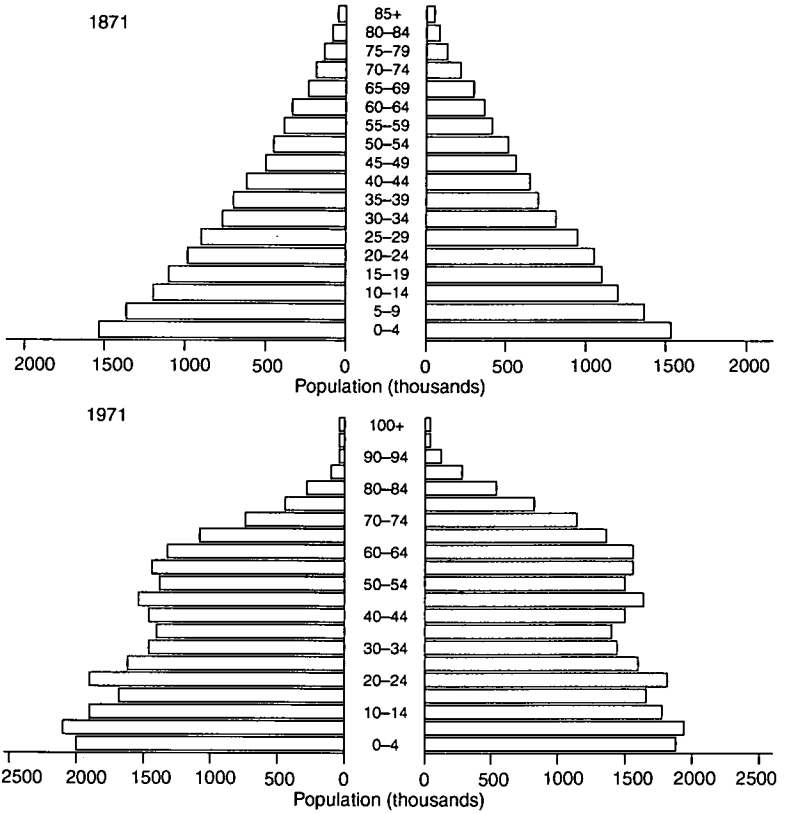


Figure 2.2 The population structure of England and Wales, 1871 and 1971. Source: Census data

Three main issues should be noted. The first is the traditional role of marriage in Britain (and other western European nations) in relation to fertility control and the moderation of population growth. In part because of the influence of the church and in part because of north western European traditions of inheritance, late marriage was commonplace and births outside marriage were relatively rare right up to the start of the modern era. For instance, it is estimated that in the seventeenth century the average age at marriage for men in England was 28, and for women 26. Further, about a quarter of the population never married at all (Wrigley and Schofield 1983).

In times of decreased prosperity marriages were particularly likely to be delayed. This—rather than fertility control exercised in marriage—helped the British population to achieve a 'low pressure' demographic system which avoided the worst excesses of poverty driven by population growth. Although figures for divorce and births outside marriage in recent years are markedly different from those of the past, cultural traditions of monogamy and/or fertility control exercised in relation to long-term expectations still appear to be strong in the bulk of the population.

In relation to health and social care provision today this background is relevant to understanding the strong tensions which surround issues of sexuality, sexual health, and single parenthood. The establishment of appropriate family planning services which help to ensure that every child is positively wanted (arguably a key long-term requirement for the health of the nation) depends on a sensitive approach to such issues.

Another aspect of this country's demographic history which can be linked to current concerns is the position of elderly people in the family. It is often assumed that extended families living together were the norm in England before the industrial revolution, or even in Victorian times. This is not the case. The British population has long been relatively mobile, with substantial movements to and between urban areas even in the sixteenth and seventeenth centuries. Customs such as sending young people away from home to live 'in service' promoted such trends, and the existence in Britain of a relatively fluid, competitive, labour market was a precursor to, rather than a consequence of, industrialisation.

As a result many British people lived, even before Victoria's reign, in nuclear rather than extended, multi-generational, families. The belief that 'traditional English values' demand that dependent elderly people should automatically be cared for by their relatives, as is the case in some other cultures, is not correct. It is, however, true that as the relative number of people aged over 65 has increased the percentage living with their children has fallen. This trend can be observed in virtually all developed countries since the second world war (Figure 2.3). It has obvious health and social service implications.

A third issue to note is the relative homogeneity (and protection from major domestic war) of the population of the

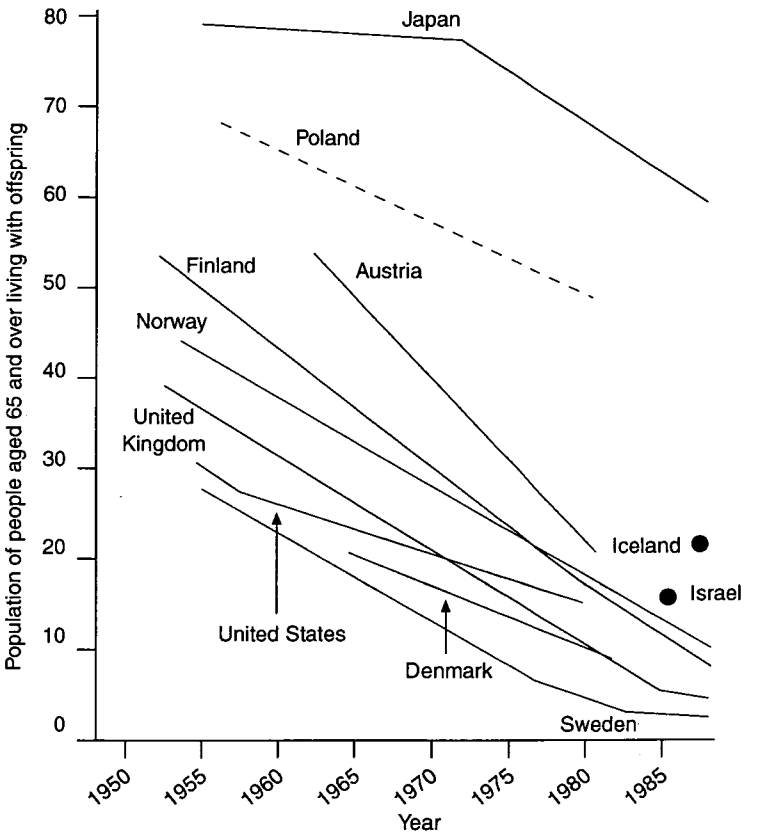


Figure 2.3 Percentages of people aged 65 and over who lived with their children. Data for selected countries 1950–1988. Source: as quoted by Okamoto (1992)

British Isles from the time of the Norman conquest up to the twentieth century. Although there have been serious religious and other conflicts in the British Isles during the past few hundred years the basic unity of the people (coupled with their physical separation from the mainland of Europe) permitted relatively even development. The population did not experience a demographically significant war until 1914–18, and can only genuinely said to have become 'multi-cultural' since the late 1950s. Again, such societal events and

characteristics have potentially significant implications for health and the delivery of health care.

The above issues are three of many topics linked to historical demography and epidemiology which are of relevance to current and future health promotion and health care. For example, questions about the ways in which conditions like bubonic plague, smallpox (see Razzell 1977) and, in the middle nineteenth century, scarlet fever were contained and eventually eliminated as significant threats to the population are not matters of academic curiosity alone. The examination of such historical events and trends casts light on how attitudes towards and beliefs about health and disease derived from events long past still influences behaviour today. It may also help build a practical understanding of how best to deal with current or future threats to health, whether from infectious causes or hazardous lifestyles.

2.4 The role of medicine and expectations of the public

Authors such as McKeown (1976) have examined the impact of medical interventions *per se* in promoting major changes in the health of nations. Until the last few decades curative medicine has been much less important in saving life than is sometimes assumed. During the nineteenth and early twentieth century periods of demographic transition in countries such as England the nature of infectious disease was first clearly understood, and some very important steps towards the introduction of effective forms of drug treatment and immunisation were made. However, it is now recognised that changes in behaviour and in the living and working environments of the population were of much greater significance in the achievement of longer average life spans.

Even claims to the effect that 'public health medicine' was responsible for the introduction of better sanitation and clean water supplies, and so of better health, should be regarded with some caution. Such achievements (and the perhaps even more important one of improved nutrition) were largely the result of a gradual diffusion of knowledge and opportunity throughout society, coupled with personal efforts made by individuals from many backgrounds, not any one clearly delineated profession.

The situation today is different. It would be misleading naively to project the experience of the past into the future. The limits of the natural life-span appear to have nearly been reached (Fries 1983), and the medical technology available for treating ill-health has become very much more sophisticated. Although broad public health and 'social' interventions still have a very considerable amount to contribute to the welfare of the community (see Chapter 3), the benefits of curative medicine also need realistically to be appreciated. The most productive way forward will depend on enhanced co-ordination and partnership between all the possible contributors to better health. The dangers of exaggerating the value of any one group's sectional role should be recognised. Health is literally 'everybody's business'.

Demographic changes during the last century have created a gradual re-alignment of public expectations of, and patterns of delivering, welfare services. This may be referred to as 'care transition'. Factors such as population ageing have directly altered care needs. Rising rates of disability stemming from the chronic conditions of later life are the most obvious example of this. In addition, there are social consequences of falling family sizes and the more intense relationships which attend 'high risk' reproductive strategies, in which the loss of just one child may mean reproductive failure. This has influenced the experience of both illness and positive health.

In certain instances the resultant trends could have negative effects. For instance, it is possible that people raised in 'post transitional' circumstances may be more self-centred than their forebears. This could in time threaten the funding of some established forms of public health service, even though the population of today's Britain has higher expectations of good health than did past generations. However, members of modern societies are also more educated, and the majority are more tolerant of differences between individuals in given communities. Publicly expressed values place more emphasis on equity and concern for the rights and well-being of each member of society, regardless of sex, race or (dis)ability, than is usually the case in pre-transitional societies. Demands for greater responsiveness to individual need may thus be balanced by an increasingly sensitive general awareness of whole population requirements.

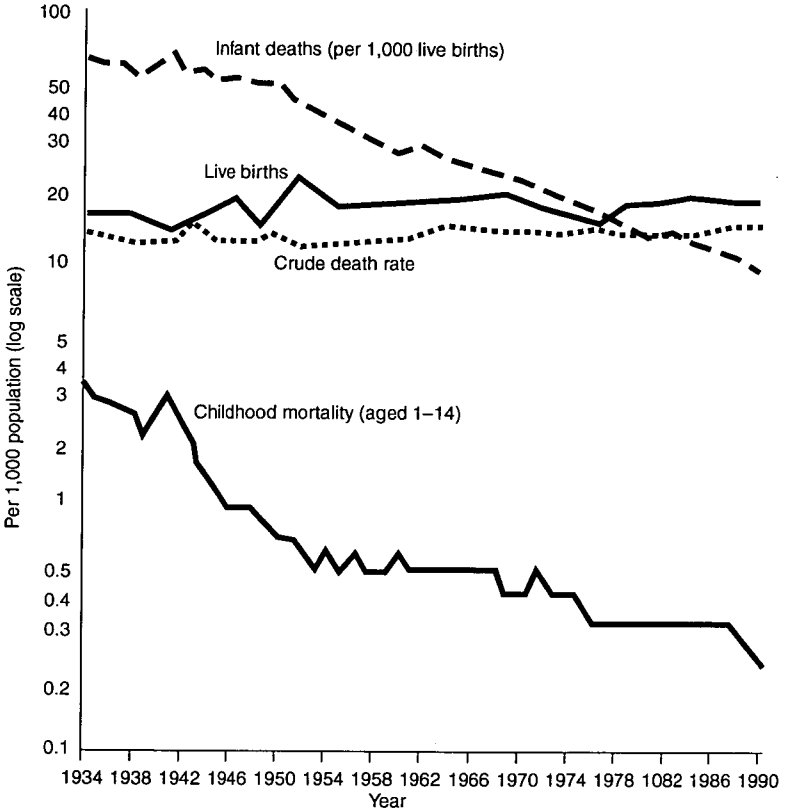


Figure 2.4 Birth and death rates, UK. Source: Chew 1992

These shifts, which are linked to greater levels of overall material wealth and technical knowledge and ability, could have a far reaching impact on the health care sector. Recent policy developments include those relating to health promotion, care of and support for people with intellectual, psychiatric and/or physical impairments, and the gradual shift in balance away from a hospital centred health service towards one more focused on general practice backed by an array of domiciliary and other community provisions. The broad concept of 'care transition' provides a useful guide to the underlying nature of the changes taking place as the UK health care system approaches the twenty-first century.

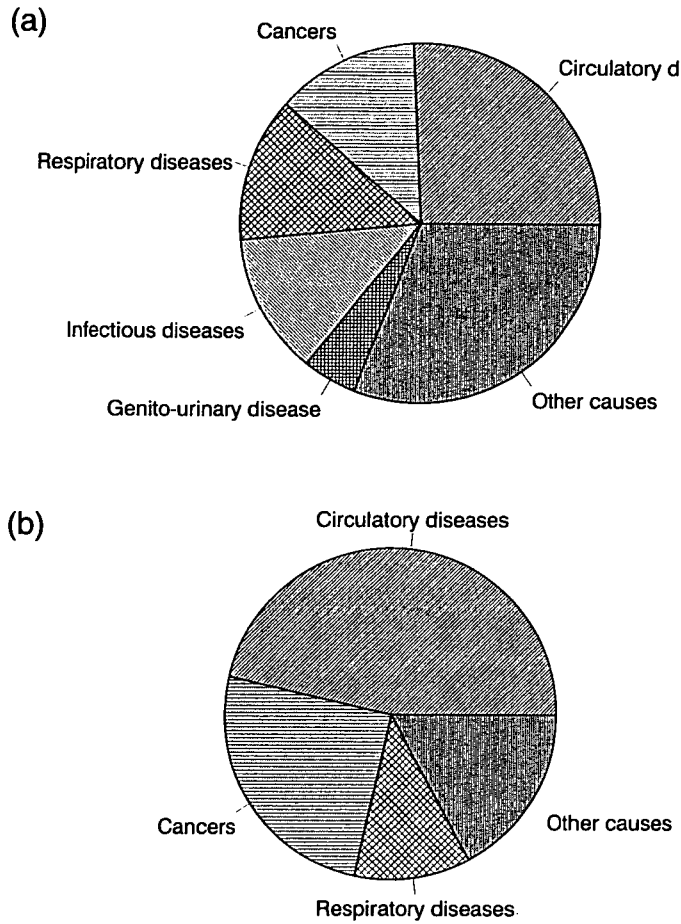


Figure 2.5 (a) Major causes of death 1931. (b) Major causes of death 1991

2.5 Changing patterns of disease and care need

The control of infectious disease and resultant steep declines in infant, child and maternal mortality during the twentieth century (Figure 2.4) can in a sense be compared with peeling a layer from an onion, or removing the top from an iceberg. As the first, most visible burden of early mortality was lifted from the British population, so another has been revealed or generated. Cardiovascular conditions, cancers and accidental and allied causes of death are now the dominant causes of both

premature and all age death (Figure 2.5). In terms of morbidity, complaints like asthma in childhood, depression and other psychologically based forms of distress in middle life, and the rheumatic diseases in later years are still growing in significance. They are a major component of the primary care workload. In some instances these illnesses are a paradoxical function of an environment which protects against the old hazards of hunger, cold and physical exhaustion.

There remains of course a serious potential threat from infectious diseases such as polio and tuberculosis. Polio is another example of a disorder where the symptomatic prevalence is positively associated with improving environmental conditions. As infants are protected from early exposure, they become more likely to suffer harm when they initially encounter the virus at subsequent stages in their development. (The polio virus may also have an as yet not fully understood role to play in the later life aetiology of the neurological disorder motor neurone disease). Immunisation has now led to the virtual elimination of the wild virus in many communities, but for the foreseeable future protection rates will have to be maintained in order to guard against a return of infantile paralysis and allied conditions.

Tuberculosis now has its highest relative prevalence in this country amongst immigrants from areas of Asia where it is still widespread (world-wide TB kills 2–3 million people a year) or in disadvantaged, often homeless or poorly housed and fed sections of the community. Nevertheless, it can 'spill over' into other population groups in developed countries unless adequate immunisation, disease surveillance and drug treatment facilities exist. The recent experience, most notably in US cities but also in Britain, of infection by the TB bacillus being associated with HIV infection underlines the need for continuing vigilance, both at the general practice level and through specially targeted efforts to protect those most 'at risk' from such hazards. The outbreaks of diphtheria in the former Soviet Union offer a similar illustration of the need for continuing vigilance against a major killer of past generations.

In 'developed' populations cardiovascular diseases and cancers are the main causes of mortality. Available data are insufficiently robust to provide clear comparisons of age specific rates in Victorian times with those of today. This is partly

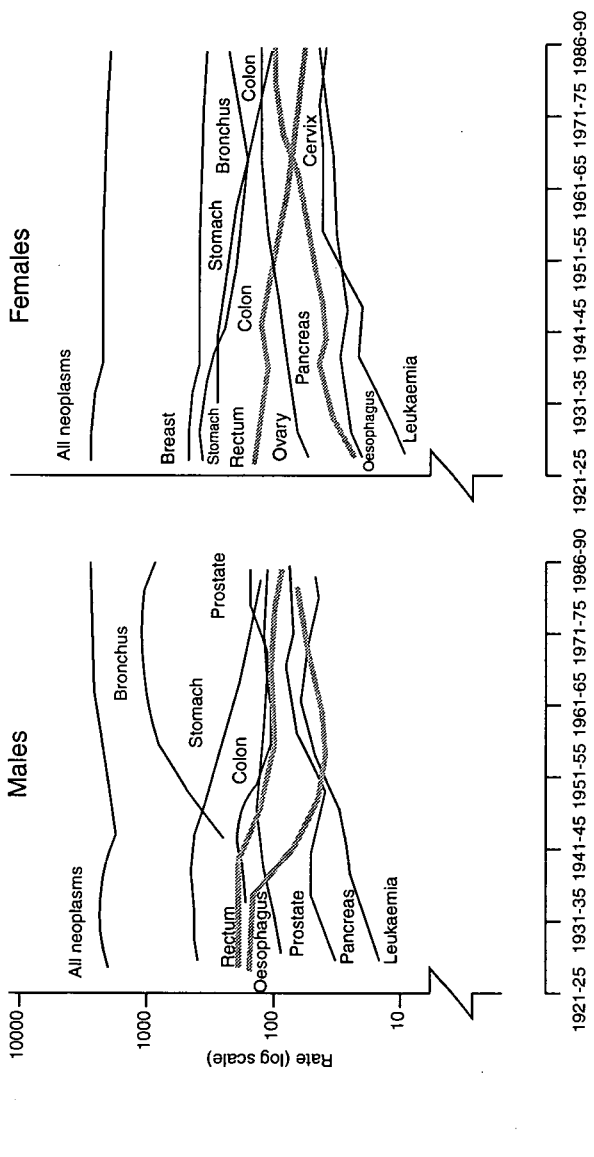


Figure 2.6 Main types of cancer: age standardised death rates per million population by sex, England and Wales 1921–1989.
Source: DoH 1992

because of improvements in diagnostic practice, and partly because of the removal of intervening causes of death. Yet it is generally accepted that factors such as the increasing consumption of animal fats and the emergence of smoking as a mass habit amongst males at around the time of the first world war (and in women more recently) significantly raised the true incidence of heart disease, initially in the higher social classes. The health promotion task thus seems relatively clear cut. However, the available data now show a strong inversion between cardiovascular death rates and social class within communities such as that of modern Britain, which variations in current (known) risk related behaviours do not appear fully to account for.

Awareness of this has led Barker and his colleagues at the MRC Environmental Epidemiology Unit at Southampton to embark on an series of studies (see subsequent chapters) on the relationship between pre-birth and early life deprivation and adult vulnerability to cardiovascular morbidity and mortality (Barker 1989, Robinson 1992). Their findings remain controversial. But they serve to reinforce the point that a comprehensive approach to health promotion should not only be aimed at goals like eliminating smoking. Services such as improved sex education, family planning and health care from the pre-conceptual period through to mother and infant support could have a critically important long-term role to play.

In the case of cancers, often reported increases in numbers of deaths are in many instances a function of population ageing, with the major exception of conditions linked to smoking. Figures 2.6a and 2.6b indicate that death rates per million for neoplasms have remained relatively constant for the past half century or so, despite the lung cancer epidemic. Trends such as the significant reduction in mortality from stomach cancer in the period shown are believed to be associated with dietary improvements such as the greater availability of fresh fruit. The gradual rise in total breast cancer deaths (followed in the last few years by a decline associated with a fall in the number of childless women in the at-risk population) is unlike most other neoplasms in that it is positively associated with social advantage. The aetiology is not yet satisfactorily understood. Some of the other changes in recorded mortality, such as that for leukaemia, may be

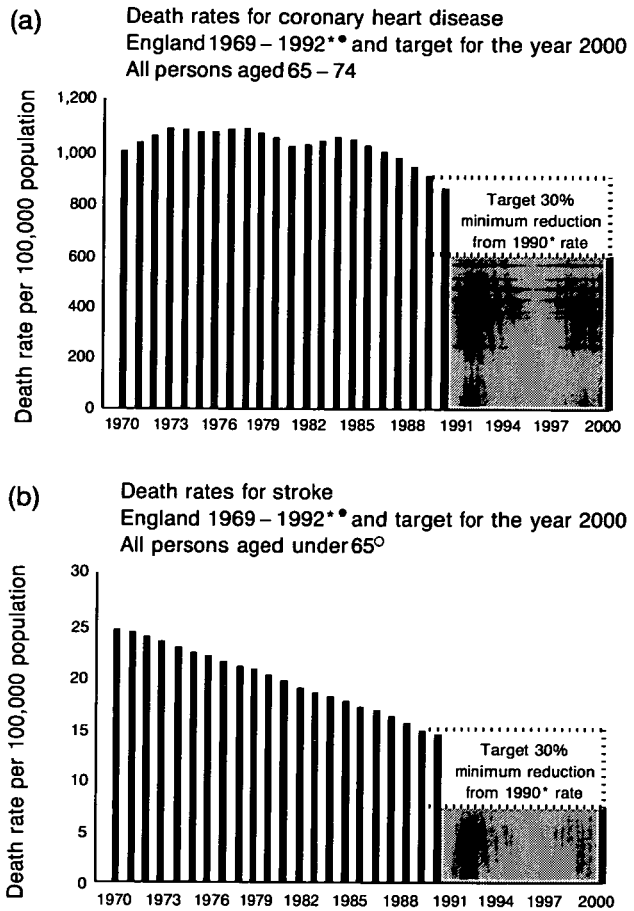


Figure 2.7a and 2.7b Death rates for coronary heart disease, and stroke, England 1970–1990, and targets for the year 2000. Source DoH 1993

related to enhanced diagnostic abilities, while others, such as that for oesophageal cancer, could be linked to fluctuations in alcohol consumption and interactions between alcohol and smoking.

Figure 2.7 illustrates recent falls in heart disease and stroke mortality. Developed communities should be able to continue to make significant advances in the prevention and control of most forms of physical ill-health leading to relatively early deaths. But such optimism should not be taken to imply that

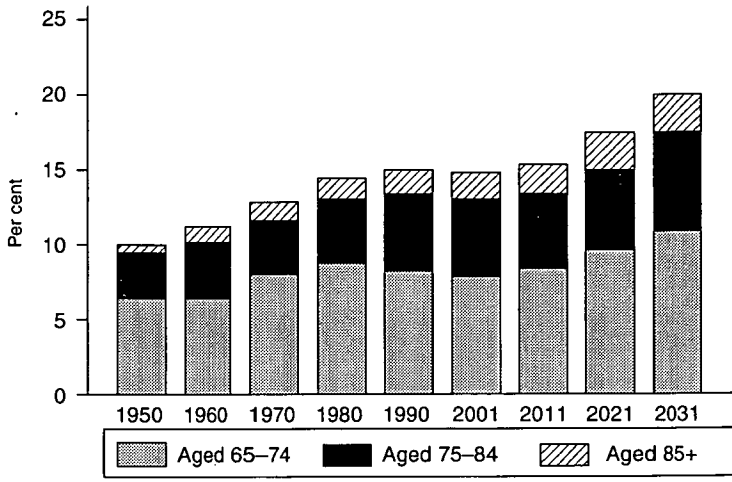


Figure 2.8 Elderly as per cent total population

this will necessarily mean that the population will enjoy a better quality of life. It may prove harder (and more expensive than is often assumed) to add life to years than years to life, both in old age and for younger individuals who have to face the challenges of very severe disability. This underlines the need clearly to define what is meant by terms like 'the achievement of health gain'.

2.6 Current population trends

2.6.1 Old age, disability and isolation

Figure 2.8 shows recent and projected trends in the ageing of Britain's population. Although the overall number of people aged over 65 is today increasing relatively slowly, the ratio of 'young' elderly to 'old' elderly is still shifting rapidly. In 1901 there were in total some 1.7 million people in Britain who were aged over 65. Of those just under 60 000 were 85 and over. By 1981, however, over 500 000 of the 8 million people aged 65 plus in Britain were over 85. And by 2001 there will be more than one million people aged over 85, compared with a total 65 plus population of some nine million. In 1901 only one person in 20 was aged over 65, and only one in roughly 700

Table 2.1 Projected changes in self-care capacity 1985–2025, Great Britain

	1985	1991	2001	2011	2021
Unable to bath/shower unaided			People (000s)		
65–74	193	197	188	204	239
75–84	345	366	381	375	417
85+	208	272	356	407	410
all 65+	746	835	925	986	1066
Unable to walk down the road					
65–74	290	295	282	307	446
75–84	488	518	540	531	591
85+	315	412	540	617	622
all 65+	1093	1225	1362	1455	1659
Unable to cut toe nails					
65–74	965	983	937	1022	1197
75–84	1120	883	921	906	1008
85+	436	569	747	853	861
all 65+	2531	2435	2605	2781	3066

Source: Henwood 1992

British people was 85 or older. By 2001 the equivalent figures will be one in six and one in 50 (Henwood 1992). Such changing dependency ratios are of concern in that often 'the young elderly' are the individuals most heavily involved in supporting 'old elderly' people living in the community.

Physical disability rates, together with the conditions responsible for dementia, are positively related to age. Although even at the age of 85 and over 30 per cent of the population is free of all but minor limitations, Table 2.1 (based on General Household Survey data—OPCS 1989) indicates that large numbers of elderly individuals are affected by impairments which inhibit their capacity to care for themselves independently. Despite hopes that in the future disability free life expectancy in old age will increase (Fries 1980) there is currently no evidence of any such trend.

Even independent life in one's own home is of decreased value if it has to be experienced in isolation. Factors which may contribute to isolation include chronic pain, rapid social change, and bereavement. Inequalities between average male and average female life expectancies (only 13 per cent of men are currently aged over 65 compared with 19 per cent of women) mean that the great majority of individuals who live

on after their spouses have died are women. Over a third of men surviving to age 85 live with partners, compared to under 10 per cent of women. Almost two thirds of women reaching 85 live alone, compared with little more than a third of men. Understanding the needs of older women living alone should thus be a special priority for today's primary health and social care providers.

2.6.2 *Caring and the role of men*

There will be a marked absolute and relative drop in the number of people aged 15–24 at around the start of the next century, exacerbating past changes in dependency ratios. Depending on demand for labour in the economy as a whole this may result in a shortage of nurses and/or other formal carers, although against this rationalisation of hospital structures in both the acute and long-stay sectors should release staff for work in community contexts.

Similar uncertainties apply to the changing roles of women and men as workforce participants. Since the 1930s the proportion of married women in paid employment has increased from around 10 per cent to a little over 60 per cent in this country, a more rapid development than that observed in most other developed nations. Such trends are projected to continue, while male employment rates in manufacturing industry appear set to fall further. Hence by the first decade of the twenty first century the participation of men and women in the workforce could have reached parity.

The extent to which this will affect informal care arrangements in the community is difficult to predict. Figures from the General Household Survey indicate that around 12 per cent of adult males are carers. The equivalent figure for women is 15 per cent, although the intensity of their input is considerably higher than for men. If male participation rates in 'carer' roles continue to rise then reductions in informal support by women of dependent people living in the community may be compensated for. But if men do not adapt their behaviours additional burdens will be placed on primary health and community care professionals. The stresses of role changes and relationship 're-engineering' could also be a source of psychological distress leading to new care demands.

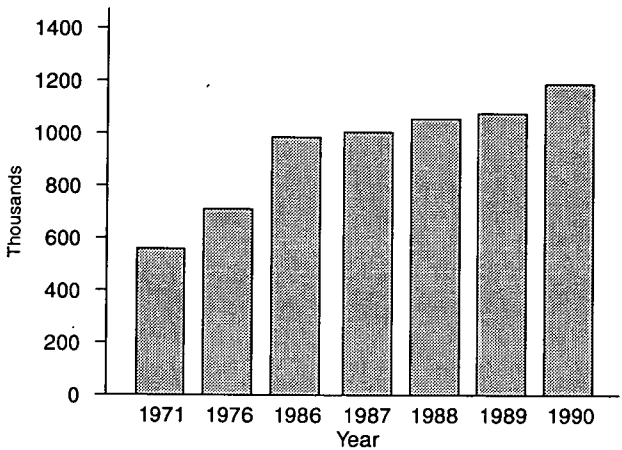


Figure 2.9 Total families headed by one parent

2.6.3 One parent families

Trends such as those displayed in Figures 2.9 have caused apparent alarm in some quarters. The fact that over a third of current marriages are now likely to end in divorce and that one family in six with dependent children is now headed by a lone parent have been taken by some commentators to be evidence of a breakdown of social order and/or a perverse effect of state benefit payments (*Sunday Times* 1993). Such fears have been associated with those related to the formation of an 'underclass' characterised by high rates of unemployment and fertility outside marriage coupled with above average levels of ill-health and premature death. Illegal drug use, inner city violence and other self-destructive behaviours contribute to the latter.

These concerns clearly deserve attention, but should not be exaggerated or accepted uncritically. For example, a strong case can be made against suggestions that welfare payments to poor single mothers should be cut in order to remove any inappropriate incentive to have children. A more productive approach could be to establish better safeguards against poverty, disadvantage and lack of self-esteem as they currently affect significant numbers of potential young single mothers. (Work in this area might also cast light on health promotion issues like smoking amongst young women).

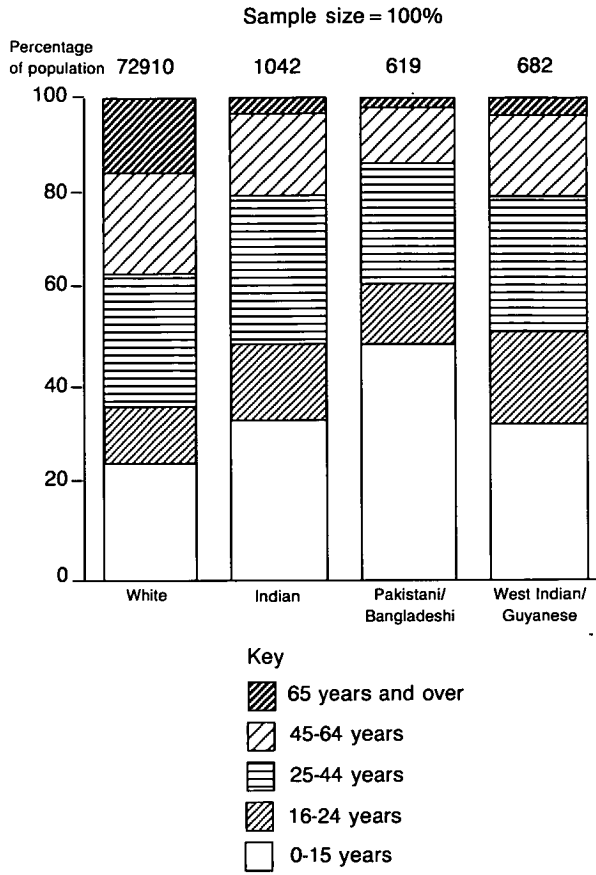
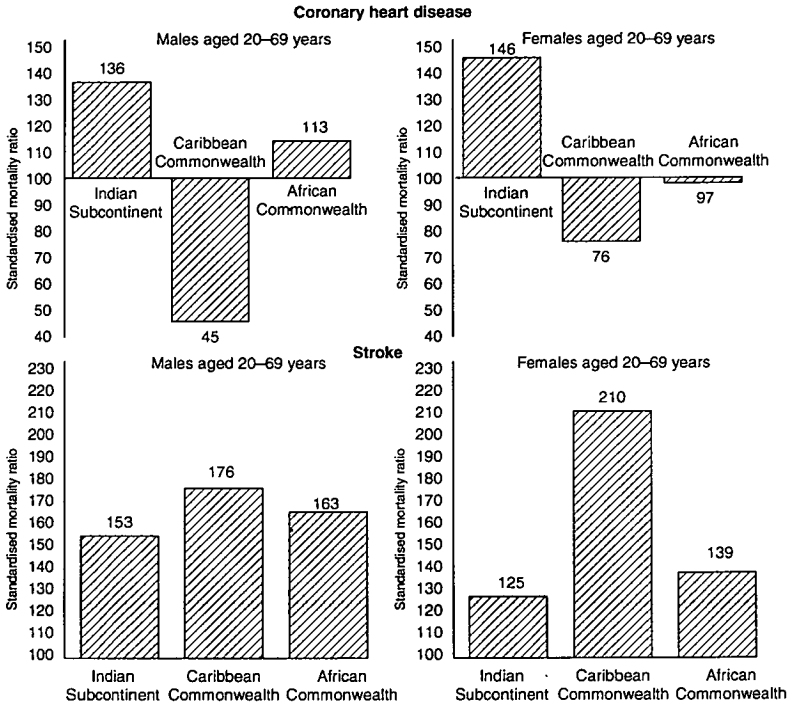


Figure 2.10 Age structure of private household population by age and ethnic group, Great Britain, 1987–1989 combined. Source: General Household Survey 1989, DoH 1992

2.6.4 *The health of ethnic minority groups*

About three million people in the current population of England and Wales (around 50 million) are non-white. About 70 per cent of these individuals live in the major English metropolitan areas. Although people of Irish birth and descent comprise the largest single cultural minority in the UK (and one which is in health terms particularly at risk from conditions



Note: Deaths from coronary heart disease and stroke amongst ethnic groups vary from the average of the whole population of England and Wales (expressed as a standardised mortality ratio where England and Wales = 100); values above 100 indicate higher mortality than the average, values below 100 indicate lower mortality

Figure 2.11 Variations in death from coronary heart disease and stroke by sex and ethnic origin, England and Wales, 1979–1983. Source: quoted in DoH 1992

such as heart disease) those of Asian and Caribbean origin are now the most visible, particularly in the inner cities.

Figure 2.10 shows that the age structure of the ethnic minority community in Britain is far younger than that of the rest of the population; this explains why about 10 per cent of pre-school children in Britain are non-white. Caribbean families are more likely to be lone parent households, while Muslim populations tend to have higher fertility rates than groups with other religious faiths. Both these observations may be related to the position of women in these two quite different cultures.

In the 1992 edition of *On the State of the Public Health* (DoH 1992) the Chief Medical Officer presented a special review of

the health of black and ethnic minorities. It showed that some non-white sections of the community are, in addition to being at raised risk from heart disease and stroke (Figure 2.11), particularly prone to conditions such as diabetes, osteoporosis, blood disorders such as sickle cell disease, and infections like tuberculosis and hepatitis B. The Chief Medical Officer also noted that schizophrenia appears to be between three and six times more prevalent in people of Caribbean origin living in England than is the case with Caribbeans living in Jamaica, a fact which appears to be linked to socially engendered stresses. Other forms of mental illness may be (at least in the NHS context) under-reported amongst some groups, including anxiety and depression amongst Asian women.

To some extent all of these observations are likely to be affected by social class as distinct from ethnically significant variables. For example, higher than average rates of childhood accidents affect all those families living in less advantaged circumstances, not just those who happen to belong to minority groups but who may also be affected by poor housing and hazardous local environments. Even so, there is clearly an important specific challenge facing primary health and other care providers in ensuring that individuals from ethnic minority backgrounds have adequate access to appropriate services. This is particularly relevant in inner city areas, where this country's general practice based services have historically been relatively weak.

2.7. *Conclusions: The challenge for general practice*

There have been, and continue to be, profound changes in the nature of the British population, its health status, and its medical and social care needs and expectations. All the factors described above, from alterations in family structure and marriage stability to the emergence of a multicultural community, can be seen to have been directly or indirectly driven by the forces of national and international demographic transition.

To some, such observations carry extremely negative implications. The ageing of the population alone has been cited as a major threat to the future viability of the 'welfare state'.

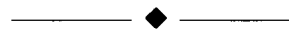
But there is no inherent reason to contradict the belief that, with appropriate effort and personal and collective will, Britain can develop as a successful twenty first century society, offering all members of the population a good chance of healthy and satisfactory lives. To contribute to this, professionals working in settings such as general practice need to develop a realistic understanding of the particular challenges affecting their local communities, and to plan and implement effective strategies to help achieve enhanced welfare. A sensitive and responsive balance between meeting diverse individual health care needs and expectations, and respecting overall population requirements and resource limitations can only be achieved through the active, committed involvement of primary care professionals in both personal care and service management.

Summary

- The process of demographic transition has extensive implications for the health care sector. For example, smaller family units mean that the life of each individual is valued more and more highly.
- Demographic changes have created a gradual realignment of public expectations of, and patterns of delivery of welfare services care transition.
- Patterns of disease and care need are continually changing. Population ageing, changing family structures and multicultural communities all present challenges to health care providers.
- Professionals in primary care need to develop a balanced awareness of both individual patient needs and population wide requirements. Individuals can only be understood in their social context, and populations can only be understood through the individuals in them.

3

INEQUALITIES IN HEALTH



3.1 The scale of health loss

There are many forms of health inequality. They include—in addition to those known to be related to low income and poverty, occupational class and the stresses of unemployment (see, for instance, Moser *et al.* 1991)—age linked variations; gender differences in mortality and morbidity; the apparent influence of marital status on health; variations with respect to ethnicity (discussed in Chapter 2); and health differences related to area of residence. On a pan-European level there are also significant and by no means fully explained contrasts in the mortality and morbidity experiences of the populations of even adjacent nations such as France and the UK, while world-wide there are gross differences in the health and well-being of, for example, the people of sub-Saharan Africa as against those of northern Europe.

A strong case could be made for concentrating on world-wide inequalities as the main problem confronting all modern societies. They dwarf in scale and severity any internal problems affecting countries like the United Kingdom, and if unresolved are likely to present formidable future challenges to trans-continental peace and the maintenance of a viable environment. Even now the tensions between the emergent industrial economies of the 'third world', with their young and expanding populations, and the already developed nations are apparent. (Increased global economic competition is one driving force in the rethinking of welfare system funding in countries like Britain). The possibility of more overt conflicts in the future underlines the potential relevance to the health of all nations of the achievement of global population stability and health equity.

However, confining the analysis to within the UK, a fairly robust argument could be made to the effect that issues such as gender related health inequalities are as important as, and

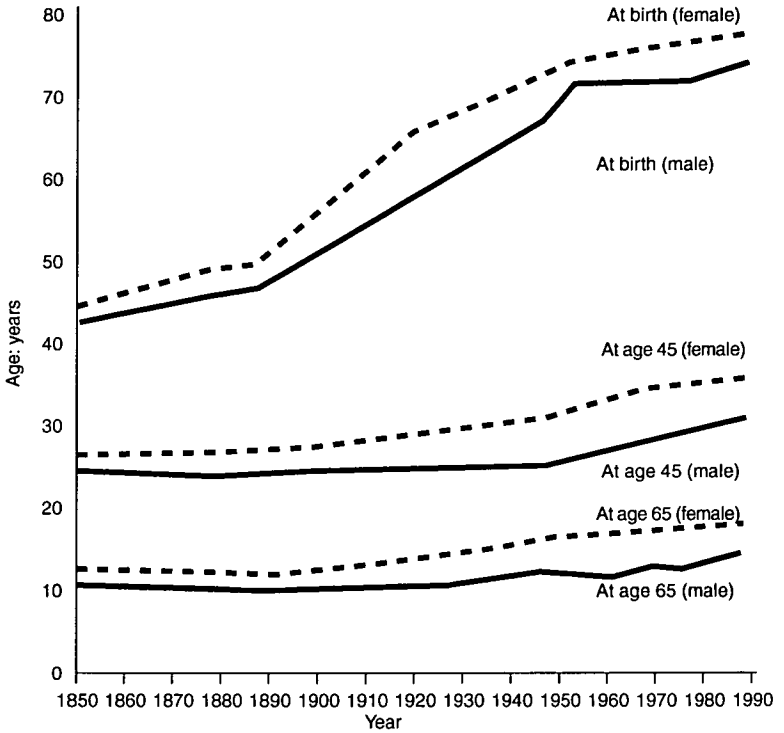


Figure 3.1 Life expectancy in England and Wales. Source: Chew 1992

as undesirable as, those observed in relation to occupational class and income. Crombie (1984) has, for instance, stressed the significance of the consistently expressed male/female death rate disparities outlined in Figure 3.1. They raise important considerations as to how in modern societies social disadvantage might relate to excess mortality. It has been suggested, for instance, that males are more adversely affected by poor material circumstances (not least, perhaps, because of associated behaviours like excessive drinking) than women, for whom social deprivation (defined as a lack of support networks) may be of more significance (Benzeval *et al.* 1992).

The degree to which such observations (and related data such as those showing the higher morbidity rates reported by women as opposed to men) reflect fundamental biological, as

distinct from socially engendered, differences between the sexes is unclear. Reducing violent and destructive behaviour amongst men living in stressful, status diminishing, conditions such as unemployment (or the threat of it) could alleviate not only the associated ill-health burdens but also broader community problems. For example, if one of the elements reducing quality of life for elderly people and others living in poor housing is the perceived threat of attack from young males living in the same localities, then the 'knock-on' benefits of directing more resources to the former might be considerable. Equivalent programmes aimed at giving more social support to women living in isolated and stressful circumstances, such as having to rear a young family in a tower block flat, have already been shown to be of value. (For example, NEWPIN—see Taylor and Taylor 1989).

Another illustration of a significant form of mortality variation is that of regional differentials. Macintyre (1986), in an extensive review of health and social positioning, observed that there are long-standing contrasts between the experiences of people living in the north and south of England. For example, Lancashire had the highest mortality rate in England recorded in the late 1830s, and still does today. Standardised perinatal and infant mortality rates show a marked gradient between the south east and the north west of the country, while in Scotland the life chances of adults in Glasgow appear to be worse than those for people elsewhere in the country, even after adjustment for class and for known risk factors for conditions like heart disease (Watt and Ecob 1992).

It is the issue of social class which has taken centre stage in most British debate on health inequalities, and has to a significant degree influenced governmental and professional approaches to health promotion. Studies such as *The Black Report* and *The Health Divide* (Whitehead 1987) stimulated intensive discussion—amongst middle class observers at least—of the implications of data such as that shown in Figure 3.2. More recently the government's strategy for health in England (Secretaries of State 1992) was criticised for failing to set targets for reducing class related inequalities in health, and choosing to emphasise differences in risk behaviour rather than the poverty and disadvantage of the most vulnerable sections of the community. There were also

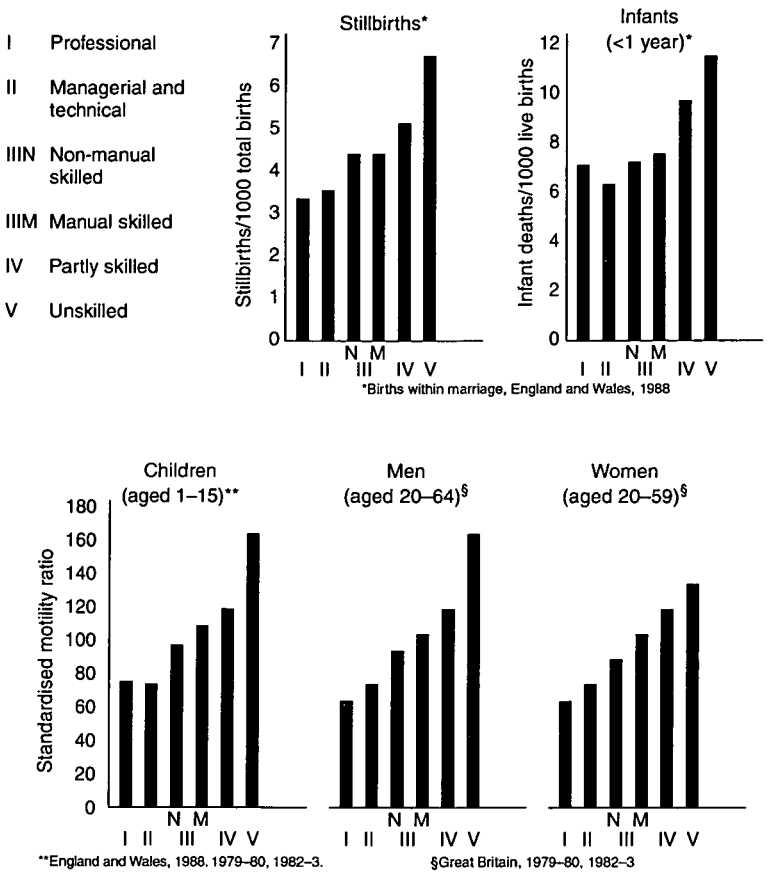


Figure 3.2 Socio-economic class and morality. Note: The available figures indicate that for each year of potential life lost in the working age population in Classes I and II, between two and three years will be lost to individuals in Class V. Figures for stillbirths and infant mortality would, if standardised for factors such as maternal age, show somewhat less of a class shift, although the excess of deaths in Class V remains substantial after such correction. Source: Delamothe 1992, and OPCS

concerns—reasoned or not—that health promotion aimed at the population at large, rather than targeted to the most disadvantaged, would further increase relative health inequalities. Some commentators seem to believe that this

would be inherently undesirable, regardless of observed trends in absolute mortality and morbidity.

This area is complex, often involving abstruse statistical manipulations of epidemiological and allied data coupled with highly contentious political debate. There is a danger that non-specialists may at best feel that they are not qualified to have an opinion, and at worst become cynical about the value and meaning of such work. Indeed, it may well be that the motivations underlying some interventions in this field are questionable. One arguably undesirable aspect of British society is the use elite groups and ambitious professionals alike sometimes make of legitimate concerns about issues like poverty and socially patterned ill-health further to secure their own positions, and so quite possibly the social conditions which perpetuate snobbery and destructive, unfair inequalities.

Nevertheless, there is genuine reason for concern. Unskilled adults suffer over double the standardised mortality rates experienced by their professional peers. The available figures indicate that if people from less advantaged social groups could enjoy the reduced mortality (not to mention the lower morbidity) of those classified as being in class I, some 3000 child deaths a year would be saved in the UK as a whole. So too would a further 40 000 premature deaths amongst adults aged under 75. For anyone concerned with personal or family health care, or broader community health promotion, it must be worth paying serious attention to determining the extent to which, and means by, such massive potential health gains could in practice be achieved.

3.2 The political background

The members of the Working Group on Inequalities in Health (who produced the 1980 *Black Report*) examined four principal explanations for observations such as those in Figure 3.2. They were:

- the possibility that class related health variations might be a statistical artefact;
- the possibility that inequalities in health between social classes are a function of social selection, with healthier people moving 'up' and those with health problems going 'down';

- the degree to which culturally determined and allied 'lifestyle' behavioural factors (such as smoking) generate social class differences in health;
- the extent to which material factors like housing standards, employment status and low income are causal.

The conclusions drawn by the Working Group placed emphasis both on lifestyle and material factors as the key determinants of class related health inequalities. Their report also argued that lifestyle differences were in general a result rather than a cause of the economic infrastructure. To tackle them at root would therefore require basic issues such as relative and absolute poverty to be addressed. Although the report called for interventions such as stronger measures to reduce smoking, it also argued in favour of increased child benefits and similar payments to reduce child and family poverty. The government estimated the cost of the proposals to be around £2 billion (£1980).

The Black Report thus touched on an area of dispute which has been central to the identity of Britain's rival political 'tribes' throughout the twentieth century. (For instance, a Poor Law Commission minority report published in 1905 caused a furore not dissimilar to that which occurred in the early 1980s when the *Black Report* recommended higher levels of welfare payments). At a time when the then new Thatcher administration was determined both to control public spending and create a more competitive (and in taxation terms less redistributive) social environment, it was not surprising that the *Black Report's* recommendations were rejected.

There is still considerable tension surrounding this issue, not least amongst academics. (See, for example, Davey Smith *et al.* 1990a, 1990b, Strong 1990, Baker and Illsley 1990, 1992). However, careful reading of publications such as *The Black Report, The Nation's Health* (a study first published in 1989, which involved the King's Fund, the former Health Education Council, the London School of Hygiene and Tropical Medicine and the Scottish Health Education Group) and *The Health of the Nation* green and white papers reveals a perhaps surprising coincidence of thinking on many important issues.

During the 1980s and early 1990s income disparities have been permitted to rise in the UK, along with long-term

unemployment (Delamothe 1992). However, it appears that the level of consensus about the desirability of achieving better health throughout the population has increased in the last few years. Regardless of disputes as to how best this goal can be attained any group or individual choosing to understate this growing accord about the ends of health promotion may risk undermining the public's interests by needlessly prolonging sterile conflict.

3.3 The statistical record

3.3.1 International comparisons

Class and associated income related disparities in health have been reported throughout modern British history, and in all other communities. Despite claims in *The Black Report* that they have been eliminated in countries such as Sweden this does not appear to be the case (Vagero and Lundberg 1989, Ostberg 1992). Compared to many other parts of North America, Western Europe and the old Soviet block Britain's performance seems relatively good (Fox 1989, Illsley and Svensson 1990, Baker and Illsley 1992, Power 1994). World-wide only Japan can, as a large industrialised country, lay convincing claim to a markedly better overall record of both longevity and low levels of recorded health inequality (Marmot and Davey-Smith 1989).

Yet comparisons with Japan are complicated by factors such as the high level of racial pride and exclusiveness, coupled with the community's strong traditional emphasis on discipline and the domestic role of women. These attributes could help account for Japan's industrial performance, as well as its high standards of infant and child care and low rates of divorce and/or single parent (and hence low income) family formation. Japan's health record could be in part because of choices about lifestyle and behaviour that sections of the British community are not willing to make. In this sense health inequalities are not necessarily unacceptable inequities.

3.2.2 A Victorian legacy

One reason why class-based differences in health status are of particular importance to many British commentators is

probably the unusual extent of the statistical record in the UK. The information available suggests that until the seventeenth century privileged groups such as priests and aristocrats did not, on average, enjoy longer lives than others. High rates of infection and common vulnerability to epidemics and other 'exogenous' environmental hazards, including the risk of death by violence, were responsible for this equity of misery. However, from around the 1600s onwards there is evidence of significant disparities between survival rates of richer and poorer sections of society.

During the early nineteenth century French and British researchers began systematically to relate social conditions to mortality. By the end of the Victorian era, the very high rates of death amongst infants and children in poor families had become an issue of well recognised political significance. For example, the researcher Seebohm Rowntree recorded an infant mortality rate of just under 100 per 1000 live born babies in the better off sections of the population of York during the late 1890s; amongst the poor of that city infant mortality was at that time well over 200 per 1000.

At the beginning of the twentieth century the Registrar General's Classification of Occupation was introduced to help quantify further national health data in class terms. It led, and continues to lead, world understanding of this field. The picture which has emerged between 1911 and the present day is one of greatly reduced overall death rates (average infant mortality is now about a twentieth of that recorded at the start of the century) but of continuing, apparently near constant, proportional differences between the main social groupings. It can today confidently be concluded that disparities in the mortality and morbidity between the Registrar General's social classes in Britain are real, not a statistical artefact, even though some arguments about class inequalities becoming 'worse' may be potentially misleading.

At the time of *The Black Report* there were concerns that because the collection of census data about the overall size and composition of the population is a separate process from that of the recording of deaths, inconsistencies between the two could have promoted a false picture of excess lower socio-economic class deaths. Since then, however, research such as the 'Whitehall' study of nearly 18 000 civil servants and a

Table 3.1 Mortality according to alternative social classifications in the Longitudinal Study

	Mortality 1976–81 (SMRs)	
	Men 15–64	Women 15–59
Car access		
Yes	87	84
No	122	122
Housing tenure		
Owner occupier	85	84
Privately rented	108	109
Local authority	117	119
Educational qualifications		
Degree	51	53
Higher qualification, not degree	75	53
A level & equivalent	87	73
Lower or no qualification	104	103

Source: Davey Smith *et al.* (1990a)

longitudinal analysis of a one percent sample from the 1971 census conducted by the Office of Population Censuses and Surveys (Marmot *et al.* 1984, Davey Smith *et al.* 1990) have shown that this is not the case.

Indeed, figures such as those in Table 3.1, generated by the OPCS longitudinal study, suggest strongly that use of the Registrar General's classification alone understates the impact of material deprivation on health. The reasons why the north/south divide in British health seems stronger than that expected on the basis of class structure alone probably relate to these observations. It is also significant that the first *Health and Lifestyle Survey* (Blaxter 1990) revealed a positive link between various forms of reported morbidity and income, although this is not a simple linear relationship (Figure 3.3).

3.2.3 *Overall progress*

The proportion of the population classified as being in social classes IV and V has fallen significantly in recent decades, from nearly 40 per cent in 1931 to around 20 per cent today. Also, in absolute terms, the reduction in infant and other death rates amongst poorer people recorded in the last 50 years has been

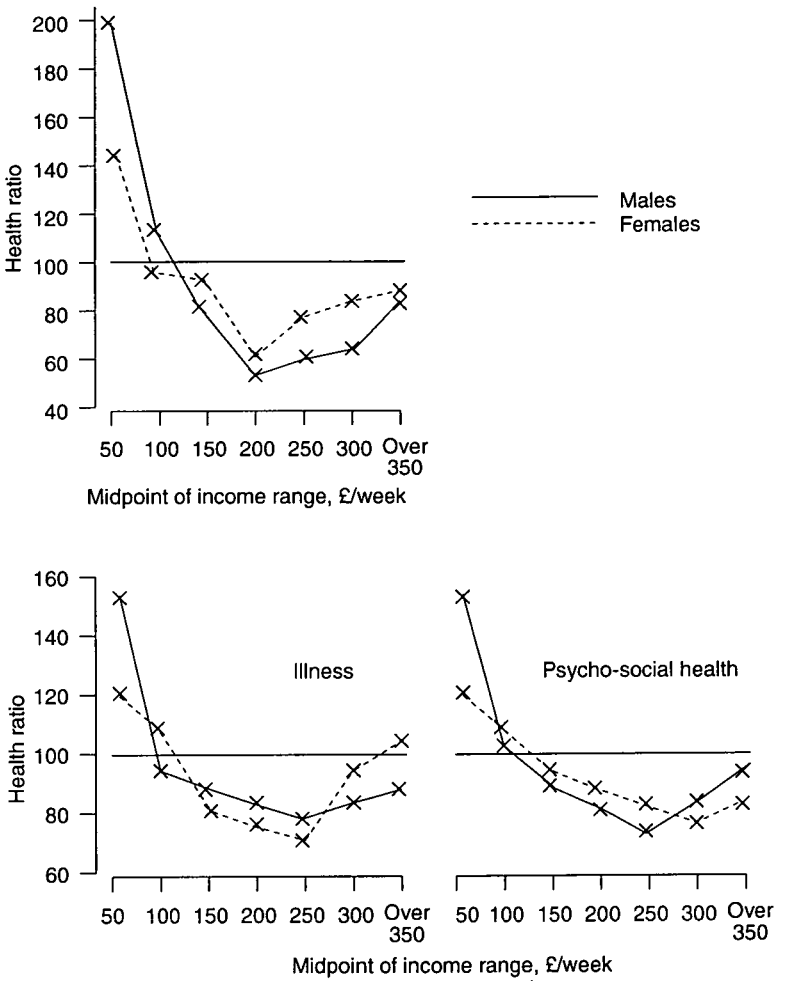


Figure 3.3 Income and health: age-standardised ratios, illness and psycho-social health, in relation to weekly income, demonstrating the effect of £50/week increments in household income, males and females aged 40–59 (all of a given age and gender = 100). Source: Blaxter 1990

greater than that amongst the better off. It would be perverse to argue that today's situation, in which infant mortality amongst professionals is around 6–7 per 1000 live births and that in the 'unskilled' population is some 14–15 per

1000, could be less desirable than one in which infant mortality was, say, 20 per 1000 across the entire population.

Compared with the situation in the 1940s or 1950s today's overall figures are clearly an advance. Reports of a worsening relative gap between social class I and II's mortality experience and that of people in class V thus need to be treated with caution, not least because they could induce an over-defensive response on the part of those responsible for health and social policy. This is not to deny, however, that recent figures such as those from the Northern region (Phillimore *et al.* 1994) deserve serious attention. This study examined data from 1981 and 1991 and showed, in addition to widening relative health inequalities between the most and least advantaged localities, that there appeared to be an absolute increase in mortality in poorer men aged 15–44. The specific factors contributing to this should be identified as a matter of high priority. The government's decision in mid-1994 to set up an inquiry into the links between social disadvantage and ill-health appeared to reflect acceptance of this conclusion.

3.3 Natural selection?

It is intuitively reasonable to argue that observed differences in health between social classes may be related to mobility between social groups, rather than only a reflection of the effect of social conditions on individuals in given groups. There is some research evidence to support this view. In the early 1950s Illsley reported that women who rise in social status at marriage tend to be more intelligent, better educated and physically more robust than those who do not, and that those who fall in status have the opposite characteristics. More recent work on the social mobility of people in adolescence (Glendinning *et al.* 1992) produced similar findings. Figures derived from past Scottish experience indicated that only a third of women bought up in families classified (by father's occupation) as social class IV or V stayed in that class at marriage; and only about 40 per cent of those born into social class I families married men of that status.

Women's educational and health status is linked to the subsequent health status and education of their children. Regardless, therefore, of any data relating to the health of males

who move between classes, the scale of female social mobility before the time of child bearing is probably such that it cannot be ignored as an influence on class related health inequalities. However, it is equally true that it cannot be regarded as a dominant explanation for the observed differentials. Further, it is reasonable to argue that any form of avoidable ill-health should be a matter of concern in a civilised society. Seen from this perspective the issue of social selection in health becomes by itself relatively unimportant. It is more important to identify the mechanisms underlying the social patterning of illness, disability and handicap, and to develop effective ways of preventing or treating such unwanted states (Macintyre 1994—see 3.4 below).

The scale of internal population movements, especially to and from the cities in general and London in particular, is such that they too could have or have had an appreciable influence on observed patterns of morbidity and mortality. Health selection through migration is recognised as a significant factor in international population movements. There is a possibility that it could also help explain some elements of Britain's internal geographical health skews. This has important implications for care provision in areas of high population mobility.

Figure 3.4 shows how heavily the inner London residential population structure is distorted in favour of younger adults. Obviously, any tendency differentially to 'import' or 'export' healthy young or chronically ill older people could influence considerably the value of standardised mortality ratios and other statistics based on static cross sectional views of London's (or any other area's) health. Only longitudinal studies which follow people's health and movements over time can show the extent of such phenomena, and hence whether or not investment in health promotion and care is genuinely sufficient in inner city localities. In the context of primary care such considerations could also be relevant to the question of cash limiting practice budgets in line with formula based needs estimates.

3.4 Socially influenced health risks

Known risk factors explain only a limited proportion of observed class related health inequalities, even allowing for

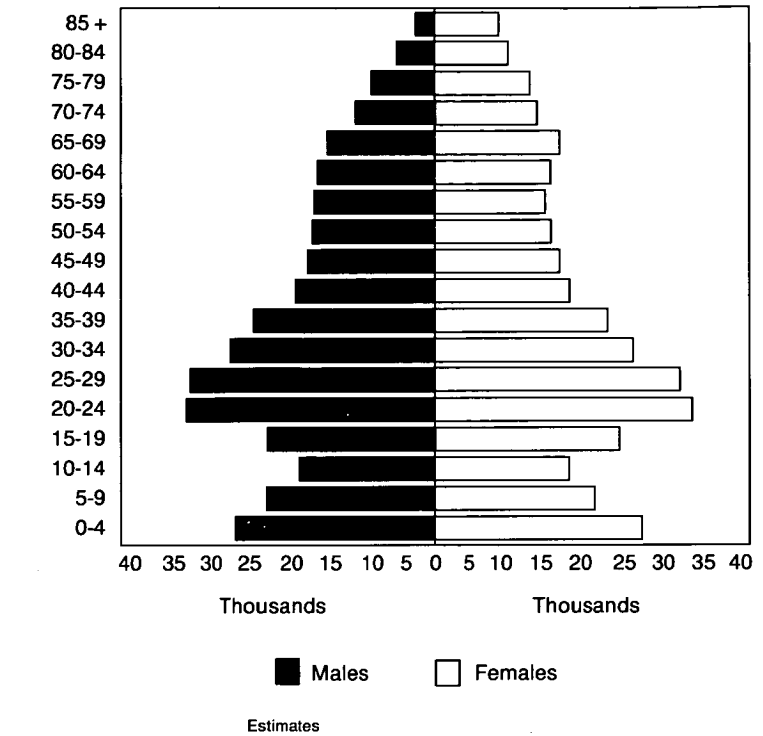


Figure 3.4 Population pyramid for Lambeth, Southwark and Lewisham (1990). Source: OPCS

technical problems such as regression dilution in measuring their significance. Habits such as cigarette smoking can cause conditions such as lung cancer and coronary heart disease, and biological characteristics such as hypertension contribute to conditions like stroke. Even so, a significant proportion of the variance in mortality between the social classes is not explained by identified biological variables. Similarly, the reasons for the correlation between factors such as car ownership, housing tenure and mortality (which exist over and above the health disparities revealed via the Registrar General's classification) are not as yet understood.

The response of some commentators to such observations has been to focus their attention on the general relationship

between relative poverty and ill-health. For instance, Wilkinson (1992) analysed the available international data on income distribution and life expectancy, apparently revealing a powerful relationship. More egalitarian societies, according to this source, enjoy better health (above a basic, quite low, level) regardless of their absolute wealth. He suggests that *'there has been a fall in the importance of the direct physical effects of material circumstances relative to psycho-social circumstances. The social consequences of people's differing circumstances in terms of stress, self-esteem and social relations may now be one of the most important influences on health'.*

Although Wilkinson's analytical methods and conclusions are open to some question many of the ideas about health promotion described later in this book rest on similar conclusions. Such thinking is consistent with the concept of care transition (Chapter 2). This does not necessarily imply an acceptance of assumptions to the effect that rapid, large-scale interventions to reduce income disparities could quickly or effectively eliminate inequalities in health. The costs, in terms of lost social consensus alone, incurred as a result of imposed redistributive measures may prove to be greater than the health gains which might—or might not—result. It does however indicate the long-term direction of change in terms of patterns of expressed authority and social status which may be needed to tackle some of the key problems associated with health inequalities in 'developed' nations.

It is important to clarify the association between relative poverty and enhanced risk of ill-health. A priority task for all social and medical scientists working in this field is to undertake research into the aetiologies of epidemiologically important conditions such as heart disease, diabetes and depressive illness, in order to build understanding of the specific mechanisms which link social and physiological problems. Optimally cost-effective—and politically viable—programmes to reduce of health inequalities require a sound scientific base.

Potential areas of investigation include the hypothesis that immune responses are impaired in individuals under stress, and that pressures associated with being subject to inferior positions in certain forms of social hierarchy cause men (and perhaps women) to have altered plasma levels of proteins such

as fibrinogen (Marmot *et al.* 1984). Similar direct or indirect mechanisms might apply in relation to HDL cholesterol and heart disease.

Links between cardio-vascular disease and poverty during infancy and childhood were reported in Norway more than two decades ago. More recently Barker and his colleagues have put forward their 'programming hypothesis', which suggests that factors such as malnutrition (involving perhaps just specific vital nutrients at particular developmental stages) experienced during fetal life and very early infancy may influence the subject's subsequent vulnerability to ill-health in adulthood (Barker 1992, Barker and Martin 1992). It is also possible that certain forms of bacterial infection may promote vulnerability to cardiovascular disease, as well as other class skewed conditions such as peptic ulcer.

In the area of mental well-being the longstanding work of Brown and his colleagues (Brown and Harris 1978, Brown *et al.* 1972) on schizophrenia and depression also indicates a complex relationship between social experience and short or long-term disposition to organically based psychiatric disorder. Work by neuropharmacologists is now beginning to reveal the mechanisms through which these relationships may be mediated. For example, it is now thought possible that prolonged periods of stress relatively early in life (resulting in physiological effects such as raised levels of plasma cortisol) induce brain chemistry changes rendering affected individuals subsequently vulnerable to depression and anxiety (Gerston and Rieder 1992).

3.5 Implications for primary care development

The information on health inequalities and related social trends summarised above may at first sight have little relevance to the day-to-day challenges facing a busy general practice. It may be true that a greater national and local attention to road accident prevention, housing standards, air quality, education, employment and safety at work has considerable potential to improve the life expectancies of less advantaged community members relative to those of their better-off peers. But can family doctors and their practice colleagues, already often hard pressed by demands for immediate medical treatments, possibly influence such environmental factors, much less the

tidal flows of social and demographic history taking place around them? Apart from immunising those in need of such protection and giving well researched, effective treatments and life-style advice of proven value to patients at risk of ill-health, can they and should they try to play any broader role in health promotion? Indeed, has too much already unrealistically been asked of them?

The analysis presented in later chapters accepts that there are dangers in overloading or over-extending the role of general practitioners, particularly if this involves implementation of politically inspired prescriptions of no clearly demonstrated health value. Nevertheless, the GP and his or her practice based colleagues do not merely serve as 'the gateway' to the health service, passing patients with serious care needs on to other centres. The referral function is of course important. But general practitioners are the main providers for most health service users most of the time—good quality care delivery depends on their performance and the level of support practices are given by the rest of the NHS. General practices are arguably the most universally accessible of all health and other welfare facilities; contrary to fears raised in *The Black Report* most socially less advantaged NHS users see their family doctors as or more often than the rest of the population. Individuals working in primary care are also a potentially vital source of information and guidance for other professionals and agencies whose role is to plan and purchase care—including health promotion—at a locality level.

Seen from this perspective general practice is of pivotal significance. For patients in direct need of help and personal support the family doctor and his or her practice colleagues can provide an immediate, tangible, response. This puts such staff in a trusted position to communicate longer-term health messages. Given the time and appropriate competencies they can also mediate between service users, secondary care providers and other, less directly involved but perhaps more broadly informed, health policy decision makers.

Britain's heritage of general medical practice therefore offers, despite some recognised weaknesses, a base upon which to build a genuinely integrated, consumer focused approach to health care and health promotion. It should be able to make an important contribution to minimising health inequalities

in the twenty-first century. Through initiatives such as fund holding and locality purchasing programmes attempts are now being made to exploit this opportunity, although all sides involved in such work need realistically to understand the scale and complexity of the task they are undertaking.

It will require very considerable development effort to equip practices and practitioners with the technical, managerial and social skills needed to achieve a primary care led 'health market' which genuinely serves the public's interests, although this is not to deny the desirability of attempting to achieve this goal. It may be argued that a fundamental danger to avoid in the coming decade is the alternative prospect that practice level patient care may become excessively controlled and routinised and so reduced in status, flexibility and value to its end point users, while consideration of 'higher level' public health, disease prevention and service management issues becomes confined to a remote stratum of specialist professionals and 'purchasers' working in agencies whose role and nature are incomprehensible to ordinary people.

Summary

- Forms of health inequality include those related to income, occupational class, age, gender, marital status, ethnicity and area of residence.
- The issue of social class has taken precedence in the UK debate on health inequalities. It has been subject to political polemic and academic wrangling.
- Known risk factors explain only a limited proportion of observed class related health inequalities.
- GPs are the main providers for most users of the health services. They are the most universally accessible of all health and welfare facilities and are a vital source of information and guidance for those currently commissioning local health promotion and health care provision.
- Further devolution of purchasing power and service choice towards the patient/primary care level will demand considerable developmental effort. Cascading the devolution of power on towards the consumer is, however, an inherently desirable goal.

4

FROM BEVAN TO GRIFFITHS— THE NHS FROM THE 1940s TO THE 1980s

4.1 General practice in the early NHS

Box 4.1 outlines the origins of Britain's main health care institutions. The creation of the National Health Service was strongly influenced by social events associated with the second world war. This stimulated a period of unusually strong consensus, and questioning of traditional values and class distinctions within British society. It also offered, through innovations like the Emergency Medical Service (established in anticipation of massive civilian casualties from air raids) practical illustrations of how the planned and co-ordinated utilisation of hospital and allied facilities could enhance the efficiency and effectiveness of the nation's health care. The result was widespread acceptance of the need for reform, and a desire for the establishment of services which would be adequate to meet the needs of everyone in the peace-time to come.

This spirit was reflected in the 1942 Beveridge Report (Cmnd 6404), which recommended a post-war system of publicly funded and provided welfare services. A comprehensive national health system was seen to be a central component of the latter, and the wartime coalition government moved swiftly to determine the form it should take.

The initial proposals in 1943 envisaged a unified health service administration, linking under one body hospitals, local government health care and general medical practitioners. The latter were to be salaried. The perceived role of general medical practitioners was influenced by the conclusions of the seminal 'Dawson Report' (Ministry of Health 1920), which had called for an integrated health service based on expanded primary health care centres.

Responses to these suggestions were mixed. The British Medical Association feared excessive influence on the part of

Box 4.1 Stages of Health Care Evolution

Stage 1: Before the seventeenth century
The early origins of institutionally based care can be found in the support for sick and destitute people offered (through the Roman Catholic church) in the medieval monasteries and the first of the voluntary hospitals. St Bartholemew's, for instance, was founded in 1123. Most care was informal, however, or derived from the commercial activities of a wide range of providers, including spicers and fairground traders.

Stage 2: From 1600 to 1800
It was during this period that the Church of England became established and a secular system of poor law outrelief developed. Towards the end of the eighteenth century, when the first phases of industrialisation were taking place, the workhouse system came into being. Bodies like the Royal College of Physicians and the Society of Apothecaries (founded in 1677) heralded the arrival of modern professional groupings and structures.

Stage 3: The Victorian era
During the nineteenth century rapid population growth, urbanisation, industrialisation and institutionalisation of the poor sick took place simultaneously. For example the 1808 County Asylums Act enabled local authorities to establish (often rurally situated) facilities for the insane, and the 1834 Poor Law reforms opened the way to an expansion of that system's town and city centred provisions; these were run not by local authorities but via an independent, national, system of commissioners/guardians.

The Medical Act was passed by Parliament in 1858. Following it general medical practice emerged as a clearly defined part of a unified medical profession. (General medical practice's roots can be traced back to the apothecaries, who split in the first part of the nineteenth century into the pharmacists in one branch and the nonphysician doctors on the other).

For most of this period people avoided admission to hospitals wherever possible, with the better off preferring to be treated by specialists at home. But by the end of the Victorian era London in particular, then the richest and largest city in the world, had a significant number of private for profit hospitals. These operated alongside the major voluntary/teaching institutions, poor law hospitals, and the asylums ringed around the city.

Stage 4: The early modern period
By the first decades of the twentieth century medical interventions had become advanced enough usually to save lives rather than to endanger them. Specialists became mainly confined to hospitals in the UK. By the beginning of the 1930s control of the old 'Poor Law' institutions had passed to the local authorities, and publicly funded hospital provisions were significantly improved in some, but by no means all, localities.

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Middle class consumers became increasingly concerned about costs of private hospital care, and, in part as a result, support for a comprehensive national insurance/health service began to build during the interwar period.

On the family practitioner/community side the 1911 National Insurance Act laid the basis for a compulsory primary care insurance system, financed via several thousand separate funds but coordinated by a nationwide system of Local Insurance Committees. This scheme was initially narrow in focus, covering only lower paid (usually male) workers. Mother and child care and support for unemployed adults was initially available through the school and local authority community services, although as the first half of the twentieth century unfolded the scope of the national insurance arrangements widened. For example, dental care gradually became available, alongside coverage for workers' dependents.

Stage 5: The first NHS 1948–1990

In the period of strong British social consensus immediately following the second world war, the NHS was created as a comprehensive, universally available, general taxation funded, service. Its widely understood and applauded task was to provide the best possible medical care to everyone in need, regardless of their ability to pay.

Its structure, the development of which is discussed in Chapter 4, carried the community through the closing stages of the process of infectious disease/infant mortality reduction which had commenced during the Victorian era, and into the current situation of an older population facing high levels of chronic, disabling disease. Whereas better nutrition and the control of environmental hazards like polluted water was the central contributor to enhanced health in the Victorian era, the extended use of antibiotics and other pharmaceuticals prescribed by both family and hospital doctors was one of the dominant characteristics of health/medical advance in the second half of the twentieth century.

Stage 6: The NHS from 1990

The development of the NHS following the reforms embodied in the 1990 NHS and Community Care Act is discussed in futher detail in Chapter 5. The introduction of the purchaser/provider divide coincides with a number of other watershed changes likely to have a profound impact on the future of the health service in general, and general medical practice/primary care in particular. They include a shift back from hospital centred care to, where possible, the delivery of treatments in home/community settings; a movement of services allied to daily living support out of health into social care; and a stronger focus on the maintenance of health (health promotion) as a priority, as distinct from the delivery of health care.

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The desirability and longer term viability of some moves related to theses ends may be questioned. Yet there can be little doubt that pressures for such changes will, alongside altered patient attitudes and service expectations, cause major reorientations within the health care world during the coming decade.

local government and allied interests, including the Medical Officers of Health—the forerunners of today's specialists in public health (Levitt and Wall 1992). Following further public debate the 1944 white paper, *A National Health Service* (Cmnd 6502) proposed a less unified approach. One significant policy modification was the concept that general medical practitioners would be independently contracted to a central board, unless they chose to work on a salaried basis from health centres.

In 1945 Attlee's Labour administration gained power and Aneurin Bevan became Minister for Health. The plans for a National Health Service underwent further modification. The final result was a structure less radically different from that which had preceded it than is often assumed—see Figures 4.1 and 4.2. The new NHS offered comprehensive health care for all regardless of their ability to pay, and its creation represented a step forward not just in British, but in world-wide, terms. It was in this sense a victory for 'equity, rationality and

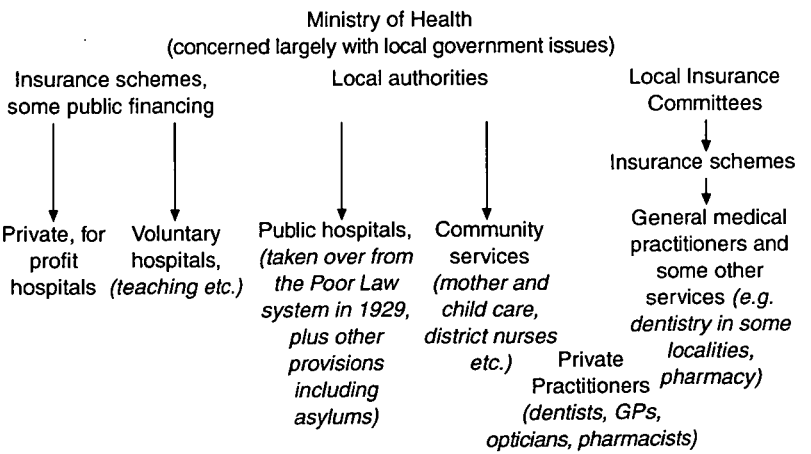


Figure 4.1 Before the NHS—English health care in the 1930s

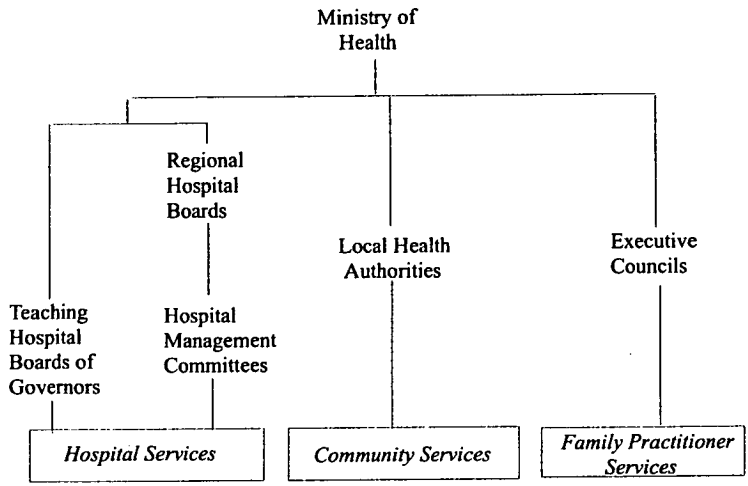


Figure 4.2 The NHS 1948–1974

efficiency' (Klein 1983). But organisationally it represented an arguably less than ideal compromise between such values and the interests of the sectional groups most powerfully involved in health policy formation and care delivery.

This conclusion was to a degree borne out in the early 1950s by the personal comments of Sir John Maude, a member of the Guillebaud Committee of Enquiry into the cost of the health service. The committee's 1956 report (Ministry of Health 1956) found that despite fears that a tax funded service free at the point of demand would lead to unchecked, wasteful, public spending (which at the start of the 1950s had led to the introduction of prescription and dental charges by the then Labour government of the day) the NHS's overall use of resources was adequately controlled. But Maude argued that the tripartite structure, with few horizontal links between its separate branches and only very loose vertical co-ordination, could not deliver care in an optimal manner. His favoured solution was, ultimately, a transfer to unified local authority responsibility. This is a theme which has since recurred in the thinking of many other commentators, especially those tending towards the political left. However, the key point is that, whatever the structural mechanisms preferred, calls for closer

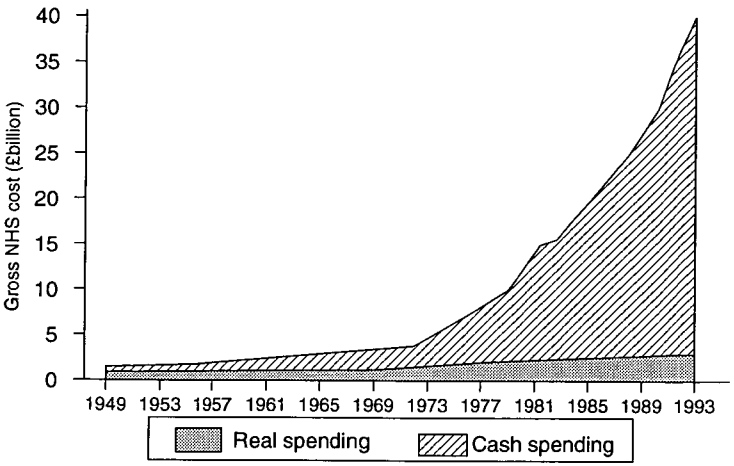


Figure 4.3 Gross cost of the NHS, UK. Adjusted by GDP deflator at factor cost. Source: Chew 1992

integration between the main elements of the health service date back to the very beginning of the existence of the NHS. Understanding the reasons why this aspiration has been difficult to translate into practical reality is central to a balanced appreciation of the likely future of general medical practice, and that of primary health care overall.

4.2 Developments during the 1960s

During the first two decades of its existence the resources available to the NHS grew relatively steadily (Figure 4.3). Their distribution was largely determined by the pre-existing patterns of supply and demand. The grossly uneven geographical spread of acute hospital and allied provisions was not really challenged until the 1970 'Crossman formula' began to focus attention on patient population sizes and structures rather than historic levels of provision. However, many other significant developments did take place in and around the 1960s. These include:

- **the 1959 Mental Health Act and, in the area of learning disabilities, the progress initiated via the 1971 White Paper *'Better Services for the Mentally Handicapped' (Cmnd 4683).***

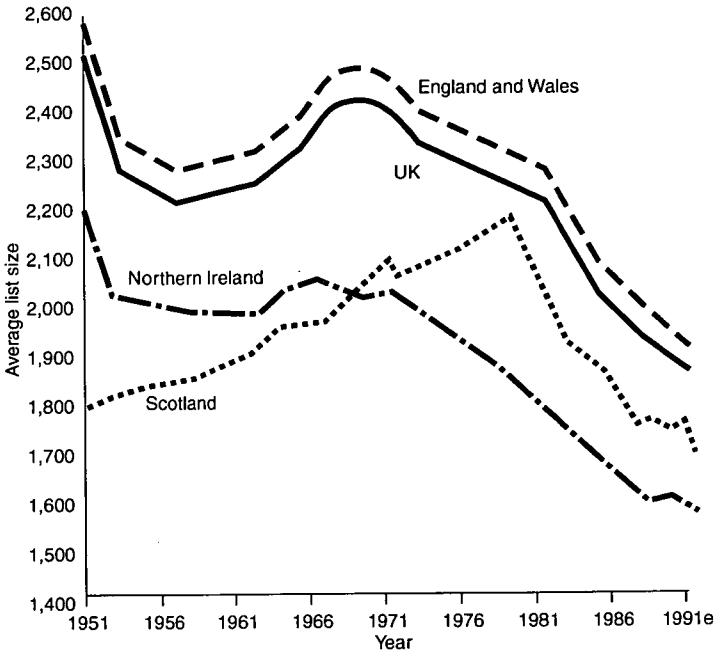
Even at the start of the 1990s there were still around 40 000 occupied beds in English hospitals for people with mental illness, and over 20 000 in traditional institutions for those with learning disabilities. To some commentators these seem high figures; there is a case for arguing that the rate of closure of the older hospitals, and the build up of adequate alternative provisions, has been disappointingly slow. But in the 1950s the number of beds in mental illness hospitals was over 150 000, and that for mental handicap around 60 000.

In the field of learning disabilities the NHS was beset by a number of hospital scandals, of which the 1969 Ely revelations were the most dramatic. Independent academic research also helped to draw attention to poor conditions. However, following *Better Services for the Mentally Handicapped* there were fundamental revisions in the health service's approach to this client group. In retrospect the most important questions (which also apply today) relate to what degree better planning and stronger management systems could have taken forward reforms in areas like mental health and learning disability more smoothly, and without the external stimuli of scandals.

- **the 1962 Hospital Plan for England and Wales.**

This illustrated that at that time nearly half the nation's hospitals dated back to the 1890s or before; such facilities were in many respects ill-suited to the changing needs of the British community. For instance, the decline in the morbidity burden imposed by tuberculosis meant that, even though only a decade or so earlier Bevan had recognised a need for more TB beds, the often isolated sanatoria were no longer required. The plan envisaged a gradual process of reorganisation, with the closure of smaller outlying facilities and the development of district general hospitals in each locality. The subsequent *Bonham Carter Report* (DHSS 1969) suggested that DGHs might be very large, with as many as 1000 or 1500 beds.

At the time of the Hospital Plan's publication the then Health Minister, Enoch Powell, first predicted a rapid decline in the number of traditional mental hospital beds. The fact that relevant service developments have taken place only slowly emphasises the problems the NHS has had in both implementing centrally determined policies in 'the field', and



Note: All figures relate to 1 October and 1 July in Northern Ireland

Figure 4.4 Average list size of unrestricted principals. Source: Chew 1992

co-ordinating developments. Powell said of the old hospitals: *'There they stand, majestic, imperious, brooded over by the gigantic water-tower and chimney combined, rising unmistakable and daunting out of the countryside, the asylums which our fore-fathers built with such solidity. Do not for a moment underestimate their power of resistance to our assault. . . .'*

The Minister could also have added that it would be equally wrong to underestimate the problems of establishing alternative—non-hospital—services. His Hospital Plan was an attempt to rationalise and better to direct NHS resource use. But it failed realistically to predict the costs of the developments which it advocated, or to analyse adequately the problems inherent in policy implementation. This is why it ultimately had less impact on the history of NHS than it at first promised.

- **the 1965 'Doctor's Charter', which reversed the decline in British general medical care which had taken place during the 1950s and early 1960s.**

From the mid-1950s onwards general practitioners' list sizes rose throughout the UK (Figure 4.4). At the same time the number of GP trainees dropped to a nadir of just 200 in 1965. The equivalent figure was 400–500 in the early 1950s. (It stood at over 2000 at the start of the 1990s). Such trends reflected a crisis in the confidence of general practice; family doctors were often seen by their peers as relative failures, who had 'fallen off the career ladder of medicine'. Many worked from inadequate premises, with few if any staff to support them. However, following the election of a Labour government in 1964 and the appointment of Kenneth Robinson as Health Minister, the 1966 Charter improved the remuneration of family doctors. Introduced after strong pressure from the BMA/GMSC, it also contained innovations such as the ancillary workers scheme, which reimbursed GPs for 70 per cent of the cost of practice staff such as receptionists.

These reforms gave family doctors new incentives to expand and develop their practices, and enabled changes in the standards of primary medical care in many parts of the country. However, problems remained in the inner cities and poorer rural communities, where the economic conditions for practice development were (and still are) less favourable. The practitioner level incentive led family health services development programme initiated in the 1960s was in many areas relatively successful. The comparison between this and the slow development on the 'planned' hospital side continues to offer important insights into today's NHS development options, three reorganisations and almost three decades later.

There were many other instances of significant change in the NHS and related services in the 1960s. In nursing and social work, for example, the Salmon (Ministry of Health 1966), Mayston (DHSS 1969) and Seebohm (Cmnd 3703, 1968) investigations led to the restructuring of professional relationships. These may have reinforced functionally based divides within the health and welfare services, which inhibit effective cross-boundary working. The 'Cogwheel' reports, the first of which was produced in 1967, promoted changes in the

organisation of hospital medicine, to a degree serving to herald the resource management initiatives of the late 1980s. But as the decade progressed, public debate began to focus on questions relating to the overall structure of the NHS and its relationship with local government controlled provisions.

4.3 The 1974 changes

In 1962 the report of a Review Committee chaired by Sir Arthur Porritt argued strongly in favour of a more unified NHS: *'the advantages of the preventive and personal health services and their effective integration with the family doctor and hospital services can only be achieved by transferring both services and staff to the (proposed) Area Health Boards'* (Medical Services Review Committee 1962). This conclusion, reached by a body representing the medical Royal Colleges, the then College of General Practitioners, and the BMA was not only similar to views on an ideal structure of the NHS expressed in the early 1940s, but also offered a foretaste of more recent thinking on health service development needs. (See, for example, NHSME 1991).

The Porritt report, like many previous documents, failed to tackle coherently the organisational problems inherent in creating a 'single,seamless, NHS' (Taylor 1984). But when in the mid-1960s political decisions were taken to reform the structure of local government, it provided a convenient starting point for those wishing to design more complementary and effective NHS and local authority service formats.

Kenneth Robinson's green paper, *'The Administrative Structure of the Medical and Related Services in England and Wales'* (Ministry of Health 1968), proposed the creation of 40–50 Area Boards. These were to be responsible for the management of all services, including those offered by independent contractors, and were to link directly to the Ministry. However, this plan, with its relatively clear-cut managerial emphasis, was not implemented, partly because of concerns within the Labour party about excessively strong central control.

There followed a second Labour party green paper, *'The Future Structure of the National Health Service'* (DHSS 1970). This doubled the number of Areas proposed, and re-introduced the concept of a regional tier, while confirming that health

would remain a central rather than local government function. However, local government retained important public health responsibilities and control of the social services, with inter-service co-operation encouraged and facilitated by making the new Areas coterminous with local authorities. Richard Crossman's green paper (he became Secretary of State at the end of 1968) also suggested that health authorities should include both local authority and professional members, and that local committees might be formed to involve both members of 'the community' and health service workers in the running of the NHS.

However, the Conservatives were returned to power in the 1970 general election, and it fell to Keith Joseph to continue the planning of the first major restructuring of the NHS. This took place in April 1974, simultaneously with local government reforms. Important facets of the revised health service structure, outlined in Figure 4.5, included:

- **the creation in England of 14 Regional and 90 Area Health Authorities (AHAs) with executive powers, together with just over 200 District Management Teams.**

AHAs were coterminous with the local authorities, although the Districts (based essentially on hospital catchment areas) often straddled local government boundaries. The role of the upper tiers was centred on performance monitoring and strategic planning, that of the Districts on operational matters. A complex planning cycle was introduced, and heavy emphasis placed on 'management by objectives', and 'accountability upwards balanced by delegation downwards'. But managerial staff at the various levels were not actually in direct lines of accountability, and decision making within the tiers was dependent on consensual agreement.

- **the preservation in England and Wales, but not Scotland or Northern Ireland, of the separate system of Family Health Services administration.**

The old Executive Councils were converted into Family Practitioner Committees (FPCs), with boundaries matching those of the AHAs. At the time some commentators suggested that in as much as the FPCs were 'serviced' by the AHAs (that is, they were not employing authorities) they had effectively been

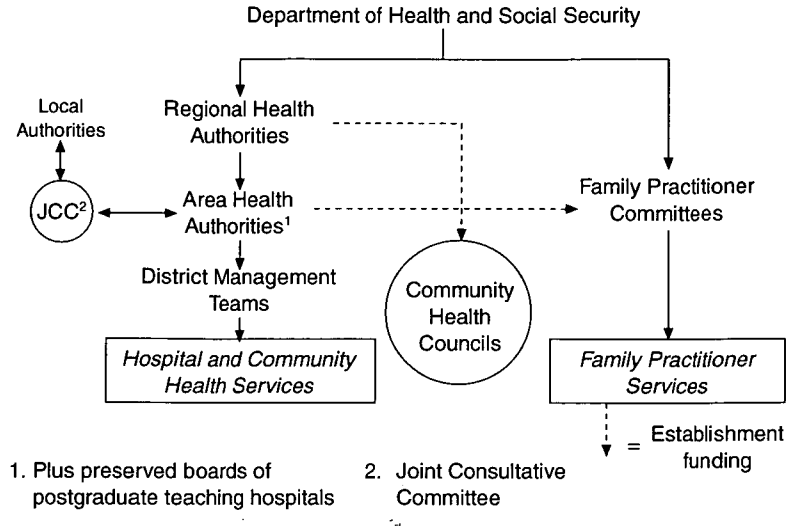


Figure 4.5 The English NHS 1974–1982

incorporated into a unified structure. However, this was neither legally nor in practice the case. They remained separate, independent, and in many respects syndicalist in nature. The result was that the NHS shifted from becoming tripartite to bipartite, with community services such as district nursing linked to the hospital oriented RHA/AHA/DMT management chain rather than the independent contractor/primary care side of the service.

- **the formation of Community Health Councils (CHCs) to 'represent consumer interests in the NHS' at the District level.**

This proved to be one of the most interesting and original aspects of the 1974 changes, even though CHC activities have sometimes been bitterly resented by NHS managers and appointed authority members alike. Local authority members were also to be appointed to Area Health Authorities.

4.4 The emergence of general management

4.4.1 Expenditure control

A Labour government was re-elected at the beginning of 1974, shortly before the reorganisation took place. Barbara Castle

was appointed Secretary of State for Health. The plans approved by her Conservative predecessor, Keith Joseph, were already quite close to those outlined in Richard Crossman's 1970 green paper. However, Mrs Castle moved swiftly to strengthen local government representation on NHS Authorities, in part by extending it to RHAs. She also gave the new CHCs formal powers relating to the approval of hospital closures (Democracy in the National Health Service—DHSS 1974).

During the second half of the 1970s (leading up to the election of 1979, and the first term of Mrs Thatcher's administration) there were a number of important internal developments within the NHS. These included the publication of the first comprehensive analysis of NHS spending patterns and projections, *Priorities for Health and Personal Social Services in England* (DHSS 1976a), which was the national level starting point for the new NHS planning system; the introduction of joint financing arrangements, through which AHAs could help initiate new local authority projects; and the start of RAWP, a new approach to NHS resource allocation.

In the field of health promotion the publication of *Prevention and Health: Everybody's Business* (DHSS 1976b) was a significant attempt to develop a more comprehensive policy approach. It identified several areas of special importance. These included smoking, alcohol usage, the reduction of heart disease, water fluoridation and road traffic accidents. As such it touched on much of the ground more recently explored in the *Health of the Nation* programme (containing the 1990's outcome focused priorities), although it offered relatively little in practical terms to facilitate positive action to promote health.

The *Prevention and Health* initiative did, however, lead on to the establishment of the 'Black' working party on inequalities in health (see Chapter 3). In addition it triggered a vigorous, and controversial, advertising campaign by the Spastics Society on reducing the numbers of low birth weight babies. (The complexity of the relationship between low birth weight and cerebral palsy has since become more apparent). It also served officially to mark a change in the nature of government thinking about public health, which to one degree or another began to take place throughout the developed world in or around the middle 1970s. (See Box 4.2). Internationally the

Box 4.2 Changing concepts of health and illness

Illsley (1977) described the shifts in emphasis in thinking about illness and health which bacame apparent during the 1970s as in outline involving the following elements:

Illness	Health
Treatment	Cure
Disease	Behaviour producing disease
Individual	Population as unit of treatment
Illness as a concern of the medical profession	Health as everybody's business
Right to treatment	Right to end duty to remain healthy

Many commentators have seen this process as representing an inherently desirable trend away from relatively narrow medical models of health (i.e. the absence of disease or disability) towards a broader 'social' understanding of the determinants of physical and mental distress and/or successful coping with life. However, there is an obvious risk that such thinking could undermine awareness of the care needs of particular individuals or groups, and in some circumstances lead to 'victim blaming'. Driving forces underlying the conceptual revolution indicated above included both increasing political concern about the rising costs and decreasing returns associated with virtually all forms of conventional health care provision, and rising public expectations of full, disease free, lives.

Sources: Illsley R (1977), Allsop J (1984).

most important example of this trend was the Canadian white paper, *A New Perspective on the Health of Canadians* (also known as the Lalonde Report) published in 1974.

One factor which was causal in promoting new thinking about health care at that time was the 'oil crisis' of the early 1970s, and the consequent downturn in world economic growth. The latter lead to a near universal questioning of levels of health spending, and of the role of health services in

achieving good health. In the UK this had a profound effect on the direction taken by the newly reorganised NHS. A structure which was designed for conditions of growth and service extension had to face from its establishment relative economic austerity, associated with a general decrease in political support for additional health resources.

Under Labour firm cash limits were introduced into government (and most NHS) expenditure planning, and the NHS capital expenditure programme was severely cut. After 1979, with the Thatcher administration in power and commitments to the NHS made in the run up to the general election absorbed, overall NHS spending was stabilised (frozen) at about six per cent of gross national product (at factor cost). This is approximately the level at which it stood up to the start of the 1990s, since when further downturns in the economy had the effect of increasing the share of national wealth going to the relatively protected NHS. It now stands at about 7 per cent of GNP but is projected.

4.4.2 *Further restructuring*

In addition to economic pressures the NHS was during the later 1970s exposed to tensions resulting from conflicts over issues such as private practice and pay beds (leading to the 'Goodman compromise') and the teething pains of the reorganised NHS itself. These lay behind the Labour government's decision to set up the 'Merrison' Royal Commission on the NHS, which reported in the summer of 1979. This document pointed to many positive aspects and achievements of the NHS. It also suggested that the NHS should in future pay more attention to health promotion, and argued that the structure established in 1974 had too many tiers, and was too bureaucratic.

The new Conservative administration reacted rapidly to the latter finding. In December of 1979 the Department of Health published *Patients First* (DHSS 1979), a consultative document which proposed a reduction in the number of levels of NHS authority and suggested target savings in NHS administrative costs. Its very title (like *Working for Patients* a decade later) signalled an intent to confront the perceived dominance of provider and professional interests in the NHS. It was clear

that the Thatcher approach to the public sector was fundamentally different from that of all previous post-war governments.

On ideological grounds the NHS was clearly a potential target for reform by the 'radical right', although some sources suggest that early investigations of the extent to which the British health care funding system might be revised and/or privatised met strong opposition from within the Conservative party itself, as well as criticism from external professional advisers. One concern was that any viable alternative would probably increase overall British health care spending faster than the general taxation funded NHS approach. Another was that groups representative of Conservative women appeared to value highly NHS care for their families, particularly as provided free at the point of demand through the general medical practitioner system.

During the early 1980s, therefore, the developments introduced by the Conservatives concentrated on improving the NHS by enhancing its capacity to deliver value for (controlled levels of) public money, rather than fostering a major move towards increased personal or private payment for care. In addition to the implementation of policies designed to redistribute more equitably NHS resources across the country (although not necessarily between Scotland, England, Wales and Northern Ireland) key measures in the early 1980s included:

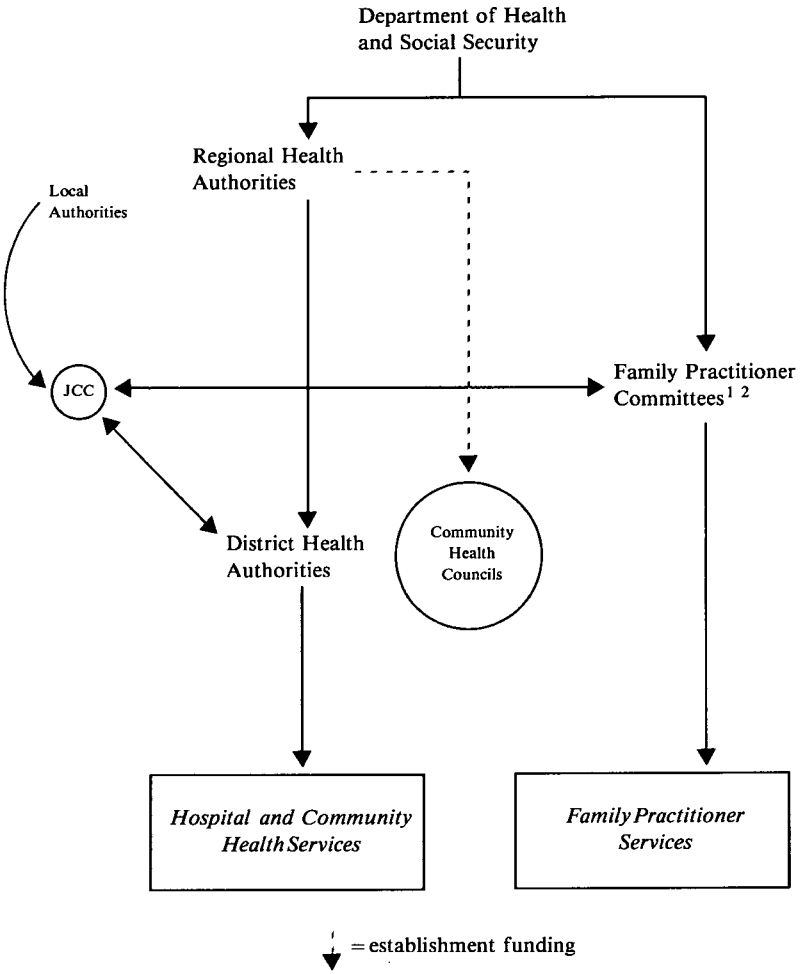
- **The 'Care in the Community' (DHSS 1981) reforms.**

These built on joint financing arrangements between health and social services created in the 1970s, in essence to permit health authorities further to initiate, support and direct funds towards service developments in the local authority controlled sector.

- **The 1982 reorganisation.**

This eliminated the Area tier of the NHS structure in England, and created the District Health Authority based system outlined in Figure 4.6. Emphasis was also placed on enhanced unit level management.

- **The 1983/84 'Griffiths' Management Inquiry, and the subsequent introduction of general management in the NHS.**



1: FPCs 'independent' from 1985 2: FPCs represented JCCs from 1985

Figure 4.6 The NHS in England 1982–1991

This led to fundamental changes in the style of NHS management, breaking away from the functionally oriented consensus based approach and providing a mechanism for reducing bureaucracy and breaking deadlocks in decision making. It also stimulated the creation of Supervisory and Management Boards at the top of the NHS structure which, at

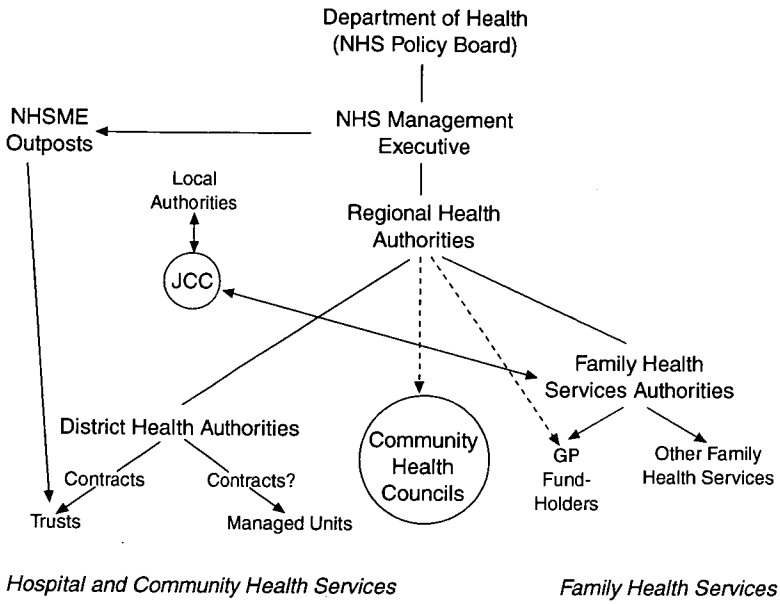


Figure 4.7 The NHS in England 1991–1994
See also Figure 5.1

the start of the 1990s, were superseded by the Policy Board and NHS (Management) Executive format indicated in Figure 4.7.

The Griffiths changes proved to be amongst the most significant ever to affect the NHS, although initially they were focused only on the DHA rather than the then FPC side of the service. Indeed, in the early to mid-1980s it seemed that the independent contractor provided family health services were to become even more separate from the rest of the NHS, with the re-establishment of Family Practitioner Committees in England and Wales as fully independent bodies in April 1985. However, with the transfer of Kenneth Clarke to the Department of Health (initially as Minister of State) a more firmly managerial ethos also began to develop in the FHS. A full transition to general management followed in 1990, with the implementation of the NHS and Community Care Act's provisions for the creation of Family Health Services Authorities.

4.5 The challenge of 'seamless care' in an NHS market

4.5.1 The need for closer working

Chapter 5 considers the future changes likely to occur in general medical care, relating to local funding and more effective links with other community based and hospital services. However, before this it is relevant to return to a question raised at the start of this chapter. Arguments in favour of the better integration of all branches of health care—general medical and other independent contractor provisions, community services developed first by local authorities, and hospital based facilities—have been put forward since the creation of the NHS. Why then in the first forty or so years of the NHS's existence did this fail to culminate in effective action? Why in particular did the structural divide between the FHS and the rest of health service management remain?

Despite many broad, essentially theoretically based, calls for greater NHS unification and the assumed benefits it would generate, little attention was paid to the practical problems of implementation. At the top of the old NHS members of the civil service had great skills in the area of policy debate and the complex political issues to be addressed in and around Whitehall and Westminster. But their managerial abilities to ensure policy implementation further down the NHS structure were less extensive. Furthermore, the protection of the perceived vested interests of various groups (including not only general medical practitioners but also political parties and authority members originally appointed to pursue and/or protect the public interest) also on occasions inhibited the emergence of a structurally more unified NHS.

With the emergence of a sharper focus on ensuring the efficient management of NHS resources the path towards 'seamless' service provision may have been cleared. This is certainly the case with unified commissioning, which many commentators believe will promote a continuing change in the ethos of the NHS (Day and Klein 1991, Marinker 1992a). This can be described as a transition from an *'implicit, unspoken concordant between the state and the medical profession'*, in which the former provided funds and the latter allocated them, to an explicit, contractually defined relationship between the holders of the public purse and the providers of care.

4.5.2 Benefits of front line empowerment

There are many potential advantages to be gained from this shift, but there may also be costs. There are arguably positive reasons why, despite the rhetoric and theory of NHS integration, Britain's internationally unique general medical practitioner system has so far remained a distinct, separately funded, part of the NHS. These include:

- **the role of generalists in acting both as the main supplier of medical treatment to people in their daily lives, and as the gateway for referral to specialist secondary or tertiary level care.**

Protecting the public from the unnecessary interventions of specialists is a key function of the British GP system. This can be resented and misunderstood by other actors in the NHS. A central objective of general medical practice should be safely to exclude serious illness in members of populations where the true prevalence of any given condition will be low, whereas that of specialists is more often to be able accurately to identify disorders in members of a presenting population in which the prevalence is relatively high.

- **the need for the GP service (as *de facto* the first stage of a rationing system) to be flexible and open to all demands expressed in the population, prior to the selection of priority, often high treatment cost, cases for more specialised care.**

A potential danger of more closely integrating primary and secondary medical care is that the latter could draw in an even greater percentage of the overall resources available, potentially serving to increase care costs while decreasing overall consumer well-being. The distinction between 'open ended' FHS funding and cash limited HCHS care has in the past, whether by accident or design, protected against this. The implications of these observations are discussed further in Chapters 8 and 9.

Summary

- The NHS, created in the period of postwar social consensus, offered comprehensive health care for all regardless of ability to pay, and represented a worldwide step forward in health care provision.

- During the 1950s and 1960s, expenditure on the NHS grew steadily, and the NHS developed through initiatives such as the 1962 Hospital Plan and the 1965 'Doctors' Charter'.
- During the 1970s and 1980s health care policy became increasingly concerned with expenditure control. The emergence of general management in the NHS, and changes in the structure and organisation of the service, to a degree reflect this.
- There are some positive reasons why primary health care has remained a distinct, separately funded part of the NHS. However, arguments in favour of the better integration of all branches of health ,care are convincing, and moves towards more unified commissioning may clear the way towards 'seamless' health care

5

THE NHS IN THE 1990s

5.1 Background to the 1991 Reforms

5.5.1 'Reflections on the Management of the NHS'

In 1984 the Nuffield Provincial Hospitals Trust took the initiative of inviting Alain Enthoven, a professor at Stanford University, to visit Britain and examine the ways in which the NHS might be reformed. This led to the publication *Reflections on the Management of the National Health Service* (Enthoven 1985), a document widely regarded as being the original blue-print for the 'internal-market' model of the NHS.

Enthoven's analysis brought together a wide variety of criticisms and concerns about the NHS. Among the most important were:

- **the NHS was resistant to change.** Union and professional power within the service, with factors such as national pay and working agreements and the monopoly care supply position of Districts, meant that the NHS was caught in a gridlock of conflicting forces;
- **there was a lack of economic incentives for efficiency within the NHS structure**. In fact, perverse incentives could mean that units doing extra work often incurred costs but had no source of additional resources, leading to an 'efficiency trap';
- **units had difficulties associated with raising and disposing of capital;**
- **management had highly imperfect information about costs;**
- **consumer power within the NHS was very limited.** In addition, there was inadequate managerial accountability for defining and deriving true value from the money spent in each part of the service.

The prescription for change suggested by Enthoven centred on the introduction of a purchaser/provider divide within the NHS structure. Through this he believed that *'hospitals and their medical staffs, GP practices, and others would become sellers of services to DHAs. They would lose their monopoly status and would have actual and potential competitors. Their budgets would depend on the services they could produce and sell. Money would follow patients. A hospital that developed an attractive service would be paid*

for providing it to patients from the referring DHAs' (Enthoven 1991).

This contribution to British policy debate proved to be extremely influential. However, its impact should be seen in the context of both pre-existing thinking about possible NHS developments, and the pressures on the Conservative government's health policies which emerged during the second half of the 1980s.

For example, even before Professor Enthoven's visit to Britain in 1984 there had been extensive discussion about 'cross boundary' cash flows between health authorities. It was widely argued that if money could be made to follow patients more easily then efficient hospitals, able to attract high numbers of GP referrals, would be able to prosper. From this starting point models of a primary care led NHS, including the concept of GP fund holding, can be traced back to the early to mid 1980s (Marinker 1984, Maynard 1986, Maynard, Marinker and Pereira Gray 1986) and before. Indeed, there were also prior suggestions from organisations such as the pharmaceutical industry funded Office of Health Economics that the contractor status of family doctors and other FHS professionals might be extended to hospitals and other provider agencies, permitting them to become semi-autonomous actors in a more flexible NHS structure.

Seen against this background Enthoven's plan for the creation of District purchasing agencies was not so radical or so new as is sometimes assumed. It offered a means for cash limiting health spending on the residents of any given locality in a planned and prioritised manner. However, it made no creative use of the potential of Britain's unique primary medical and related services to offer consumers a more direct chance to exercise informed (professionally mediated) choice in the selection of secondary NHS care provision.

5.1.2 Financial restraints

Government thinking regarding the development of the family health services in the mid- 1980s appeared to be primarily concerned with issues of expenditure control. In 1982 the

DHSS commissioned the 'Binder Hamlyn' report, which addressed the problem of cash limiting the NHS's 'demand determined' independent contractor services. There followed a relatively prolonged period of policy analysis and debate. Eventually, after the circulation of a green paper in 1986 (also the year of the Cumberlege report on community nursing) the white paper *Promoting Better Health* (Secretaries of State 1987) was published.

The title of this document reflected growing public and professional interest in the possibilities of extending health promotion. Some politicians and service users appeared to see health promotion as a 'cure-all'—avoiding illness and therefore avoiding increases in health expenditure. Yet much of the substantive content of the paper was related to the challenge of strengthening the management of the FHS side of the NHS to match the progress already made in HCHS sector. Its proposals included the creation of better management information systems, and the establishment of budgets at practice level, either indicative or actual, in order to help control spending on items such as pharmaceuticals.

In certain areas *Promoting Better Health* also appeared to be advocating changes which were interpreted by some as the beginning of an attempt to 'privatise' the NHS. This was apparent in the case of ophthalmic care, where the sale of certain spectacles was de-restricted and free NHS sight testing was limited, and in dental care, where free checks were also limited following the white paper.

The Conservative government's policies towards care sectors such as dentistry and the general ophthalmic services had already moved towards higher consumer charges and reduced exemptions earlier in the decade (Taylor 1990, 1992a,b). However, the reaction to *Promoting Better Health* focused attention on this trend. Perhaps in reverse of the intentions of the white paper's authors, this proved to be at the expense of the electorate's awareness of health promotion and allied topics. It also helped set the scene for a second storm of concern about the NHS. This played a key role in the events leading to the subsequent *Working for Patients* and linked *Caring for People* reforms, and so the translation of ideas such as those of Alain Enthoven into practical reality.

5.1.3 *Events influencing the political climate*

David Barker and Matthew Collier were born with congenital heart defects. David died in November 1987; but not before he had been seen on national television gasping for breath while waiting for an operation at the Birmingham Children's Heart Hospital. It was postponed five times. The story was widely perceived to reflect a crisis in NHS funding, and media coverage soon led to the discovery of other comparable events. The case of Matthew Collier similarly achieved national prominence after his parents, like David's, took legal action in an attempt to obtain the operation they believed he urgently needed.

In an unprecedented statement, three presidents of medical Royal Colleges (including Sir Douglas Black, chairman of the inquiry into inequalities in health which had been set up by Barbara Castle in the late 1970s) declared that *'acute hospital services have almost reached breaking point. Morale is depressingly low'*. This attack from the medical establishment, coupled with the human face to the situation presented by the televised suffering of the children and their families and the reactions of dismayed hospital staff, created a response which no politician could afford to ignore.

Matthew Collier died in February 1988, because of a condition which might well inevitably have been fatal, whenever he had received surgery. But this was not before Margaret Thatcher had been forced on television to face challenging questions about 'the safety of the NHS in her hands', and the then Secretary of State John Moore had announced formally (in January 1988) a review of the financing of the NHS. This was chaired by the Prime Minister.

The following intensive process of consultation and analysis, which took place at the same time as the separate *Promoting Better Health* initiated negotiations between the Department of Health and the medical profession about a new contract for general medical practitioners, eventually led to the preparation and publication of *Working for Patients* (Cmnd 555) (Secretaries of State, 1989a). Shortly afterwards a second white paper, *Caring for People* (Cmnd 849) (Secretaries of State 1989b) was released. The proposals in these two documents were embodied in the National Health Service and Community Care

Act 1990, the implementation of which commenced in April 1991. (The community care legislation followed a second—1988—Griffiths review, itself stimulated by a critical Audit Commission report entitled *Making a Reality of Community Care*).

5.2 Working for Patients

The key elements of the changes introduced at the start of the 1990s as a result of the 1989 White Paper were as follows:

- **the development of the purchasing function.** District Health Authorities were re-established as purchasing agencies, with responsibility for identifying the health needs of their local populations and buying appropriate services from a range of NHS and/or private providers as cost effectively as possible. Specialists in public health medicine are required to play a critically important role in identifying patterns of need and the local strategies needed to achieve optimal amounts of 'health gain'. This last term lacks formal definition, but it can be seen as a translation of economic concepts such as the quality adjusted life year into a form relatively easily understood and accepted by managers and health professionals alike;
- **the establishment of NHS Trusts.** Hospitals and community services were in the early stages of the 1990/91 changes still managed as 'arms-length' units of the district authorities. But nearly all have since gained the status of independent NHS Trusts, managed quite separately from the purchasing authority. By April 1994, more than 90 per cent of NHS services (other than the Family Health Services) were managed by 440 Trusts (DoH 1993). Ostensibly, a central objective of this innovation is to help ensure that an 'objective' relationship exists between district purchasing authorities and powerful local providers. In this situation providers' interests are less likely than in the past to come before those of NHS consumers in the processes of resource allocation. The creation of Trusts has, arguably, also worked to keep able managers in positions close to the management of services of direct benefit to NHS users, rather than taking them up career ladders to situations more remote from day-to-day care;
- **the creation of Family Health Services Authorities.** In September 1990 Family Practitioner Committees were re-established as Family Health Services Authorities (FHSAs), with smaller membership and stronger management structures headed by newly appointed general managers. The FHSAs were not dominated by local professional representation, as were old FPCs, and their staff have greater executive powers to allocate certain cash limited resources (such as ancillary staff monies) directly to selected practices. FHSAs may be seen as interim bodies, moving towards purchaser functions within a more integrated NHS structure. Their role in helping to develop services provided by a wide range of

small, independent contractors clearly differs from that of DHAs in purchasing from (locally) a smaller number of large Trusts. Closer working relationships between DHAs and FHSAs have been encouraged by the Department of Health, 'to ensure a better balance between HCHS and primary care services' (DoH 1993), and these alliances will lead to a system of unified commissioning by 1996. Within this it may be necessary to ensure that the discrete development function of the FHSA is retained in some form. In addition, the lack of central guidance regarding how DHAs and FHSAs should join, while maintaining a flexible approach, has led to severe tensions in many localities;

- **the introduction of GP fundholding.** GP fundholders have cash budgets to purchase certain hospital services (mostly elective referrals) and other treatments for their patients, and for prescribing and diagnostic costs. They act as purchasers of services on behalf of their practice populations, as well as providers of care. By April 1994, fundholders cared for over a third of total patients (DoH 1993). This aspect of the reforms, which reflects pre-Enthoven thinking about how to make the NHS more market-like, has been criticised strongly by some 'mainstream' NHS managers and DHA chairs. However, it appears to have been a relatively successful initiative to date (Glennerster *et al.* 1992, 1994), and it has recently been extended in two directions. The list size of practices eligible for fundholding has been reduced from an original figure of 11 000 down to 7000. And fundholding GP practices have from April 1993 been able to purchase community nursing services from Trusts or remaining directly managed units of DHAs. In some localities fundholders are also leading initiatives to form consortia of practices, or 'multifunds' (for example the Newham GP Purchasing Forum in East London and the Birmingham Multifund). In time these creative initiatives may spread, and could perhaps become more like some US health maintenance organisations than traditional general practices.

5.3 The 1990 GP contract

Box 5.1 outlines the original features of the 'new contract' for family doctors, introduced in the autumn of 1990. This was intended to encourage health promotion. Its provisions included the introduction of payments for and/or contractual obligations to provide health promotion clinics; three yearly 'health checks' for registered patients; annual assessments for those aged over 75; payments for achieving 'target' immunisation and cervical screening rates; and child health surveillance. However, these terms were considerably revised in July 1993 (DoH 1993). Elements such as the three yearly health check for healthy patients were removed, and the system of payment for health promotion was revised. In place

Box 5.1 A Summary of the original 1990 GP Contract

Service delivery, planning and monitoring
FHSAs will plan service development in order for the resources available to be used to best effect. LMCs should be consulted and GPs supplied with aggregated information about health care provision and achievements in their areas. FHSAs are also to develop effective working relationships with DHAs and RHAs to ensure appropriate service provision, and will analyse GP referral patterns. GPs should produce for FHSAs annual reports describing their practice services and plans, to which the FHSA may invite them to add further data if it is needed.

Prescribing
FHSAs are required to establish rational prescribing policies for their localities and to monitor individual practice prescribing.

Practice teams
The new contract required FHSAs to determine the percentage of practices' staff costs to be reimbursed, with total spending restricted to a cash limited amount in each area. Practice staffing is to be reviewed on a three yearly basis. Bars on the range of professionals employable which applied under the previous ancillary staff scheme have been lifted.

Premises cost rent and improvement grants
Standards were tightened and cost rents made payable in line with regional variations in costs. FHSAs can set the level of improvement grant payable within a defined range, and here again overall locality expenditure cash limits apply.

Computers
The new contract enables help to be offered towards the cost of purchasing/leasing hardware and software for GPs. Training costs may also be met.

Medical manpower
FHSAs have some discretionary power in relation to defining satisfactory arrangements and and local needs, both in relation to discussions with individual GPs and Medical Practices Committee decisions. Key changes include the introduction of a retirement age of 70 as from April 1991; use of Jarman indicators in considering manpower needs in deprived localities; GPs to be available for direct consultation for at least 26 hours over at least five days; newly appointed GPs to live within a 'reasonable' distance of the surgery; and FHSAs to be notified of GPs' other professional appointments.

Information for consumers
More information to be supplied for example, medical directories must show sex, age/date of qualification, clinic sessions and practice staff offered by each practitioner. Special services (eg child health surveillance), languages and the availability of linkworkers may also be indicated. GPs to produce leaflets, changing doctors made easier and FHSAs to encourage consumer surveys.

continued

continued

Remuneration system
The new contract abolished a considerable number of established GP payments (such as seniority and childhood immunisation on a capitation basis) and modified the basic allowance and night payments system, as well as the higher capitation payment for patients over 75. The latter should now receive an annual home visit and assessment. New payments introduced include those for registration examinations of new patients; the achievement of defined immunisation and cervical screening targets; minor surgery; undergraduate supervision/education; child health surveillance; and health promotion clinic provision. Also, a deprived area supplement to the basic practice allowance was introduced, based on Jarman index measures.

Medical education
GPs are now entitled to a payment for each undergraduate medical student they are responsible for. As to postgraduate medical education, they are entitled to receive a fee of a little over 2,000 a year provided at least ten half day education sessions are attended. However, travel costs and session fees must be paid from this.

of the relatively open ended commitment to pay for health promotion clinics (which enabled a few GPs in certain localities to earn very large sums) a banded system of fixed payments for specified services has been introduced.

The first activity, which involves basic efforts to reduce smoking in practice populations, in 1993 attracts a fee of £420 per annum. Band two, involving more sophisticated attempts to address hypertension, generates a payment of £1135. Band three, requiring a full scale stroke and coronary heart disease prevention programme, generates £2015. Limited payments for diabetes and asthma continuing care clinics are also available.

Initial approval for programmes is required from local FHSAs, and the system is monitored via practice reports. Remuneration for health promotion in general practice is thus being made more focused in its approach. This reflects a recognition that the previous arrangements were encouraging overspending and were having a perverse, inequitable, influence on the distribution of health promotion resources. They also discouraged the doctors from screening and advising their patients opportunistically during routine consultations. However, the value of the new system is also questionable:

at worst it generates numbers and records rather than effective interventions.

5.4 Community care reforms

The implementation of the community care reforms was delayed until April 1993. They, like the reforms of the NHS, centred on the introduction of a purchaser/provider divide between local authority social services departments and the various types of public and private agency offering social care. The NHS and Community Care Act made local authorities clearly responsible for the non-medical support 'in the community' of people with mental illnesses, learning disabilities and problems associated with old age. It transferred cash in a lump sum (around £565 million in England in 1993–94, rising to £1274 million in 1994–95—Hansard 1993), to the local authorities for daily living care previously made available to individuals as part of their social security entitlements.

This policy shift was widely welcomed, and regarded by many individuals working in social services as having the potential to improve the efficiency and effectiveness of community based support for society's most vulnerable members. There have, however, been persistent concerns regarding the long-term adequacy (and protection) of the funding likely to be available. In addition, there have been doubts relating to issues such as the likely degree of NHS/social services co-operation and the impact of social care charging policies on groups such as the moderately disabled, moderately affluent elderly. The reforms effectively narrow NHS responsibilities towards these groups and broaden those of the social services. In practical terms this suggests not only a probably desirable de-medicalisation of the care of people with disabling conditions, but also an extension of charged, as opposed to free NHS, services.

5.5 Managing the new NHS

Management arrangements in the NHS were changed very little by the 1991 reforms. Figure 5.1 shows the structure in 1991. Since then, many DHAs have merged to form larger

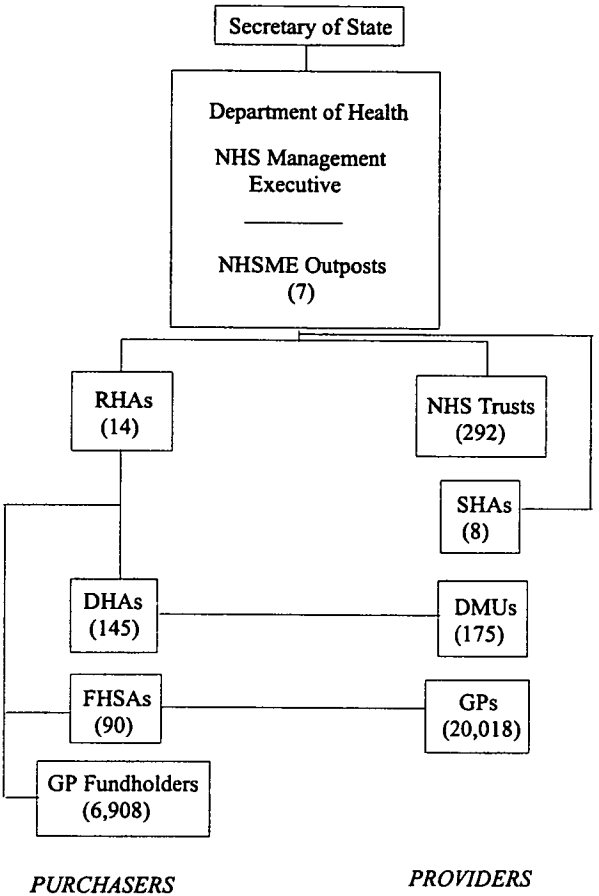


Figure 5.1 Management structure of the NHS, 1991. Source: DoH 1993

purchasing units, with the overall number of such authorities falling from 145 in 1991 to 108 by April 1994. There are proposals to reduce this to between 80 and 90 in the longer term (DoH 1993). In addition, many DHAs and FHSAs have established joint management arrangements, even though fully integrated purchasing was not permitted by the statutory requirement for the separate existence of the two authorities.

In May 1993, a review of the structure, functions and manpower required to 'manage' the NHS was set up (DoH

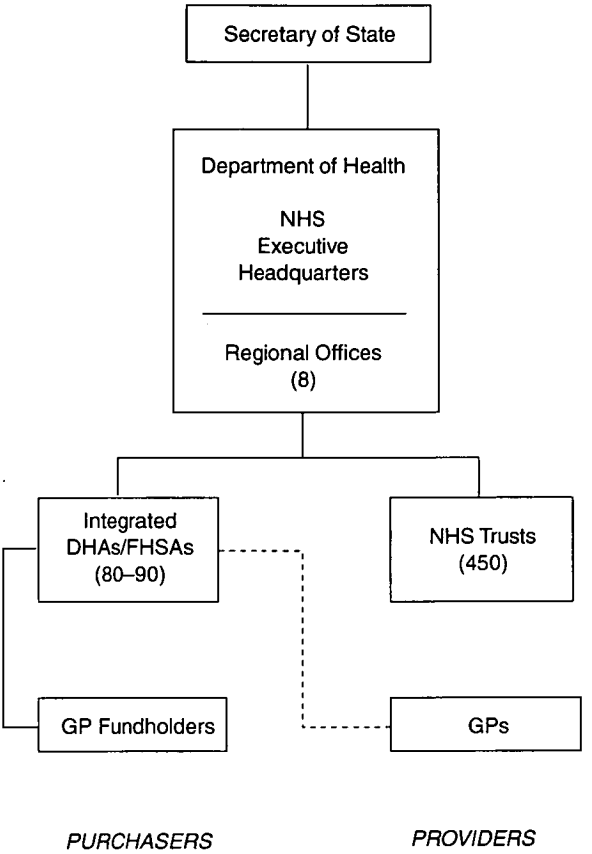


Figure 5.2 Management structure of the NHS, 1996. Source: DoH 1993

1993). This recommended changes at local, regional and national levels. These include:

- the abolition of the 14 statutory Regional Health Authorities;
- streamlining and reorganising the NHS(M)E to include eight regional offices to replace RHAs and the existing NHSME Outposts;
- appointing non-executive members to the NHS Policy Board to cover each of the eight regions, providing a link between Ministers and local DHA, FHSA and Trust chairmen;
- enabling DHAs and FHSAs to merge to create stronger local purchasers, and actively encouraging such mergers (DoH 1993).

Figure 5.2 summarises the likely new structure of the NHS. Overall it appears designed to promote continued decentralisation, devolving responsibility and decision making as far as possible to local level (DoH 1993). It remains uncertain, however, whether or not this will in practice be achieved. It has been argued that the new structure could engender continuing temptations to interfere in and 'overmanage' the market (Best *et al.* 1994).

Managing the NHS market to balance competition and regulation is an important challenge. Too much government intervention can blunt incentives for efficiency, and too little intervention may result in inadequate NHS cover or abuse of monopoly powers. Ham and Maynard (1994) suggest that effective market management requires eight core elements:

- openness of information—for purchasers to make comparisons between providers;
- control of labour and capital markets—for example regulation of the numbers of clinicians and GPs and the demands they make;
- regulation of mergers and takeovers—to avoid creation of monopolies and cartels, and exploitation of market power;
- arbitrating in disputes—by an arbitration agency independent of purchasers and providers;
- protection of non-profit making functions—for example research and development;
- overseeing provision of health services—to identify gaps in service provision where they occur;
- protection of basic principles of the NHS—particularly equity and access;
- dealing with closures and redundances—easing the 'exit' process of transition and redeploying displaced staff and expertise.

5.6 The wider agenda

5.6.1 Weighted capitation formulae

Since 1991 there have been further moves towards achieving an equitable distribution of NHS resources via 'weighted-capitation funding' of DHA purchased services. The NHS Management Executive commissioned a study to recommend a formula for distributing NHS revenue based on small area use of hospital beds, and data from the 1991 census.

The use of weighted capitation formulae to distribute health care resources between geographical areas is now well established in the hospital and community health services

sector, and the use of such formulae since the implementation of RAWP in 1977 has reduced differences in financial capacity quite considerably. However, the RAWP report (DHSS 1976c) also advocated integration of processes of priority setting, manpower planning and the provision of care within the HCHS with these processes in family practitioner services, local authority social services and other carers. This integration has not occurred, and RAWP type formulae have been applied to HCHS budgets only, not to primary care expenditure.

Weighted capitation formulae have been used in small areas of the primary care budget—for example to develop indicative prescribing budgets, and in sub-district allocation of HCHS resources to GP fundholders. But there are large historic differences between regions in their levels of primary care funding which do not appear to be justified in health 'needs' terms. The case for incorporating primary care budgets into a RAWP type formula has been expressed by many authors (Birch and Maynard 1986, Bevan and Charlton 1987, Carr-Hill and Sheldon 1992). But the impact of any such development should be carefully monitored—it could have negative effects if insensitively pursued.

5.6.2 *The Patient's Charter*

The Patient's Charter (DoH 1991) was launched in October 1991 as part of the Citizen's Charter scheme. It outlined seven established rights in NHS care, and introduced three new ones: to be given detailed information on local health services, including quality standards and maximum waiting times; to be guaranteed admission for treatment by a specific date no later than two years from when the consultant places the patient on a waiting list; and to have any complaint about NHS services investigated, with a full and prompt written reply from the chief executive or general manager. In addition, nine national charter standards were set out, including standards for waiting times in clinics and A & E, and local charter standards are encouraged.

The original Patient's Charter concentrated particularly on hospital care—none of the national standards or new rights apply primarily to GP services. The impact of the Charter has not been evaluated and Mahon *et al.* (1994) found that, despite the publicity surrounding the launch, in a patient survey in 1992

over 40 per cent of respondents had not heard of it. Despite their inherent desirability the targets imposed by the Patient's Charter could have ambiguous effects on other areas of health care. For example, the focus on reducing waiting lists directs resources away from other areas, and targeting non-urgent cases waiting for long periods may be at the risk of not treating more urgent cases with shorter waits (Yates 1987). This could lead to an inefficient use of resources. Hence the standards set in the Patient's Charter, along with other government initiatives which focus on activity should be subject to careful evaluation. It is possible, for instance, that the net effect of charter type projects could be to promote greater discontent with the public sector.

5.6.3 Audit and quality management

A decision that all doctors are required to undertake audit was announced in 'Working for Patients' in 1989. At the time this was one of the least controversial aspects of the reforms. However, implementation of medical (and subsequently clinical) audit in hospitals has proved problematic (Kerrison, Packwood and Buxton 1994) and has apparently been even more patchy in primary care.

There is evidence that individual audit projects in primary care can achieve important benefits for patients. But the durability of these benefits is variable and the results of audit are not always adequately disseminated (NHSME 1993). The quality and impact of audit is often uncertain, with audit more likely to be carried out in large, and/or well organised, practices.

5.6.4 The Tomlinson Report

The Inquiry into London's Health Service, Medical Education and Research (Tomlinson 1992) recommended major changes to health care in London, with a significant reduction in the number of acute beds (through merging and closing hospitals). The report emphasised the need for substantial improvements in the capital's primary and community health services, to raise the standard of GP premises and increase flexibility of services. The impact of this report on primary care is discussed further in Chapter 8.

5.6.5 Health of the Nation

The Health of the Nation White Paper (Secretaries of State 1992) represented a shift in policy reflecting worldwide trends towards setting clear targets for improvements in population health. This initiative and its effects are discussed in Chapter 6.

5.7 Health Promotion and the politics of leadership

5.7.1 The origins of conflict

Taken altogether, policy makers and officials can point to an impressive array of recent health care initiatives. A positive interpretation of these suggests that health and social care could now become more effectively managed and delivered than ever before. It may be argued that the Conservative administration has tackled head-on the economic and allied problems of health care in the late twentieth century. It has attempted to re-orient the ethos of the service more towards health promotion and primary care, while radically re-addressing the system of financial incentives operating within it. In place of central, 'top down' planning and resource direction a more decentralised, flexible and dynamic, set of field level incentives is being instituted. In addition, the tax funded, comprehensive, nature of the NHS itself remains intact.

Against this, however, many professionals in the NHS remain uncertain as to the value of the recent reforms. Morale amongst GPs is said to be low (McBride 1992). The confidence of some members of the public may also have been undermined, not least because of changes in ophthalmic and dental care. The government strongly denies any intention to create a privatised or semi-privatised pattern of services, but its statements are not universally believed.

In the area of health promotion, debate between policy makers and health professionals has been particularly bitter. The 1990 contract was imposed upon, rather than agreed by, general medical practitioners. After a prolonged period of tension between the profession and the government during the 1980s this act had a considerable psychological and medico-political significance. It demonstrated that family doctors' threats of mass resignation (the weapon which many believed

had been crucial to the 'winning' of the 1965 Doctor's Charter) are in current circumstances of limited credibility. The costs of general medical practice premises and staffing structures are now such that relatively few GPs seem willing to break with the NHS, regardless of any other personal or professional concerns.

The resultant anger and dismay amongst family doctors, who during most of the 1970s and 1980s tended as a group to believe that no government would risk direct conflict with them, revealed itself in their attitude to the provisions of the new contract. This was particularly so in the health promotion context, partly because of flaws in the terms of service and partly because of fears amongst some doctors that the demands being imposed were intended—regardless of their relevance to health—to force changes in the structure of general practice. (In the mid 1980s moves to restrict the use of deputising services were similarly seen as aimed at increasing pressures on older, single-handed, practitioners).

The imposition of the new contract resulted in an immediate and sustained questioning of the moral and scientific value of everything from the introduction of payments for the attainment of immunisation and cervical smear targets to the requirement that family doctors should provide three yearly health checks for patients aged 16–74 and annual domiciliary checks for those aged 75 and over (Noakes 1991, Harding and Guthrie 1991). Individuals such as Dr Michael D'Souza openly refused to comply with the terms of his contract, fearing that the government was introducing for political reasons ineffective (although potentially popular) health checks which would increase workloads and divert doctors from more valuable activity. The logic underlying the introduction of health promotion clinics was also strongly disputed, not only by the medical profession but also by economists (Scott and Maynard 1991).

Policy makers appear now to have accepted that such criticism was in many instances well founded. During 1992 the relevant provisions of the contract were renegotiated by the Department of Health and the General Medical Services Committee of the BMA. The resultant three band structure, as described in section 5.3, represents an advance, which opens up opportunities for more structured relationships between

practices and FHSAs/commissioning agencies. The requirement for three yearly checks on the non-attending practice population has also been removed, as it involved highly questionable procedures (e.g. urine analysis for glucose and protein) as part of a multi-phasic (general, non-specific) screening programme for an apparently healthy population (Mant and Fowler 1990, Fowler and Mant 1990, Fowler 1992). As such the position of individuals such as D'Souza appears to have been vindicated. The restructuring of the 1990 contract may also in some respects be taken to reinforce the warnings given by the GMSC and RCGP about political and managerial interference in the practice of medicine, and the need for scientific evaluation of proposed policy initiatives (Bogle 1994).

5.7.2 The public's interests

However, against the above points there are several balancing considerations to be noted. The first relates to the problems of evaluation. It is frequently very difficult to arrive at a clear cut, reliable view of the value to a community of given interventions or programmes. Even clinical evaluations of efficacy and effectiveness can be ambiguous—for example, there is still uncertainty regarding the usefulness of cholesterol lowering drugs as a protection against heart disease (Effective Health Care 1993). Economic and other forms of analysis are often subject to profound difficulties (see Appendix). In complex areas of social and psychological care designed to influence health behaviour and ultimately health status, the multiple causal, casual and confounding factors to be taken account of mean that 'proving' many hypotheses is likely to be near impossible. In such circumstances calls for strict 'scientifically' rigorous evaluations of new initiatives can be related to individual or sectional special interests, rather than intellectual integrity or the pursuit of the broader public good. They may be intended merely to delay or to undermine the implementation of reasonable policies.

Secondly, it is important to note that by no means all the 1990 contract's provisions have been discredited or abandoned. For example, the target payment systems have shown themselves to be effective in stimulating improved performance in the areas of immunisation (Britain's childhood immunisation

scheme's performance is now world class—Anderson 1994) and screening for cancer of the cervix (see chapter 7). Initial objections that they could undermine doctor/patient relations seem to have been overstated, and largely unjustified.

Similarly, the value of annual domiciliary checks on the health of people aged over 75 is likely to be greater than some medical critics have suggested (D'Souza 1992). There is evidence that if such assessments are conducted in a positive, comprehensive manner they can help reveal a considerable value of unmet medical and related social need (Brown *et al.* 1992). There may be a case for targeting them to a more specific population, defined on the basis of age and/or other personal/service use criteria. But the attitude of those who suggest that primary care professionals such as GPs already know all that it is useful to know about the health care and allied support requirements of their elderly patients is hard to defend.

It is also relevant to note that during the 1980s the position taken by those representing the interests of the medical profession was often inflexible, and perhaps unduly defensive. The dogmatic assertion that 'there is no such thing as a bad doctor' prevented bodies such as the GMSC from understanding fully the long-term interests of family doctors to adapt their practices in response to a changing environment, as well as to ensure that all patients receive care of a satisfactory minimum standard.

The uncompromising and blinkered attitudes in the past adopted by the 'medical side' were, many observers believe, to no small degree responsible for the government's decision to impose the 1990 contract; its imperfections in part reflected a failure of proper negotiating process for which none of the groups involved can claim complete freedom from responsibility (see GMSC 1991). Indeed, even the Royal College of General Practitioners was not without fault. The College (and its individual members) has made important contributions to thinking about subjects such as anticipatory care, and also concepts such as GP fundholding, during the past 10 to 20 years. (For example, RCGP 1983, 1984). But the inability of the College either to unify professional thinking about acceptable standards and forms of practice or to confront with courage and determination those members of the profession

with alternative views may well have added to the confusion surrounding the 1990 reforms.

Against such a background of relatively weak medical leadership, and the profession's reluctance to discipline itself, the imposition of the 1990 contract provided a starting point from which further constructive change could follow. This now seems to be understood by professionals, managers and public health policy makers, who need to co-operate to achieve better services for NHS primary care consumers in the 1990s. Successful progress in this depends on a mature appreciation by all concerned of the complimentary roles that members of these three broad groupings have, together with health service users themselves, in improving the health of the nation.

Summary

- The analysis of Enthoven (1985) is widely regarded as the original blueprint for the internal market model embodied in the 1991 NHS reforms. This document was extremely influential, but was not so radical or original as is sometimes assumed.
- The key elements introduced at the start of the 1990s following the 1989 White Paper 'Working for Patients' were the development of the purchasing function, the establishment of NHS Trusts, the creation of FHSAs and the introduction of GP fundholding.
- Reforms were also introduced in the GP contract, community care and, more recently, in the management structure of the NHS. Other initiatives include further moves towards equitable resource allocation using weighted capitation formulae, the Patient's Charter, the Health of the Nation targets, medical (clinical) audit and the implementation of the recommendations of the Tomlinson report in London.
- Taken together, this is an impressive array of health care initiatives, encouraging a more decentralised and flexible system while leaving the tax funded comprehensive service largely intact. However, the long term value and consequences of the recent reforms are as yet uncertain.
- In the area of health promotion, debate between policy makers and health professionals has been particularly bitter. The 1990 contract was imposed upon, rather than agreed by, GPs, partly because of their own failure to take a positive approach. Some of the criticism of the original contract has been accepted in the changes made in 1993, although health promotion in primary care remains a controversial area.

6

HEALTH PROMOTION—DEFINITIONS, MODELS AND STRATEGIES

6.1 Defining good health

6.1.1 Medical and social dimensions

Good health is valued in all human communities. But, like beauty or sanity, what it means may vary between individuals and groups (see Blaxter 1990). Various concepts of health include:

- the absence of diagnosed disease;
- the state of not being recognised by others as ill, and so of being required to fulfil normal social obligations—going to work, caring for oneself and others, being held responsible for one's actions;
- fitness, energy and vitality;
- an approach to life which is likely to minimise the risk of disease—the avoidance of 'bad' habits;
- freedom from acute material and physical limitations—affording and being able to care for oneself, and conduct everyday activities like shopping, driving or going out to, say, a pub or a cinema;
- the ability to function socially, to be able to maintain satisfactory relations with others;
- 'psycho-social well-being', to be in a state of contentment with and acceptance of life, or the approach of death;
- being able to cope with life's challenges, despite diseases or disabilities.

It follows that patients' experiences of ill-health are complex. From a primary care viewpoint in particular they go well beyond the parameters of formally defined, medically identified disorders. Even though it may be reasonable for professionals to limit their personal interventions to those areas where they have special expertise, narrow, reductionist, assessments of an individual's overall care and support needs can have perverse consequences. This means, for instance, that it may be both destructive and costly to divide rigidly between health and social care. This has been illustrated by Townsend *et al.* (1988). Their work indicated that a brief period of social and

allied rehabilitative care delivered to elderly patients in their homes immediately after hospital discharge approximately halved their subsequent long-term re-admission rates. Enhanced patient confidence and contact with other formal and informal support agencies appear to have played an important role in achieving this.

6.1.2 Denormalisation

There will often be tensions between individuals being cared for, and accepting a status of 'sickness', and individuals avoiding long term dependence and the loss of a 'normal' social situation. As people age, and/or have to face chronic disease or permanent disability, these tensions are likely to increase. Younger, intrinsically confident and able individuals, naturally equate health as being free from any obvious physical problem, and being able to maximise their sense of bodily well-being and functional fitness. If they have a temporary illness or traumatic injury it may well be beneficial for them to accept being judged sick, and to remain in a relatively passive state for a short time until their normal life can be resumed. But for people with longer-term problems, whether they be related to physical, psychological or intellectual functioning, the denormalising effect of being labelled sick can permanently deprive them of an independent life. In such circumstances concentration on health as coping, and achieving the strength to adjust to one's circumstances despite illness or reduced ability, is vital.

The challenge for all health professionals here is to enable service users to gain or retain a sense of autonomy and control over their lives, while being prepared to support, protect and care if and when an individual is being overwhelmed. A philosophy of normalisation, if applied with due empathy, should help to avoid some of the paradoxically disabling consequences with which institutional and other services based on the 'medical model' have in the past been associated.

6.1.3 Mental and physical health

Another key set of observations about the nature of good health relates to perceptions of mental as distinct from physical illness.

There is an association between an individual's psychological status and how he or she is able either to avoid risks to health or to respond to the challenges of ill-health when faced with them. Given the changes in the patterns of morbidity and mortality which have occurred in Britain over the course of the twentieth century this has become an increasingly significant field.

For example, it is known that psychological distress may influence pain thresholds, and so alter the subjective experience of conditions like arthritis and angina. Similarly, physical pain is over time likely adversely to affect mental well-being. An individual's reaction to stressful situations can also involve linkages between emotional feelings of helplessness, resentment, loss of control, anger, anxiety and depression on the one hand and physiological responses such as raised serum cholesterol levels, increased platelet adhesion properties and raised blood pressure on the other (Frost 1992).

In attempting to promote health it is therefore relevant to try to understand as fully as possible the relationships between individuals' social and/or physical environments, their mental states and their relative risk of disease. Specific patterns of vulnerability will differ between individuals and groups. For example, it appears that (as noted in chapter 3) in today's social conditions the physical health of men is more adversely influenced by material deprivation than is that of women, while womens' health may be more dependent on the existence or otherwise of supportive social relationships.

In relation to mental health attempts to comprehend the challenges faced by service users are further complicated by the problems inherent in distinguishing between biologically based brain disorders and essentially normal mental responses to adverse circumstances. Uncertainties about this interface may in part account for the social stigma sometimes still inappropriately associated with mental ill-health. In schizophrenia, for instance, many affected individuals have to face not only disturbances of cognition stemming from primary biological/brain impairments, but also secondary psychological and allied mental distress generated by their own fear of the primary symptoms and also changes in social circumstances that others' responses to their illness cause.

Similarly, in many cases of anxiety and depression the 'primary lesion' may (following a disturbing life event or

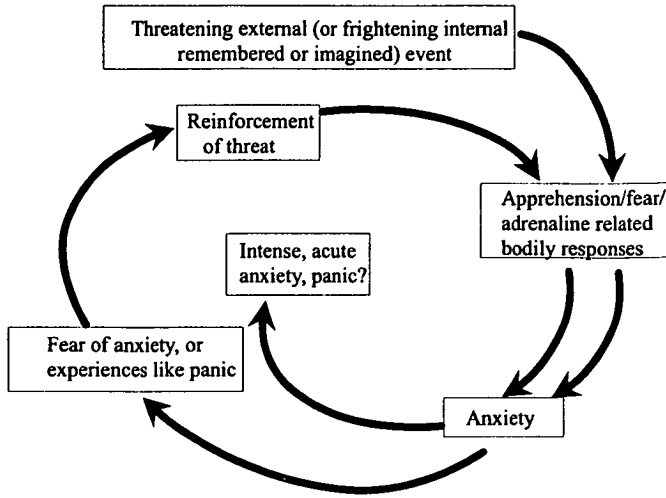


Figure 6.1 The anxiety spiral. Source: Taylor and Taylor 1989

events) be an essentially normal response to the external environment. But subsequent patterns of expectation and behaviour, reinforced by biological mechanisms, can become powerful factors in the perpetuation of pathological distress (Figure 6.1). Extreme explanations of mental ill-health, from those which are exclusively social/psychological to those which are purely biological, are likely to undermine genuinely effective approaches to both its prevention and its treatment.

6.2 Models of health promotion

6.2.1 Impairment, disability and handicap

Figures 6.2 and 6.3 offer further models of health and disability, and the interaction of social and physical factors associated with such states. Figure 6.1 underlines the fact that even at the time of birth, external as well as genetic factors will have played a significant part in shaping the make up of each individual. The balancing of constitutional and acquired characteristics continues throughout each person's life, influencing everything from reproductive behaviour to the nature and conduct of their eventual death.

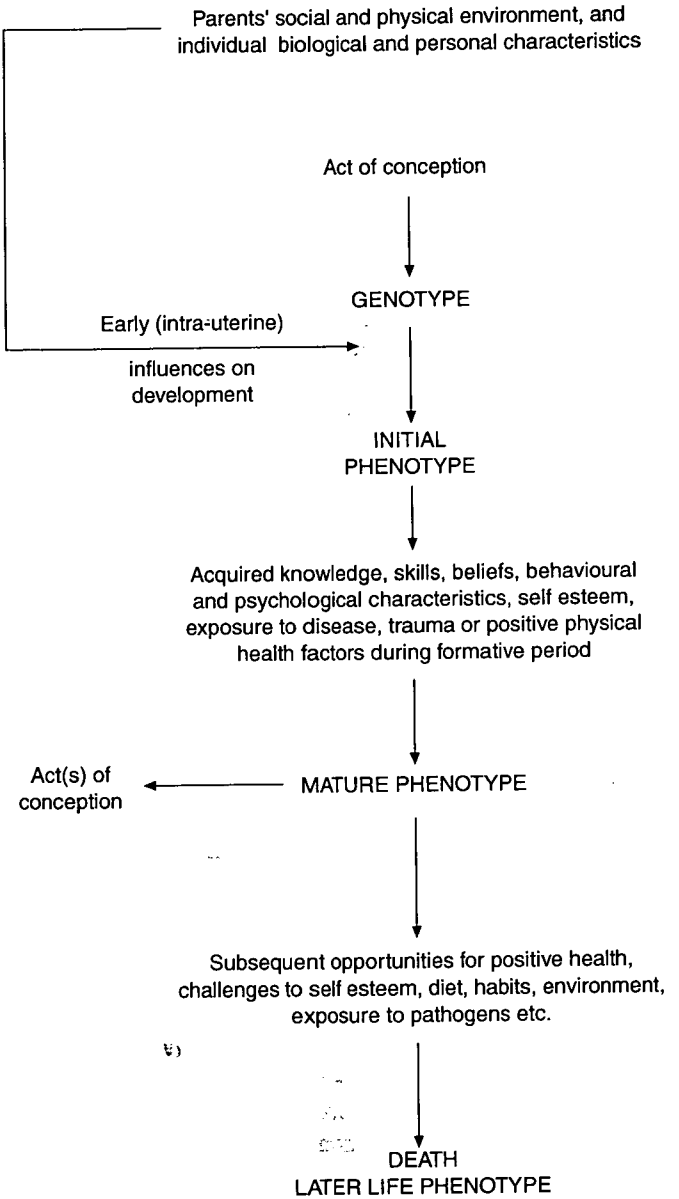


Figure 6.2 From genotype to phenotypes

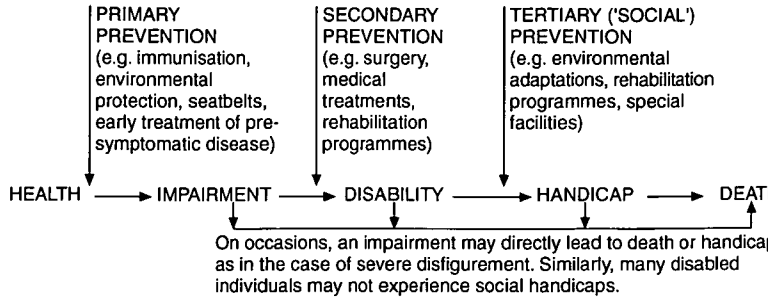


Figure 6.3 The impairment, disability, handicap model. Note: Use of prevention terms differs from conventional applications—see text

Inheritance may therefore be seen as a social as well as a biological process. Even in diseases with a significant genetic component a sensitive understanding of the involvement of environmental factors is needed. Many chronic conditions appear to be the result of a complex juxtaposition of plural genetic and external influences. To take the example of schizophrenia(s) again, the observed concordance rate between identical (homozygotic) twins is a little less than 50 per cent. That is, if one twin displays the condition there is, in current conditions, a slightly less than one in 2 chance of its being seen in the other. Concordance in ordinary siblings is about 10 per cent. This implies an aetiological process in which a combination of inherited characteristics and subsequently experienced challenges or insults (perhaps in this case exposure to an infection such as influenza early in life, certain forms of emotional/social stress, and even factors such as the sensory and social deprivation caused by deafness) result ultimately in the expressed condition.

In circumstances like these the idea that some future form of genetic screening could beneficially be used to label those 'at risk', and so permit specifically targeted protective action to be taken, should be treated with some caution. The same conclusion applies to other 'partially inherited' conditions. Even when their causation is more fully understood, prevention may often be better achieved via general programmes, such as those aimed at optimising mother and child health. (This is not, however, to deny the need for improved preconceptual and antenatal services in the area of genetic disorder—see chapter 7).

Figure 6.3 is based on work originally conducted by Wood and his colleagues for the World Health Organisation. It introduces three key concepts:

- **impairment**—a physical injury or lesion such as a lost or malformed limb or damaged nerve;
- **disability**—the loss of specific functional capability derived from an impairment. For example, inability to walk or to see, or to read or write;
- **handicap**—the loss of a social role or position necessary to normal life—for instance, to have a job, marriage or home of one's own.

This model reinforces the point that preventive care can and often should go beyond simply helping particular subjects to avoid risks and/or initial impairments. Rehabilitative support, reconstructive surgery, and/or long-term medical treatments can all serve to reduce or eliminate functional disabilities, while appropriate mixes of health care and social support can prevent handicap despite the existence of impairment and disability. In this last context—arguably health promotion in its widest sense—the focus of activity and responsibility is not only on individuals and their attributes and skills. It also involves the attitudes and social structures surrounding them, and their ability and willingness to accept and accommodate those with atypical needs.

The *impairment, disability, handicap model* was developed to enhance insight into the challenges facing and options available for supporting people with conditions such as rheumatic diseases. But it can also usefully be applied to learning disabilities, and mental health issues (see, for example, Taylor 1979). As implied above, it suggests that an overall view of health promotion could logically distinguish between primary impairment avoidance, secondary disability reduction, and tertiary handicap minimisation. However, to avoid confusion it is important to note that this is not the way such terms are conventionally used.

Table 6.1 shows the way in which the Royal College of General Practitioners differentiates between primary, secondary, tertiary and quaternary prevention, while Figure 6.4 provides a broader, non-medical model of health promotion. This differentiates between protective activities (ranging from water fluoridation to the introduction of no smoking policies); prevention (including screening, immunisation and medical

Table 6.1 Terminology of primary care

Primary care			
Anticipatory care		Disease management	
Primary (Prevention)	**Secondary (Screening)**	**Tertiary (Management)**	**Quaternary (Palliative care)**
Disease prevention	**Disease detection**	**Disease management**	**Disease containment**
Health protection Lifestyle management Removing the cause	Detection of early signs of disease before symptoms	Management of established disease to avoid or limit the development of disability or handicap	Management of advanced disease to acceptable death

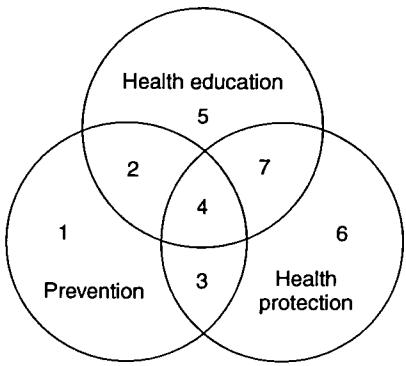
Source: RCGP 1992

interventions such as those designed to control hypertension); and health education (informing individuals about risk empowering them to select healthy behaviours).

6.2.2 *The case for positive intervention*

These alternative approaches to thinking about how best to gain or maintain personal and/or overall community health have many interesting applications. But their overall utility lies in the extent to which they help generate effective and efficient action for better standards of health and welfare. This can be taken by legislators in Parliament, by health care professionals working in general practice or other settings, or by individuals in their everyday family and working lives. None of the approaches are 'correct' in an absolute sense. Indeed, there is a degree of conflict and controversy surrounding all aspects of health promotion, not least because of uncertainties regarding the extent to which it is legitimate to intervene in the lives of others to protect them against risks which they may regard as acceptable.

In considering this topic Downie, Fyfe and Tannahill (1990) drew attention to the WHO's 1946 definition of health as *'a state of complete physical, mental and social well-being, and not merely*

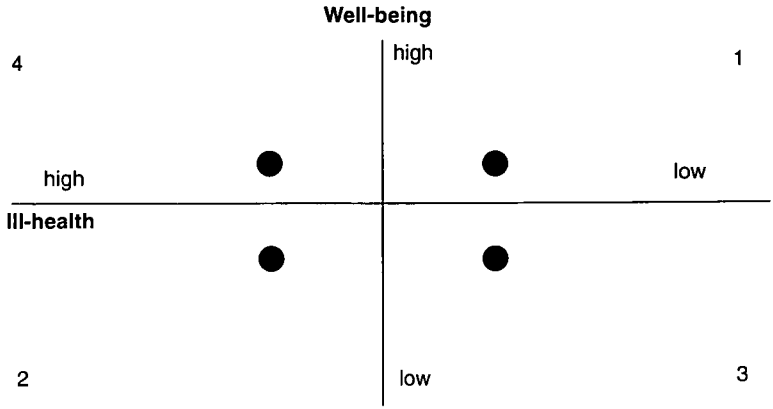


Notes:
1. Examples include immunisation, smoking cessation aids
2. Education about lifestyle choices e.g. avoiding smoking
3. Examples include fluoridation of water supplies to prevent caries
4. Examples include lobbying for legislation to oblige people to wear seat belts
5. Positive health education — e.g. about taking exercise, enjoying an active social life
6. Positive health promotion — antismoking policies in public places, availability of healthy leisure activities etc.
7. Examples include educating policy makers about the need for positive health protection measures

Figure 6.4 Types of health promotion. Source: Downie, Fyfe and Tannahill 1990

the absence of disease or infirmity'. They accept that this has much criticised shortcomings, not least that it is utopian. But it has certain merits as well, particularly in that it makes a distinction between the positive and negative aspects of health. 'Health' involves, according to these authors, not just the absence of disease (negative health) but also the attainment of a state of positive psychological and allied well-being. This involves a quality that Downie and his colleagues termed 'empowerment'. Through it individuals are said to be able to take control of their lives, and express their true values. This will naturally lead them to adopt healthy behaviours.

Downie and his colleagues go on to suggest that there is not a simple continuum between ill-health and positive health.



1. This individual is free of ill-health, and this is matched by a high level of well-being. This is clearly a highly desirable state.
2. This person has a high level of ill-health and a correspondingly low level of well-being. He or she may, for example, have terminal cancer, be in a great deal of pain, and feel desolate.
3. The third individual does not feel ill, and has no other evidence of ill-health, but for some reason this state is accompanied by a low level of well-being. He or she may, for instance, feel too socially unskilled or physically unfit to enjoy a 'clean bill of health'.
4. This person is experiencing a high level of well-being despite a high level of ill-health. Such people may feel in peak physical condition, unaware of an advanced malignancy, or may be terminally ill but well-adjusted to their fate, at peace with themselves and the world.

Figure 6.5 Well-being and ill-health. Source: Downie, Fyfe and Tannahill 1990

Rather, they see 'well-being' and health as being on opposed axes—Figure 6.5. This model is used to compare and contrast the situations of individuals such as those with high well-being and low health status and vice versa.

Their attempt to distinguish between 'true' well-being (the product and promoter of a 'good' life) and false well-being (a subjective state induced, say, by alcohol, illegal drug use, or sexual or other hedonistic pleasure which may *'overall be detrimental to an individual's functioning or flourishing, or to society'*) can be questioned. It offers a conceptual framework in some ways similar to Marx's economic and social idea of *false consciousness*. This suggested that workers in capitalist societies may feel that their needs are being met, but are actually having their fundamental human requirements denied.

By postulating the existence of a state of 'true' well-being, based on in-built values which are inherently health seeking, advocates of health promotion programmes avoid the charge

that they are trying to impose their personal beliefs and preferences on others. Rather, they can claim to be helping to clarify the values already latent in their audiences, so enabling people autonomously to choose to give up smoking, excessive drinking, or sedentary or sexually dangerous lifestyles. But the credibility of this argument is limited.

An alternative approach is to accept that some people may for a variety of reasons—from lack of information to the pressures of immediate stress, low self-esteem or fear of surviving to old age—adopt potentially harmful behaviours. They are free to do so. But other individuals concerned with health in their communities are also free to try to inform those at risk and/or to alter their behaviours, and also to change environments which may be hazardous to others, now or in the future.

A sense of control over and responsibility for one's own life is likely to be a necessary facet of 'healthy' behaviour in most adults most of the time. It would therefore be counter-productive to approach health promotion in an authoritarian manner. But at the same time it is pointless to spend too much effort debating whether or not health promotion is aimed at supporting the expression of 'true' human nature as distinct from merely expedient, pragmatically justified, ways of life. It is far more important to ensure that change is pursued within a democratic political and legal framework, in which there is appropriate opportunity for others to express alternative views and through which the unavoidable conflicts of social evolution can be contained with a minimum of harm.

6.3 A strategy for the health of the nation

6.3.1 Origins of change

The desire for a nationwide strategic approach to health promotion is not new. For example, in the early 1940s Julian Huxley wrote an article in the then widely read journal Picture Post, entitled *Health for All.* It called for a co-ordinated approach, focused particularly on enhancing the health of mothers and young children. At around the same time the British Medical Association produced a 'Charter for Health', which again advocated the establishment of a coherent strategy

(Calman 1992). During the 1970s and 1980s both the Labour and Conservative parties argued for more effective programmes of disease prevention and health promotion.

Internationally, the United States has since the late 1970s been developing a targeted to the health of its people (US GPO 1980). In addition, the work of groups such as the Canadian Task Force on Periodic Health Examination and the US Preventive Services Task Force (1989) made relatively early and significant steps towards understanding what forms of medical/health care can most effectively contribute to this area. (See also *Preventing Disease—Beyond the Rhetoric*, Goldbloom and Laurence 1990).

In Britain, however, there was apparently little government effort directed at identifying a comprehensive approach to health promotion during most of the 1980s. Although the record of the Welsh authorities in building a targeted strategy deserves recognition, perhaps the most important contribution to this goal came from an independent group originally established and supported by the Health Education Council (the body which preceded the Health Education Authority) the Scottish Health Education Group, the King's Fund and the London School of Hygiene and Tropical Medicine.

Formed in 1985, it produced a report entitled *The Nation's Health* just under three years later (Revised edition Jacobson, Smith and Whitehead 1991). This contained a wide ranging review of evidence relating to prevention and health, which identified 17 major areas for public health action. These were further prioritised on the basis of information available about the scale of the problem/opportunity involved, the probable effectiveness of the intervention options available and the levels of public, professional and political support likely.

Using a framework not dissimilar to a categorisation first employed by the Canadian Task Force, the 17 public health action areas were consequently divided into three groups. Those where immediate action was recommended were:

- tobacco use;
- diet;
- alcohol use;
- physical activity;
- sexual health;
- road safety;

- maternity services;
- dental health;
- early cancer detection;
- high blood pressure reduction;

For each of the recommended action areas *The Nation's Health* laid down a series of general objectives, specific targets to be achieved by or before the year 2000, and implementation recommendations. Suggestions were made for central government action, health promotion programmes, and industry, media, professional, local authority, health service and trade union contributions.

Some of the thinking underlying this report can be questioned. For example, while recognising the role played by successful economic activity and personal employment in maintaining health, it made little effort to quantify the impact on certain industrial sectors that its recommendations could have. Suggestions that, for instance, total alcohol usage should be cut by 20 per cent and sugar consumption almost halved in a period of a decade or so might well have a significant impact on those industries. Nor did *The Nation's Health* examine in detail the mechanisms by which many of its targets could be implemented, or calculate the full costs of the interventions required as against measures of their benefit. The authors pointed out that such data was in many instances not available to them.

However, notwithstanding these and other similar concerns, it was an impressive contribution to the British debate on health promotion, which at the central government level had moved little since the publication of *Prevention and Health: Everybody's Business* in the mid 1970s. It was followed shortly afterwards by the *UK Levels of Health* papers from the Faculty of Public Health Medicine (1991, 1992). These created further pressure for a coherently planned, target driven, approach to maintaining and improving standards of health. Virginia Bottomley claimed in her introduction to the 1992 white paper *The Health of the Nation* that *'the reforms of the NHS have made this strategic approach possible'*. An alternative interpretation of events is that mounting external demands finally made strategic inaction an impossible option for health policy makers.

The objectives and targets laid down in the 1992 document (see Box 1.1, page 3, and Box 6.1) may seem modest compared

Box 6.1 Health of the Nation risk factor targets

Smoking

To reduce the prevalence of cigarette smoking to no more than 20% by the year 2000 in both men and women (a reduction of a third) (Baseline 1990)

To reduce consumption of cigarettes by at least 40% by the year 2000 (Baseline 1990)

In addition to the overall reduction in prevalence, at least 33% of women smokers to stop smoking at the start of their pregnancy by the year 2000

To reduce smoking prevalence of 11–15 year olds by at least 33% by 1994 (to less than 6%) (Baseline 1988)

Diet and Nutrition

To reduce the average percentage of food energy derived by the population from staturated fatty acids by at least 35% by 2005 (to no more than 11% of food energy) (Baseline 1990)

To reduce the average percentage of food energy derived from total fat by the population by at least 12% by 2005 (to no more than about 35% of total food energy) (Baseline 1990)

To reduce the proportion of men and women aged 16–64 who are obese by at least 25% and 33% respectively by 2005 (to no more than 6% of men and 8% of women) (Baseline 1986/87)

To reduce the proportion of men drinking more than 21 units of alcohol per week and women drinking more than 14 units per week by 30% by 2005 (to 18% of men and 7% of women) (Baseline 1990)

Blood pressure

To reduce mean systolic blood pressure in the adult population by at least 5 mm Hg by 2005 (Baseline to be derived from new national health survey)

HIV/AIDS

To reduce the percentage of injecting drug misusers who report sharing injecting equipment in the previous 4 weeks from 20% in 1990 to no more than 10% by 1997 and no more than 5% by the year 2000

with those suggested by other analyses. In many disease areas they represent little more than extrapolations of trends established (after long time lags) by past changes in the living conditions of the population. And it could be argued that it would have been more logical to make changes in risk factors the main targets of the programme. Effects in this area could more

Table 6.2 Mortality from leading causes, England and Wales, 1991

	Males				Females			
	No of deaths (000s)		Years of working life lost (000s)		No of deaths (000s)		Years of working life lost (000s)	
	All ages	(%)	15–64	(%)	All ages	(%)	15–64	(%)
All causes, all ages	278		967		292		568	
All causes, 28 days and over	276	(100)	881	(100)	291	(100)	502	(100)
All malignant neoplasms	75	(27)	185	(21)	68	(24)	196	(39)
Lung cancer	23	(8)	41	(5)	11	(4)	20	(4)
Breast cancer					14	(5)	58	(11)
Genito-urinary cancer	14	(5)	15	(2)	10	(3)	38	(7)
Leukaemia	2	(1)	14	(2)	2	(1)	9	(2)
Circulatory disease	126	(46)	211	(24)	136	(47)	76	(15)
Ischaemic heart disease	82	(30)	148	(17)	68	(24)	34	(7)
Cerebrovascular disease	26	(9)	28	(3)	43	(15)	23	(5)
Respiratory disease	31	(11)	41	(5)	32	(11)	26	(5)
Pneumonia	10	(4)	14	(2)	19	(6)	8	(2)
Bronchitis, emphysema, asthma	5	(2)	11	(1)	3	(1)	7	(1)
Sudden infant death	1	(0)	29	(3)	0	(0)	17	(3)
All accidental deaths	7	(2)	143	(16)	5	(2)	42	(8)
Motor vehicle traffic accidents	3	(1)	87	(10)	1	(0)	25	(5)
Suicide	3	(1)	67	(8)	1	(0)	14	(3)

Source: DoH 1992

immediately be linked to policy and service developments. But political restraints, perhaps in part related to the Department of Health's perceived need to lead the *Health of the Nation* initiative, appear to have precluded this approach. Many commentators also regarded the failure of the white paper clearly to analyse and recommend action on the relationships between poverty, inequity and poor health as a major omission.

But the white paper was a welcome step for all those concerned to see government address more explicitly health promotion issues and responsibilities. In political terms there is little doubt that it would have been counter-productive for those seeking progress to have made the ideal the short-term enemy of the viable. It may be argued that it was appropriate that the initial programme should be focused on a limited number of realistic, achievable and measurable goals. Issues such as tobacco smoking, obesity and lack of exercise, fat consumption, excessive alcohol usage, HIV transmission, blood pressure control, accident reduction and breast cancer identification and treatment were central to its approach. This array of factors contributes critically to the premature loss of life recorded in Table 6.2, although research evidence is not fully complete in all these contexts.

6.3.2 *Building the programme*

The arrangements announced in *The Health of the Nation* white paper included:

- **the establishment of a Cabinet Committee** (covering 11 departments) to oversee the introduction, monitoring and development of the English strategy. This is supported by three working groups, the *Wider Health Working Group*, the *CMO's Health of the Nation Working Group* and the *Chief Executive's Working Group on NHS Implementation*. They concentrate on issues related to broad health policies, health priorities and the implementation of appropriate NHS policies respectively;
- **the formation of 'healthy alliances'** between organisations operating at both local and national levels. In addition to NHS authorities, Trusts and general practices, agencies with health related interests and responsibilities include local authorities, voluntary organisations, employers and the media. The *Health of the Nation* approach creates new opportunities for such bodies to work together in areas such as smoking reduction and the encouragement of healthy eating and exercise;
- **the identification of key settings for health promotion campaigns**. The *Health of the Nation* lends support to 'healthy city' programmes such as

those in Sheffield, Liverpool and Camden, and to similar initiatives focused on schools, hospitals, work-places, homes and other environments. These are aimed at involving people in health promoting activities in the places where they spend most of their working and/or domestic lives;

- **special responsibilities for the NHS**. The health service is required to set an example to other employers and service providers, as well as to address generally the achievement of better health standards. The 1992 white paper argued that a major challenge confronting the NHS *'is to establish a more direct link between what it does and the results in terms of improved health for both individuals and the population more widely'*. It charged health authorities with the task of establishing local health targets and helping to form healthy alliances with other agencies. Providers, both hospitals and general practices, are to contribute directly to health promotion efforts, and to become exemplary 'healthy work-places'. Arrangements have been made to share relevant knowledge and expertise through, for example, the establishment of appropriate networks and the publication of handbooks on key areas;
- **mechanisms for performance monitoring and strategy development and review**. These entail new or extended health surveys on topics like fitness, nutrition and mental health/morbidity, together with epidemiological overviews of areas such as the health of elderly people. The *Health of the Nation* strategy also requires sustained research on outcome indicators and on the collection and transmission of effectiveness information; enhanced annual health reports from local directors of public health; and national level progress reviews, issued on a regular basis.

The Health of the Nation: One Year On (Department of Health 1993) detailed the wide range of activity undertaken during 1992/93 in establishing this programme. It provided evidence that in the health service in particular it has already achieved a marked impact, and that with respect to most disease targets satisfactory progress has taken place. Yet during the course of the next decade the agenda laid down in *The Health of the Nation* will require a great deal more effort from people working in the NHS and other public and private organisations if it is to prove a genuine success. In return it has the potential to contribute significantly to the well-being of the British population. Even in areas where either target attainment proves impossible or health gains fail to follow as expected it could generate new understandings, and so open the way to new opportunities for more effective action.

There are of course criticisms of the strategy. 'Management by target setting' may distort overall health service activities (and particularly those in complex, quality of life related areas

where the value of care is not easily measured). Further unachievable goals could undermine the credibility of more attainable health promotion objectives.

One particular problem area at present is that data on health dangers like smoking, hypertension, obesity and adversely raised cholesterol levels is not aggregated in a manner which can generate meaningful information about local populations' overall chances of developing conditions such as heart disease. Synergies can only be taken into account if the extent to which there are overlaps of different risk factors in individuals or defined groups of individuals are recorded. This is not at present happening to a satisfactory degree, which could lead to an undesirable fragmentation of effort and health promotion resources in general practice and elsewhere.

It is also disturbing that it is in the area of risk factor control, and targets such as reduced smoking in young people and adults in disadvantaged social positions, that progress has been most disappointing. If approaches like anti-smoking advice from doctors and their colleagues backed by annual real increases in tobacco product prices are ineffective amongst these priority groups, new policies may need to be introduced. For instance, the long-term use of alternative, safer, routes of nicotine administration might need more actively to be encouraged, and if necessary subsidised in cases where there is highly resistant addiction.

A final illustration of concern regarding the *Health of the Nation* plans and goals relates to suicide, the only quantified mental health objective. This is currently the third commonest cause of years of life lost in young men. The target is to reduce the overall rate by fifteen per cent by the year 2000. But the actual rate is rising, and there are no interventions available which have as yet been shown to have an effect sufficient to meet the goal set (Gunnell and Frankel 1994). At worst this could encourage misleading activities like the reclassification of suicide deaths under other headings. A more likely possibility, however, is that it could engender a degree of cynicism, and renewed questioning of the extent to which the NHS should be investing in unproven preventive activities as against curative and allied interventions of immediate, tangible, value.

6.4 Health care and health promotion

Most people turn to the health service because they feel ill, or need help with a pressing problem. Even patients attending health 'checks' may well be looking for psychological support to assist them in facing the present, rather than making investments in their long-term future health. Failure to recognise such simple realities could encourage developments in the health service which would reduce for little or no commensurate gain its ability effectively and efficiently to help those with current care needs to maintain an acceptable quality of life.

As illustrated by the models discussed above, health promotion is not only about disease avoidance—ultimately everyone must age and die. It is also about equipping individuals to cope with painful or distressing disorders, minimising their disabilities and, wherever possible, curtailing the occurrence of social handicaps. Although primary and secondary forms of intervention such as screening and educating healthy individuals about how to avoid risks are valuable, they should not be allowed to obscure the worth of interventions to help those already affected by symptomatic illness. There is a growing body of work that suggests that long-term health promotion advice is often only accepted in circumstances where those receiving it feel their immediate treatment needs have appropriately been met (Pill *et al.* 1988).

To achieve goals such as that of reducing premature mortality through primary prevention a long-term strategic approach is needed. (One important lesson to be derived from the *Health of the Nation* could be that Britain might benefit from the formulation of similar plans in a wide range of other areas from transport to energy, education and housing). But there is no inherent reason for the nation's broad health strategy to be led medically, or by the Department of Health. The primary business of doctors and health services is arguably to treat illness. To deny this may in some ways destructively reduce awareness of the ability of everyone in society to help generate positive health, and of the vital roles to be played in this context by agencies in the local authority and private sectors.

The *Health of the Nation* programme does acknowledge this type of concern. There is nevertheless a danger that in practice health promotion will remain seen as exclusively a health

service Health Department responsibility. This would be counter-productive, particularly if in future it served to impair the efforts and/or commitment of health professionals to meet the immediate care needs of service users.

Summary

- 'Health' is a concept with various medical and nonmedical meanings. Patients' experiences of 'ill-health' are complex.
- Various models of health promotion follow from different approaches to health. Their utility lies in the extent to which they help generate effective and efficient action for better standards of health and welfare.
- In Britain, government appeared reluctant to identify a comprehensive approach to health promotion until recently, despite calls for such a national strategy since the 1940s.
- The objectives and targets in the *Health of the Nation* document appear modest compared with those suggested by other analyses. However, they represent a positive, viable approach to health promotion issues and responsibilities.
- Health promotion is not only about disease avoidance, but also about equipping individuals to cope with painful or distressing disorders, minimising their disabilities and where possible stopping the occurrence of social handicap.
- There is no inherent reason for the national health strategy to be medically, or Department of Health, led. There is a danger that health promotion will remain seen as exclusively a health service responsibility, which would be counter-productive.

7

SCREENING AND CASE FINDING IN PRIMARY CARE

7.1 Screening programmes

7.7.1 The need for evidence of effectiveness and efficiency

In his 1971 Rock Carling monograph *Effectiveness and Efficiency* Archie Cochrane commented:

> 'it is surely a great criticism of our profession that we have not organised a critical summary, by specialty or subspecialty, updated periodically, of all randomised controlled trials'.

His point is as valid today as it was two decades ago. Indeed, given the plethora of medical and allied research now being generated, there is arguably a greater need than ever before for brief, authoritative guidance for family doctors and other health care professionals as to what interventions and delivery procedures are believed to be of optimal value right across the broad range of care responsibilities they carry. The formation in the early 1990s of the Cochrane Centre in Oxford as part of the NHS research and development programme can be taken as a (perhaps somewhat belated) recognition of this requirement (Chalmers *et al.* 1992). So too is the production of publications such as the *Effectiveness Bulletins*, and the establishment of agencies such as the NHS Centre for Reviews and Dissemination at York.

There are already some examples of reviews in the context of screening. The work of the Canadian Task Force on Periodic Health Examination and the subsequent US Preventive Services Task Force and, in Britain, the Nuffield Provincial Hospitals Trust study *Screening in Health Care* (Holland and Stewart 1990) go some way to providing examples of the sort of comprehensive, disciplined work Cochrane believed to be vital. However, there is still a widespread tendency towards uncritical acceptance of the value of medical interventions,

especially those which, like screening, are popularly thought to be harmless. Whether beliefs of this sort stem from patients' fears of illness and the consequent reaction that any chance of protection or treatment should not be accepted, or from the excessive claims sometimes made by those on the providing side, they can have damaging results.

7.1.2 Positive and negative consequences of screening

McKeown (1968) defined screening as a medical investigation which does not arise from a patient request for advice for help with a specific complaint. Such events may occur, first, in the context of research; second, as part of public protection programmes aimed at identifying risks not necessarily to the individual but to those around her or him; and, third, as measures aimed directly at enhancing the future welfare of the subject being examined. Less desirably, screening may also be offered purely as a means of deriving earnings or profits for the provider, regardless of whether it does the patient good or harm. And in some circumstances its provision may have a political objective, serving perhaps as a way of gaining popularity for governments whose 'health credentials' have been questioned (D'Souza 1992). The fact that screening may be advocated for reasons which have little or nothing to do with the health of those being examined and/or subsequently treated adds further to the need to look carefully at its disadvantages, as well as its potential benefits.

The latter can include an improved prognosis for those treatable cases detected early, together on occasions with a reduction in the need for more radical interventions; financial and other resource savings; and reassurance for those told that there is nothing wrong. It may also be suggested that testing individuals for risk factors such as cholesterol levels will serve to inform them about factors which may cause ill-health and positively encourage the adoption of less hazardous life-styles (Standing Medical Advisory Committee 1990—unpublished) although this contention is unproven. At a community level screening can result in reduced levels of infection transmission, and/or information leading to the redistribution of resources towards those judged most in need of care.

There are however a range of negative possibilities:

- **extended morbidity for cases whose prognosis is unaltered**. Mant and Fowler (1990) pointed out that in the 1950s mass radiography and sputum cytology tests for lung cancer detection were at first thought to facilitate effective early treatment. Trials showed five-year survival rates to be twice as high in subjects whose lung cancer was detected by screening as compared to controls. But this proved to be a chimera. Ten-year survival rates were eventually shown to be the same in screened and control populations—the only 'benefit' received by the former was longer knowledge of their condition. Currently there is some concern in the United States some young women are being advised to accept breast cancer screening and treatments on the basis of similarly inadequate data (Neuberger 1992);
- **overtreatment of questionable abnormalities, and the 'medicalisation' of normal individual variations in physiological or psychological functioning.** For example, over-enthusiastic and/or inappropriate interventions in cases of mild hypertension can lead to a disproportionate level of unwanted side effects, such as impotence in males. The compensatory gains for the individuals concerned in terms of reduced personal risk are likely to be very modest. Rose (1981) has pointed out that it is a paradox of prevention that the largest gains for a community as a whole are, statistically at least, often likely to stem from actions affecting the majority of the population who are at relatively low risk, rather than the minority at high risk. Targets such as the reduction of average blood pressure or LDL cholesterol levels in a given population could, if inappropriately pursued, result in the mistreatment of many individuals whose disbenefits might exceed the benefits enjoyed by others (Davey Smith and Egger 1994a). There is also evidence that labelling individuals as, for instance, 'hypertensive' may cause psychological and related morbidity (Haynes *et al.* 1978). In the case of individuals identified as, say, smokers or HIV positive there is also a risk of unfair discrimination;
- **displacement of resources from productive to less productive areas of care**. Screening programmes already cost the NHS around £400 million per annum. But prevention is not always better than cure, both in simple monetary and true economic terms. Resources spent on demonstrably unproductive screening such as mass investigations for proteinuria, haematuria, glycosuria and/or bacteriuria represent a loss of more useful opportunities for action, while attending screening programmes may impose financial as well as psychological costs on patients;
- **false reassurance for individuals with false-negative results, and needless anxiety for those with false positive findings.** On occasions, being screened and found to be in reasonable health may encourage individuals to ignore warnings about hazardous life-styles. Those with false-negative results may be led to disregard signs or symptoms of illness. And at worst people with false positive results may become depressed or even be led to suicide. So too, of course, may those with true positive results, especially in cases where the responses of those around them are aimed primarily at protecting the rest of the population;

- **harm caused by the test itself.** Unwanted abortions and fetal damage caused by amniocentesis offer direct examples of this potential disbenefit. But as noted above tests for habits such as smoking or excessive alcohol use could also prove harmful in social terms if they ultimately encourage health professionals emotionally to reject and/or to refuse to treat those seen as the 'authors of their own misfortunes' because they behave in ways not approved by the health care establishment.

With good organisation and appropriate patient care values the above dangers may be minimised, if not entirely avoided. At national level, for instance, the recently announced approach of forming policy advisory committees rigorously to evaluate the case for new screening programmes should help avoid any tendency to drift into unproductive practices (Calman 1994). But at the same time major efforts are needed better to structure and run existing programmes, let alone new ones. To avoid inappropriate screening and allied workloads being placed on primary care professionals during the 1990s a rigorous approach will also be needed to the evaluation of current programmes, including the working of the new banded health promotion payments system in general practice. There are informed concerns that this stimulates large amounts of data collection (unstructured risk factor screening) rather than more useful efforts to identify those cases where specific, effective, interventions could be made.

7.2 Programme development

7.2.1 Key issues

Wilson and Jungner (1968), Cochrane and Holland (1971), Cuckle and Wald (1984) and Holland and Stewart (1990) have all elaborated sets of principles and requirements for the establishment and evaluation of worthwhile screening programmes. Key issues to be resolved relate to:

- the sensitivity, specificity and value in use of the tests available;
- the social acceptability of the procedures involved, and their ethical implications;
- the benefits to be gained from reductions in the morbidity/mortality caused by the condition being screened for, and the effectiveness of the interventions available to achieve this; and
- the total costs and workloads likely to be imposed by the treatment needs revealed.

Table 7.1 Screening in the UK at the end of the 1980s—summary of the recommendations of Holland and Stewart (1990)

Life cycle stage	Condition	Status (1990)	Holland and Stewart's recommendations
Antenatal	Down's syndrome	Selection of women for diagnostic amniocentesis on the basis of age (>35 yrs) or family history of chromosomal abnormality	Screening using amniocentesis on the basis of maternal age in conjunction with three biochemical markers and possibly also ultrasound
	Haemoglobin-	No national policy—local fetal screening for at-risk groups either on request or in research context	Serological screening and chorionic villi sampling for appropriate ethnic minority groups
	Neural tube defects	No national policy—*ad hoc* screening arrangements satisfactory in some areas, less so in others	Routine AFP screening in high-risk areas
	Syphilis	Serological screening performed routinely at first antenatal visit	As at present
	Rubella	As for syphilis	As at present
	Hepatitis B virus (HBV)	Effective tests available	Not recommended at present. Further research needed
	HIV virus (AIDS)	No national policy. Effective tests available	Not recommended at present. Further research needed
	Gestational diabetes	Effective tests available	Not recommended at present. Further research needed
	Asymptomatic bacteriuria	No national policy. Doubt as to whether treatment is effective	Routine assessment in the first three months of pregnancy. Effective treatment available

(continued overleaf)

Table 7.1 *(continued)*

Life cycle stage	Condition	Status (1990)	Holland and Stewart's recommendations
Neonatal	Phenylketo-uria (PKU)	Routine in the neonatal period	Routine screening as at present
	Congenital hypothyroid-ism	National screening programme established in 1982 working with the programme for PKU	Routine screening as at present in conjunction with that for PKU
	Other inborn errors of metabolism	No national policy—screening availability variable according to locality	Other conditions where early detection could be useful include galactosaemia, maple syrup urine disease, homocystinuria . . . Further research is needed
	Cystic fibrosis	No national policy—screening availability variable according to locality	Screening may be appropriate in affected families. Better tests are being developed using DNA technology
	Congenital dislocation of the hip Developmental disorders Impairments of vision/ hearing Heart disease Asthma Undescended testes	Routine clinical practice in neonatal period but doubt about whether tests are adequate or meaningful	Further evaluation of benefit essential although serious defects are likely to be identified by routine neonatal examination

Child-hood	Immunisation status	90–100% uptake is aim	Routine examination in primary care and education service—every opportunity should be taken to encourage uptake of appropriate immunisations to reach target
	Visual/ hearing impairment	Routine examinations in primary care and education service	Routine check of visual acuity and hearing in conjunction with observations from parents, teachers etc
	Iron deficiency anaemia	No national policy—*ad hoc* local arrangements and research programmes	Screening may be useful in certain ethnic minority or socially deprived groups. We do not consider that screening should be done routinely
	Mental and physical development	Routine examinations in primary care and education service but value uncertain	Changes in developmental screening practices may be evaluated first in one or two areas. No evidence that routine measurement of height and weight is beneficial
Adole-scence	Scoliosis	Routine examination with visual inspection the suggested procedure	Routine screening not recommended until there is further evaluation
	Rubella	No national policy	Effors should be devoted to improving awareness of the potential dangers of the virus in pregnancy and providing immunisation as necessary

(continued overleaf)

Table 7.1 *(continued)*

Life cycle stage	Condition	Status (1990)	Holland and Stewart's recommendations
Young adulthood	Hepatitis B HIV Venereal disease Cigarette smoking Alcohol or drug abuse	No national policy—variable local arrangements	No routine screening recommended. Every opportunity for health education should be taken
	Family planning/ genetic counselling	No national policy—variable local arrangements	Referral to specialist service for those considered to be at risk
	Psychiatric disorders	No national policy	An important problem but no satisfactory screening test or solution. Further research needed
Adulthood **Men**	Risk of coronary heart disease; Hypertension; Cigarette smoking;	No national policy—emphasis on advice in primary care and health education (note subsequent *Health of the Nation* and revised GP contract)	Screening for risk factors during normal consultation—weight, family history, cigarette smoking, blood pressure routinely, cholesterol if indicated
	Blood cholesterol level	Individual local arrangements and research projects	

	Cancer:	No national policy	
	Colorectal	No national policy	Screening no recommended at present—results of current research may change this
	Lung	No national policy	Routine questions about smoking habits during normal consultation
	Bladder	Takes place as part of occupational screening	Worksite screening
	Psychiatric disorders	No national policy	An important problem but, as noted above, no satisfactory screening test or solution. Further research needed
	Diabetes	No national policy	No recommended routinely—further evaluation necessary
Adulthood	Risk of coronary heart disease	No national policy—emphasis on advice in primary care and health education (see above note)	Screening for risk factors during normal consultation—weight, family history, cigarette smoking, blood pressure routinely; cholesterol if indicated
Women			
	Cancer:		
	Cervix	National screening programme established in 1964	Continuation and improvement of national screening programme established in 1964
	Breast	National screening programme established in 1988 for women aged 50–64 years	Effective establishment and evaluation of national screening programme
	Osteoporosis	No national policy	Not recommended at present but those at risk should be offered hormone replacement therapy

(continued overleaf)

Table 7.1 *(continued)*

Life cycle stage	Condition	Status (1990)	Holland and Stewart's recommendations
	Diabetes	No national policy	As for men
	Psychiatric disorders, particularly depression	No national policy—ad hoc local arrangements	An important problem but no satisfactory screening test or solution. Further research needed. More attention to be paid to basic psychiatric training for GPs
Old age	General functions: sight, hearing, mobility		Screening to be undertaken during normal routine consultations with referral to specialist services as appropriate
	Psychiatric disorders: dementia, depression	No national policy—*ad hoc* local arrangements	
	Anaemia	*(see revised GP contract)*	Attention to be paid to those felt to be at risk of certain conditions—e.g. glaucoma. Eye tests should be exempt from charge
	Hypertension		

Source: Holland and Stewart 1990

Table 7.1, reproduced from Holland and Stewart's study, indicates the range of screening activities which these authors, on the basis of information available in the late 1980s, judged to be of value. It remains highly relevant to the circumstances of the mid 1990s, although since its publication several important developments have taken place, and some additional screening issues have arisen. The *Health of the Nation* policies towards coronary heart disease prevention and other key areas offer the most important illustrations of the former, while the growing interest in the possibility of a screening programme to detect aortic aneurisms in older men is an instance of the latter.

The sections below comment on questions raised by Holland and Stewart on an age group by age group basis. But before this it is worth emphasising that it is unrealistic to expect each busy practitioner and/or practice team to be able to make detailed, independent, assessments of which screening procedures they should or should not offer to their patients, or advise them to accept. In an attempt to translate the complex range of issues that screening and allied topics raise into practical questions for general practitioners and their practice colleagues Mant and Fowler have suggested that the following should be answered to the satisfaction of each professional:

- can we offer effective treatment for patients positive on testing?
- how many positive tests will prove to be false alarms, and is this acceptable?
- how many patients will need follow-up over the next five years, and can we sustain the workload?
- how are we going to audit routinely the quality of the test, of the intervention, and of the follow-up?

Even reduced to this set of minimum criteria, many or most non-academic practices/practitioners would on their own be hard pressed to produce adequate responses. If the performance of primary care screening services is effectively to be monitored and their development guided on the basis of the best available information, new forms of long-term partnership between practices and external (local) support agencies will very probably have to be formed. The approach of unified commissioning authorities to this challenge is likely to be a significant influence on the nation's long term health.

7.2.2 *Antenatal and child care*

In many areas of antenatal and neonatal screening primary care professionals are not, as yet at least, normally in a position to offer screening tests directly. Yet they may well be uniquely placed to identify particular individuals and/or families who might derive significant benefit from the tests, to help them access services, and (in cases where either prevention is possible or life-long problems will have to be faced) to act as a focal point for subsequent programmes of personal support or continuing family centred service provision. This is a sensitive and challenging area because of social as well as technological factors. Providing effective support and advice on matters such as family planning, abortion, and child care to all members of a highly plural community requires both tact and the ability to respect values which may differ from one's own.

Given advances such as 'triple test' blood screening for Down's Syndrome risk markers and the availability of an expanding range of detection procedures (and treatments) for conditions such as cystic fibrosis, Huntingdon's chorea, and fragile X syndrome (Yorke-Moore 1992) family doctors need constantly updated information on the services which are, or should be, available to their patients. Around 2-3 per cent of all couples are at high risk of having children with genetic disorders; by the age of 25 about one person in 20 shows signs of such a complaint (Harris 1991). Facing such problems constructively can be a very demanding task, which requires close cooperation between service users and providers.

A similar need for positive partnership between parents and professionals such as general medical practitioners, practice nurses and health visitors exists in the context of child health, even with respect to seemingly simple tasks such as promoting improved immunisation uptake rates. The findings of the Hall reports (see, for instance, Hall 1989) placed emphasis on the importance of parental (and teacher) concerns, and the extent to which health professionals should be guided by them in their efforts to identify developmental problems. In the related area of attempts to reduce the incidence of low birth-weight babies and morbidity and/or mortality amongst infants born to vulnerable mothers there has also been a shift of emphasis away from imposed professional prescription towards increased

recognition of the benefits of less directive support. Once again, this is likely to demand additional investments of time and effort, together with new attitudes towards the delivery of health and social care within an appropriate framework of general practice.

7.2.3 *Care for young adults*

Adolescents and young adults are normally physically robust, but frequently under considerable psycho-social stress (Blaxter 1990). Their preventive and other health care needs can easily be neglected, both by themselves and those around them. This group is subject to a wide range of pressures and risks, from the more commonly recognised anxieties and hazards of exploratory sexual behaviour (which include today HIV as well as unwanted pregnancy) to the problems of unemployment and the challenges of further education. During the inherently difficult (and in modern society frequently extended) period of transition from childhood dependence to the establishment of a satisfactory adult identity many people are high risk from psychological distress, accidents and self inflicted harm, homelessness, interpersonal violence, and the acquisition of smoking or other drug habits.

From a health promotion viewpoint a strong case can therefore be made for disciplined, comprehensive efforts to identify and supply effective services for this group, designed to meet their needs and priority concerns rather than crudely to impose the values of other sections of the community upon them. In general practice, for example, more emphasis on constructing 'rights of passage' to enable children and adolescents to change status within the practice context without having to sacrifice care continuity could prove a valuable approach.

7.2.4 *The working age population*

Measures introduced to reduce the number of deaths from cancer of the cervix and breast in women (aged over 50) provide contrasting examples of mass screening programmes. In the former area a report from the National Audit Office (NAO 1992) observed that *'general practitioners and National Health Service staff*

deserve credit for (recently) *securing a significant increase in the proportion of eligible women screened'*. This rose in England from 43 per cent in 1989 to 74 per cent in 1991. Given the long-standing concerns about this programme, which dates back to the 'Doctor's Charter' in the mid-1960s, this was a striking achievement. It and subsequent progress appears to justify the target payment oriented approach taken in the 1990 contract.

Although there is still some reason to be concerned about matters like the accuracy of the (GP list based) population registers available and the apparently low take up of screening in areas such as inner London, the available evidence now indicates that cervical screening in this country may soon begin to show the sorts of life-saving return already being recorded in parts of Scandinavia. The overall value and cost effectiveness of the programme will, however, depend on its ability to reach those women in socially less advantaged positions who use traditional mass screening provisions least, and are at the highest risk of death from cervical cancer.

The NAO also considered the programme to screen for breast cancer, which is harder to treat successfully and, unlike cancer of the cervix, is more likely to affect women in higher social classes. It found the national arrangements, first established in 1987, to be well managed. Their emphasis on defined standards and quality assurance was contrasted favourably with the relatively haphazard approach which in the past has characterised the more disseminated cervical screening programme. In the latter context the need for more central guidance on how to interpret smears and to deal with abnormalities reflects the general requirement of worthwhile screening programmes to be based on an objective, effectiveness information based, consensus about diagnostic criteria and therapeutic regimens.

This last observation also has important implications with regard to the prevention of coronary heart disease, a central objective of the government's *Health of the Nation* strategy. The 1990 contract and the subsequent developments have encouraged a broad multiphasic approach to screening for risk factors in general practice. But established data from this country, the United States and Scandinavia casts considerable doubt on the value of such a strategy (Holland 1994). Several large trials aimed at demonstrating the benefits of advising

populations (mainly of males in middle and later life) about diet, physical activity, smoking and the control, where appropriate, of raised blood pressure and cholesterol levels, have not shown the results hoped for. Indeed, they could even be taken to indicate that 'broad brush' interventions intended to prevent heart disease are at best useless and at worst do more harm than good (Oliver 1992; see also McCormick and Skrabanek 1988).

Debate in this area, for example that related to the desirability or otherwise of using cholesterol/low density lipoprotein ratio lowering drugs, is complex (see Law *et al.* 1994, Davey Smith and Eggar 1994b, Law and Wald 1994). However, it is now widely agreed that raised levels of cholesterol are the primary predisposing factor to ischaemic heart disease, and that diets which result in naturally low levels protect individuals from this condition (the largest single cause of death in Western developed nations). Recent estimates suggest that in a population such as that of the UK a 10 per cent fall in serum cholesterol could lead to a 50 per cent reduction in heart disease at age 40 and a 30 per cent reduction at age 60 within two to five years.

The value of reducing average cholesterol levels through lifestyle alterations, eliminating smoking, treating hypertension and diabetes, and exercising more (Wannamethee and Shaper 1992) is not really in any doubt. What can be seriously questioned is the effectiveness of untargeted, blanket health checks in contributing to desired life style changes (Mant 1994, Stott 1994). Recent results from the OXCHECK and British Family Heart studies (ICRF OXCHECK study group 1994, Family Heart Study Group 1994) of intensive nurse led programmes in primary care show that overall levels of risk were only slightly reduced. By contrast findings on the life saving potential of interventions such as the use of aspirin and thrombolytic drugs to protect individuals suffering suspected heart attacks (see, for instance, Underwood and More 1994) emphasise the value of good tertiary prevention/treatment.

The conclusion to draw in this context therefore seems to be that in relation to primary prevention and the overall reduction of the population's risk of heart disease and other disorders with common causes, more emphasis needs to be placed on non-medical strategies. The efforts of professionals

in primary care can be devoted most efficiently to the care and case management of individuals situated at the more extreme end of the hazard distribution curve, such as those who already have conditions such as diabetes, angina or a record of heart attack, and those who need emergency help (Charlton *et al.* 1994). Yet in accepting this it is important not to neglect the proven value of opportunistic case finding in general practice, of good personal advice given at the right time, and of the focused provision of support for individuals such as those trying to give up smoking (Fullard *et al.* 1989, ICRF general practice research group 1993). The contributions of committed family doctors and other practice and community care professionals can have very a significant impact on life, as well as death, in their communities (Hart *et al.* 1991).

7.2.5 Screening and case finding in old age

Harris (1992) conducted a review of evidence available in this field. He identified four randomised trials (Tullock and Moore 1979, Vetter *et al.* 1984, Hendriksen *et al.* 1984, McEwan *et al.* 1990). Taken overall they indicated that interventions such as regular visiting and screening by nurses and/or annual health checks by doctors have little effect on morbidity amongst people aged over 70. They may, however, contribute to the morale of patients, and in two of the four studies examined hospital admission rates fell. However, in interpreting such findings it is necessary, as in all other areas, to distinguish between general screening and case finding, and the extent to which effective action to help those found to be at risk of or suffering from a condition is, first, technically possible and, second, has actually been taken.

Harris also noted that '*so far, easily defined measures of outcome, favouring the detection of medical disorders, have usually been chosen in preference to sensitive measures of functional disability.*' This is a critically important observation. If health care helps ensure the survival of increasing proportions of each population cohort to old age, then each individual can expect with increasing certainty to have to face challenges such as failing sight and hearing, dental problems of later life, and reduced mobility and cognitive ability. The work of health care professionals should arguably be increasingly focused in such

fields, which lie at the borderline between traditionally defined medical care and nursing/social support.

To some practitioners such a prospect may seem depressing. Escape to areas of high technology, disease focused care, perhaps legitimated by the efforts of other interested parties to narrow the responsibilities of the health service and broaden those of other agencies, may seem attractive. There is also a case against 'medicalising' old age. This can result in patterns of care and support which needlessly and harmfully undermine their recipients' sense of independence, self-worth and control over their lives.

But many elderly service users may still prefer to define their problems as in large part medical. For example, stroke, Alzheimer's disease and Parkinsonism are biological disorders, even if they have important social consequences. Being obliged to seek support from bodies like social service departments can itself be denormalising and a source of shame for some people. Further, most elderly people continue to need immediate treatment services provided by family doctors and other primary care professionals at fairly regular intervals. As such there is a powerful case for building on the initiative of the 1990 contract, defining and organising the preventive and other care contributions of general practice to this patient group.

Of course given current limitations in the community and other services available some professionals might argue that screening to reveal as yet unmet need amongst the population aged over 75 (or whatever threshold level is eventually judged best) is in some respects unethical. That is, it could create expectations which cannot be met. However, the identification and expression of unsatisfied service demand is often a vital pre-requisite for improved provision, and failure to expose care failures and/or to help stimulate consumer expectations which may ultimately drive improvement processes is also potentially unethical.

Indeed, if the availability of care for many old people is inadequate, it may be wrong for doctors and other health professionals to strive to extend life expectancy in the first place. Why attempt to restrict smoking, reduce hypertension or cut saturated fat consumption among young or old if survival well into later life is not a valued, desirable, state?

Given the central involvement of the medical profession in 'selling' activities which extend life, its members arguably have a moral obligation also to work to maximise its quality for those who survive to an age where minor impairments become a norm and disabilities commonplace.

7.3 Practice organisation

7.3.1 Structural requirements

Fowler and Mant (1990) outlined the practical issues to be addressed in making screening successful in general practice. They concluded that basic requirements include:

- **an accurate register of the population covered, and good records of the activities undertaken.** All the members of a practice involved in screening and structured health promotion of any type have important roles to play, although one named individual should have ultimate responsibility for maintaining the screening register. Training and professional development of reception staff is in this context as important as that for any other group. However, there is also a national responsibility for ensuring that genuinely efficient mechanisms exist for tracing NHS patients who move from one practice to another;
- **appropriate disease management protocols and training schedules for each programme element.** Helping people to stop smoking or to recognise and understand some of the psychological problems that they may face involves specific skills, as does supporting the implementation of dietary or other life-style related advice. Adequate long-term results in areas involving chronic ill-health also depend on clear disease management protocols. These are becoming available in a growing spectrum of areas, along with overall guidelines for preventive approaches in areas such as coronary heart disease. (See Figure 7.1 and Haines and Rayner 1991);
- **quality assurance schedules.** These should provide for the monitoring and review of each stage of screening and related processes, paying attention to practical details of, say, taking smears, blood pressures or blood lipid analyses as well as functions such as record keeping.

Regarding the organisational options to be considered the authors identified the following key areas:

- **patient recruitment.** The main choice here is between opportunistic screening initiated during normal patient instigated consultations (around 70 per cent of an average practice population consults every year, and over 90 per cent at least once in five years) and targeted population screening. Both can have advantages and drawbacks, although the former is now widely accepted as often the more viable way of reaching the

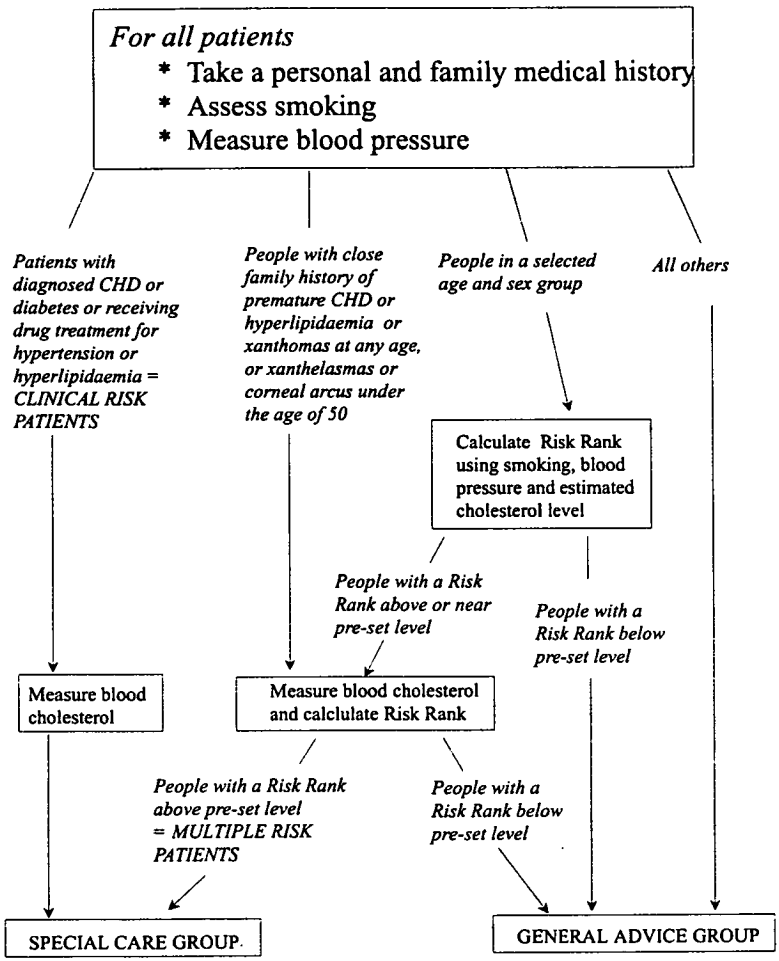


Figure 7.1 Preventing CHD in primary care: action plan. Source: Haines and Rayner 1991

most at risk sections of the community. However, to ensure comprehensiveness it is desirable to support this relatively informal approach with an audit system capable of identifying long term non attenders and comparing expected and actual intervention rates in the practice population;

- **dedicated clinics.** These are best used in the routine management of chronic diseases. As noted earlier an important criticism of the original

1990 arrangements for health promotion in general practice was that the incentive structure introduced caused a plethora of 'prevention clinics' to displace opportunistic screening conducted during normal consultations. The challenge with the system of payment that succeeded the 'healthy patient clinic boom' is to ensure that the greatly increased rate of discrete risk factor and symptom recording is matched by satisfactory increases in health gain. This may require more dedicated clinics for sick people;

- **targeting and staff roles.** One alternative to the practice based 'MOT check' model of health promotion in primary care is to make greater use of services which are designed to support patients in their own homes. For example, following an exercise designed to overcome the 'inverse care law', Marsh and his colleagues (Marsh and Channing 1986, 1988, Marsh 1992) achieved significant success in encouraging patients living in a relatively deprived area (of Stockton on Tees) to take up a range of preventive care opportunities. This was through a combination of opportunistic attention, letters to each household about preventive care items still outstanding, health visitor support, and domiciliary visits.

To gain practice improvements in areas like immunisation uptake and cervical smear rates Marsh and his colleagues employed extra staff, paid for from research and other non-NHS monies. They argued that the then allowance of up to two (70 per cent funded) ancillary staff was *'hopelessly inadequate for preventive care at this level'*. These authors suggested that an ancillary staff/GP ratio of 3:1 would be more appropriate.

7.3.2 Workload implications

Warnings about increased workload have also emerged from the findings of Tudor Hart in West Glamorgan (1991, 1992) and the Imperial Cancer Research Fund OXCHECK study group (1991). The former emphasised that the provision of continuing care is far more difficult than risk/need ascertainment, and argued that appropriate care for many people with chronic conditions can only be achieved through the organisation of dedicated clinics involving *'protected time, delegation to nurses and specialised training for them, recognition of defaulters, and shared learning in groups of patients with common problems'*. However, it is encouraging that Tudor Hart's case finding and sustained care approach appears, over a period of twenty five years, to have been effective in reducing mortality risks of at least a proportion of the individuals in his (relatively small) practice population.

Table 7.2 Indicative prevalences for problems identified as priority areas for health promotion and management of chronic disease in general practice for a hypothetical general practice in Newcastle upon Tyne with a list of 10 000 patients. Diseases are defined according to ICD-9

Condition	Scale of problem
Smoking[1]: Never smoked	2830 people at any one time
Former smoker	1969 people at any one time
Smoker	2689 people at any one time
Cardiovascular disease: Angina	175 people at any one time
Family history of premature myocardial infarction[1]	1715 people at any one time
Myocardial infarct deaths	18 deaths/year
Myocardial infarct survivors[1]	347 people at any one time
Coronary artery bypass grafts	3 operations/year
Hypertension	1145 people at any one time
Transient ischaemic attack incidence	4 new cases/year
Stroke incidence	20 people/year
Stroke deaths	18 people/year
Exercise target[1,2]: Achieved	617 people at any one time
Not achieved	6871 people at any one time
Body mass index[1,3]: Normal	4703 people at any one time
Moderate obesity	2183 people at any one time
Extreme obesity	602 people at any one time
Alcohol consumption[1,4]: Safe	5920 people at any one time
Hazardous	1285 people at any one time
Dangerous	283 people at any one time
Diabetes mellitus: Prevalence[1]	165 people at any one time
Deaths	1 death/year
Asthma: Admissions	41 people/year
Deaths	3 deaths/10 years

Source: Charlton *et al.* 1994

[1]Only people aged 16–74 years

[2]> = 12 occasions of vigorous activity in past four weeks for 16–34 year olds
> = 12 occasions of vigorous activity in past four weeks for 35–54 year olds
> = 12 occasions of moderate activity in past four weeks for 55–74 year olds

[3]Normal < 25, moderate obesity 25–39, extreme obesity > 39

[4]Safe < 22 units/week (15 for women); hazardous 22–50 (15–35 for women); dangerous > 50 (> 35 for women)

The OXCHECK study involved analysis of health checks given to a group of over 2000 patients drawn from five general practices in Bedfordshire. It found that amongst the 80 per cent of individuals aged 35–64 years who accepted the invitation to receive a nurse conducted health status/risk examination about three-quarters needed some form of specific advice or

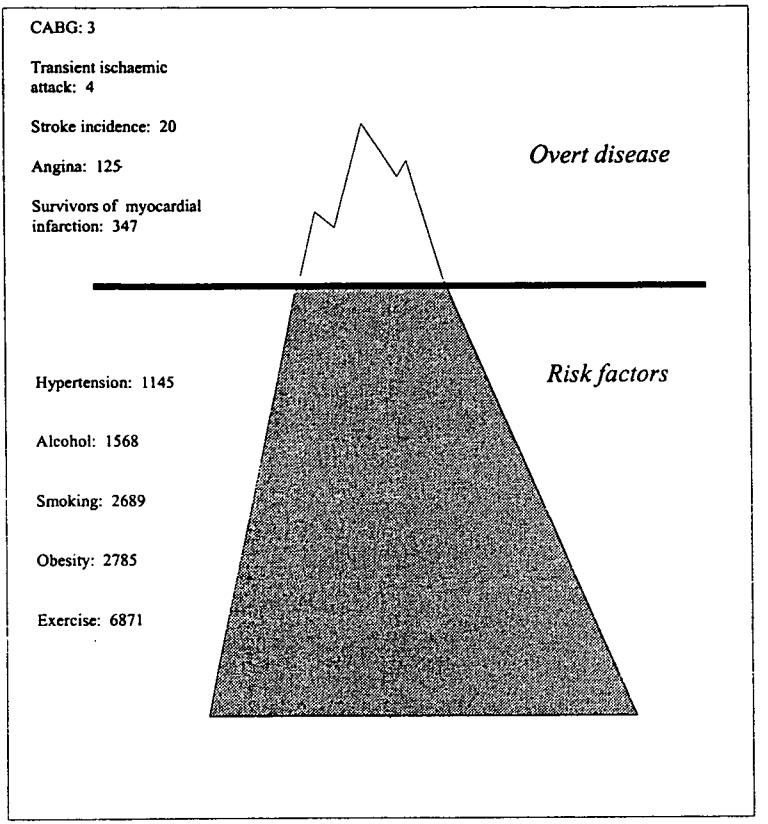


Figure 7.2 Coronary heart disease and stroke iceberg. Represents indicative prevalences for a hypothetical practice in Newcastle upon Tyne with list of 10 000 patients. Below the water line are hidden risk markers for CHD and stroke; above the water line are overt clinical events. Source: Charlton *et al.* 1994

follow up. Of the men 35 per cent were smokers, 31 per cent had high fat diets and 55 per cent were overweight or obese. For women the equivalent figures were 24 per cent, 18 per cent and 48 per cent. It also showed that more than a quarter of the older patients (55–64 years) seen already had a diagnosis of heart disease, hypertension or diabetes, and a further 12 per cent had symptoms suggestive of angina or a previous infarct. More than a third of the total sample had a cholesterol concentration at or above 6.5 mmol/litre, this distribution being

skewed significantly towards older patients. Eight per cent had cholesterol concentrations above 8 mmol/litre, a level where drug rather than dietary treatment may well be considered necessary (Silagy *et al.* 1992).

These data, which correspond fairly well with the indicative prevalence estimates contained in Table 7.2 and Figure 7.2, suggest that a considerable volume of important but as yet unmet need for secondary and tertiary health promotion may exist in many communities. Although exceptional practices like those of Marsh and Tudor Hart have (in very different ways) demonstrated that challenges in this field can be met with a degree of success, the extent to which and manner in which the average practice's performance can best be enhanced remains uncertain. What is clear, however, is that screening alone is no substitute for effective care, just as an appreciation of broad community needs is no substitute for personally responsive, flexible treatment, advice and care.

7.4 Towards community oriented primary health care?

These last observations raise a final set of issues for consideration in this chapter. They touch on both development support needs in primary care and the relationship between public health medicine and general medical care. This is an important area, not least because of the potentially complementary roles of specialists in public health medicine and general practitioners in service purchasing/commissioning. The former also have, like primary health care professionals, a key part in the implementation of the *Health of the Nation* strategy, as befits a group whose professional activity has been defined *'the science and art of preventing disease, prolonging life and promoting health through organised efforts of society'* (Public Health in England 1988—the 'Acheson Report').

It has been suggested, perhaps unfairly, that unlike other sections of the medical profession specialists in public health medicine enthusiastically embraced the NHS reforms of the early 1990s (Whitty and Jones 1992) essentially because they embody the main recommendations of the 1988 Committee of Inquiry chaired by Professor Acheson. This was published under the title *Public Health in England*. Although set up in response to outbreaks of salmonella food poisoning and

Legionnaire's disease in the mid-1980s, it presented a comprehensive programme for the development of the public health function and its position in the evolving NHS management structure.

The success of those seeking a stronger role for public health doctors has been welcomed by many who believe that the NHS should play a stronger role in health promotion, and make more vigorous efforts to address issues such as the need to reduce health inequalities. But to some groups it has caused concern, and on occasions jealousy. For example, it could be argued that the 'public health lobby' sometimes oversells initiatives with as yet unproven benefits relative to cost. The *'Healthy Cities'* movement is a case in point. Public health advocates also on occasions promulgate views which might serve to reduce awareness of the value of conventional, curative and palliative, approaches to health care. Instances of this include an over-emphasis on the relevance of nineteenth century experience (in which curative medicine had a small part to play in improving health) to today's developed societies, in which the relative potential of medicine and medicines may be greater.

Groups such as health economists and medical sociologists might also argue that there is little reason why public health should be a medically controlled function. Although such views may in part stem from a desire for sectional advantage rather than an entirely disinterested concern with effectiveness and efficiency, counter claims to the effect that *'the public health function must be led by doctors because only they will be accepted by other doctors'* have limited credibility. Some non-medical NHS managers also question the desirability of the seemingly fragmented pattern of public health research and analysis being undertaken in virtually every locality, and the quality of the relationships between public health doctors and other senior management staff in some commissioning authorities.

However, the main issue to be pursued here relates not to public health as a specialty, but to the clearly desirable goal of being able effectively to link community level insights into overall health care needs and commonly experienced problems with effective personal/patient care. In this context it is of note that Tudor Hart's approach to his practice population in the Welsh village of Glyncorrwg was in part modelled on that

of Kark, who developed his work on community oriented primary health care (COPHC) in South Africa and then Jerusalem (Abrahamson 1988, Epstein and Eshed 1988, Frome 1989).

COPHC is a form of integrated, team or 'firm' based, primary care practice which combines personal care with an epidemiologically based assessment of the needs (and positive health) of the entire community being served. In the context of the near universally available British general medical system it offers a way to link at or around the level of consumer/provider contact (that is, the practice) public health oriented insights with more traditional, individually and family focused health care. One of the most significant of Tudor Hart's achievements is his demonstration of this possibility working in practice.

GP fundholding could in time help further this sort of approach, given appropriate incentives and market regulation. Ideally, the combination within practices of public health knowledge and concern for overall welfare with the traditional professional commitment to meeting individual patient's needs will promote informed, service user driven, care development. So too might alternative, 'purchasing for all', initiatives. With regard to health promotion, for instance, local consultation and contracting systems could in future serve to ensure that enhanced practice level data collection is matched by effective, sensitive forms of personal care within a whole population framework. That is, a framework which ensures that no group's needs are neglected.

This opportunity may be related back to the need for local primary care development support agencies identified in earlier chapters. It is arguably through initiatives based on the COPHC model that future practices may be best able to provide more co-ordinated preventive, curative and chronic disease care to their patients. And the arrangements needed to achieve this throughout a locality could also provide a new route via which the skills of public health doctors would inform and guide the working of a primary care driven NHS health market.

Summary

- There is a lack of evidence from randomised controlled trials of the effectiveness and efficiency of some screening tests.

- Screening can result in an improved prognosis for treatable cases detected early, resource savings and reassurance. However, there are negative possibilities such as extended morbidity for those whose prognosis is unaltered, 'medicalisation' of normal individual variations in functioning, displacement of resources, anxiety and sometimes harm caused by the test itself.
- Antenatal screening tests require a sensitive approach and close cooperation between serivces users and providers.
- The preventive and other health care needs of adolescents and young adults are often neglected. This group is subject to a wide range of pressures and risks, both physical and psychosocial.
- Primary prevention and strategies for heart disease, some forms of cancer and other disorders with common causes should be based on sound research evidence. Nonmedical strategies should be given more emphasis in the whole population context.
- Successful implementation of screening programmes in general practice requires a number of practical and organisational issues to be addressed. The workload implications and appropriate skill mix demands require careful analysis. Screening by itself is of no value to patients. Emphasis should be given to case finding and effective treatment and/or education.
- The link between public health and general practice should be clarified. It is desirable to link community level insights into overall health care needs with personal patient care. GP fundholding could, with appropriate incentives and regulation, further a move towards community oriented primary health care.

8

GENERAL PRACTICE IN TODAY'S NHS

8.1 The development of general practice

The NHS model of general medical care provided by independent contractors has been acclaimed as 'a British success' (GMSC 1983). The combined provider and secondary care gatekeeper role of the UK GP can both promote equitable access for the population, and assists in cost containment. As a model it is currently being emulated in other countries including Sweden and the United States, where it is being adopted by a number of health maintenance organisations (HMOs) (Hillman *et al.* 1992). However, many key aspects of the UK system appear to have evolved more as a result of muddling through than because of clear planning for 'health gain' or any other defined goal. For example, the comparatively clear cut distinction made between primary medical services and secondary/tertiary provisions in Britain owes much to the attempts of Victorian doctors to resolve demarcation disputes between themselves to their mutual advantage. Similarly the discrete FHS funding system, still to date based on a parliamentary vote separate from that supporting the hospital and allied community health services, can be linked back to the arrangements originally established by the 1911 National Insurance Act.

Some critics of the UK primary care system believe that even after the creation of the NHS general practice's development continued to be haphazard and unsatisfactory. They maintain that the survival of the atomistic, shopkeeper come small-businessman spirit of the FHS independent practitioner into the late twentieth century is at best an anachronistic left-over from the past, and at worst a significant barrier to the emergence of an optimally effective and efficient NHS structure. However, against this Morrell (1992, 1993) has argued that progress in FHS medical care, particularly after the mid 1960s, has been more soundly based than is commonly appreciated.

Table 8.1 Characteristics of GP practices 1951–1991

Year	Proportion of GPs[1] single handed	Average list size
1951	~40%	2560
1971	20%	2450
1991	11%	1847

[1]Unrestricted Principals
Sources: DoH (1993), Chew (1992)

In the late 1940s/early 1950s the role of family doctors, charged under the new NHS with providing the entire population with comprehensive primary care, was ill-defined. Upwards of 40 per cent were single-handed. Many had lists of 3000 or so patients, and worked from their own homes with little or no additional support—see Table 8.1. Hospital medicine was at that time strongly dominant, and general practitioners were in the main seen as 'poor relations'—both financially and in terms of professional status.

By the end of the 1950s a declining trend in the number of young doctors electing to train for family practice was well established (Horder and Swift 1979). General practitioner morale moved towards a nadir. The Gillie report (SMAC 1963) drew attention to problems such as inadequate premises and practice staffing arrangements, together with others stemming from the purely capitation based remuneration system then in place. Decline turned into perceived crisis in the mid-1960s. The eventual result, following tough negotiations between the BMA/GMSC and representatives of the then Ministry of Health, was the introduction of the 1965 'Doctors' Charter'.

The 1965 contract was based on knowledge which had accumulated through bodies such as the Royal College of General Practitioners. It created a remuneration system based on a combination of capitation payments and practice allowances with some additional item of service fees. It also permitted the establishment of more adequate funding arrangements for premises and practice staffing. Commentators such as Morrell believe that the 'new contract' was based on research knowledge, was rationally designed, and opened the way to constructive solutions of many of the challenges then

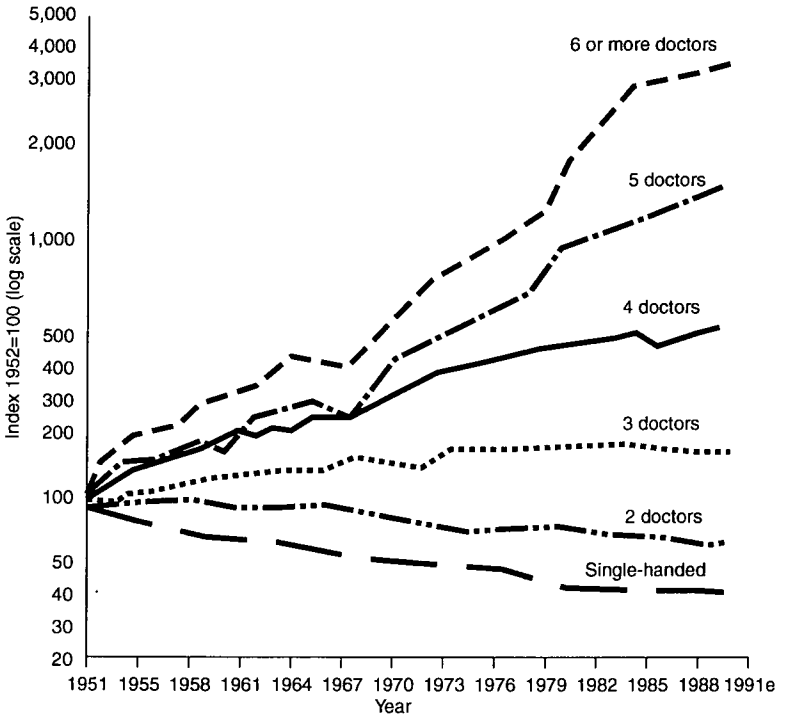


Figure 8.1 Number of unrestricted GPs by type of practice in England and Wales, Index 1952=100. Source: Chew 1992

confronting general practice. The revised economic incentives introduced at that time encouraged the formation of partnerships—well over half of all GPs now work in groups of four or more (Figure 8.1); and it established a strong base for the specialty of general medicine. The academic development of general practice continued with the promotion of comprehensive vocational training (compulsory from 1982) and extensive continuing education arrangements. By the mid-1980s the status of GPs was widely recognised as comparable to that of hospital specialists, and average list sizes had dropped to below 2000.

Against the above background, the imposition of the 1990 contract seemed to some GPs to be an act of ideologically inspired vandalism. By enforcing state determined practices

and approaches to medical care it threatened their autonomy, and it appeared to many family doctors to ignore general practice research findings and deny the achievements of the previous 25 years. This discontent became apparent thought the debate on health promotion—see Chapter 5. However, as Chapter 5 also outlines, the attitude taken by general practitioners' representatives during much of the 1980s was also questionable. Their unwillingness to recognise that poor standards of general practice existed and were a threat to patient well-being contributed to the government's action. Although elements of the new contract were clearly unproven in terms of effectiveness and efficiency (Scott and Maynard 1991) some of its terms reflect recommendations such as those of the Acheson report on London's primary care (LHCPC 1981), which were well researched and widely accepted.

This chapter examines the basis of general practice in today's NHS, considering the shifting balance between hospital and non-institutionally based health care, definitions of general practice and terminology relating to primary, secondary and community health care. The strengths and weaknesses of the current structure of general practice are examined, as are the threats to, and opportunities for the improvement of, NHS primary health care services.

8.2 The rise (and fall?) of the hospitals

The period from around 1850 through to the middle of the 1970s can be thought of as a 'golden age' for hospital based care. Factors promoting its extension included:

- **the urbanisation of Britain**, and humanitarian challenges and threats to social order presented by poverty amongst 'the lower orders'. The build up of asylums and Poor Law health care provisions was directly related to such pressures. Much of the NHS's original hospital capital stock derived from the resultant Victorian investments;
- **enhanced therapeutic techniques** and the introduction of effective infection control towards the end of the nineteenth century. As hospitals began successfully to treat more patients than those who died on the wards, better-off sections of the population increasingly sought care in them.
- **the rise of the medical profession**. From the 1850s onwards the unified medical profession assumed more or less unquestioned control over the health sector. Health care became one of the stronger areas of a growing

economy. Hospitals represented strongholds of the profession's power. Self-governing control over the profession's own education and the subsequent behaviour of its members meant that health care was very difficult for any outside group to manage. Because of the perceived needs of teaching hospitals and their standing with the population the development of primary care tended to be neglected in the inner city areas where hospitals have historically been located.

The main factors which are now tending to reduce the use of hospital based services are:

- **better living conditions** and higher expectations amongst the mass of the people. Despite the ageing of the population, fewer individuals seek the shelter of institutional care. Most are able to remain in more conventional domestic settings;
- **improving technology**, including safer curative and palliative medicines, less invasive surgical techniques and greater peripheral availability of sophisticated diagnostic and other procedures. The average length of hospital in-patient stay has declined markedly over recent years, and this trend is likely to continue with the further development of minimal access surgery (Cuschieri 1994). This ongoing revolution has not yet reduced the need for concentrations of high technology investment in acute hospitals, but it is already a significant driving force in the shifting balance between primary and secondary care. Public expenditure on community services (including primary care, personal social services and social security support for care in the community) already exceeds that on NHS hospitals (Audit Commission 1992b);
- **the rise of health services management**. From the 1973 'oil-crisis' onwards the control by the traditional professions of health sector resources has come under increasing challenge right across the developed world. This has tended to promote further (only in part financially driven) questioning of the value of hospital based care relative to the other opportunities available. Managers have both weakened the traditional power of doctors, and tended to move into the power vacuum created. In England, following the Griffiths Report (NHS Management Inquiry 1983), the number of NHS staff classified as general and senior managers rose from 510 in 1986 to 13 338 in 1991 (DoH 1993). The 1991 reforms appear to have continued this trend.

Taken together, these factors mean that pressures towards inter-professional and inter-agency co-operation have increased markedly. General medical care is being drawn further into an integrated primary health and social care system, and at the same time into being much more closely co-ordinated with the secondary health services (NHSME 1991). As long term in-patient admissions are curbed and lengths of stay reduce,

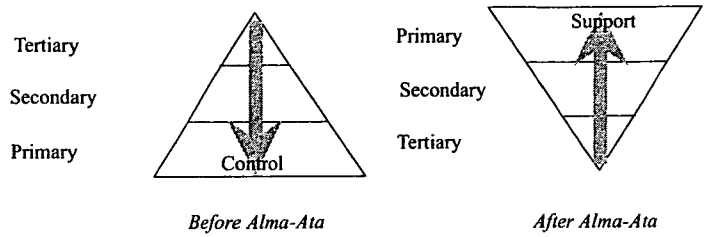


Figure 8.2 The relative roles of primary, secondary and tertiary care, before and after Alma Ata. Source: as quoted by Pereira Gray, 1992

general practice is becoming increasingly central to the complex variety of services in the modern NHS. This reflects a general, post Alma-Ata, conceptual approach to primary provisions as an ascendent element within all health care systems. (See Figure 8.2, and Pereira-Gray 1992).

8.3 Defining primary and secondary care

The trends outlined above make it increasingly important to define appropriately and precisely what is meant by terms such as general practice and primary health care, community care, and secondary care. The Royal College of General Practitioners (RCGP 1972) described the general practitioner as:

> 'the doctor who provides personal, primary and continuing medical care to individuals and families. He (sic) may attend his patients in their homes, in his consulting-room or sometimes in hospital. He accepts the responsibility for making an initial decision on every problem his patient may present to him, consulting with specialists when he thinks it appropriate to do so. He will usually work in a group with other general practitioners, from premises that are built or modified for the purpose, with the help of paramedical colleagues, adequate secretarial staff and all the equipment which is necessary. Even if he is in single-handed practice he will work in a team and delegate when necessary. His diagnoses will be composed in physical, psychological and social terms. He will intervene educationally, preventively and therapeutically to promote his patient's health'.

This definition was subsequently developed by a European working party to form the 1974 Leeuwenhorst statement. This

has provided the basis of almost all subsequent attempts to specify general practice for the purposes of vocational training. However, the RCGP (1987) has expanded the range of activities it believes that general practice/primary health care include, to cover:

- the diagnosis and management of some acute and chronic conditions, treatment in emergencies and, when necessary, in the patient's home;
- antenatal and postnatal care, and access to contraceptive advice and provision;
- prevention of disease and disability through immunisation, screening and case finding (including cervical cytology, paediatric surveillance and detection of hypertension) and health education (including advice on smoking, diet and alcohol consumption);
- the follow-up and continuing care of chronic and recurring disease, for example asthma, coronary artery disease and diabetes mellitus;
- rehabilitation after illness;
- relocation of services previously provided in a secondary setting such as physiotherapy, occupational therapy, dietetics;
- care during terminal illness;
- co-ordinated services for those at risk, including children, people with a mental illness, bereaved people, elderly people, people with handicaps and those who care for them;
- help for patients and their relatives to make appropriate use of other agencies of care and support, including hospital-based specialists.

This may be compared with a model of extended primary health care put forward by a group established by the North East Thames RHA (1991), which suggested that 'primary care mark two' should also contain some or all of the following components:

- development of new approaches to managing primary care, including the use of protocols and formularies, and professional evaluation/audit;
- relating practice activity to agreed assessment of local needs, based on clinical assessment, views of users, and data provided by FHSAs and district health authorities;
- development of additional skills and services, widening the scope of diagnosis, treatment and care in the surgery;
- new initiatives by fundholding practices, both in clinical areas and as purchasers of health care on behalf of their patients;
- practices working more closely with locality management schemes;
- motivated and forward-looking GPs in smaller practices;
- greater understanding and closer networks between smaller practices;
- development of the role of the practice nurse and the nurse practitioner;
- new programmes by district nurses and health visitors.

More recently still, Hughes and Gordon (1992) describe primary care as:

> 'a network of services that covers the whole spectrum of health and social care: prevention for the young and well, treatment of acute and chronic illness, rehabilitation, respite care, residential care, support at home for patients who are frail, elderly, disabled or acutely or chronically ill, and terminal care. Primary care is provided by general practitioners, health authority community health services, local authority social services, voluntary organisations, the private sector and unpaid carers who all play a part in that network'.

These quotations (some of which are ambiguous and debatable) illustrate the shifting position of general medical practice within primary health and social care. Family doctors are under increasing pressure to work as professionals committed to co-operating closely with a range of colleagues (including managers, community nurses, social workers, and other doctors) who have quite discrete skills and expertise. This epitomises the shift from primary medical care to primary health care.

Effective management of the changing relationships required presents a challenge to all those involved. General practitioners are having to modify their expectations and expressions of authority and autonomy at practice level, which could be a factor influencing GP morale. The latter is widely believed to be low since the 1990 contract (Handysides 1993). Other groups must also accept that within primary care it is unrealistic to retain rigidly defined, sectionally led, 'functional' management structures. In addition, shifts in the hospital/family practice balance mean that the traditional location focused distinction between primary and secondary care is changing. It is unacceptable to think of primary or community care as involving relatively unsophisticated types of intervention provided in surgeries or patients' homes or long-stay residential settings 'in the community', and of secondary or tertiary care as necessarily requiring complex, high technology care in hospitals (Malcolm 1991). Secondary services can exist in community settings and primary care may on occasions take place in hospitals.

Key determinants of a satisfactory distinction between primary and secondary care include:

- is access to the service directly controlled at the patient/professional interface (primary care), or is it subject to referral by a professional intermediary (secondary care)?
- is the service part of a pattern of continuing personal support available to the service user as part of their normal daily life (primary care) or is it a 'once off' intervention delivered in special circumstances (secondary care)?
- is the safety and marginal cost of the service commensurate with widely disseminated provision by non-specialists? High risk and high marginal cost treatments have historically been located in the secondary sector;
- is the central focus of the service positive identification and treatment of a specific, single, condition which may be a significant hazard to life, or is it aimed at reaching a decision in conditions of uncertainty, when serious risk relatively unlikely to be present? The work of general medical practitioners tends towards the latter, although the long-term support of patients with chronic conditions like diabetes is shifting more to the primary care level. The management of uncertainty and risk exclusion is no less a skilled and important task than specific hazard identification; in both cases the consequences of error may be severe, and the resource use implications of the decisions taken considerable.

8.4 Current strengths of general practice

8.4.1 Universal access

The available data indicates that upwards of 97 per cent of the population is registered with a practice (Ritchie *et al.* 1981), and that of this proportion the great majority know and feel known by their own doctor. This fact alone distinguishes the UK position from that in most other countries.

For example, Sweden has, it is often claimed, one of the most advanced health care systems in the world. At the primary care level it has community health centres in which multi-disciplinary teams are responsible for a given area deal with a broad range of health and social care issues. This is favoured by some commentators critical of the traditional, medically dominated, GP system in Britain. However, the Swedish system is unpopular with significant numbers of its users (Lewis 1992), who reportedly complain of anonymity a lack of personal care, and difficulties in getting access to a doctor.

The Swedish Department of Health and Social Affairs proposed, in the Spring of 1992, the introduction of family doctors. The suggestions put forward include increasing the number of GPs appointed, with primary health care teams of

a GP, a nurse and a clerk. Each individual will be able to select his or her general practitioner without residential restriction. The model of reform for Swedish health care reform is being implemented, and should be in place by 1995 (San Jose 1993). It is intended that under the new arrangements remuneration should be largely capitation based, with each list numbering around 2000 patients. This, it is hoped, will attract more able doctors into primary care, redressing its current 'Cinderella' status.

Commentators from nations such as the US (for example Enthoven 1984), with its fundamentally fragmented services, often fail fully to understand the significance of the opportunities presented by the universally available FHS system. The concept of a primary care led health service is obviously not feasible in circumstances where many patients do not have a general practitioner, and may seek care directly from specialists on a more anonymous, incident by incident, basis. However, in the UK, the patchwork of naturally selected GP lists represents reasonably coherent populations and covers virtually the entire community. In this case primary care practices can effectively act as the basic building block of the health service, with patient/GP choices acting as a central driving force in the selection of secondary hospital and community health services.

8.4.2 Continuity

Research commissioned at the time of the Royal Commission on the National Health Service (Ritchie *et al.* 1981) showed that around three quarters of the British population had been on the list of the same family doctor for five years or more. Forty per cent had been with their doctor for 20 years, or since birth. Such average figures do not apply to all areas equally—inner cities have unusually high mobility rates and numbers of unregistered patients. They also do not in themselves provide a comprehensive measure of the quality of doctor/patient relationships and care. They do suggest a desirable level of close, ongoing, contact. Over 70 per cent of respondents to this survey rated highly the approachability of their family doctor.

One result of this continuing relationship is likely to be significant economies in the time and resources used in each

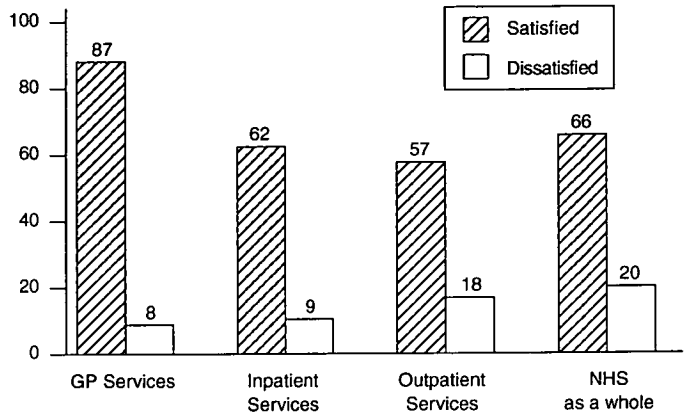


Figure 8.3 Patients' expressed satisfaction with the NHS in 1991/2. Source: Solomon 1992

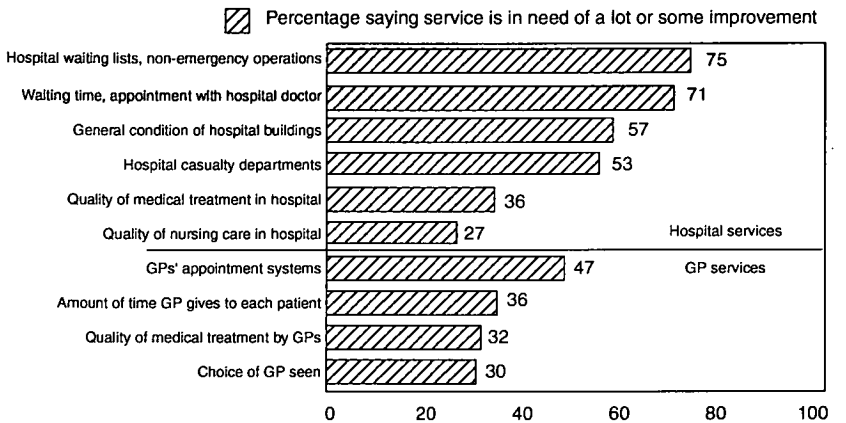


Figure 8.4 Patients' priorities for NHS service improvement in 1991/92. Source: Solomon 1992

consultation, as doctors are aware of the patient's history. Although average GP surgery consultations are said to be significantly shorter in the UK than in much of Europe and the US (7–8 minutes compared to around 12–15 (Pereira Gray 1992)) the continuity factor serves to help maintain care standards and to reduce the need for avoidable diagnostic tests and referrals.

Figures 8.3 and 8.4 confirm that there is strong reported public satisfaction with family doctor care (Solomon 1992),

Table 8.2 Patients' views of how GPs should improve services

Desired improvement	% asking ($n=915$)
1. More time explaining about illnesses	91
2. More time listening to patients	89
3. Free general health checks	89
4. More information about hospitals/specialists	84
5. More time explaining about drugs	82
6. A more helpful receptionist	80
7. Shorter waits at surgery	79
8. A choice of which hospital to go to	77
9. A nurse at the surgery	71
10. More home visits	71
11. More convenient surgery hours	69
12. Minor surgery at the surgery	68

Source: Consumers' Association 1989 (Which? pp 481–4)

although the desire for improvement in areas such as appointment timing and duration is significant. The 1989 Consumers' Association survey data shown in Table 8.2 similarly reflect a desire for increased patient/doctor contact time and convenience of access.

A degree of caution is required in interpreting patient criticisms of hospitals and/or the NHS in general as against their more favourable views of GPs. Attitudes towards a personally known family doctor will be formed by direct experience, and their expression influenced by loyalty; those relating to the health service as a whole are more likely to be based on hearsay, and opinions drawn from the media. However, this does not detract from the point that the general practice provides a favourably viewed, familiar 'front door' to the NHS.

8.4.3 Patient/doctor interaction

The family doctor centred model of primary care permits, by right, all members of the public to have, on demand, face-to-face contact with a well qualified, high status professional. More hierarchically organised structures tend to remove able, educated, individuals away from direct interaction with the service users. Justifications for this may include claims that

it enables the former to contribute to the care of larger numbers of people, and make their skills more available through supporting less well trained professionals. The converse view is that it may deprive service users of high quality care.

This is a contentious area, affecting a variety of interests. For example, some managers concerned with day-to-day cost may wish to limit the numbers of more extensively trained staff in direct patient contact. However, research in fields such as nursing and support for service users with learning disability indicates that it can on occasions be economically desirable to elect for 'rich' field level skill mixes (Bagust *et al.* 1992, Carr-Hill *et al.* 1992). Doctors do not always have the abilities their patients need, and in some circumstances nurses or other professionals offer more appropriate and/or acceptable care. But the value to many consumers of the traditional primary care physician, both as a social property and a source of skilled medical and allied support in times of stress and uncertainty, should not be underestimated. Any loss of the right to direct contact with their GP could severely disbenefit patients.

8.4.4 Flexibility

The positive attributes of British general practice therefore include, potentially at least, universality, continuity, public trust and relative cost containment. In addition, general practice has a strong academic, educational and intellectual base, and is flexible in response to changing consumer demands and financial or other incentives. This property has been illustrated by the responses of family doctors to the immunisation and cervical smear target payments in the 1990 contract, and their recent performance in the field of computing.

8.5 Current weaknesses

8.5.1 Limits to general practice

Against the impressive list of its strengths the current GP system has a significant number of weaknesses. The most significant of these are:

- variability in practice and care standards—the 'inverse care law' (Tudor Hart 1971) and 'the London effect' (see Tomlinson 1992)—and little accountability to effective local management;
- insensitivity to the needs of some patient groups, for example the homeless (Tomlinson 1992);
- the isolation of general practitioners and general practices from each other, from other professionals, from other parts of the NHS and from local authority social service and other agencies (Hudson 1994);
- the high level of personal stress reported by many family doctors, and the lack of a career structure within general practice (Handysides 1993). Together these may lead to relatively early 'burn-out', or the fear of it;
- a reportedly high prevalence of destructive tensions and communication problems between practice partners (Marinker 1994);
- allegations of unchecked referral or prescribing practices leading to unnecessary expenditures which ultimately decrease HCHS funding or distort activity patterns;
- poor practice level management arrangements, inadequate information systems, lack of self or external audit;
- inadequate premises, particularly in poorer localities, and low levels of (capital) investment in practice equipment, as with computers during the 1980s (Bosanquet and Leese 1989);
- a widespread lack of functionally coherent practice teams combining nursing and other professional inputs with those of GPs;
- few political 'friends' amongst other NHS and care provider groups, and intra- and inter-professional jealousies and disputes;
- inappropriate or unsatisfactory leadership at locality and national levels.

8.5.2 Practice variations

Throughout the life of the NHS there have been uniform contractual terms and (through the work of the Medical Practices Committee) an increasingly even distribution at FPC/FHSA level of family doctor numbers. However, there are still considerable disparities in opportunities available to practitioners, and practice 'firms' respond to differing local conditions and incentives. Bosanquet and Leese (1989) compared seven different types of district in 1986/87. Their results showed that the mean net income per partner in an affluent rural area was almost £34 000, compared with £27 000 in a north eastern industrial area, £26 000 in a north western suburban area, £24 000 in a Midlands area and only £23 000 in inner London. The figure for a northern mining locality (obtained a year earlier in a pilot study) was similar to that for London.

This study (which has been repeated in the field in 1993) differentiated between traditionalist (less progressive) and innovative practices, confirming again that 'GP firms' with better services are more easily established in more affluent areas. This implies that—at least in terms of practice quality as defined by Bosanquet and Leese—the inverse care law has to date remained a relatively strong influence in the British primary care structure.

Factors associated with the wide variations in income of GPs included the availability of options such as a practice based dispensing service (not permitted in urban areas with accessible pharmacy shops) and the existence of economies of scale and scope (particularly as larger practices can employ more ancillary staff). Bosanquet and Leese recommended that single-handed practices should be grouped either together or with other practices as opportunities occur, and that the then FPCs should work more closely with practices and DHAs on joint development plans. Bosanquet (1992a, 1992b) has since strongly advocated local payment systems for general practice. In his view negotiations between FHSA/commissioning agencies and practices might desirably cover up to 60 per cent of total practice income.

Single-handed practitioners (who were excluded from the Bosanquet and Leese sample) also have widely distributed earnings. Some, with large lists and low operating expenses, are amongst the highest net earners of all GPs, whereas other older single-handed doctors with small lists are, as might be expected, unusually low net earners. It is also apparent that even within small localities the distribution and/or availability of FHS (and CHS) services can be quite strongly skewed. The consequence may be further discrepancies in the nature and quality of the services available in richer and poorer communities. Figures 8.5–8.9, drawn from data applying to a London FHSA, illustrate the wide range of practice staff expenditure levels at the start of the 1990s.

However, against such observations there is no evidence that people in social classes IV and V see their family doctors less often than those in social classes I and II. If anything the reverse is true (OPCS 1992). In addition, the type of service available in less advantaged areas may in some important respects meet the needs of these communities more appropriately than do

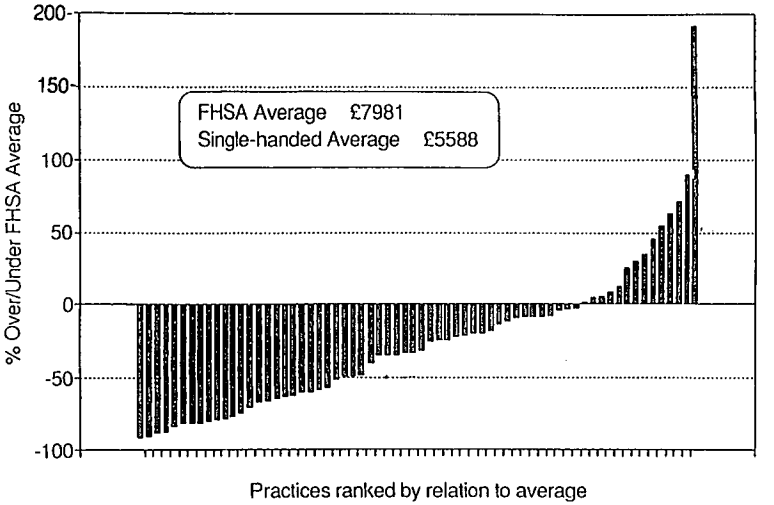


Figure 8.5 Practice staff budget allocations 1991/92 (an inner London locality). Cost per '000 patients: single handed practices. Note to Figures 8.5–8.9: These data reflect the pattern established before FHSAs could direct practice staff budget allocations—that is, they indicate practitioner willingness/ability to employ practice staff. Additional payments by GPs to staff are not included in the figures

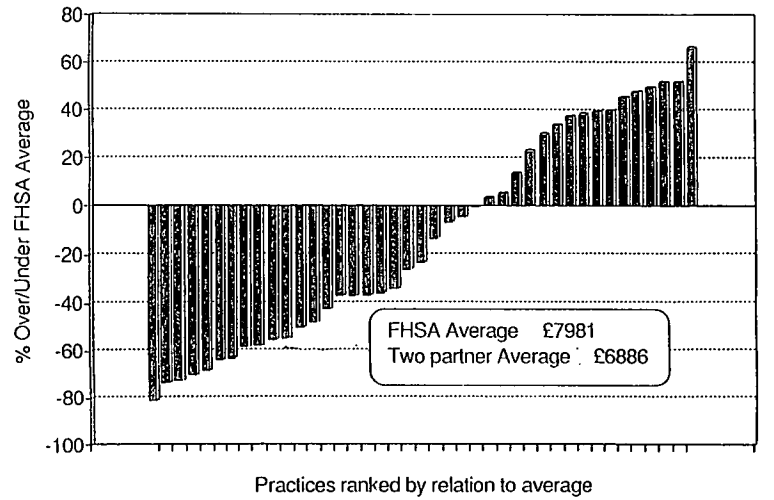


Figure 8.6 Practice staff budget allocations 1991/92 (an inner London locality). Cost per '000 patients: two partner practices

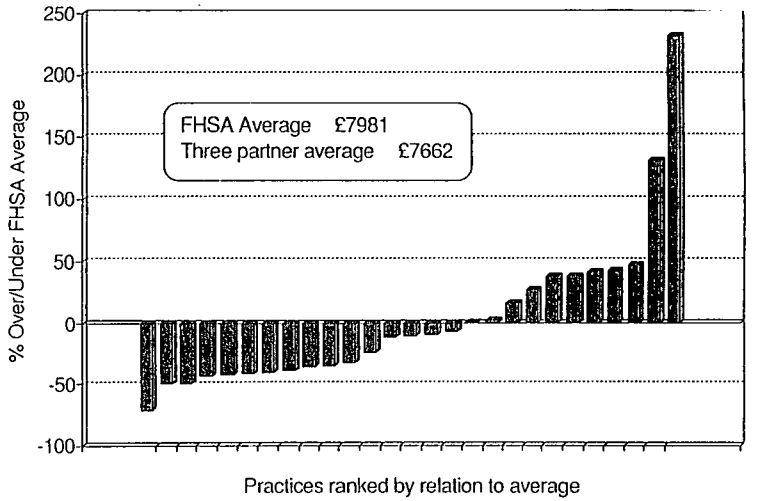


Figure 8.7 Practice staff budget allocations 1991/92 (an inner London locality). Cost per '000 patients: three partner practices

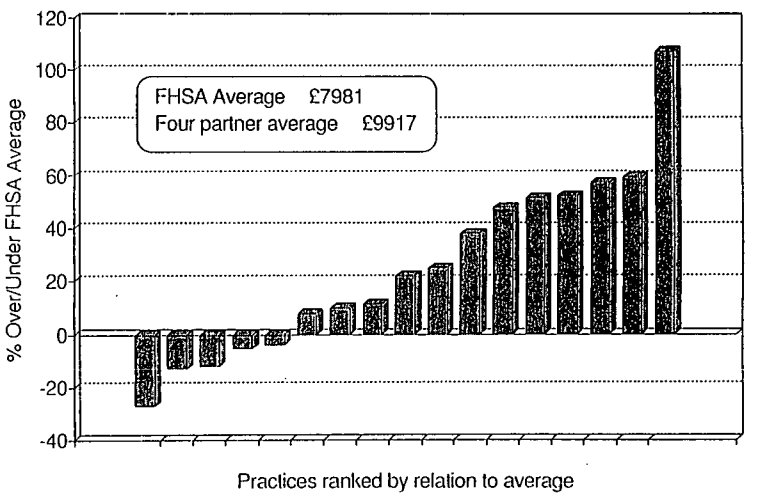


Figure 8.8 Practice staff budget allocations 1991/92 (an inner London locality). Cost per '000 patients: four partner practice

those provided by innovative practices. Certainly research linking patient attitudes with practice characteristics has in the past shown single-handed practitioners to be relatively popular (Cartwright 1992).

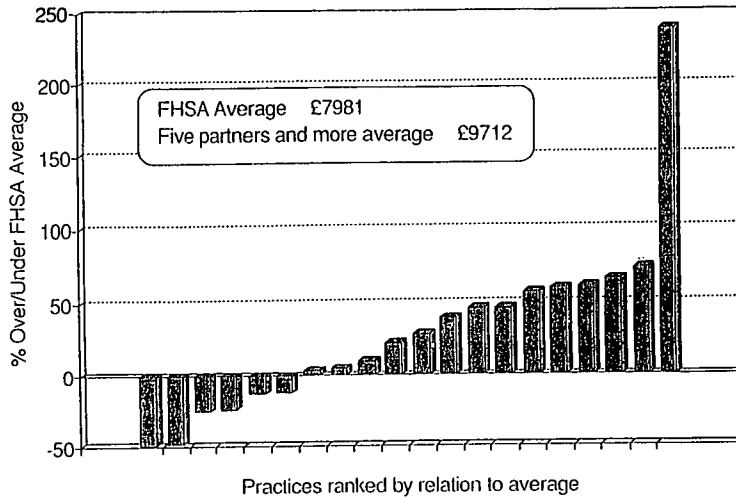


Figure 8.9 Practice staff budget allocations 1991/92 (an inner London locality). Cost per '000 patients: five partner practices

8.5.3 London and the inner cities

The work of the King's Fund and The Tomlinson Inquiry on the challenges confronting the capital and its teaching hospitals (King's Fund 1992, Tomlinson 1992) focused further attention on the deficiencies of inner city primary care. Both groups called for more capital investment in premises in London, although the figures they produced were crude. They arguably understated the vital importance of investment in primary and allied forms of care as a precursor to change in the hospital sector at a time that vital planning decisions were being made.

Both Tomlinson and the Kings Fund also favoured the introduction of a limited number of new community facilities modelled along the lines such as those of the West Lambeth Community Care Centre (which could also serve as a possible future focus for 'nurse beds'), and drew attention to issues such as how to attract committed, able, primary care professionals into the inner city.

The Tomlinson recommendations additionally emphasised the need to strengthen the role of Family Health Services Authorities in the further development of London's services. The report envisaged FHSAs playing a stronger part in commissioning community health services. It promoted the

creation of special development zones within which there is a maximum degree of freedom to experiment with novel approaches to primary care delivery. The outcomes of the resulting initiatives are as yet difficult to judge, but they represent a significant step towards locally led primary care development.

The 'London problem' is long standing, complex and unique. Its relevance to the rest of the country's experience is limited, although questions of national interest have been raised by the debate on care in the capital. One such issue is out-of-hours and emergency care. An option here is the creation of primary care emergency centres (advocated by the RCGP). These would be run largely or entirely by local practice staff and could perhaps incorporate some in-patient care facilities. They might serve practice based 'patches' of 50–100 thousand people (Wain 1992). Another suggestion, noted in the Tomlinson Inquiry, would be to accept that hospital based accident and emergency facilities can legitimately have primary care functions, particularly in inner city areas. Pioneer studies in King's College Hospital, which involve general practitioners working in accident and emergency, suggest that this strategy could prove viable in economic as well as technical terms (Dale *et al.* 1991, Roberts 1992). The placement of primary care emergency centres in hospitals is under investigation in a number of localities.

8.5.4 Costs, funding and fundholding

GPs are usually viewed as both low cost care providers and as effective gatekeepers to secondary and other forms of NHS and social care. However, there is clearly scope for improvements in efficiency. Wide variations in referral rates suggest that some GPs could be behaving inappropriately, although firm evidence to demonstrate this is not generally available. A recent report (Audit Commission 1994) has also suggested that there is considerable scope for further improvements in prescribing behaviour. Around 10 per cent of all NHS expenditure is spent on GP prescribed drugs. GPs in the UK have a good record in prescribing compared to many other developed countries—pharmaceutical expenditure per person in the UK in 1990 was around £64, whereas in France this was

£112, Italy £107 and Switzerland £106 (OHE, in Audit Commission 1994). Nevertheless, there are wide unexplained variations in prescribing rates and there appear to be considerable opportunities for further economies.

Family Health Services have been traditionally funded from a discrete, 'open-ended', Parliamentary vote, whereas the HCHS are financed via a cash limited amount, which may be held down or even cut if spending at the primary level exceeds projections. This could provide perverse incentives for cost shifting to GP budgets. One of the attractions of GP fundholding is that it transfers some GP expenditures to the cash limited part of the NHS's budget. The fundholding model may in the medium to long-term serve to bring all NHS expenditure into a unified cash limited 'purse', ultimately for distribution by single overall purchasers in each locality. Local contracting between authorities and individual practices could help achieve this end.

This possibility raises a number of interesting and challenging questions about the future of primary care and its management (Taylor 1991). There are potential advantages from family doctors and their practice colleagues gaining a stronger sense of ownership over their practice resources, and of the costs and benefits of the secondary care purchasing opportunities open to them. But there may also be disadvantages associated with the creation of unified local cash limits for health spending, and/or the attendant formation of single commissioning agencies.

For instance, in development terms there may be a case for maintaining some sort of a check and balance system between the primary and secondary care commissioning levels. From the patient's viewpoint, an advantage of the traditionally dualistic approach between the FHS and HCHS is that it served to keep the NHS's general practitioner 'front door' open to everyone. Rationing was made overt when patients who had been referred for further care confronted waiting lists and/or were told by individuals such as hospital consultants that suitable NHS care was not available. Hence the working of the established NHS system has, on occasions to the embarrassment of governments and managers, promoted exposures of care shortfalls. Extension of GP fundholding and/or increased GP/DHA purchaser co-operation could result

in the point of rationing moving fully down to the less visible patient/primary care practitioner interface. The likely effect of this on service efficiency is unclear.

8.4.5 Primary health care teams

The relationship between family doctors and community nurses (district nurses, health visitors, and practice nurses) has developed considerably in recent years. In many parts of the country primary health care teams are becoming more comprehensive—they often include community physiotherapists, occupational therapists, chiropodists, counsellors and other health care providers. However, potentially destructive rivalries still exist. In many practices the term 'team' is at best a euphemism for a situation in which individuals and professional groups are in reality working in isolation, with occasional encounters or communications between each other, but no real collaboration or integration of effort (Armitage 1983, RCGP 1992).

Despite the increased interest focused on matters like practice nurse development, out-patient community nursing, and the introduction of 'physician's assistants' and nurse practitioners (see, for example, Bowling and Stillwell 1988) there is still little consensus as to where such developments could or should lead. Marsh, who believes that the advantages of large GP list sizes (of up to or around 4000) and extended primary care teams outweigh the disbenefits, has argued that in future much of or most of the care of patients attending general practices will appropriately be delivered by nurses, including nurse practitioners (nurses who diagnose, and treat certain conditions). In his view of the years to come the major function of the doctor *'will be as the person responsible for the co-ordinating of care for a particular individual'* (Marsh 1992a, 1992b. See also Marsh 1991).

Nevertheless, most family doctors are convinced of the desirability of smaller list sizes (down to say 1500), and are concerned about the effects of introducing nurse practitioners on a widespread basis. There is a wish to retain overall control over the evolution and extension of the duties of practice based nurses (Georgian Research Society 1991) and the cost effectiveness of nurse practitioner care has been questioned

(Heath 1994). The issue of skill mix in general practice requires careful monitoring and detailed economic evaluation.

Similar considerations apply to the issue of integrating community nursing and general (medical) practice. After an extended debate the NHSME has accepted that this would be desirable, and that eventually all primary community nursing (as distinct from specialised secondary domiciliary care services) could be based in primary care practices (NHSME 1993). This should promote considerable benefits for patients, and lead to the inclusion of nurse partners in general practices alongside doctors and practice managers.

Nevertheless, many nurses may feel threatened by the prospect of such developments. Despite the more enlightened approaches to internal practice management now being advocated (Macmillan and Pringle 1992, Pringle 1992, Pritchard and Pritchard 1992) the extent of further learning still needed should not be understated. Metcalfe (1992), in a thoughtful overview of the problems of managing change in general practice, has pointed out that in Britain's highly class oriented culture the exercise of power is frequently concealed or disguised, not least because of doubts about its legitimacy. Failure to address head-on questions like *'who is in charge in what context?'*, *'what is the basis of and limit to this authority?'*, *'what are the agreed procedures which determine decisions?'* may, despite a superficial flavour of democracy, actually encourage the idiosyncratic, arbitrary, misuse of personal position. He concluded that general practitioners and their colleagues will cope better with the future if *'they start by reviewing, honestly and openly, the distribution of power and respect within their partnerships and practices'*.

8.6 Threats to NHS general practice

The possible threats that those working in (and using) the FHS primary care system may encounter over the coming decade or so may be summarised as follows:

- **role overload**. Reductions in hospital provision, extended community care programmes, and pressure to make new 'high technology' care

opportunities widely available mean that primary care teams could, in theory at least, become overextended. The relationship between levels of provision and costs in primary care teams is not known but all 'firms' have an optimum size. If practices exceed this costs could rise disproportionately to output gains, and care standards and service acceptability to consumers could fall. Another potential danger is illustrated in Sweden, where large primary care centres mean that patients complain of anonymity and a lack of personal care (Lewis 1992);

- **loss of 'ownership'**. Moves toward a salaried service, with extended multi-disciplinary practice teams and special out-of-hours emergency care centres to allow doctors more normal working hours, could undermine family doctors' sense of ownership of and personal responsibility for their practice populations.
- **'macho management' and imposed care distortions**. The introduction of good management structures and practices at national, local and practice levels is an essential requisite for raising care standards. A central challenge for family doctors during the 1990s is to recognise this reality in an informed manner, and to balance effective management with a focus on individual care so as to maximise patient welfare. Failure to achieve this would be a profound threat to the future of general practice. But the dangers of unduly prescriptive, authoritarian or aggressive NHS management approaches have been outlined in earlier chapters, particularly those on health promotion. It would be a sad paradox if attempts to make the NHS more effective and efficient ultimately led to styles of internal control which undermined the self-confidence, self-respect and sense of self-control enjoyed by those working in it, just at a time when it is being recognised that a central objective of much health care is to promote such qualities in those receiving it. This point can be related back to the dangers of role overload. Schorr (1992) has described how in the area of social care the combination of excessively strong management and weak professionals can lead to unrealistic burdens being placed on service providers. He also quotes the National Audit Office as commenting that *'many managers . . . believe that life would be easier if they did not have to employ professionals. Professionals take years to train; . . . their primary commitment is often to their profession rather than their employer; and they doubt the ability of outsiders to judge the value of their work . . . (they) can create management problems'*. The point to draw is that high quality care provision demands mutual respect between management and professional authority;
- **loss of patient confidence**. The success of the general practitioner role depends critically on service user trust. Familiarity and favourability are powerful elements in effective communication. If confidence were eventually to be undermined by the sorts of threat to the GMS listed here much of the essential value of the traditional model would be lost;
- **two-tier care**. If fundholding and practice innovation were to continue along present lines in rural and other affluent areas, while inadequate

or less adequate facilities were to become perceived to be the norm elsewhere, then the universality of general practice would erode. This would probably have significant implications for all aspects of British health care, including its funding. If, for instance, better off people in cities were increasingly to opt for private primary care such a trend could undermine their willingness to fund 'care for all' via general taxation. It appears that a significant factor underlying Conservative voter support for the NHS concept may in the past have been the popularity of free family doctor care with 'the middle classes'. The introduction of concepts like 'polyclinics' in some localities might, despite positive intentions, have the unwanted consequence of helping to stimulate perceptions of a two-tier service, and so weaken the sense of common interest which currently links many GMS patients.

- **perverse incentives and inappropriate practice level specialisation.** The strong generalist tradition in the family doctor service, coupled with the absence of perverse economic incentives to offer patients unnecessary treatments or diagnostic tests, has served the public interest well. But the establishment by some fundholding practices of devices such as limited companies which in effect allow 'item of service' fees for certain tests or treatments 'sold' might adversely influence patterns of care provision;
- **the establishment of unified commissioning authorities.** To the extent that such agencies actively strive to develop general practice competencies they could promote a long-term cascade of 'purchasing power' down to the patient/primary care professional level. But some staff and members of commissioning authorities may feel threatened by such trends, and seek to resist them. This may be particularly so in localities where DHA/FHSA fusion has been experienced as a hostile 'takeover' of the FHS by the 'hospital side'. Even in localities where relations have been more harmonious there may prove to be a need for independent FHS development support services.

8.7 Opportunities for better care

The fundamental opportunity for better primary care integration today exists within practices themselves. Given a district wide management system capable of guiding and supporting change, the development of a practice and patient centred general nursing service alongside, and unified with, the traditional general medical service could make fundamental contributions to improved care by the beginning of the twenty first century.

The emergence of appropriate contracting systems between integrated primary health care practices and local commissioning

agencies could also help practice based professionals (together with their patients) to in time play a more central role in purchasing decisions affecting secondary services located in either hospitals or the community. The opportunity is for the 'general health practice' to become the cornerstone of the future NHS, serving as an anchor point for patients in a system which otherwise may be set to become increasingly plural, not to say fragmented.

The consolidation of all primary health care services in multi-professional general practices might also open the way to a more widespread implementation of the community oriented primary care approach, and other extensions of the generalist role. For instance, computer based health promotion, chronic care and acute treatment protocols and record handling systems should during the 1990s enable professionals working in primary health practices to deliver high quality care to service users with a considerably increased range of needs. The central opportunity here is further to combine and improve the convenience, familiarity and continuity of general practice with the levels of technical knowledge and judgement in the past only available from specialists. The implications of this are considerable, not just for hospital based staff but also for individuals working in public health. Their contributions will increasingly be directed at supporting, and exchanging information with, primary providers.

A final area of potential opportunity for the general practice of the future is—alongside the further development of its management procedures, partnership arrangements and audit/accreditation quality provisions—the formation of stronger links with social care providers. The analysis presented in earlier chapters points out some of the dangers to service users inherent in narrowing the definition of health care too far, while broadening that of separately provided social care.

The work of the Audit Commission (1992a, 1992b), has suggested a possible way forward. It involves the emergence of generalist social 'care managers', who may in time make and share close links and common purposes with primary health care professionals.

One of the key problems to be overcome in social care is that there is as yet no equivalent figure to the general

medical practitioner, someone with relatively high status and broad decision taking capacity in ready contact with service consumers, who has sufficient devolved authority and expertise effectively to co-ordinate support to each individual. Another is that social service users often have to accept being placed in difficult, 'denormalising' circumstances in order to access support. Against this a visit to a general practice can easily be seen as a part of a satisfactory, normal, life.

To meet these challenges social service care managers could in future develop along the lines pioneered in general medical practice. Indeed, depending on the resources available and the degree of devolved authority which can in practice be achieved, the location of primary social care managers in or near general practices might well foster both effective collaborative working and acceptable patient access to a full range of linked health and social services. In the era of 'care transition' the potential importance of such progress should not be underestimated, although neither, too, should the obstacles to its achievement.

Summary

- The 'British success' of general practice has developed over the years partly through chance and partly through planned policy initiatives. Some of the latter were developed with the medical profession (for example the 1965 Doctors' Charter) and some imposed upon it (for example the 1990 contract).
- From 1850 to the mid-1970s urbanisation, enhanced therapeutic techniques and the rise of the medical profession created a 'golden age' of hospital based care. Better living conditions, improved technology and the rise of health services management are now tending to curb the use of hospital based services.
- Current strengths of general practice include universal access, continuity, flexibility and direct interaction between doctors and patients.
- There are however weaknesses, including injustifiable practice variations, the isolation of GPs, communication problems and deficiencies in inner city primary care. These pose a number of possible threats to the FHS primary care system over the coming decade.
- The fundamental opportunity for better primary care integration exists within the practices themselves. A general health service could make major new contributions to improved patient care by the beginning of

the twenty first century, with practices acting as the driving force in a patient/primary care practitioner led health care 'market' defined by better information on treatment effectiveness and efficiency and a cooperative commitment to the attainment of greater health and welfare gain.

9

THE FUTURE GENERAL PRACTICE

9.1 Forces for change

9.1.1 The individual in society

The introduction to this book posed a number of questions about the costs and benefits of health promotion programmes, and the future of general practice. Subsequent chapters have emphasised that the achievement of better public health standards will depend on an effective, mutually complementary, integration of curative and preventive health care, and on both individual and society wide efforts to establish 'healthy' ways of life. That is, patterns of normatively supported behaviour which help people to maximise their personal sense of well-being, and cope successfully with the challenges that face them, their families and their communities.

Improving 'health' does not, from this perspective, mean taking every measure possible to extend life or minimise the risk of disease. On the contrary, it may rather require that the medicalisation of ordinary life—or death—should be avoided. Yet at the same time there is usually good reason to avoid known health hazards, and to use proven and cost-effective techniques of anticipatory, curative and rehabilitative medical care. A pragmatic balance between the personal freedom for each individual to spend his or her existence as he or she chooses and the maintenance of a social framework which prevents harm to others and enables those within it to avoid danger if they choose to do so is the best that any nation can aim for.

In Britain general medical practice has an established, widely trusted, place in the community. Hence family doctors and their colleagues are in a number of respects uniquely placed to contribute to health promotion. But if efforts to expand their role in this area were to impair performance of their central task of responding to individually expressed demands and anxieties about sickness, then their power effectively to help patients select less hazardous lifestyles or adapt to disease

and/or disability would be undermined. Any credible health service must be seen to treat illness and attend to emergencies before it addresses longer term concerns relating to the prevention of what might happen in the future.

However, several of the trends identified in this book suggest that primary health care will move further in the direction of anticipatory care, as broadly defined in chapter 6. One of the most important is care transition, which comprises the late health and related social sequelae of demographic transition and the economic growth attending it. These include population ageing and the demands created by an increased prevalence of life style related, disabling conditions of later life, coupled with the psycho-social developments associated with small family sizes and the increased anxiety surrounding the survival of each child when such 'high risk' reproductive strategies are adopted.

A second set of factors driving change relates to advances in medical technology and the adapting role of hospital and associated institutional care. There is increasing demand for good quality home based services, designed not only to help recovery from illnesses and the interventions made to treat it (to avoid disability or handicap) but also to permit the delivery of sophisticated therapies in domiciliary settings. In economic terms, conventional acute health care appears to have reached a point of 'diminishing marginal return'—more and more needs to be spent to gain less and less. This is another factor underlying the nation's growing interest in preventive measures.

9.1.2 Limits to traditional professionalism

Along with these long-term, historic pressures, general medical care has also in recent years been affected by events such as the introduction of GP fundholding, the 1990 'new contract', and the emergence of a stronger cadre of health service managers. To medical professionals in a system which had previously been largely immune to changes affecting other parts of the NHS these changes frequently seemed destructive and threatening, even though the importance of good primary care is receiving more recognition.

At worst, the reforms of the early 1990s have been regarded as the deliberate de-stabilisation of a public service which had hitherto been evolving in a demonstrably satisfactory way. Many doctors believed that (whatever the rhetoric) the purpose of imposed change was ultimately to weaken their authority and to bring undesirable aspects of market competition to the heart of the NHS. One reason why health promotion became such a disputed area at the start of the 1990s is that it offered a scientific ground upon which to fight such perceived hazards. Arguments about whether or not GPs should be required by the state regularly to take samples of all patients' urine in a sense symbolised the entire issue of professional judgement and commitment versus government/management 'interference'. They demonstrated well that politicians who meddle with health care can do harm, because so many of these interventions were clearly unproven.

Yet in the wider area of general practice standards, and variations in the quality of patient care between practices and localities, the balance of objective observation and the public interest may favour more government intervention. Regardless of the level of competence or incompetence with which the terms of the 1990 contract were determined (and issues like DHA/FHSA mergers subsequently approached) the case for a more carefully and effectively managed process of general practice development right across the country is strong. The purchaser/provider split, the strengthening of a population based approach to health care and promotion, and greater emphasis on demonstrating 'health gain' in return for the money spent in every part of the health service are all potentially beneficial to patients. The *Working for Patients* reforms challenged past inertia and could open the way to better care in many areas.

Furthermore, it may be argued that the level of professional power enjoyed by general medical practitioners working independently not only of the rest of the NHS but also of each other was in some respects unhealthy from their own viewpoint, as well as that of some service users. Isolated within the relatively narrow walls of medical knowledge and those of their own premises, many GPs have had little opportunity to form good working arrangements with their peers or with other professionals. Collectively all the professions failed during the 1970s and 1980s to build a sufficiently sound understanding

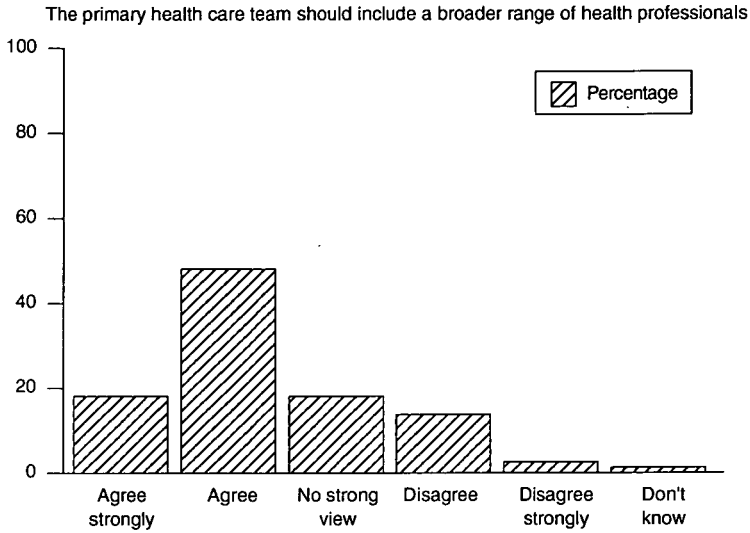


Figure 9.1 GP attitudes 1991/92—the primary care team. Source: GMSC 1992

of health policy issues. The result was their effective disenfranchisement during the later years of the Thatcher administration.

9.1.3 Choices for the future

In 1991 the BMA's General Medical Services Committee published *Building Your Own Future*, which was followed in 1992 by *Your Choices for the Future*. These documents indicated an awareness of the problems facing general practice, and a determination to try to establish a firmer, better informed, professional consensus about the development options available.

Your Choices for the Future contained the responses of over 25,000 family doctors to a survey conducted early in 1992. As Figures 9.1–9.4 illustrate, it produced a wide range of information about GPs' expectations and fears for the 1990s. The four key areas covered were:

- out-of-hours responsibility (24-hour care).
- how GPs should be paid.
- how to maintain care quality and standards.
- the kinds of service which should be available from the future general practice.

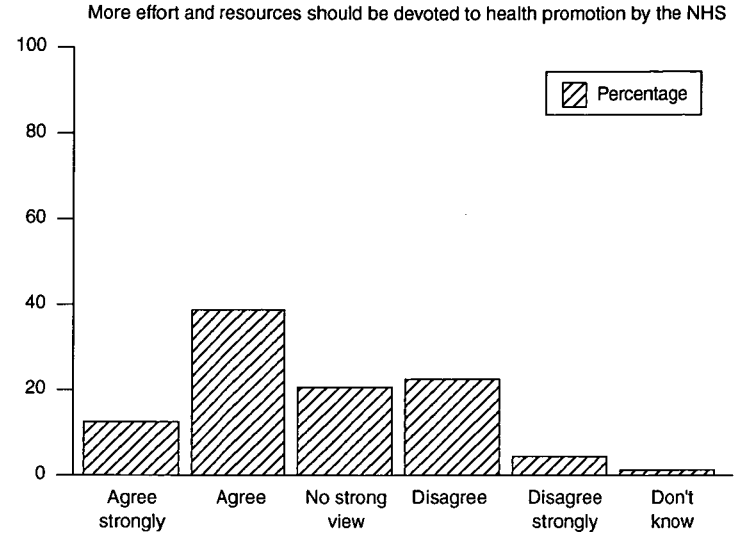


Figure 9.2 GP attitudes 1991/92—health promotion. Source: GMSC 1992

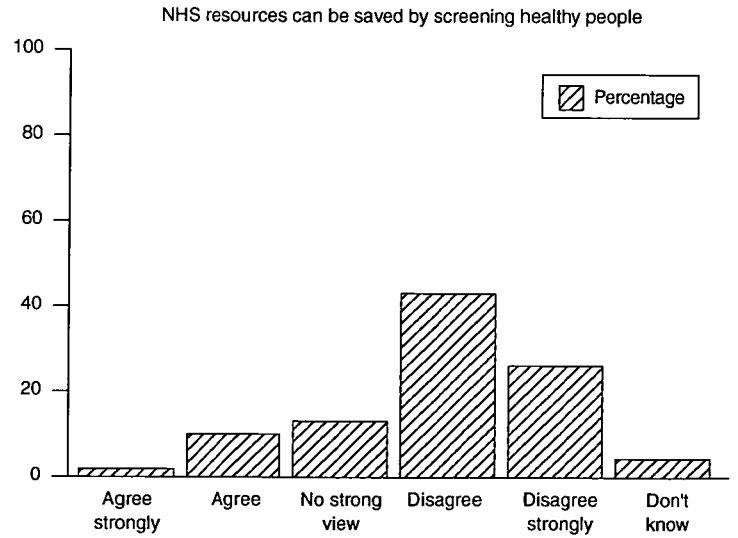


Figure 9.3 GP attitudes 1991/92—screening. Source: GMSC 1992

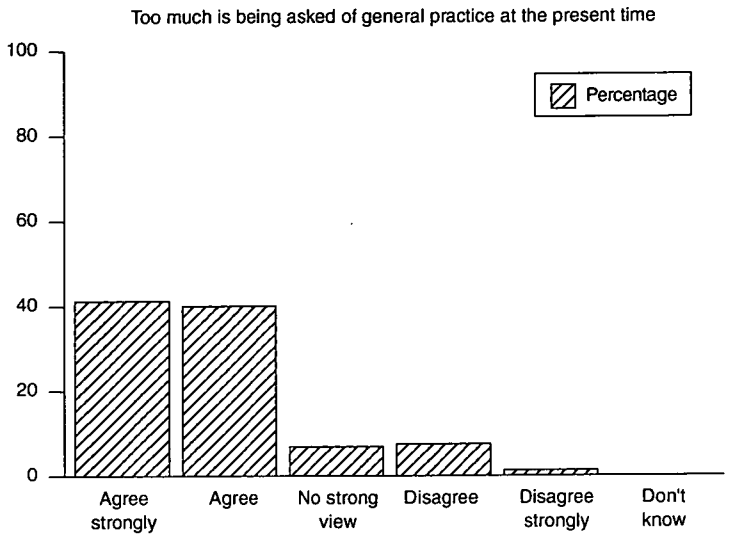


Figure 9.4 GP attitudes 1991/92—GP 'overload'. Source: GMSC 1992

With regard to the first of these a clear majority of GPs (73 per cent) said they would like to opt out of the existing 24-hour commitment, although many would be prepared to participate in a rota system of local out-of-hours care provision. Over four-fifths supported the development of new provisions such as primary care emergency centres. A significant factor in this appeared to be the increasing number of female family doctors, and the growing expectation amongst younger people of a 'normal' family life.

On the question of payment and employment the survey revealed strong support for the retention of independent contractor status. But over half of all family doctors accept that GPs should have the choice of being salaried if they so wish, and more than four in every six said that they would like to see practices rather than individuals contracting with FHSAs or their equivalents. Over half of all GPs also said that a system of accreditation and re-accreditation would help improve standards of patient care. Many favoured the introduction of a wider range of services in general practice surgeries, and the possibility of having practice managers and nurses as practice partners—see Tables 9.1 and 9.2.

Table 9.1 'Your choices for the future'—GP responses. 'Which of the following do you think it would be appropriate to provide at GP surgeries in the future, assuming that adequate resources were made available?'

Service	Provide at GP surgeries? Yes (%)	No (%)	No strong view (%)
Crisis counselling (e.g. divorce, bereavement) ($n=24\,774$)	68.8	15.2	16.1
Addiction counselling (e.g. alcohol, drugs) ($n=24\,539$)	54.9	26.5	18.6
Hypnotherapy ($n=24\,093$)	22.9	41.9	35.2
Homeopathy ($n=24\,052$)	17.8	50.1	32.1
Acupuncture ($n=23\,986$	29.2	36.3	34.5
Dietetics ($n=24\,462$)	79.7	8.9	11.4
Physiotherapy ($n=24\,575$)	88.5	5.9	5.7
Chiropody ($n=24\,317$)	80.0	9.6	10.4
Chiropractic ($n=23\,836$)	21.4	42.4	36.2
Osteopathy ($n=23\,865$)	29.1	37.5	33.4
Laboratory analysis/pathology ($n=24\,226$)	41.2	38.0	20.8
Full pharmacy service (i.e. including OTC drugs) ($n=24\,226$)	32.6	45.8	21.6
Optometry ($n=24\,011$)	35.1	35.0	29.9
Hospital consultant sessions ($n=24\,388$)	58.9	20.4	20.7
X-ray services ($n=24\,143$)	28.2	51.9	19.9
Endoscopy ($n=24\,220$)	29.6	45.2	25.2

Source: GMSC 1992

These results indicate that a large proportion of family doctors are prepared to accept further, in some respects radical, changes in the 1990s. But progress since 1992 in deciding how the profession should move forward appears to have been disappointingly slow. And neither the GMSC nor the Royal College of General Practitioners has taken any major initiative to extend their internal debate about the future of primary care to include other provider groups or, more importantly, end point customers. Issues which in the mid 1990s will require sustained attention include:

- **24-hour care.** The views of GPs who find their responsibility to provide 24-hour care onerous are understandable, but limiting their caring role to nine to five on weekdays could undermine the nature of general practice in Britain. The best compromise is likely to leave family doctors with the responsibility for deciding how out of hours cover should be

Table 9.2 'Your choices for the future'—GP responses. 'Assuming there were no serious practical difficulties, would you like to appoint any of these non-medical personnel as profit sharing partners?'

Non-medical personnel	Yes (%)	No (%)	Don't know (%)	Have done so already (%)
Practice managers ($n=24\,772$)	38.9	48.2	11.6	1.4
Practice nurses ($n=24\,683$)	26.1	61.7	10.9	1.3
District nurses ($n=24\,278$)	10.0	79.4	10.2	0.4
Health visitors ($n=24\,140$)	10.1	79.5	10.0	0.4
Pharmacists ($n=24\,179$)	12.9	74.4	12.6	0.1

Source: GMSC 1992

provided to an acceptable standard for the people on their lists, but to transfer accountability for poor clinical care directly to the professionals working in the emergency services selected;

- **salaried practitioners.** Experience in areas like community dentistry indicates that the introduction of salaried status is no easy solution to the problems of managing a highly disseminated professional service. Indeed, it could be thought to run against the entire ethos of the new NHS. However, in selected localities the greater use of salaried GPs and other primary care staff could be appropriate. With the formation of unified commissioning authorities with relatively small staff complements, it may, in the absence of appropriately structured community trusts, be necessary to establish new forms of NHS development agency to facilitate the use of this option;
- **practice based contracts.** The GMSC (1992) has described practice based contracting as *'perhaps the purest form of independent contractor status'*. Yet despite this lead and the support for a shift from individual to practice based primary care contracts (which could encourage new sorts of partnership) shown in *Your Choices for the Future*, little progress towards such an approach has been made. The most probable outcome in the immediate future will be a combination of nationally negotiated terms for individual contractors with local service level agreements negotiated between commissioners and each primary care team. As commentators like Bosanquet (1992a, 1992b) have pointed out, the latter could swiftly become the most important single element within overall practice income, provide that appropriate legislative changes are introduced;
- **fundholders and non-fundholders.** Fundholding has been one of the most immediately visible successes of the 1990 reforms (Glennerster *et al.* 1994). But it has also caused concern, not least because it may have drawn attention away from the problems of how to improve primary care in less advantaged parts of the country. By early 1994 around 36 per cent of the English population were cared for by fundholders (a proportion which could rise to 50–60 per cent by the later 1990s). But this still leaves a large number of patients under the care of

non-fundholders. Their health care needs are, at least in some respects, greater than average. While developments such as extended fundholding (for example those in Bromsgrove and Worth Valley) and the formation of multifunds by established fundholders are of considerable interest, attention must also be given to options like practice sensitive purchasing (with indicative budgets, as pioneered in Bath) and other forms of comprehensive locality purchasing. These may never replace fundholding, not least because the reality of at least a proportion of family doctors controlling discretionary funds is a powerful spur for authority based commissioning to develop in a flexible, sensitive, manner. But locality purchasing involving non-fundholders could in future help ensure that structural plurality in primary care serves to reduce traditionally accepted variations in standards of primary care between localities, rather than amplifying them;

- **accreditation systems.** Practitioner acceptance of the need for individual level, professionally controlled, systems of accreditation and re-accreditation seems to be fairly well established. However, the place of practice level arrangements for testing and confirming the appropriateness of management systems and practice values and relationships, controlled by a third party, is much more controversial. Bodies such as the King's Fund are currently developing organisational audits for general practitioners to use on a voluntary basis. But as local commissioning gains strength there is likely to be an increasing demand for compulsory external accreditation. Accreditation systems should be designed to implement cost-effective improvements to patient care;
- **cash limited general medical care.** The allocation of resources for all aspects of NHS care the FHS (including indirectly) is cash limited from a global budget, which is subject to assessment in relation to health needs and related criteria. Only independent contractor supplied primary care is ostensibly demand led, in that practitioners are in part paid on the basis of fees per item of service supplied, and their pharmaceutical spending has not, at least until recently, been set by any 'objective' measures of patient need. There appear to be equity arguments in favour of a firmer 'RAWPing' of primary care (Birch and Maynard 1986, Bevan and Charlton 1987). Yet this needs to be approached with care to maintain a flexible approach and, as discussed in previous chapters, to avoid perverse consequences.

9.2 Development principles and assumptions

9.2.1 Practice level decision making

The following sections consider the nature of a typical general practice at the beginning of the twenty first century, and the place of practice based health promotion/anticipatory care in the future pattern of NHS services. One of the most important

of the principles on which the projection presented is based is that 'subsidiarity' is a vital concept in health care. Wherever possible power and decision taking should lie with patients and their personal health care advisors, within an aligned framework. If this view is accepted it will require a continuing cascade of NHS purchasing functions 'down' to the service user/family/practice professional partnership.

To achieve this devolution of decision making, practitioners will need to balance the professional/patient relationship, defending each individual's best interests, with awareness of overall practice population needs. This will need ongoing developmental support from unified commissioning authorities, which may in time result in a reduced, or at least changed, role for such bodies. Areas in which practice guidance may be necessary range from the use of information technology and staff management and support to the assessment of local health needs and public priorities. In the area of staff, for example, existing partnership arrangements could desirably be extended and modified to include non-medical professionals, to prevent exploitation of junior practice members, and to permit more structured career development for GPs in their 40s and 50s. This last could help to reduce the incidence of 'burn out' in family doctors.

One possibility is that individual partners could specialise in given therapeutic areas. This is already happening in fields such as minor surgery. There is a danger, however, that if taken too far specialisation could undermine the generalist base of British primary health care. The worst case analysis is that 'specialoid' GPs would in effect become secondary care suppliers, and potentially inappropriate economic incentives could influence patient care decisions.

An alternative approach to GP career structuring relates to service and management (quality) development. Individuals could, for example, take responsibilities within the practice for human resources, information system expansion, research and teaching (undergraduate and postgraduate) or public health matters. Responsibility for relations with external agencies like commissioning agencies or local authorities could become another area of formally recognised family practitioner career progression in the practice environment of the early twenty-first century.

9.2.2 *From loose group to unified team*

The extension of care outside hospital settings will require increasingly close working between all primary and community care professionals. It is assumed here that in operational terms, virtually all primary health services will become organised around a practice centred system of management and delivery by around the year 2000. This will involve the establishment of a general nursing service, and its integration with general medical care. From being 'team' members whose ultimate loyalties are to their own professional groups the staff of unified practices should be able to move towards a strong common commitment to their shared enterprise, and meeting the needs of patients/users. Fundholding could encourage such an ethic.

More effective integration of general medical and community nursing functions should permit the future general practice to act as a centre for the co-ordination of support for chronically ill people, and others who have to cope over extended periods of time with difficult social circumstances as well as medical problems. Health promotion is closely related to these areas, inasmuch as it is often most usefully directed at patients with existing illnesses or individuals at very high risk.

Critics of the NHS reforms have argued that fundholding will bring a destructive awareness of costs the work of family doctors and their relationships with their patients. This could undermine practitioners' awareness of the value of social aspects of care, as well as patient trust in their doctor's advice. But, carefully managed and supported by local contracting, fundholding need not have such an effect. A fundamental challenge for everyone working in the health service is to integrate concern for the 'physical, psychological and social' needs of each service user with the political, economic and managerial skills required to deliver a good standard of service to all those receiving care from, and paying for, the NHS.

9.2.3 *Practice choice and list sizes*

If the new NHS is to act as a market in which its end point customers have an opportunity directly to select between providers, then practice and practitioner choice should be maintained. Even if patients usually prefer to exercise 'voice'

within a known environment rather than express discontent by moving to a new practice they should at least have that option available to them as a final sanction. In many localities this requirement may curb the formation of very large practices, serving populations of, say, 15 000–20 000 patients. An emphasis on generalism and the value of making high levels of expertise and advice directly available to service users facing uncertainty will also need to be retained, and the imposition of 'catchment area' access restrictions confined to a minimum.

In fact, despite the interest being shown in models such as American HMOs and the formation of large groups of practices in the UK to take on extended purchasing roles, the available data suggests that there is already a tendency to check the formation of primary care 'mini-institutions'. Extrapolating from recent trends it appears that the number of medical partners will have converged at around five in the average/median general practice by around the year 2000. Despite increasing numbers of non-medical practice staff it also seems likely that the average list size per whole-time principal in England will continue slowly to decline to around 1700 by the start of the twenty first century. *Your Choices for the Future* showed that only one family doctor in 40 believes that the current average list size (around 1900 in England and Wales) should be increased, while three in every four said that it should be reduced.

Finally, another important aspect of the identity of many successful general practices is that the partners own their premises. Although additional public funds will be required to ensure that all primary health care providers are housed in an acceptable manner, there is a good case for suggesting that practice partners should continue to be able to invest in their premises and play a central role in their selection, design and upkeep. Part ownership or flexible leasing arrangements may facilitate this, along with rationalised arrangements for the payment of 'rents' by the NHS to independent contractors.

9.3 The future primary health care practice

9.3.1 Structure

Given such patterns of progress, what will general practice be like in the early years of the twenty first century? All

predictions are uncertain, especially in developing fields which are frequently subject to political intervention. In primary care, new models of funding could lead to either increased or decreased diversity. There will certainly continue to be significant differences between inner city primary care, where new forms of community care and accident and emergency centre (particularly to support unregistered NHS users) are most likely to emerge, and rural areas, where activities such as practice based dispensing and the more traditional cottage hospital could well have survived and prospered. Even so, the average practice is likely to share some key characteristics with those offering primary care in every other part of the country.

In the illustrative, 'ideal type', practice outlined here (referred to below as 'the practice') there are five whole-time equivalent medical posts, held by four full-time partners and one held by two other medical partners in a job share. Five are equity partners (that is they own a share of the practice premises and other capital stock). The other (younger) partner works on a salaried basis. The practice manager and two senior nurses are also equity partners. Consideration is being given to the appropriate status of the psychotherapist and the physiotherapist, who has a half-time contract. So far the practice has been cautious about extending the use of the title 'partner', but it is clearly a powerful motivating factor.

Three of the full-time medical partners have management, external liaison and teaching roles which are formally recognised in their internal practice contracts. (The practice does not have a vocational trainee at present, but there is a limited amount of undergraduate teaching). The practice has a model constitution, approved by the BMA and the RCN, which gives its equity partners (and to a slightly lesser degree the salaried ones) specified voting rights in the event of disputed decisions, together with equitable terms of service. However, it normally operates on a consensus basis with development options being discussed in regular fortnightly meetings open to all staff. The total number of whole-time equivalent staff, excluding doctors, is 16, including six nurses (three practice, three primary care community), receptionists, secretaries and records workers. There is also a practice researcher who contributes to planning, report writing and

patient consultation exercises, and an attached social worker/case manager.

To accommodate its extended staff the practice purchased (with help of the primary care development agency created by the unified health authority) a building adjacent to its original premises in the late 1990s. This provides space for clinics, counselling services and the social worker. It also has a staff room and a seminar room. This split site arrangement works relatively well. The practice has had little trouble in gaining the bi-annually renewed accreditation from the RCGP/Organisational Audit (formerly King's Fund) scheme required by the commissioning authority.

9.3.2 *Assured service standards for a defined population.*

The practice serves a population of approaching 9000. It does not operate within strictly defined boundaries, although it is very reluctant to accept new patients whose assessed clinical needs (including community nursing and possible emergency care) might be better met by other practices. In such cases patients are advised of the issues involved, and their preferences carefully discussed. The practice, with four similar ones, is part of a co-operative which provides out-of-hours and emergency services. The partners have a collective 24-hour care responsibility for their patients—clinical responsibility for emergency interventions lies with the individual(s) who give care but any organisational failing on the part of the co-operative would relate back to the practice.

The practice is not part of any wider fundholding consortium, because the local primary care development agency and commissioning authority together provide a full range of information and support services. The secondary care trusts active in the local community (employing former hospital nurses, and staff with more specialised community experience to offer intensive domiciliary services and run a community care centre) also offer back-up facilities, including nurse locum services which the practice purchases along with domiciliary and specialised clinic packages.

There is a formal mission statement drawn up by the partners. It stresses the goal of enabling service users to exercise informed choice and enjoy a positive sense of control over their

lives. A detailed description of the practice's services, performance standards and targets has been agreed with the local commissioners, and is available to interested patients. (The term 'charter' went out of fashion during second half of the 1990s). It does not have a patient consultative committee, but the practice's internal audit and allied care quality programmes involve structured analyses of patient experiences and opinions. Informal conversations between staff and service users about how things are done and what patients would like are actively encouraged. The practice has consciously developed an informal, 'talkative', culture.

Patient lists are kept fully up to date. This involves periodic automatic checking via the National Health Register, except in the case of the very few patients who have not given consent for the inclusion of their records. This system allows limited locality and national access to data such as practice demographics, and specified diagnostic and treatment delivery rates, although the programme cannot allow individual names and addresses to be searched at any level above the practice. Access is also protected within practices.

The practice prepares files contain aggregated, manually prepared information about the non-consenting members of its population living within each commissioning locality. A special fee has been negotiated. These reports contribute to the construction of the commissioning districts' needs and service delivery assessments. Such documents are prepared in parallel with practice annual reports/service development plans. Together they provide the basis for local primary care contracting. Independent specialists in public health medicine, working in the primary care development agency, support practice level planning and therapeutic effectiveness analysis.

9.3.3 A focus on personal care

Compared to the norm up to and including the 1980s, the typical practice of the early twenty first century is remarkable both for its automated, computer based systems of financial and activity monitoring, and for the sophistication of its personnel and other management procedures. Staff training and psychological support is recognised as an important priority.

Some patient consultations are supported by computer held protocols; practitioners and patients on occasions together interrogate the voice-activated consulting room terminal, to assess the desirability or otherwise of available secondary treatment and support options. Practice equipment is relatively advanced (and expensive) compared with that of the 1980s, although fewer surgical procedures and consultant consultations are undertaken in GP surgeries than some authorities once hoped for. Surviving hospital outpatient departments are much improved.

Contrary to the fears of pessimists who in the early 1990s believed that general medical practice in Britain would by the turn of the century have degenerated into an anonymous emergency walk-in system, the practice has not lost its personal focus. Patients can elect to see a practice based nurse as they wish, and practice nurse and visiting specialist nurse led clinics have a stronger role in the care of many chronically ill individuals than was previously the case. However, the close personal relationship between many patients and their doctors has survived. Indeed, the medical partners feel that in many respects the improved level of support available has freed them to concentrate on health and related social care issues instead of paperwork and administration. The unity of the practice team has also helped them to form better relationships with nurses and other professional partners and colleagues. This is also true with regard to the attached social worker/case manager, although the resource constraints affecting both sides of the continuing health and social care divide make this role a difficult one.

9.4 The future health service

9.4.1 Building on a British success

This relatively optimistic outline of how an average general practice might look and work a decade or so into the future is of course highly speculative. It is derived from what are at best only informed 'guestimates'. Many factors may serve as confounding agents. For instance, the projection that the practice based nursing workforce will grow to something over four times its current size (that is, that the number of practice

nurses *per se* will double, and that they will be joined by an approximately equal whole-time equivalent number of practice based community nurses) is open to question. The social and economic barriers to a fuller integration of primary care nursing and general medical practice may prove to be more substantive than the presentation here suggests.

Within general medical care, it is possible that the incentives created by fundholding and/or the influence of unified commissioning authorities will be less positive than predicted. Destructive forms of competition could emerge (such as 'cream-skimming' patients to exclude those at risk of requiring costly treatments) if the market is not adequately regulated. It is also conceivable that insufficiently vigorous efforts will be made to develop the full potential of general practice in some localities.

Changes in other fields, such as pharmacy, could also bring new dimensions to general practice based activities and structures. For example, pharmacist partners may be willing and able to join both urban and rural primary care practices in or around the year 2000. In addition, the high street pharmacies of the twenty first century could play an extended role, serving as 'walk-in' health centres for people prepared to pay directly for advice or treatments. They may even employ doctors, and offer a radical alternative to other patterns of primary care for younger people.

Nevertheless, the case for suggesting that it would be desirable to build on the existing, internationally exceptional strengths of this country's general medical care base (and its community nursing heritage) to create a primary care driven NHS is a robust one. Its desirability is not so much in question as its attainability, and the identification of viable ways forward.

9.4.2 *Health promotion*

During the 1980s it became, as noted in the introduction to this book, relatively widely believed that the nation needed 'a health service, not a sickness service'. It was suggested by individuals at both ends of the political spectrum that a constructive way forward for the NHS, and for general practice in particular, would be to concentrate more effort on the

prevention of disease. Growing awareness of the immense burden of ill health caused by smoking and other life style related factors understandably helped to fuel such arguments. But in some respects they tended to be over-simplistic.

The social determinants of ill-health have proved more complex than was on occasions assumed, and the effectiveness of broad programmes aimed at primary prevention through life style modification has, in the context of general practice, been increasingly questioned. The findings reviewed in Chapter 7 emphasise that in a number of important areas case finding and secondary/tertiary prevention approaches have greater proven value. In addition, it has become apparent that primary care providers cannot, if they are to retain the confidence of those using their services, take too narrow a view of what constitutes health gain, or focus their activities too exclusively on prevention as distinct from the alleviation and treatment of ill-health. A possible cause of public distrust of even the most positive of preventive approaches is that they may on occasions be seen as an alternative to, as distinct from an addition to, investment in conventional medical and other health care activity.

Health promotion programmes cannot eliminate existing illnesses or the need for (and costs of) a 'national sickness service'. A combination of increased longevity and the availability of more specific (and almost certainly more expensive) treatments for the illnesses of later life could well mean that demand for (and spending on) medical and allied care will rise as the implementation of *Health of the Nation* policies proceeds. So too could overall health service workloads, particularly if greater health knowledge and awareness raises the public's need for explanations of, and reassurance about, even slightly abnormal states.

Honest recognition of these points should not draw attention away from the inherent worth of objectives such as those identified in the *Health of the Nation* documents. Effective, efficient approaches to the maximisation of individual and collective health and wellbeing will require very sophisticated combinations of bio-medical, psychological, epidemiological, social and economic intervention at many levels in the community. The fact that achieving better standards of health is a complex task which cannot in many cases be gained by

medical or other conventional health care interventions alone should not discourage primary care professionals from making effective contributions whenever they can.

Indeed, a more informed awareness of the complementarities which exist between all the inputs to prevention, cure and care may help to reduce disputes and misunderstandings between professional groups, allowing them to work together more constructively. It could also open the way to a more balanced relationship between management direction and professional discretion in the health service.

9.4.3 Professionalism for the twenty first century

This last opportunity is central to this book's conclusions. The evolution of the NHS and all health care systems in the developed world has, over the last twenty years or so, involved a reduction in some aspects of established medical authority and autonomy. That of managers has increased, but the legitimacy of the new power centres which have emerged is not fully accepted. The result has been an uncertain situation, to the dismay and discomfort of many people using and working in the NHS and other care systems (Freidson 1988, 1990).

The conflict surrounding the 1990 contract for general medical practitioners and their ambiguity of feeling towards the reformed NHS can be seen as an aspect of this international process. Recent debate about health promotion in general practice has, to a degree, been another facet of the same phenomenon. But the potential significance of the 'new sort of general practice' described in this chapter is that it could provide a base for the resolution of conflict between managerialism and professionalism in the health sector. By reducing the individual and group isolation and fragmentation characteristic of the traditional organisation of professional work, the structure of the future general practice could enable all its members to share common challenges, goals, incentives and information. It could thus provide an environment in which a new sort of professional, committed to overcoming boundaries and barriers to co-operation between health care providers rather than defining them, will develop.

The emergence of multi-professional primary health care 'firms' as the key structural unit within the future publicly

funded health service could also facilitate the emergence of informed consumer demand as a stronger directing force in the provision of high quality care. In a world of limited resources any one individual's needs have to be balanced against those of others—the informed rationing of health care based on individual consumer consent is essential to achieve the best possible overall outcomes. The failure of traditional professional groups to address this issue in a way which satisfies both the public's concerns and elected governments' requirements has helped to cause a global health care crisis.

To the extent that patient demands for care can be successfully informed and met by primary health care professionals, operating within the resources available to the future general practice, this could offer a way out of the dilemma currently facing the health service. Although the task of assessing the requirements of known individuals, and acting as their advocates, is a difficult one to balance with that of caring for a whole population's needs, it is at the practice level that this can often best be achieved. Arguably, the future position of independent professionals such as general medical practitioners in the health care system will hinge on whether or not they are prepared to take on such an extended role. If successfully accomplished, it would provide a means of 'rationing' care provision which is both acceptable to patients and consistent with professional knowledge. This is the key to maximising all those elements of the nation's health and wellbeing which are amenable to health service intervention.

Summary

- General medical practice in Britain has an established, widely trusted place in the community. Family doctors are in a number of respects uniquely placed to contribute to health promotion.
- Historical trends and more recent initiatives have created pressures for change in general practice. Issues which need attention in the mid-1990s include 24-hour care, salaried practitioners, practice based contracts, fundholding, accreditation systems and locally based cash limitation.
- Wherever possible, power and decision taking should lie with the patient and his or her personal health care advisors. This requires a continuing cascade of purchasing functions 'down' to the service user/family/practice professional partnership.
- The extension of care outside hospital settings requires increasingly close working between primary and community care professionals of all types.

Better integration of general medical and community nursing functions should permit the future general practice effectively to act as a centre for the coordination of support for chronically ill people.

- There is a strong case for suggesting that it would be desirable to build on the strengths of this country's general medical care base to create a primary care driven NHS.
- A more informed awareness of the complementarities which should exist between all the inputs to prevention, cure and care may allow professional groups to work together more constructively, and could create a more balanced relationship between management direction and professional discretion in the NHS.
- The emergence of multiprofessional primary health care 'firms' as the key structural unit within the future publicly funded health service should also facilitate the emergence of informed consumer demand as a stronger directing force in the provision of high quality care. 'Professional process re-engineering' may offer a way out of the current health care crisis, and a path towards the equitable rationing of health resource use based on informed consumer consent.

APPENDIX

ECONOMICS, HEALTH AND PATIENT WELFARE

Since the impact of the 1973/74 oil crisis on public spending programmes across the developed world, economic analysis has had a growing influence on the formation of health policies. Its focus as a discipline is on the study of how individuals, groups and societies use the scarce resources available to them to make and distribute commodities and services, and on the costs and benefits of changing patterns of allocation. Economics is sometimes called 'the dismal science', as it emphasises that any choice made to devote finite resources to one end necessarily means foregoing the alternatives available—that is, everything has an opportunity cost. However, its central purpose is to help maximise individuals' well-being.

Health care is primarily aimed at generating benefits such as increased life expectancy or reduced anxiety, pain and/or disability. It is important to understand that economic analysis does not only look at financial matters like cash flows. Results may be expressed in money terms; but welfare economists attempt to quantify not only 'tangible' items such as hospital spending or lost production, but also intangible factors such as the cost of human suffering. In cost-benefit analysis, all are expressed in common terms—usually a monetary value.

Economists aim to provide an informed basis for decision making, not to tell any individual or community what 'ought' to happen. Given a set of ethical values and related objectives, economists can indicate what resource allocation choices would be more, or less, efficient. Alternatively, economics may reveal the values implied by given patterns of resource distribution.

Politicians, civil servants and other decision makers often acknowledge that saving money is not in itself an inherently desirable goal. For example, in the context of community care the DHSS (1985), in a response to the House of Commons Social Services Committee, noted that *'a good quality*

community-oriented service may well be more expensive than a poor quality institutional one. . . . The aim is not to save money, but to use it responsibly'. However, often in using the work of economists the pressures of limited budgets coupled with a desire to keep taxes low means that 'actual' money flows are paid much more attention than are monetary values which are indicators of 'intangible' factors like human distress. This is a failing of which health professionals and policy makers should be aware, although it should not be seen as discrediting economics.

In looking at the value of activities such as health promotion, economic appraisals are typically focused on questions such as:

1. Could more morbidity and/or mortality be avoided by altering the way in which existing prevention resources are currently deployed?
2. If more resources for prevention were made available, how could they most productively be used to reduce mortality and/or morbidity?
3. If a target decrease in morbidity/mortality is to be achieved, how can this be done with the minimum opportunity cost?
4. Would the benefits of devoting more resources to prevention outweigh the opportunity costs, for example in terms of the acute medical or nursing care reductions which might result? If so, how much resource should be transferred? (Cohen and Henderson 1988.)

Economic evaluation of health care programmes has two main features:

- it values both inputs (costs) and outputs (consequences) of any activity;
- it compares more than one alternative.

The type of economic analysis chosen to evaluate a programme depends on the question which is to be answered, and on the perspective of the study—i.e. the viewpoint of the decision maker (for example, hospital, NHS, society). In some comparisons, one alternative may be clearly dominant—greater effectiveness at lower or equal cost. However, in most cases a more effective alternative is also more costly, and economic evaluation is required.

There are four major types of economic evaluation (see Drummond, Stoddart and Torrance 1987):

Cost minimisation analysis is relevant only if the effectiveness of the alternatives under consideration has been demonstrated to be equivalent. In this case, the lowest cost alternative is the

most efficient alternative, and therefore only cost analysis is required.

Cost effectiveness analysis includes both the costs and outcomes of the alternatives under consideration using a single outcome measure, most frequently expressed in terms of natural units (for example life years saved, number of live births, illnesses avoided). This allows comparisons between interventions when the effectiveness is not equal, but results are meaningful only when the alternatives being compared result in a change in the same outcome measure. It informs choices about the economic merits of interventions within but not between therapeutic categories, and it permits inclusion of only a single outcome measure.

Cost utility analysis compares two or more alternatives by combining multiple outcomes into a single measure of utility, such as a quality adjusted life year (QALY). Cost-effectiveness analysis is then carried out using the utility measure as the measure of outcome. It allows comparisons between different therapeutic categories with different natural outcomes. QALYs are calculated through the use of psychometric techniques designed to measure each individual respondent's valuation of a given state of ill-health, as compared with full good health. For example, if a year of perfect health is rated 1, then a year spent with pain from an arthritic knee may be, say, 0.9, and one with some loss of physical and other abilities from a stroke only 0.5. Some states may be negatively valued. When gathered for a representative sample such results are aggregated, and used to express the outcomes of various health care interventions in costed QALY units (see, for example, Williams 1985).

Cost benefit analysis links costs and outcomes by expressing both in terms of the same units—a monetary value. This forces an explicit decision about whether the benefit of an intervention is worth its cost. Various techniques can be used to attach a monetary value to the health outcomes of different interventions.

There is no consensus among economists about all aspects of economic evaluation (Maynard 1993). In addition, there are difficulties in some economic evaluations which mean that the results of analysis should be used with caution. Examples of the sorts of difficulty which may lead to misinterpretation include:

- **inadequate outcome data and lack of good clinical and epidemiological information.** Economic studies can only be as good as the material upon which they are based. In many areas of health care, outcome data is at best insufficient, and heroic assumptions often have to be built in to economic models. There is a considerable hazard that users of economic studies fail to recognise this, and do not look for measures of their vulnerability/sensitivity to minor or major changes in their assumptive base.

  For example, all the available data indicates that reducing smoking through GP counselling of patients should be a 'good buy' for the NHS (for example, see Williams 1985, Buck and Godfrey forthcoming). This is certainly so. But individuals such as Julian Tudor Hart (a family doctor whose long experience for caring for a relatively disadvantaged Welsh mining community led him to originate the term 'the inverse care law') have suggested that long-term GP counselling programmes alone might not produce the full level of result that their initial impact promises. In the first years around 5 per cent of those counselled may well be able to quit; but as the removal of layers of the population able and willing to stop smoking proceeds, a hard core of committed smokers may be revealed (Hart 1992). Other commentators (including those based at the HEA) question this view, but it illustrates one type of problem to be faced in evaluation studies.
- **adjustments for time preferences—discounting.** Conventional economic approaches involve discounting. Individuals generally have a time preference about when costs and benefits occur. For example, many people would value £100 today more highly than an £100 (adjusted for inflation) in ten years time, and would prefer a cost of £100 in ten years time to £100 now. In health economics, however, there is debate not only about the rate of discounting which should be applied, but also whether it is appropriate to discount health benefits at all (for example see Parsonage and Neuberger 1992, Cairns 1992). For the community as a whole, is a life saved today really more valuable than one saved in ten years time, or is the practice of discounting actually responsible for encouraging an undue neglect of our society's long-term health interests?

  Such questions are not 'scientifically' answerable, although the assumptions made in relation to them could influence critically policy decisions. Discounting health benefits at a rate lower than that for costs (such as zero) has the effect of greatly increasing the projected benefits of policies aimed at disease prevention/health promotion (including those advocated in the *Health of the Nation* White Paper) as compared to those to be derived from spending more on today's acute and chronic care services. This has important implications for health policy in general and health promotion in particular.
- **the nature of personal preferences.** Conventional neoclassical economic analysis assumes that consumers are sovereign, and that their preferences should at a given time be regarded as absolute. This has an important, and arguably very valuable, political and social significance. However, if some preference patterns are the result of socially determined habits which can be changed (with no inherent cost to the consumer) by

advertising or similar means, or are the result of involuntary behaviour demanded by addiction, then the basis of many economic calculations and recommendations can be questioned. This sort of concern is relevant to issues like, say, sugar consumption in the former case and tobacco usage in the latter.

- **marginal or average costs and benefits?** Marginal costs are the costs of producing one additional unit of a good or service (e.g. one extra consultation in a GP surgery or one extra dose of a drug) or the costs saved by providing one less unit. The marginal cost of a good or service is often very much less than the average cost. This is because there are generally fixed costs of production (constant and independent of services provided in the short run). Only in the case of goods or services which are extremely labour intensive are marginal and average costs likely to equate. Returns (outcomes) may also fall at the margin, although this will depend on circumstances. Economists agree that in most situations the preferred approach is to look at the impacts of change at the margins of production and consumption. In reality it is often difficult to obtain accurate estimates of marginal costs and benefits. Many studies use crude average cost and benefit figures, making their applicability limited.
- **whose costs, whose benefits?** Costs and benefits of health care include not only the individual whose health is affected, but the experiences and preferences of everyone involved. Disability, mental distress, and premature death affect whole families, local groups and whole societies, as well as the individuals who directly experience them. This can cause problems in valuing interventions, and also in calculating their costs. Economists in general prefer to take a broad viewpoint in evaluation, incorporating direct and indirect costs and benefits to individuals, families, the health service and to society as a whole. This does however create measurement difficulties, and in many circumstances studies decision makers may be interested in a much narrower viewpoint.

These issues of debate illustrate the difficulties of 'scientifically' valuing many of the products of a health care system. Economic evaluations should be viewed as one input into the decision making process and used in an informed and practical manner.

Turning to macro-economic (society-wide) issues, economic analysis is of course unable to give an unequivocable view of how much resources any society should devote to health services relative to other valued alternatives, including the pursuit of good health through, say, better housing. But it can illustrate how some of the problems to be confronted in establishing a generally fair and efficient system of health promotion and health service funding might be overcome. As noted in the main body of this book, economic thinking influenced many of the reforms contained in the NHS and Community Care Act 1991.

The genesis of economics as a discipline was intimately linked to the emergence of modern market economies in and around the late eighteenth century. The work of writers such as Adam Smith and Karl Marx both reflected and helped to further the break up of the aristocratically dominated European social orders which preceded the industrial era. And as Malthus' contribution illustrates, the emergence of economics was also intimately linked with the demographic events which commenced around that time, and are central to this study's understanding of health care development.

Market economics (to which the Marxist and allied traditions may be seen as providing an anti-thesis) rests on the normative assertion that consumers are sovereign, and that the pursuit of well-being is best conducted through the individual pursuit of 'demand side' preferences and 'supply side' profit in the context of a free market. A perfect market can be shown to achieve allocative and productive efficiency (producing what consumers want, at the lowest possible cost) through the price mechanism. The exercise of plural consumer choice in conditions where there are many independent producers should prevent resource allocation rigidities, and ensure that production activities evolve to exploit new techniques and changing social priorities.

Supporters of this approach also believe that it will help protect communities against the exercise of undue political power by any one group, and so preserve human rights and personal autonomy at all levels. Critics of the market approach may deny its morality and/or its practical capacity to deliver what is hoped of it. But to those who place their faith in it, it is certainly much more than a prescription for individual selfishness. Rather, given the reality of the human condition, they see it as the best guarantee of collective welfare.

However, all sides agree that there are very few or no examples of a 'perfect market'. Laws, regulations, controls and balancing interventions—including planning at local and national levels—will always be needed to protect the public interest, although opinions vary as to the extent to which this is so. In the post-communist world, debate between the varying schools of economists is to a significant degree concerned with defining and assessing the advantages and disadvantages of differing ways of moderating the functioning of imperfect markets in favour of the public's welfare.

The fact that all markets tend to have imperfections (that is, that without intervention their working would not produce efficient outcomes and maximise well-being) can be illustrated in the context of health promotion and health care. Patient welfare is likely to be jeopardised in unmanaged health care market-places because:

- information is asymmetric—service users often lack the treatment information and analytic skills they need to judge their own best interests. That which they decide to 'demand' may not be that which they 'need' to secure or preserve good health;
- health care professionals, in response to the knowledge problems described above, act as patients' agents. That is, they are proxy consumers as well as service providers. This gives them considerable power and can generate mixed motives. This can itself, if unchecked, lead to serious distortions in patterns of resource allocation;
- health care provision is often seen as a 'life or death' issue. It is an area which raises anxiety levels, which in turn can help foster inappropriate patterns of spending. Politicians and charities may, for instance, feel themselves under pressure to meet funding demands for what might in reality be poor value-for-money services provided in highly emotional areas. At the same time other more desirable options, especially those distant in time and impossible for any one individual clearly to appreciate as having been conferred on him or her, can be neglected;
- the need for health care is uncertain, and therefore third party payment schemes such as taxes and insurance are widely used to finance health care systems. These exist to protect insured populations from catastrophic costs and to correct imperfections related to the fact that people in most need of care may not be able to pay for it. However, they do so at the possible price of creating new distortions. These include 'moral hazard' (where neither patients nor doctors have any incentive to limit service use, and costs therefore increase) and monopsony purchasing, the demand side equivalent of monopoly provision.

It is in the area of health service financing, and the pressures on governments to support good public services on the one hand and yet to keep taxes down on the other, that the NHS has some special problems and some particular strengths. Health care costs and benefits do not fall evenly, and because of this there are often conflicts of interest between those who gain most directly from services and those who feel that they are paying more than 'their share' for them.

The NHS has since 1948 had a relatively good record in caring for those most in need in society, and in providing a service to the whole community which in international terms accounts

for an unusually low proportion of national resource usage. The central cash limited budget for health services, with government control over NHS salaries, has helped to keep NHS costs relatively low compared with those of other developed countries, particularly those with insurance based systems.

The starkest contrast to the UK position is that of the United States, which spends twice as much of a much higher GDP on health than does the UK (over 14 per cent). It would be wrong to underestimate the complexities of the US system, or to ignore the fact that many consumers there receive outstandingly good health services. But it does appear that poorer, more vulnerable individuals are not well supported—the problems of health insurance coverage have created pressures for the wide ranging review of health care currently under way in the USA. Even where care is available to vulnerable individuals it may carry the stigma of being, in effect, a 'poor law' service. Everyone in the US pays a high cost for their medical and allied care. Arguably, it is too expensive in that the foregone opportunities imposed are excessive. The traditional American focus on health care as an individual rather than collective responsibility (and benefit) is thus coming under increasing scrutiny, as is its manifestly imperfect, weakly co-ordinated and managed, health market.

It would be beyond the scope of this book to enquire into different approaches to health care funding in depth. (For further discussion of this area see, for example, Hurst 1987). However, it is relevant to note the following points:

- **The reforms introduced in the NHS and Community Care Act 1991 were clearly intended to make this country's health and related welfare systems more market-like; but to suggest that they have 'privatised' care in Britain or abandoned the provision of services to the unmodified direction of market forces would be incorrect.** Innovations such as the separation of commissioning and provision, and the attempts to provide increased plurality through the creation of Trusts and GP fundholders can be interpreted as aiming to create a less rigid, more flexible internal service structure sensitive to consumer interests. Doctors and others in the NHS may criticise aspects of procedures such as contracting on practical and personal grounds, not least because of the perceived threat to professional autonomy. But the accumulated body of economic knowledge and observation underlying such policy initiatives deserves serious attention.

Indeed, perhaps the most telling criticisms of the 'new NHS' will ultimately prove to be not that it is a market, but that it is not market-like enough. Certainly it seems structured to keep spending tightly controllable, and not to permit a 'market-driven' expansion in resource use. Under such circumstances it may be questioned whether or not the purchasing agencies now emerging will really prove to be adequate, flexible, champions of consumer interest. A more 'perfect' approach might be to concentrate on creating greater personal choice over which health authority is chosen to purchase on each individual's behalf (current changes in the Dutch health service were originally aimed at providing this; the British equivalent could in time involve allowing citizens to select which agency will contract for them, regardless of their place of residence) and/or further developing primary care practice fundholding. Fundholding is a unique opportunity for Britain, which might eventually offer a satisfactory way forward towards creating an NHS system guided by professionally informed consumer preference—that is, of overcoming the demand versus need divide in health care. But overall resource availability problems will almost certainly remain.

- **International developments suggest that thinking about health care financing is beginning to converge.** The British system is by no means unique in the health care funding challenges faced and the solutions introduced. For instance, other countries are now experimenting with purchasing/provider splits, and the establishment of local health care commissioning agencies. It should not, therefore, be suggested that the NHS system is showing signs of imminent collapse, or that recent developments represent an eccentric deviation from development patterns seen elsewhere in the developed world. Given the overall performance of our economy, British health standards, certainly as judged by life expectancy criteria, suggest that the NHS has offered unusually good value for money to date. It will probably continue to do so in future.
- **Britain's strong tradition of general medical practice has probably helped to keep NHS costs relatively low, and the effectiveness of its care relatively high. It may also have helped politically to protect the advantages of a universally available, general income tax financed, health care system.** Firm evidence in support of claims that the UK's unique general medical practice and community health services have helped to make the NHS unusually 'economic' is not available. It appears reasonable to argue, however, that this should be so. Health care costs tend to be highest in the context of specialist/hospital based care, where there may also tend to be the greatest risks of unnecessary/inappropriate medical treatment. Although a cost of keeping most care at a generalist level could on occasions be that seriously ill individuals do not get access to highly sophisticated care as rapidly as would otherwise be the case, this may be more than off-set by the protective effects of the primary care screen between consumer demand and specialist provision. This hypothesis should be tested, and research should also investigate the most effective ways of linking the benefits of a generalist system to those of rapid appropriate access to secondary level knowledge and intervention resources.

Finally, the role of the family doctor model in keeping 'middle class' NHS users content to support a universally available, common access, service may also be worthy of further emphasis and/or investigation.

Some recent developments in areas such as dentistry, suggest that at the margins of provision the British population is now more than in the past inclined to accept a system of private payment backed by special state, tax financed, protection for poorer consumers. If the latter can be established in a non-stigmatising way, such an approach has the attraction that it avoids the public expenditure limitation 'trap', a fact now obviously appreciated by, for example, the international pharmaceutical industry in the context of direct patient payments for drugs. But in many areas central to health there is a real danger that such developments would undermine care standards, and place the interests of the entire population at some hazard. In fragmented, partial care systems consumers may be caught in a network of forces which raise anxiety levels and cause them to be willing to pay highly for non-beneficial immediate services for themselves and their families, but they may then become less willing to pay taxes to support services for others in greater need but with less resources. From a rational viewpoint, the highest marginal returns to extra health spending often centre in exactly such groups.

To the extent that general practice, though criticised as being based on a 'middle class' perception of society, has acted as a stabilising agent to keep the entire population satisfied with the whole NHS, its role may be more important than even its advocates commonly understand. There is a strong case for arguing that if British society is to use its resources as efficiently as possible, it can and should afford a tax-funded NHS (albeit perhaps in future via an hypothecated, even separately identified, fund-raising mechanism) and a universally available care system. Other approaches are likely to cost more and deliver less. It would be unfortunate if attempts further to improve the GP system were in some way to undermine awareness and acceptance of this fact, as Britain faces the twin challenges of a relatively weak economy and an ageing population.

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