"It is the men that make the city"

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Thucydides

THE South-West England Faculty of the College did me great honour by inviting me to give the Gale Memorial Lecture in its jubilee year. Arthur Gale was my friend and colleague long before he came to the South West as the first postgraduate dean. I knew him when he worked in the Ministry of Education and more intimately when he came to the Ministry of Health to work on communicable disease control with the late Dr Bill Bradley, who was himself once in general practice in the South West. His erudition, allied with sympathy for the needs of continuing education in medicine, made him an ideal choice for the first post of its kind in Britain. Unhappily we were not to have him long, but he was behind such advances as the first junior hospital posts deliberately planned for training for general practice. While we are well aware of all the developments of the 1970s towards our having the best training system for family practice in any country, we should also do well to remember that there had to be a beginning and to recall how that occurred. Pereira Gray's (1979) *Occasional Paper 4* describing *A System of Training for General Practice* is the best account I know, and so the South-West Faculty of this College remains in the forefront of general practice teaching.

My quotation from Thucydides seems an appropriate title in the Faculty's jubilee year. He was speaking of Athens in the Peloponnesian war: "It is not the walls, nor the ships, but the men that make the city". Even though he was talking about a war, it was the male chauvinism of the day that permitted him to write as if the women did not exist. Since I shall be discussing health services as our "city" it would have been better to say "it is the women . . ." for it is certain that more women than men sustain the health services of this country. It is true that there are far more male than female doctors, but medical work, in the limited sense of the activities of registered medical practitioners whether male or female, is more heavily dependent upon the participation of other people, most of whom are women, than is that of any other profession.

My thesis is that our National Health Service, like all other health services, has to operate within an expenditure ceiling. That ceiling may be currently too low, as it has been for a long time, but we cannot wait for it to be raised to a level which would enable us to do all we want to: because that will never happen. There is not, and never will be, a single country in which resources of money, manpower, or equipment could meet every conceivable demand for cure, care, and prevention.

Shares of the national budget

It is our duty to obtain as large a share of the national budget as the country can afford, and then apply it, with the help of our colleagues in the other health professions and administration, in the way that will best serve the public. We are *not* working in an NHS at the point of dissolution as some would have us believe (Rogers, 1978). The people of this country have benefited enormously from the NHS and so has our profession. We may be the lowest paid medical profession in Europe; but a profession that sees its responsibility as serving the whole population to the best of its ability, within severe resource limitations, knows that there is less chance of someone in need falling through the net in the NHS than in most other systems. Moreover, the net is part of a comprehensive network of social welfare that tries to meet, and largely succeeds in meeting, needs other than those for health care.

There are too often grievous delays; there are too many occasions when the service given is less than the best; but we do not fail to recognize our collective responsibility and have long discarded the pejorative implication of charity. Navarro (1978) recently wrote of the NHS in terms of the "class struggle", but that is bizarre, for the Health Service does offer everyone resources that few other nations can match. Abel-Smith's *Thirty Years of the NHS* (1978) may take a rosy view but not too much so.

There is substance in the charge that the NHS has too small a share of the nation's resources, but that is a

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relative judgement which would be challenged on behalf of other services.

For 25 years after its inception in 1948 the NHS enjoyed a substantial annual growth in funds provided, expressed in the real terms of constant prices. In each successive five-year period from 1953, Klein (1975) shows an annual average rate of increase of 2·8 per cent, 4·8 per cent, 6·0 per cent, and 4·5 per cent. Over those 20 years the increase was 141 per cent. Education gained far more (274 per cent) and personal social services gained 506 per cent from a far smaller base. The change of the last five years was the direct consequence of our worsening national financial position, but that has not been the only change in the NHS circumstances.

The 'social budget', comprising social security education, housing, personal social services, and health, has taken a fairly constant 53 per cent of total public expenditure in the last five years. Of that, two fifths goes to social security payments, a quarter to education, and less than a fifth (in England, at least) to health. In those five years health and education have each lost about two per cent to the other three and the fastest rate of growth is in personal social services. Can we say this is wrong? I should like to, but I could not prove it. We all know the demographic changes—an increase from 10 per cent to 14 per cent of the population aged 65 and over in 25 years. Personal social services cost nearly six times as much per head for those aged 75 and over as for the whole age range and health services four times (Expenditure Committee, 1978). If compared with the 'working' ages, 16 to 64, the disparity is much larger.

International comparisons

The gross national product in Britain is less than that of the USA, Canada, Australia, Scandinavia, or most of Western Europe. We spend about six per cent of it on health and the others spend anything from 7·5 per cent (France) to 9·3 per cent (West Germany). In terms of cash per head, the USA spends three times as much as the UK and still fails to ensure adequate cover for half its poor and leaves even moderately well-to-do families exposed to ruinous costs for catastrophic long-term illness. Therefore, although we are running what some call a cut-price service, we have yet maintained a quality of care which may not reach some of the peaks of others but certainly does not have some of their troughs. Our risk is in providing dull mediocrity and the only people who can prevent that are "the men" who, for my purposes, include the women.

Maxwell (1975) has made valuable comparisons between different national rates of expenditure and vital statistics—mainly of mortality since we know so little about morbidity—and shown that high rates of expenditure do not correlate with low mortality or longer expectation of life. Nor for that matter does national wealth so correlate. Indeed, the USA and West Germany, who devote a high proportion of their great wealth to health care expenditure, are in nineteenth and sixteenth places in Maxwell's composite table of 19 countries, while England and Wales rank sixth, with only the Scandinavians, Switzerland, and the Netherlands ahead of them. It is true that Sweden heads the list and spends more heavily than most on health care. Perhaps the crucial factor is the prevalence of poverty rather than of personal wealth. Indeed, one of the oddest national differences is that between Scotland and England: Scotland, under the same NHS, has been allotted 22 per cent more per head to spend on health and employs 35 per cent more doctors to population than England, yet its vital statistics are as bad as those for the USA. Canada, during a period of more uniform expenditure on a national scale, though at a far higher level than our own, has caught and passed the USA statistics and approaches our own position. Japan has experienced an even more rapid improvement and Finland has done better still, without the great increase in national wealth. Whatever the explanation, the reason for it cannot be simply money or the organization of health care—it seems more likely to be a social rather than a medical phenomenon.

Regional distribution of resources

Maxwell (1975) has also estimated that it takes a one per cent increase annually in real terms to keep up with the progressive scientific sophistication of medicine. That is not so much the high technology, which we could sometimes ignore, but the kind of progressive improvement without which the care of patients must fall behind our potential to give. At present we are getting a 1·5 per cent annual increase and with the inexorable demand of ageing of the population, which has been said to require one per cent more each year, there will be little left of that. Of course the two figures must overlap. The effect of the regional redistribution of funds without additional pump priming must mean a cut-back of services in some areas unless economies can be found. Yet we failed in the earlier years of relative affluence to ensure that some regions with the worst provision were given more and made to use it. However, had they done so, it does not necessarily follow that the regional disparities in health records would have been reduced. Scotland, after being given a steadily increasing advantage for 30 years, still has worse figures. Nevertheless the differences between regions and between social and occupational groups exist. The causes may be more social and historical than medical, but it is also true that the use of health services has been less when related to need, as their availability has also been less. The RAWP formula (DHSS, 1976) for redistribution has technical faults, but there can be no doubt that a case exists for changing the differentials. The fault lies in its rigid and arbitrary central determination and inability to reflect social factors and local custom.

The commonest, publicly presented, medical appraisal of the reasons for difficulties in the NHS now is

first, lack of funds, secondly, the 1974 reorganization, and thirdly, the proliferation of administration in a particularly indecisive and procrastinating form. The loss of morale, especially in the hospital service, is regarded as the result of frustration produced by the first three. Whatever the emphasis accorded to the different components, there is nearly always an accusation of what 'they' have done to 'us'. However, there are always some in our profession with the honesty and clarity of vision to contest this. Peter Simpson (1978), a young surgeon, briefly sets out the reasons why our profession has to take some of the responsibility and meet administrative and other colleagues half way. Several of the contributors to *Clinical Practice and Economics* (Phillips and Wolfe, 1977), notably Brian Jennette, emphasize the necessity of rationalizing the application of clinical methods, not just to keep within financial bounds but also to ensure that patients are not subjected to arduous clinical processes of uncertain benefit to them.

I suppose all of us have our moments of embarrassment when someone trumpets that we have the best health service in the world or that the NHS is the envy of other countries. The first could not be proved and the second is simply untrue. The NHS has been reached by an evolutionary process over a century and a half. It is a characteristically British piece of continuous adjustment and development with occasional statutory changes which all too often have historical quirks that embarrass everyone until the next change, with a Royal Commission or two thrown in as an emollient on the way. Ginzberg (1977) has well stated the case for progress always being evolutionary as ours has been. Even our present delineation of areas owes nearly as much to the administrative base used to collect the Saxon fyrd for the Battle of Hastings as to a rational determination of functional health districts.

Nevertheless after 30 years the NHS is at least as well integrated a service as you will find in the world. It has less bureaucratic intervention than in Medicaid in the USA, fewer costs than in, for instance, Canada or Australia, and far greater clinical freedom than in the USSR. If it has structural problems, it has also developed a number of structural devices that have permitted professional progress and can give us a better outcome than we have yet achieved whether or not substantially greater resources become available. It can still be what Richard Titmuss (1974) once called "the most unselfish political innovation in recent history".

Structure of the NHS

Every one of these components in our service provides an opportunity for "the men" to make "the city" of the NHS better for the community and a more rewarding system in which to work. It is impossible to analyse them all and so I shall discuss the people as a whole and their opportunity to play a part in the service they use: the basic structure of the NHS, the health district; the

provision of primary care; the organization and significance of secondary care; the necessity of give and take between the professions; science and technologies which combine—or should combine—to provide services to patients; and finally the opportunities for promoting better health.

Abel-Smith (1978) avoids telling us whether he believes the 1974 reorganization gave us a tier too many in the administration, but makes the point that there was a reason for each. I shall be less shy and say that I would have preferred a two-tier arrangement, by region and district, and would have left the area function of linking with elected local government to consortia or multiple arrangements. That would have made it essential to have a district committee at the level where we now have only a community health council and a district management team. Such a change in 1974 would have caused political uproar and, with personal misgiving, since amply justified, I saw why it could not be brought about then. However, it can now, if the statements from both major parties reflect their future policies and the Royal Commission so recommends. It may not happen even in the next Parliament and therefore we have to help the community health councils to become more effective. They have sometimes had a stormy beginning, but they can allow the public's interest in its own services to flourish, and they can help to produce more acceptable local plans.

Medicine and society

There is a school of thought that says that health services are understood only by experts and should be directed by them. Years ago there were periodic demands that the NHS should be medically directed. Such ideas are heard less now and there is a powerful reaction, sometimes called consumerism. The true need is well illustrated by Newell (1975), who describes 10 projects in countries of Asia, Africa, and South America whose success, using simple technical resources, depended upon public acceptance and participation. Part of this was helped by recruiting simply trained health workers in the team locally, but their contribution was in engaging collaboration of the public, quite as much as in technical ministration. The Chinese barefoot doctor is one of the best known examples, but we do not need quite that, so long as we in the health professions are also of the community.

The same ethos has led to the recent development of patient committees at some health centres in Aberdare, Bristol, and elsewhere and the formation of an Association for Patient Participation in General Practice. WHO and UNICEF (1978) have just presented the case well, even though it is clearly designed for the less affluent countries. My point is that health services must be not only technically competent but organized in a form acceptable to the public—a concept which is an underlying principle of medicine, nursing, dentistry, and all the health professions. We must not make the mistake of rigidly imposing orthodox theoretical solutions on every district. Most people would rather live with slightly mistaken solutions of their own devising than someone else's Utopia. Moreover, experts can be wrong.

Hospitals

That brings me to my next main concern, the complex which provides most of the health care we need. One of the chief gains in 1948 was the establishment of management groups of hospitals. They were not, at first, complete, because too many special hospitals were separately managed, but they did provide the base for development of the secondary level of health care and a specialist service. Anyone who knows the divided and competitive provision of hospitals in both North and South America will recognize the economic advantage of a service organized on a district basis—provided it really is well organized. In the USA competition between 'suppliers' is regarded as an essential spur to efficiency. In the USSR general provision was made only under a unified system; but in Scandinavia and, largely, in New Zealand provision of hospitals was developed mainly under the control of elected councils. We now go beyond New Zealand, except in their experimental Northland, with an almost unified administration, but we do not have the benefit of their elected hospital authorities. Ontario and Quebec have district authorities but, like the health service areas recently set up in the USA, they do not control the hospitals, still less provide for primary care.

Successful development in the NHS depends on successful provision of services within the district. This requires close co-operation between primary care in the community and secondary care in the hospitals, as well as close collaboration with other social support systems. Much is made of the new planning system under the reorganized NHS, but it is an irrelevance unless the districts, where most decisions are made, work properly. Primary and secondary care are not distinct processes, but must be complementary to each other. Neither can work efficiently without the other. This may seem obvious, but there are still too many antagonistic or derogatory statements by either side. The most bizarre is a description by Navarro (1978) of the "patrician" consultants and "middle class" general practitioners, but there are still difficulties. It is the radiological and pathological services to general practitioners that are likely to be cut first if staff shortages occur, and that is wasteful and wrong.

Co-ordinating services

The postgraduate centres were the most important developments of a decade from 1962 and they should provide the ideal forum for exchange. They have led to great improvement in medical exchanges but they have not generally yet become multidisciplinary. Some, like

Norwich, Poole, and Stourport started as such, and others will no doubt follow. Even within medicine we need to consider whether, after a decade of experience, we have made the most of the opportunity. The traditional outpatient consultation continues, but the use of it varies widely between specialties and between practices. It has recently been suggested that obstetrician/midwife and genera! practitioner/midwife contributions to antenatal and postnatal care could often be better co-ordinated with advantage to the patient (Kitzinger and Davis, 1978). Other clinical specialties and some of the ancillary departments, such as physiotherapy, might also be more closely linked—especially in reducing the frequency of follow-up visits.

But there is a different kind of communication which might be promoted with great advantage. Some regions, notably Newcastle, have built up an advisory service in therapeutics which is increasingly necessary as drugs change and pharmacological knowledge grows more complex. Nor should these links be seen only as between doctors: one of the gains from the recent reorganization was a unified nursing administration.

None of the district patterns of other countries presents quite the opportunity we possess. We know the NHS must do the best it can to meet the needs of the whole district population—and that best will be less than some individuals could receive with benefit. The community-based and hospital-based professionals share responsibility in various ways. Many patients could have as good a result from a variety of combinations of the available skills. Can "the men' so arrange their work that "the city" gets the greatest benefit without losing the personal relationship? At least we should try, and for that some of us must shed the blinkers which restrict the view of too many specialists.

Within the district complex the pattern of primary care in Britain is distinctive. There are some analogies in Denmark, the Netherlands, and New Zealand, but two features, the grouping of community staff around general medical practice and the use of general medical practice as the portal of entry to the service, with access by patients to hospital care normally only on referral, are not common practice elsewhere. Dentistry and sight testing are available directly to patients, but pharmaceutical services are available only as prescribed by doctors. Eighty per cent of home nurses and health visitors work with general practices and only about one general practitioner in six is single handed. This has been a radical change of the last 30 years—mainly of the last 15. As a postulate for providing primary care it makes sense, but are we really making it work? Undoubtedly the system is one of the main reasons for the low cost of the NHS, but are we sure that the preservation of general practice is effective, rather than sentimental and cheap?

The development of general practice

The Collings report (1950) gave a distorted view of general practice as it was then because it emphasized the worst examples. Hadfield (1953) and Taylor (1954) later gave fairer assessments, but all three described a spread of quality from the highest to the unacceptably low. The same spread must exist now and the complexity of good group practice adds not only a possiblility of better service but also of some shortcomings.

The College of General Practitioners was the outcome of a determined effort by a group of enthusiasts to establish general practice as a specialty as important as any other. There is no doubt that they succeeded and general practice is now sought after by good graduates, who undergo an organized system of preparation. Lord Moran's (1960) designation of it 20 years ago as the destination of those who "fell off the ladder" to the consultant grade was wrong then and would be absurd now. But general medical practice no longer consists of a doctor working by himself; it is at the least the practice of medicine with the help of nurses and other ancillary staff. It is usually organized in groups and to an increasing extent, in health centres. There is an extensive literature about it, but it is no more a standardized, impersonal activity than it was in 1950. The College's report on *Present State and Future Needs of General Practice* (1973) has had interesting glosses put on it by many individual publications and lectures. Pereira Gray's James Mackenzie Lecture (1978), Fry's chapter in *Clinical Practice and Economics* (Phillips and Wolfe, 1977), and Howie's Gale Memorial Lecture (1978) are just three of the most recent examples.

The 1966 Charter, for which great credit must be given to Mr Kenneth Robinson for the Health Departments and Dr James Cameron for the profession, made possible many developments of general practice. It was the final break with an old style of isolated personal responsibility which no longer suited either the scientific or the social needs of health care. But we still need to analyse and adjust to those needs. The Joint Working Party Report (DHSS, 1974) addressed itself to some of these and it is sad that recent dissension has prevented continuation of that activity. Appointment systems and deputizing must be part of practice organization now, but both need careful management if they are to be in the interests of the patients and the profession alike—as they can be. But they can become obstacles to access by patients on the one hand and to continuity of care on the other.

Health centres are now used by only about 20 per cent of general practitioners but this increases by between two and three per cent each year. People are interested in the centres and will be more so as they replace hospitals in some ways as the foci of local interest in the NHS. Some family doctors have welcomed this and patient committees have been a logical sequel. Some doctors have expressed reservations, but it is difficult to foresee the next generation of practitioners wanting anything else. General practice should have the right kind of practice base and should be a team exercise;

young doctors should not be expected to make the capital investment themselves. Once more, it is what people do rather than where they do it that matters.

The primary health care team needs a base, but the way it uses that base determines the quality of service. Obviously the most important factor is the way in which the members work together. There really should be a multidisciplinary team—not a medical dictatorship. Of the many analyses, Marsh and Kaim-Caudle's *Team Care in General Practice* (1976) appeals to me most because it shows the extent to which the work of one practice has progressively devolved to the non-doctor members of the team in a way which has proved acceptable to the patients, and has subjected this to outside review. At a recent conference June Clark (1978), a health visitor, said "A team needs trust. If we don't understand each other, we don't trust each other". Later she also said, "Independence in its full meaning isn't possible in any sphere, and certainly not in caring". There is a vast literature on this and I will mention only the work of Barry Reedy (1972 and 1978) on nurses in general practice, and that of a few pharmacists and more attached social workers in group practice, all of which warrants our urgent attention. By such is "the city" made strong.

Secondary care

Secondary care is the essential support of good primary care. It should not be in control of the whole health system, as in the USSR, nor the goal to which most doctors aspire as in the USA. It has become rapidly more specialized and inevitably more expensive, and yet does not deserve either the adulation Lord Moran gave it nor the denigration of Illich (1974). The creation of an integrated district specialist service was the first great success of the NHS. Manning is still unequal, with the highest staff ratio in Scotland, the next highest in the South of England, and the lowest in the industrial heart of England, which means that the stresses are unequal in inverse proportion. Yet there is the paradox that at the periphery, where there is a sense of community and a freedom of exchange between hospital and community, professional morale is higher in the face of greater shortages.

Within the hospitals lies one of the main medical defects in the NHS now. The development of specialist services has been distorted by out-dated staffing patterns for 20 years and the career structure in hospital medicine needs radical reform. Young men and women spend on average four more years in pupillage than their training requires, and the ratio of consultant career posts to junior training posts is far too low. Last year the average age of consultant appointment was 36·7 years and that of senior registrar 32 years. The facts are well set out in a report by the Standing Committee of Members of the Royal College of Physicians (1977), but they have been largely ignored as was the report of a Joint Working Party (DHSS, 1969) eight years earlier. Until this situation is rectified we will go on with such inept solutions as the 'work-sensitive contract' for junior or senior staff.

Nowhere is there greater need for effective integration of hospital, community health, and social welfare support than in the care of the elderly and the mentally ill and handicapped. Bennett (1978) has reviewed 'community psychiatry' showing the necessity for mutual understanding and co-operation between the three arms in supporting the mentally ill. That is especially needed in caring for the elderly confused. The Royal College of Psychiatry arranged a symposium on psychogeriatrics in March 1978 which provided, for me at least, the best hope for an adequate service for the increasing numbers of the very old during the rest of this century. Hospital beds and hospital-based professionals do not take over the responsibility; they are the supporting forces for care which is mainly in the community. Only 5·0 per cent of our over 65s are in institutions of any kind—from small hostels to large hospitals. The age-specific admission rate to psychiatric beds of over 75s has fallen by a third in the last 10 years and that may mean later onset of senile dementia, better management, or as Shulman and Arie (1978) have suggested, failure to provide. We do not know and the Newcastle studies of 15 years ago cannot tell us now; they should be repeated. The same pattern of hospital support for mainly home care must apply in geriatrics too. There is talk of emulating the French 'hospital in the home', but we do not need to do that if we use what we have. Brocklehurst has an excellent review in *Clinical Practice and Economics* (Phillips and Wolfe, 1977).

I will not spend long on the need for understanding and mutual trust between the health professions; it is implicit in much that I have said already. But we in medicine need to make greater efforts to secure this. We are long past the stage when medicine, as the first recognized health profession, assumed and exercised autocratic control. In community and hospital there are now many others who contribute their own specific professional components in forms the physician could not match. Medicine does have still the central place because it relates—or should relate—to all the others, but that place is no longer dominant. Dr Geoffrey Marsh once gave a talk on health education in general practice in the course of which he showed a series of slides of the practice team over nearly a decade. In the first, the chairs were occupied by doctors—all male. In the last it was difficult to know which was which in a friendly mixed group, and certainly the front row did not consist wholly of doctors. I believe a good primary care team is the best of our multidisciplinary groups, but it must be worked for and there is still much to do. Especially we need to attract pharmacy and dentistry as was done for pharmacy at the first health centre in Runcorn New Town 10 years ago, described by

Robinson (1977). The hospital 'family' is far more complex both in the multiplicity of professionals and the largely unionized non-professionals. More understanding is needed but sadly all too often less is forthcoming. Even with nursing there is too little understanding, with senior doctors often ready to denounce the 'Salmon structure' which the nurses wanted. Yet a recent report in the *British Medical Journal* (1978) showed a total increase in nursing staff between 1970 and 1975 in every grade except the administrative staff.

Prevention

I want to make only one general point about prevention. We began 130 years ago with prevention of acute disease by environmental controls even before we understood why this worked; we followed that with personal prevention, from screening procedures such as antenatal care to technical intervention such as immunization. Still further research is needed, especially on chemicals in food and the environment and the control of drug safety. But the great gains we could have still in health promotion will come from changes in the pattern of living people choose to follow, and our job is to make those choices. We badly need support from the legislature to control the damaging promotion of smoking, alcohol, and the wrong foods, and to require the fluoridation of water, the wearing of seat belts, and the avoidance of drinking and driving. Those are the most vital needs but there are other, less specific, factors such as avoidance of overweight, the choice of diet, and the choice of a pattern of living. The way to change is not by direction but by persuasion, which can be done if we have a coherent message and work with those most concerned, especially in education and the media.

Conclusion

It is my belief that the NHS, even within the too narrow constraints of resources which now contain it, is really what we make it. It consists of the millions of services rendered to the people of Britain every day by the largest number of people employed in any undertaking in the country. There are those who think the administration is the service. They could not be in greater error: the administration is no more than a necessary support. That is the reason for my choice of title and I hope I have justified it.

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