high-risk mothers could be identified, unfortunately more than 90 per cent of affected babies are born to women with no previous history of the condition and no family history.

The measurement of the maternal serum alpha-fetoprotein has shown that a rise may indicate those for whom amniocentesis is justifiable (Brock *et al.*, 1973) but here other problems arise. The time at which this is done is critical and how certain can we be of the period of gestation? The risk of false positives and false negatives remains, so that a few mothers with a normal fetus will be aborted and a few affected babies will be missed and go to term. If screening were to be introduced as a routine procedure, as is done for rhesus incompatibility, what agony of mind would ensue for parents (and doctors) who had ethical objections to termination of pregnancy? All these matters are ones that vitally concern the family doctor, perhaps more than any other, who has to counsel and support families for many years.

In 1978 the Standing Medical Advisory Committee set up a Working Group (1979), under the chairmanship of Sir Douglas Black, to consider what advice should be given to health authorities on the introduction of a screening service into routine antenatal care, and that report has now been published. The review of scientific evidence was helped by the fact that the results of a screening service were available from three areas, Glasgow, Edinburgh and Bolton.

It is apparent that closed neural tube defects are not identifiable from the levels of alpha-fetoprotein in maternal serum but that, providing the tests are carried out of 16 to 18 weeks' gestation and multiple pregnancy is excluded, the sensitivity and specificity for open neural tube defects is high. Probably less than one in 10,000 normal pregnancies would be terminated and although these figures might be increased to three or four per 10,000 by losses following amniocentesis, there is evidence that some of these would have aborted anyway owing to the increased risk of spontaneous abortion where there is an affected fetus.

The report recommends to health authorities that mothers would be invited to choose whether they wish to be screened; that is, 'opting in' rather than 'opting out'. The problem of conscientious objection to termination would then be largely avoided but careful and informed counselling about the topic would need to be given to all mothers by their family doctors early in pregnancy. They would need to be told that the test is not foolproof but can pick up four out of five cases. The first positive serum test does not show involvement but only indicates the need for further investigation which would include ultrasound scan to determine the exact period of gestation and the absence of multiple pregnancy; if no other cause is found, the offer of amniocentesis would be made. The risk of fetal abnormality at this stage is still small but if the level of alpha-fetoprotein in the amniotic fluid is high there is a 99 per cent chance of an affected fetus; so termination would be offered. Up to two per cent of all pregnancies would require amniocentesis and the burden of this in terms of time and staff would be considerable.

If one had to take issue with the report it would be over the relatively small role that is envisaged for the general practitioner in the counselling procedure. A large part of antenatal care, including in most cases the all important first visit, falls to general practitioners. Patients who become confused and worried—and they often do—by the multiplicity of advice and the size and impersonal nature of some hospital maternity clinics, see their general practitioners for interpretation and solace. The technical problems may be great, but the emotional problems are at least as important; it is the family doctor who will mainly be responsible for helping parents to deal with them.

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The efficiency of general practice

PUBLICATIONS like *Health and Personal Social Services for England* (DHSS, 1977) make it possible to examine trends in the National Health Service in England for the years 1971 to 1976. These figures are particularly valuable, coming as they do from government departments.

Although the total population changed by less than one per cent, the number of people aged over 65, whom it is known account for a particularly large proportion of work, rose by half a million (eight per cent). To meet this increased demand, in addition to coping with new scientific developments in medical practice, the National Health Service increased its consultants by no less than 22 per cent, its hospital nurses by 21 per cent, but its unrestricted general practitioner principals by only six per cent.

Hospital care

A heavy capital investment programme in hospitals (£1,483 million, or 6·6 per cent of all Health Service costs each year) has contributed to an increase in efficiency, as two per cent more inpatient episodes were provided in nine per cent fewer beds. Other evidence for improved efficiency is the reduction of the length of stay in hospital for all specialties from 24 to 22 days, and in the acute specialties from 10 to nine days.

Nevertheless, there has been a great fall in the workload of consultant staff, with an average of 22 per cent fewer new outpatients per consultant and 17 per cent fewer inpatients per consultant.

General practitioner care

Even though an ageing population makes more work for doctors, it is clear that general practitioners have not been passing on all the increased load to the hospital service but have been absorbing much of it themselves, without referral. The number of new outpatients referred per general practitioner in England fell by 11 per cent during these six years, and the number of inpatient episodes per general practitioner by four per cent. Looked at another way, the number of new outpatients per 1,000 population fell by six per cent, whilst the number of laboratory tests requested per individual general practitioner rose by 46 per cent.

General practitioners have been absorbing increased responsibilities from the hospital service with a heavier burden of follow-up care as inpatient length of stay has shortened.

It is not surprising that the number of items prescribed has increased from 5·3 items per person per year to 6·3 items per person per year, and that proportionally more items are prescribed for patients over the age of 65. It is not known widely enough that the cost of pharmaceuticals as a percentage of all Health Service costs has fallen from 8·8 to 7·2 per cent.

Although many studies, such as the *General Household Survey 1977* (OPCS, 1979) show that the contact rate between patients and family doctors has remained fairly constant between 1971 and 1976 at about 3·6 contacts per person per year, nevertheless there is growing anecdotal evidence within the profession that general practitioners have been feeling more pressure in recent years. These figures suggest possible reasons, namely that the content of consultations may be becoming more complex and difficult although the number of consultations is much the same. Older people with a growing number of multiple problems can take substantially more time without altering merely the number of contacts. Ball (1978) wrote that the doctor/patient consultation rate was not a satisfactory measure of workload.

Further evidence of efficiency is the remarkable trend in the relative cost of general medical services within the National Health Service between 1971 and 1976. Not only has the percentage cost of general practice *fallen* from 7·5 to 5·2 per cent of total National Health Service costs—a proportionate reduction of almost a third—but the share of the National Health Service spent on general practice has fallen in every single one of those six years. More and more is being provided with less and less.

The general medical practitioners in England can take a cautious pride in the Department of Health figures, which show more clearly than before how general practice is taking on ever increasing responsibilities, referring fewer patients to hospital than before, and coping with the multiple problems of an ageing population with an ever diminishing proportion of Health Service resources.

Cautious pride, however, may be an appropriate professional response, but those with responsibility for planning the National Health Service may well see in these trends the makings of a crisis. Quarts cannot be poured indefinitely into pint pots. If the general medical services are denied their fair share of resources, goodwill could go.

It was not for nothing that the Royal College of General Practitioners in 1977 called for a switch in resources from hospital to general practitioner care. Figures like these suggest that in terms of value for money, it is general practice which should be backed as the current best buy in medical care.

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