surveillance of the health of the children under their care; others are finding cases of hypertension by the methods of Hart (1970) or Howe (1980). The amount we are doing is increasing, and Report number 19 is able to list some outstanding successes. What it cannot do is to say what the total amount of prevention is: how many practices do no immunization at all, how many patients are helped to stop smoking, how many to become thin or take regular exercise? For answers to some of these questions we shall be looking to the efforts of medical audit groups. For instance, it will be a natural task for these to decide such things as the reasonable attainable percentage for child immunization against measles, and to see how near the standard each practice gets, repeating the count a year later to see if increased awareness or changes in practice policy have had any effect.

There is no lack of opportunity, as Stott and Davis showed (1979), for extending the traditional content of every consultation to include health education and health conservation. Van den Dool (1970) called this anticipatory care, and Hart (1978) called on general practitioners to extend their responsibilities from the care of individuals to the care of defined communities. British primary care, with its system of relatively continuous care of relatively stable populations, all registered with a general practitioner, offers an administrative framework far more suitable for prevention than is possible in most other countries. Nevertheless, other changes are needed, notably more administrative staff (particularly those able to handle small computers), more nurses and health visitors, and more doctors trained in clinical community medicine.

But are doctors doing enough to lead society in a more healthy direction? Do we promote health any more effectively than we prevent disease? Have we ourselves stopped smoking cigarettes; do we always wear our safety belts when we are out visiting by car? Doctors are influential people, but how much do we influence local and national governments, industry, trade unions, consumer groups and even our own few patient participation groups by constantly pointing out what pressures in society are healthy and what are damaging? And, as Report number 19 says, "prevention might be better taught by those in a position to act and perceive their success or failure in a defined population small enough to be a community in real terms. It would then become possible to use the clinical experience of diseases that still occur, and the memories of disease now overcome, to give motivation and urgency to prevention and anticipatory care."

Cynics and idealists

What will happen to these reports, and to the remaining ones, still to be published, on family planning and child health? Will there be polite murmurs of approval, a little action, a few research projects started, and then nothing? Will the profession divide into two groups, the cynics and idealists? The first group will be those who see prevention as not only expensive, but strategically unlikely: to alter the working pattern of doctors, nurses, health visitors and administrative staff will, they say, take more than the few thousand words of some worthy reports. Where will the extra money come from in these economically troubled times? Why should general practitioners do more unpaid work for fewer patients when it pays them to have a big list to whom they give the usual kind of episodic care? They will be answered by the idealists, who will point out that the Department of Health and Social Security already gives money for specific preventive work in primary care, that anticipatory care delivered by an enthusiastic and well co-ordinated primary health care team is enormously satisfying in a professional sense, and that (in the words of Report number 19) "if effective prevention must in some degree be personalized, then in this country it should in that degree become a task for general practitioners. We hope it is one we will accept, and that we shall insist on the resources needed to carry it out.

"Our decision may be as important for our own future, as for that of our patients."

The three reports are available now from The Royal College of General Practitioners, 14 Prince's Gate, London SW7 1PU, price £3 each, including postage and packing. Payment must be made with orders.

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The general practitioner research club

THE General Practitioner Research Club was founded in 1969 following a ten-day course at the College on research methods in general practice (Fraser, 1969). The course participants became the founder members of the Research Club and elected Dr John Fry as President and Dr Robin Fraser as Honorary Secretary. Its aims were identified as follows:

1. To bring together people who are interested in research in general practice, be they general prac-

titioners, statisticians or academics.

2. To provide a platform for discussion of the opportunities and problems in the field of general practice research.

3. By so doing to afford its members the opportunities of gaining a sound knowledge of research methods and their practical application.

4. To stimulate the formation of local research groups.

Between 1969 and 1975 (when the Club ceased functioning), its membership rose from 15 to over 250. Fourteen meetings, with an average attendance of 40 or so members, were held in a variety of locations throughout the UK, from Aberdeen to London and from Swansea to Newcastle. These meetings were a series of whole-day symposia on a Saturday, preceded by an informal Friday evening dinner (no speeches or table plans) for members, spouses and guests. Following the dinner, discussions took place between small groups of individuals with common research interests; these often extended well into the small hours of the morning. This became one of the most valuable aspects of the meetings, as it encouraged the development of close professional and personal relationships, many of which have continued to the present time.

A typical symposium comprised morning and afternoon sessions with five contributors and an evaluation session. The opening speaker was frequently a statistician who would present an aspect of research methodology. The other contributors were usually general practitioners reporting on their own studies with the accent shared between methodology and results. The Club encouraged presentation of research ideas at an early stage of development so that constructive criticism, advice and, on occasions, lessons learned from failed projects could be discussed at the meeting. Half the allotted time for a topic was reserved for group discussion. Part of the evaluation session was set aside for suggestions on future venues and programme content.

The Research Club was a totally independent organization. Its keynote was informality. It did, however, work in close and friendly association with the College; many Club members were also members of the College which, in later years, provided secretarial assistance. The philosophy of the Research Club was that the quality of research in general practice depended above all on sound methodology. Although it included many of the most active researchers in general practice, other members were young doctors with little research experience but much enthusiasm and interest. The Club encouraged them to acquire a sound grounding in research techniques so that they would be in a position to produce good quality research.

The Research Club was a successful and in many ways a unique phenomenon. It made a considerable impact in the field of general practice research. Indeed an editorial in *Update* (1974) describing the Club called it "a cause for celebration".

It is welcome news that the Club is now being resurrected—along its former lines and under the original organizing team. The first meeting will be in Leicester on Saturday 4 April 1981. Those wishing to join (or re-join) the Research Club and obtain more details of the Leicester Meeting should write (enclosing a cheque for £3.00) to the Secretary, Dr R. C. Fraser, Department of Community Health, University of Leicester, Clinical Sciences Building, Leicester Royal Infirmary, Leicester. (Telephone: 0533-551234 Ext. 522).

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National Health Service expenditure

The Secretary of State was asked if he would list the proportion of gross domestic product spent on health in the last recorded year in Germany, France, the Netherlands, and Italy as compared with Great Britain.

Dr Vaughan replied that expenditure on health care is not recorded on the same basis in all countries, which means that there are serious difficulties in making international comparisons which are meaningful.

Dr Vaughan said that the best figures available are those produced in 1977 by the Organization for Economic Co-operation and Development (OECD), giving health provision at current market prices in 1974 (or near date) and referring to current expenditure only.

Total expenditure on this basis (that is, public and private combined) on health provision as a percentage of 'trend' gross domestic product—that is, GDP adjusted to avoid the influence of business fluctuations—in the countries requested is shown in Table 1.

Source: *House of Commons Official Report* (1980). No. 1179, vol. **988**, col. 146.

Table 1. Total expenditure on health provision as a percentage of 'trend' gross domestic product.

Country	Total expenditure as percentage of 'trend' GDP
Netherlands (1972)	*7.3*
France	*6.9*
Germany	*6.7*
Italy	*6.0*
United Kingdom (1975)	*5.2*

Source: *Public Expenditure on Health,* OECD, 1977. (OECD is in the course of updating its study, with the co-operation of member states.)