waking up to the need to solve the problems of organizational behaviour?

I often hear the plea that general practice 'is not like it was in the good old days'. This hankering for the past may be due to the fact that smaller, less complex organizations in a less complex environment could adapt relatively easily to change. Hidden beneath these portrayals of the old-style family doctor was the recurring theme of caring for people, a theme which is fundamental to the practice of medicine. However, the inertia of some established patterns of practice can be frustrating for the innovator. At this point in the history of general practice, the precise direction of future movement is difficult to predict. Those who wish to look back to so-called better days and those who prefer to look forward to improvements in care might both ponder on the words of Roberts who, as a historian, concluded his book *History of the world*[7] as follows: 'Only two general truths emerge from the study of history. One is that things tend to change much more, and more quickly than one might think. The other is that they tend to change much less, and much more slowly than one might think. Both truths tend to be exemplified by any specific historical situation and so, for good and ill, we shall always find what happens somewhat surprising.'

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Towards the possible

THE celebrated television MP, Jim Hacker, was rarely on target, but he was closer than usual with his party piece '... things are changing fast. We live in a world of change. The silicon chip is changing our lives ...' *(Yes, Minister.* BBC, 1981). Quite so, but which changes are significant to medicine, the National Health Service and consequently to general practice?

Much of what will happen to general practice in the next century is already visibly in train and the developments are fairly predictable. Medical manpower is a good example because the figures for the year 2000 are mostly determined by today's manpower state, modified by predictable changes in recruitment which reflect current medical school intakes. Average list sizes in general practice will be in the region of 1700 patients and the proportion of males in general practice will have been reduced directly by retirement programmes and also indirectly by the rising proportion of women now in medical training. Jim Hacker's silicon chip, however, will change all our lives and general practice will be involved in these changes. The application of computer technology in general practice should help in monitoring and improving the quality of care. It is already clear that there is a genuine desire in the profession to improve professional standards and the new technology will be a tool for achieving improvements. Present enthusiasm and the progress made since the 1950s offers great encouragement. Less predictable are the changes in disease patterns and therapeutics, but their influence in such a short span will only be marginal.

Of course the nub of it all is what the consumer will want in the year 2000. Unless major social changes occur in the interim it is likely that the general public will want a national health service which provides convenient access to a complete range of reliable services provided by fully trained doctors. General practice will require the proper share of manpower and resources to correspond to its central role in health care. How possible is this?

Weighing our national economic prospects and our diminishing natural resources against the nation's determination to preserve its health service it seems fair to assume that there will be little positive change in the global sum of money available for the NHS. 'Efficiency measures' can only make a limited and short-term contribution so the remaining option is for a more radical redeployment of NHS activities. In particular the present uneven allocation of resources between primary care and secondary care needs to be examined. Hospitals continue to receive the great bulk of the global NHS funding. By the year 2000 a policy to deliver all the care that is practicable through primary care services must be operative. To do this we need to have achieved a substantial redeployment of care and resources — a shift of relevant activities like minor surgery away from the institutions, away from waiting lists, away from high overheads and away from the personal inconvenience and high social costs that needless institutional care demands. Not only does the patient prefer care near home in familiar circumstances but such care makes better use of the general practitioner's skills, and precious resources are spared for the vital services which only hospitals can provide.

The social and economic arguments for such a transfer in the balance of care are not new ones.[1] Such a shift was indicated by the Minister for Health when giving the reasons for family practitioner committee independence to Parliament in 1981: '... establishing FPCs as health authorities in their own right with powers to engage their own staff is most likely both to facilitate the developments of primary care services and lead to increasing efficiency in the administration of family practitioner services.' (Vaughan G. Written answer to Parliament, 17 November 1981).

Similarly day surgery has demonstrated how specialist services and facilities can be used to best effect. It is of course difficult to give precise figures for the optimum balance between primary and secondary care since the criteria used to judge this will include subjective elements.[2] However it has already been demonstrated that many patients can be discharged from hospitals for the mentally handicapped and the mentally ill. The controversy this has sometimes caused has resulted from the failure to provide appropriate resources in the commmunity rather than a criticism of the policy. The specific enquiry into the actual and potential contribution made to health care by general practice in the United Kingdom[3] supports the view that a shift of services from secondary to primary care would prove to be more cost effective.

The implementation of Griffiths management techniques and the balance-sheet approach to medicine will underscore the economic advantages which general practice provides with its lower overheads, improved access and reduced social costs to the patient. Consequently I believe we will soon see trials and

projects perhaps on the USA pattern as suggested by Enthoven.[4] In that same direction we may see by 2000 what he describes as the 'internal market model' with health districts intertrading in care with other districts and the private sector. In terms of accountability such changes could have important consequences for hospital referrals by general practitioners but, unlike Day and Klein,[5] I do not see this or other such modifications in the general practitioner's role as a threat to the independent contractor status. Indeed I would see the alternative of a salaried service as a direct threat to the protection of the patient's own interest and to the future well-being of the NHS.

The year 2000 will see team-work involving work shared with hospital colleagues as well as extended arrangements with health visitors and nurses. However, unless a scheme of no fault compensation can be established the rising tide of litigation could impede the wider sharing of clinical activities. Such litigation will also increase the pressure for hospital involvement in cases of marginal risk because that is where the armour of defensive medicine is the thickest.

In reaching towards the future we have to judge the tempo as well as the variety of change. Much will depend on the resolution of the contest between the profession's drive and enthusiasm and the central inertia of the NHS. If one looks back to the Court Report of 1976 and beyond, the years are littered with incomplete and absent responses to reports and proposals about general practice. Nevertheless diastole is seldom forever and hopefully systole is to come so that FPC independence and the Royal College of General Practitioner's quality initiative can provide fresh ground upon which to build general practice for the next century.

I am convinced the balance of care must and will change. By the year 2000 this will bring a wider range of services directly to patients. It will reduce social costs and increase effectiveness by fully utilizing and extending our particular format of general practice. With reduced list sizes, the assistance of new technology and an increased level of professional support from nursing and other colleagues, more of the action in the health service will move nearer to the patient.

Our success will be shown by properly resourced measures which will promote:
1. A surgery-based team approach promoting healthy living, a sequence of preventive care measures ranging from paediatric surveillance through to selective support and screening for older age groups.
2. A wider range of clinical services in general practice with better support.
3. More formalized care for the chronic sick in close liaison with a consultant and with clinics operated jointly in the surgery or the hospital.
4. An extended higher professional training and improved postgraduate education for general practice providing a wider range of skills, more of which will be utilized.
5. More home care from improved dynamics with earlier discharges, increased day care and reduced outpatient attendances and reviews.
6. For the patients a greater confidence in the health service and general practice based on better access to services and information about them, about themselves, their doctors and staff and hopefully the body of the NHS itself; and from patients help to sustain and improve their health service and to narrow the growing gap in services for different social groups.

Our failure will be evident if we have not moved a long way from the most outstanding stigma of British general practice which is the five-minute consultation, an issue of longstanding concern noted by Donald Irvine 14 years ago[6] and one which remains the principal obstruction to higher standards of personal care today.

In looking forward to the twenty-first century we will also remember the past. In particular the words of Lord Rosenheim[7] which will doubtless be as relevant in the year 2000 as they were in the 1960s: 'If medical research were to stop now, we could still make great progress through the next twenty years merely by securing the full application of present knowledge.'

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