Now for the good news

WITHIN the history of the British National Health Service there have been major medico-political crises between politicians and general practitioners. In the run-up to the introduction of the NHS, on 5 July 1948, the majority of general practitioners refused to join until the final weeks; in the 1950s there was mass emigration of doctors to North America and Australasia; in the mid-1960s threats of general practitioner resignations led to the 1965 charter with improved conditions for general practitioners; and between 1989 and 1993 there have been many stresses and much demoralization following the enforcement of the new contract for general practitioners by the Department of Health.

Although the effects of the new contract still rankle, they must be considered in the wider context of national economic disasters, a general election in which the fate of the NHS figured prominently, and political philosophies in which cost controls, competitive medical marketing and value for money are features of the new NHS.

However, suffering as we general practitioners are from the present relative depression and despondency, it is important to have a cool, calm analysis of how our health system compares with health systems in other countries. How good or how bad are we?

Since retiring from NHS general practice after 45 years, I have been privileged to be able to visit a dozen countries to study their health systems and, in particular, their primary care services. These visits were supported by the Nuffield Provincial Hospitals Trust and the regents of the University of California at San Francisco.[1,2]

All developed countries are facing similar problems of meeting the demands of comprehensive health care. Costs are increasing and are difficult to contain because of growing public demands and expectations, new and expensive medical advances and technologies, and longer life expectancies leading to more elderly dependants. General inflationary costs merely add to the problems.

We are not alone, and we need to learn from others.

Following the second world war, we changed from a rich British empire with pink colours, denoting our colonies, covering many areas on the world map, to a European offshore island apparently still seeking to discover our proper place. Our place in the world wealth league, based on gross domestic product per head, has also fallen since the second world war from one of the top three to number 19. In 1990 at £11 000, it was almost one half that of the top of the league, Switzerland at £21 000.[3]

Nevertheless, we are not poor materially. Data show that 87% of households have a washing machine, 65% have access to a car, and 97% have a colour television.[4] Another set of data relate to the amount of time a worker in private employment would have to work in order to pay for certain key goods: the surprising fact is that we are now 40% overall better off than in the 1970s in that workers need to work almost half the amount of time to obtain the goods.[4]

It is a tragedy that our unemployment rate is at 10% of the workforce, but on the other hand, it means that nine out of 10 are at work, and these rates are shared by other countries.

An index of declining social mores is the rate of one in three children now being born outside marriage, but the rate is one in two in Sweden and Denmark, and one in four in the United States of America.[4]

Our NHS is probably one of the most comprehensive health services in the world — the whole population is covered. In the USA, 35 million people (17% of the population) are not covered by insurance for any medical care, and possibly twice as many have exclusion clauses for certain conditions.[2]

There appear to be three levels of expenditure on health care, as measured by annual gross domestic product and per capita expenditures.[1] The USA is way ahead, now spending 14% of gross domestic product, or over £2000 a head, on health; Canada, Australia and most European countries spend up to 10% of gross domestic product on health, for example, Germany and France spend £1200 a head, the Netherlands £1000, and in Japan it is £1100. Spending up to 7% of gross domestic product on health are Denmark, Spain and United Kingdom (£700 per head). We have one of the cheapest as well as the most comprehensive health system — is it too cheap?

Another way of looking at the system is to note the proportion of funding that comes out of public and private sources. Costs of medical care are now out of reach of the personal pocket and there has to be some input from public (tax) funds. In the UK and Sweden the proportion of medical care from public funds is over 85%; in the European Union as a whole it is 70–75% and in Japan it is 77%.[1] In the USA, with its own private entrepreneurial philosophy, it is only 42%, from Medicare and Medicaid.

In 1948 the NHS was fortunate to inherit a strong traditional level of primary care — general practice. General practice has continued with its independent contractor status and its responsibilities for registered patients (only in Denmark and the Netherlands are there similar registrations). It is only as an independent contractor that the general practitioner can truly act as a gatekeeper and protector of specialist services. In health care systems elsewhere there has to be direct access by patients to specialists. In the USA, health maintenance organizations have introduced primary care gatekeepers.[1] In her study of international care, Barbara Starfield reported that a strong level of primary care was associated with public satisfaction and lower national health expenditure.[5] She regarded British general practice highly.

How many doctors and how many general practitioners do we need? There are no reliable guidelines and there are wide international differences.[3] In the UK we have one doctor per 575 of the population, Japan one per 610, the USA one per 440, and France, Germany and Sweden one per 340.[1] For primary physicians (general practitioners or equivalents) the rates are: one per 1742 in the UK , one per 1200 in the USA, one per 1100 in France and Germany, one per 1600 in Japan, one per 2300 in the Netherlands and one per 2430 in Sweden.[1]

Such differences hide considerable variations in expenditure. Physicians are the most expensive of all health workers. I have calculated that in the UK we have to set aside £3 million once we admit a student into medical school until he/she dies, and this does not include another £4 million in general practitioner prescribing costs and perhaps another £5 million in specialist referral costs.[6]

British general practice is set up to and is able to provide comprehensive personal, family and community care that includes clinical, preventive and social services which are being promoted now within the new contract with incentives and rewards to meet targets and goals.

British general practice has been in the forefront of developing primary care teamwork and group practice. The average team now comprises some 30 health workers, with four or five general practitioner partners.[7] Only one in 10 of general practitioners works single handedly, whereas this is still the commonest pattern in other developed countries.

Fundholding is gaining popularity and has begun to improve relations between general practice and specialists, with more shared care. More management and more incentives to make profits may lead to some economies but not necessarily to better patient care. All these new activities are a great experiment that is being observed with much interest and questioning by other countries.

How do we stand in the health league? Our health indices are not the highest. While infant mortality rate and life expectancy are among the best, our mortality rates from cardiovascular disorder, cancer and chest disease are among the worst.[4] The reasons are more to do with social and environmental differences than the quality of our medical services.

General practice is popular with young doctors: it is the first choice of almost one half.[2] In the USA family medicine is the first choice of only one in 10 of young residents, and there is a similar lack of popularity in France and Germany.[2] The UK has a free medical education system, whereas in the USA, young doctors may face debts of around £50 000 to pay off for their education.

On the whole the incomes of British general practitioners are comparable with those of colleagues in other systems.[3] When grants for expenses, retirement pensions and reimbursements are included, differentials between our general practitioners and specialists at 25–50% are much less than the 200–300% in the USA.[1]

Stepping back after visiting other countries and considering facts and data, it has to be judged that while the structure, services and processes of British general practice are sound and that it is in the forefront of new ideas and methods, there are problems.

In the aftermath of political confrontation and imposition of the new contract, there is a mood of sullen anger, frustration and low morale. The untested philosophies were enforced without sufficient preparation and demonstration of any definable benefits. There is overemphasis on value for money, managerial prowess, data collection and paperwork. There is stress because of public overexpectation stimulated by a false patient's charter and constant media sniping at the NHS.

However, now, just as in the past, we need to put the bad experiences of the recent traumatic reorganization behind us and achieve better mutual collaboration and understanding under sensitive political and professional leadership. We must allow the effects of the new contract to settle and pray for no more reorganizations over the next two generations.

The goods news is that the NHS has survived and that British general practice with its stable basis for good care is still the envy of most other health systems — we have much of which to be proud.

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Training general practitioners in minor surgery

MINOR surgery by general practitioners is here to stay, and the shifting emphasis from secondary to primary care will encourage it further. Generally it works well — it is safe, cost effective and popular.[1] But there are worries. As more general practitioners carry out more minor operations, the chance of inadequately trained doctors performing inappropriate procedures increases. Incomplete excisions of skin cancers is one area of concern;[2] doctors failing to send specimens for histological examination is another.[3]

The answer to these concerns is proper training. Many general practitioners have a great deal of experience and expertise and have been doing this work for years, but many others have not. Some doctors may have avoided doing minor operations altogether if they did not like this work. However, the new contract has put all general practitioners under pressure to provide minor surgery, especially with the added financial incentive. Therefore the profession, and the public, need to know that general practitioners who do minor surgery are being adequately trained.[4]

What is adequate training and who should be providing it? Many excellent courses already exist in the United Kingdom, but there is no consistent policy on what form this training should take. An editorial in the *Journal* raised a number of important questions — who should the trainers be, how, where and when should the training take place and how can continuing education be achieved?[5]

One major problem is that general practitioners need to know many different techniques, drawn from various disciplines. They need a foundation of basic surgical principles and stitchcraft, certainly, but just as important are joint and periarticular injections, together with a whole range of techniques from dermatology, such as cryotherapy, electrocautery and curettage. Doctors used to learn how to deal with lumps and bumps during their surgical house posts,[6] but with surgical units in large hospitals becoming more and more specialized many surgical house officers scarcely set foot in an operating theatre. And with the shift of minor surgery from hospital to general practice, fewer and fewer patients will be treated in hospital. It is therefore unrealistic to expect general practitioners' training to take place during the pre-registration year. Many doctors go on to hold casualty posts or gain other experience in surgery, and perhaps in rheumatology or dermatology, but many do not. How much training they receive is often a matter of chance.

So what should a course cover? There is no doubt, for instance, that general practitioners need a clear, safe and com-