All our tomorrows

IT is fashionable for television documentaries, such as *All Our Yesterdays*, to feature eyewitness accounts of personal recollections of an historical event. Many a senior general practitioner (GP) will still remember pre-National Health Service (NHS) medicine, even if only as a child patient. Will their recollection be of tonsillectomy on the kitchen table with the sweet smell of ether, mass smallpox immunization, or perhaps the scent of a kaolin poultice? The post-war world of 1945 general practice had not much changed from that portrayed in A J Cronin's *Dr Finlay of Tannochbrae*.[1] Prescribing was done in minins and drachms, and mostly produced unpleasant coloured mixtures or the occasional box of extemporaneously prepared powders.

Before the inauguration of the NHS, access to GPs had been free only to workers on low pay, but not necessarily to their families, whose standard of living was a third of the level enjoyed by households today.[2] Hospitals charged for their services, though the charge might have been remitted for the poor. The hardships of modern warfare on the civilian population had produced a rapid and remarkable social transformation with an unusual readiness, after the victory, to push forward with radical change to social security and health services. The Beveridge Report[3] in 1942 had proposed a welfare state system 'from the cradle to the grave', and the concept of a 'right to health', with medical care free at the point of contact, proved popular with the public and profession alike.

Though there was general agreement that the old system needed reform, the detail of the radical plan proposed by the post-war Labour Government was vigorously opposed by the BMA on behalf of the profession.[4] GPs feared that they would lose their clinical independence and become salaried state employees. At the eleventh hour an agreement was reached and doctors voted to join the new NHS. A salaried service for GPs was not introduced, rather each doctor was to have responsibility for a given list of patients, an innovation that facilitated the development of general practice research in a way that had not been not possible in most other countries.

The following 50 years saw several major reorganizations of the service, each affecting the development of general practice and the concept of primary care. In 1965, overworked and frustrated GPs threatened to resign over pay. An agreement, the 'Doctors' Charter', was negotiated with the Minister of Health, Kenneth Robinson. It provided more financial support to GPs' practice costs balanced with further obligations to provide a core service. Group practice became financially advantageous, and many more health centres were built in which groups of GPs could work with other professionals, such as health visitors and nurses.

By the Thatcher years, the NHS had become a bottomless financial pit, and market medicine was introduced by the 1991 reforms, based on notions of competition, business management, and an internal market. Radical changes were introduced with no prior evaluation, the impression being that officials were left to make up the rules as they went along. The end result was unpopular with patients and health professionals alike.

The change of government from Conservative to Labour has recently brought proposals for the new NHS,[5,6] theoretically replacing the internal market by an integrated approach and abolishing general practice fundholding but retaining the purchaser provider split and some choice between providers.[7] The changes for general practice are major. In England, the chief responsibility for purchasing most hospital and community health care will eventually pass to primary care groups of GPs and community nurses.

For the last 40 of the 50 years of the NHS, this *Journal*, published by the Royal College of General Practitioners, has mirrored the progress of medical care by GPs within the service, recording advances in general practice education and research, and being witness to a remarkable renaissance of general practice, not only in the United Kingdom but also beyond.[8] From the beginning we have concentrated on scientific original papers, peer reviewed by an editorial board and other GP assessors, rather than on articles by specialists that update and summarize information.[9] This has been a forum in which GPs could report the results of their research and give an account of their views.[10] Early editions showed a developing interest in clinical trials,[11] but carried mainly individual studies rather than the cooperative research by GPs and researchers from other medical and scientific specialties more commonly published today. This individual and cooperative original research work, on and in general practice, has provided vital underpinning for the discipline that now finds itself at the centre of an increasingly primary care led NHS.

The potential of general practice research to contribute to improved patient care must be further developed, not only in relation to clinical care but also in assessing the effects of organizational change, in finding more meaningful measures of cost-effectiveness, and in discovering the mix of secondary and community care that gives the best outcome for different illnesses. We also need to understand the professional processes needed to prepare the different members of the primary care team for new responsibilities and to secure continuing competence.

The model of a primary care led NHS is attractive to Government as it is believed to be the most cost effective option and also because of the perceived patient preference for receiving health services close to home. Blocking of secondary care beds by patients not requiring acute services can be relieved by supporting patients at home[12] or in GP units. The shift in emphasis in an ageing population, from cure to care, together with the tendency for chronic conditions such as asthma and diabetes to be managed almost entirely in primary care, has highlighted the potential for the management of more types of illness by GPs. More sophisticated information systems in practices, together with new possibilities for 'near patient testing', makes it technically possible to deliver a wider range of patient services than ever before.

Improvements in patient care should not be at the expense of poor working conditions for doctors or other professionals in primary care. Longitudinal studies suggest increasing stress and a decline in mental health in senior hospital doctors, GPs and managers.[13] Rapid changes in general practice are associated with reports from GPs of increased stress and psychological symptoms combined with lower job satisfaction.[14] Registrars have additional stresses to those of established principals.[15] The increased workload of GPs with less time for family life are important stressors for the entire family unit.[16] The emergence of the 24-hour society has greatly increased the volume of out-of-hours work for GPs and has led to the development of GP cooperatives, which appear to reduce self-recorded stress levels for the participants,[17] though patients may not now have attention from their own doctor or even from the same practice.

What counts for patients is the quality of care provided. A key

concept of the present reforms is clinical governance: the governance of clinicians by clinicians, support of clinicians by managers, and the involvement of clinicians in the governance of the NHS. Clinical governance is linked to assurance of quality and accountability, not only to the individual patient but accountability to the community and for resources. The challenge is not only to promote good general practice by demonstrating examples of quality to patients, commissioners, and the general public, but to ensure that everybody moves forward, not only those already seen to be providing a high standard of care.

The 50th anniversary of the founding of the NHS reminds us of the grand vision of yesteryear to provide equal access to care, free at the point of use, to all people who need it. At the threshold of the second half-century of the health service, there seem to be as many uncertainties in 1998 as in 1948, as we contemplate all our tomorrows. The Utopia of free and equal access to comprehensive health and social care from the cradle to the grave has eluded us so far. The latest round of reforms promises a modern dependable NHS but turns a blind eye to the potential failings that can afflict a tax-funded monopoly system. Healthcare currently accounts for only about 6% of gross domestic product (GDP) — remarkably low for Western economy — so what can the voters 'realistically expect from 6% of GDP?'[18] As in 1948, much of the success of the British NHS depends still on the sacrifice of dedicated individuals: 'Doctors' surgeries are crowded out and the doctors themselves deplore that this heavy pressure of work has made it at times impossible for them to give their patients adequate care and attention.'[19]

How will the young doctors of today recall their time in the new NHS of 1998? They will not recall kitchen table surgery or the kaolin poultice. Their recollections may be of the background click of keyboards, which antedated the voice control of practice computers; the sounds of interactional patient diagnostic and information systems; or of patient juries deciding on rationing priorities. Perhaps a future issue of this *Journal* will tell?

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Matching policy and incentives in deprived areas

Economists and other rationalists restlessly tinker with people's incentives. This is a dangerous game. Although incentives are important for understanding problems and fashioning solutions, they are tricky devils, always veering off in unanticipated ways. People are complicated, social systems, almost infinitely so. A great many uninvited incentives lurk in each policy change.[1]

Providing primary care to deprived populations involves more work than giving the same service in the leafy suburbs. Yet the controversial history of deprivation payments (i.e. capitated payments to general practitioners (GPs) for patients living at an address falling within a deprived electoral ward) shows just how difficult it can be to match incentives to policy.[2]

There are at least three reasons for having deprivation payments: as recognition to GPs for the extra work created by deprived populations; as an incentive to recruiting more GPs to work in the inner cities; and as a policy tool to target more resources into practices working in poor areas. The current system satisfies none of these aims. As a reward for extra work, the present system of three bands, with payments starting at quite high levels of deprivation and sharp cut-offs, is widely perceived as being unfair. O'Reilly *et al*[3] use census data from Northern Ireland to explore the effects of using finer grained measures of deprivation (based on enumeration districts rather than electoral wards) and more bands to make cut-off points less arbitrary. Introducing 10 bands has the effect of redistributing money from very poor areas to moderately deprived areas. These changes increase the fairness of deprivation payments as a system of reward, but do so at the expense of redistributing money away from the poorest areas.

This highlights the second possible reason for deprivation payments — encouraging GPs to work in deprived areas. Cornwall may have 20% more GPs than it requires, and Rotherham 30% fewer than it needs,[4] but it is not clear whether deprivation payments are an effective way of redressing this balance. And, if deprivation payments eases the recruitment of GPs to the inner city, then a fairer system, which spreads the same money over more practices, is unlikely to benefit the very poorest areas that currently face the greatest difficulty with recruitment.

Finally, deprivation payments are a poor means of targeting extra resources into inner-city primary care. They may help GP morale but they are unlikely to do anything for other team members and, as an incentive, they may perversely encourage large lists.[5]

Providing high quality primary care to deprived populations is crucial to meeting the Government's agenda of reducing inequality. So far as policy goes, the White Paper[6] is currently the only show in town, so what difference will primary care groups and health improvement programmes make to the deprivation equation? Assuming that level three and four primary care groups can be made to work, at least two significant changes seem likely. First, the task of providing high quality care will, over time, come to be seen as everyone's business: pressure to improve practice may come as much from colleagues in primary care groups as from health authority handwringing. The strength of this effect depends on how unified the budgets of primary care groups turn out to be. Secondly, if the Government is serious about addressing inequalities, this must logically mean that effective interventions, and associated resources, are targeted at deprived populations who have the greatest morbidity and mortality. Currently, for example, the number of coronary artery bypass grafts (ABGs) performed is inversely related to the prevalence of ischaemic heart disease (IHD).[7] Reversing such inverse care will mean providing more money for deprived and under-serviced populations. This could be achieved by moving towards weighted capitation formulas to decide the budget of primary care groups, or by targeting top-sliced funds at specific interventions for deprived populations. Health improvement programmes will be the main vehicle for driving this change and will need to be robust enough to achieve this kind of switch in resources.

The effectiveness of the White Paper depends almost entirely on the details: mix the wrong incentives with inadequate forms of corporate governance, and primary care groups could find themselves under pressure to skim off the best practices or redline the most deprived areas. With good judgment, time, and appropriate resources, however, there is at least the possibility that primary care groups and health improvement programmes will do more to improve the health of deprived populations and of inner-city practices than deprivation payments ever did.

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