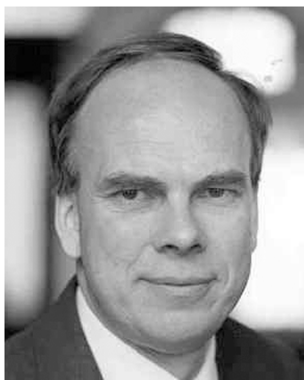
A case of mural dyslexia

David Mant



Introduction

SCRAWLED in white paint on the back wall of Keble College in Oxford, on the corner of Museum Road, is a rather sad-looking stegosaurus with the caption 'Remember what happened to the dinosaurs'. This now celebrated piece of graffiti is not only a timely warning to an ancient institution clinging cantankerously to its traditions, but also to a discipline that one of our younger colleagues recently described in the *BJGP* as 'out of date and running out of time'.[1]

The writing on the wall for general practice appeared just before I qualified as a general practitioner. It was called the Black Report[2] and had been commissioned by the Labour government in 1977. It shocked young and idealistic doctors like myself because it documented the failure of the NHS. Bevan had seen the NHS as a way of achieving good health for all, but Black's report drew attention to residual and shameful inequalities, with a twofold difference in age-standardised mortality between people of different social classes. Although Black made clear that medical care was not the most important cause of inequality in health, he drew attention to the marked inequalities in the provision of general practice care. He quoted Tudor Hart: 'In areas with most sickness and death, general practitioners have more work, larger lists, less hospital support and inherit more clinically ineffective traditions of consultation than in the healthiest areas. These trends can be summed up as the inverse care law'.[3]

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The Black Report might have led to a redrawing of the NHS in 1980, had its publication not coincided with the beginning of 18 years of Conservative government. However, in 1997 Labour returned to power and equality once more hit the political agenda. The thesis of this lecture is that we, as individual practitioners and as a College, have failed to understand the implications of inequalities in health and in general practice provision, first documented 25 years ago, and we have thus failed to read the writing on the wall for our profession. I chose the title on a family holiday this summer, when I found myself in a pub arguing with my son and his girlfriend (both history undergraduates) whether or not Neville Chamberlain had failed to read the writing on the wall when returning from Munich in 1938. My younger daughter, not yet an undergraduate but a smart aleck like the rest of the family, remarked that he was probably dyslexic. I can't remember the outcome of the Chamberlain argument, but his apparent mural dyslexia had tragic consequences. If we learn to read and act on the writing on the wall now, we may yet be in time to avoid similar tragic consequences for UK general practice.

Signs of dyslexia

Response to the Black Report

The RCGP's response to the Black Report was not impressive. Occasional Paper 25 (*Social Class and Health Status – Inequality or Difference?*)[4] was published in 1984 and argued not only that 'the main distinguishing feature between social classes is the relative capacity to cope' but also that as the proportion of the population in the manual classes was decreasing, the problem of inequality should be self-limiting. It also suggested that inequality in health was mitigated, rather than exacerbated, by the pattern of general practice care, citing evidence of 'compensatory activity'. This evidence was the doctor-initiated consultation rate reported in the Second National Morbidity Study, which was higher in social class V than in social class I (for example, 2.2 versus 1.2/1000 for non-married women aged 15 to 64 years).

The above might suggest that one reason why it was difficult to read the writing on the wall was the number of colleagues with their head in the sand, but in 1986 the RCGP published a more impressive document entitled *In Pursuit of Quality*.[5] This document recognised explicitly the inequalities in general practice care in the United Kingdom, citing 'a significant number of practices providing care of such poor quality as to make hospital back-up for patients essential'. It added, 'the question is how to make the standards of today's best practices generally available'. Unfortunately, no-one had an answer. In a commentary on the RCGP's quality initiatives, Donabedian spoke of 'an undercurrent of anxiety' in the profession, 'a reluctance to accept components that appeared threatening … those that might reveal a practitioner's own carelessness, ignorance, or lack of com-

mitment to professional norms'.[6] Caught in a crossfire between academics who questioned the validity of competence assessment, service practitioners who accused the RCGP leadership of elitism, and a profession committed to independent contractor status, it is not difficult to see why effective professional leadership on the issue of inequality was very difficult. It wasn't pure dyslexia (we recognised the problem of inequality) but it was mural dyslexia — we failed to foresee the significance of inaction and the significance of trying to retain independent contractor status in this context, for the future of general practice.

Fundholding

Inequality was not a central issue during the years of Conservative government in the 1980s and 1990s. The emphasis was on cost control and individual responsibility for health. Maybe it seemed to most GPs that the socialists were never again going to form a government and so equity would never again matter, but that was myopic rather than dyslexic. However, the consequences of fundholding were far reaching. Fundholding was embraced by many of the very best general practitioners as a mechanism that encouraged innovation and improved the range of services available to their patients. It is now evident (and some would say that it should have been evident at the time to those who volunteered) that fundholding was also a potent cause of inequality, reducing the resources available for the development of non-fundholding practices and in many areas creating 'two-tier' access to services (usually achieving better access for patients from less deprived areas). The *BMJ* published evidence of inequality in resource allocation as early as 1994[7] and summarised the evidence of the impact of fundholding three years later as showing 'little effect on clinical outcomes, the shape of secondary care, or overall costs',[8] while of course widening the gap between best and worst practice. But this was not the only problem — what fundholders also did was to split the profession, undermining the position of key professional leaders (many of whom saw the danger and stressed the role conflict between personal advocacy and rationing) while also taking the Queen's shilling to embrace a bureaucratic and managerial role in the management of secondary care resources. The key dyslexic element for me is less the political naivety and more the lack of international perspective — the adverse impact of managed care driven by economic incentive was already easily apparent in the United States by the early 1990s. Fundholding was abolished in 1997 with the return of a Labour government, but the managerial legacy was not.

A central plank?

Colleagues from other countries often remark how pleased I must be that primary care has long been characterised by the UK government as the 'central plank' of the NHS. Over the past decade, many of my colleagues in the UK also appear to have taken succour from this declared centrality. I do not share this optimistic view, for three reasons. First, our centrality is not a reflection of the government's view on the quality of care we provide. Martin Roland made this point in the 1998 Mackenzie lecture. He applauded the RCGP for the lead it had taken over many years in promoting high quality care but also gave an important warning: 'The College has successfully occupied the high ground. However, the government is more concerned about poor standards. The battle will not be for the high ground, it will be on the plains'.[9] Secondly, the main political attraction of a strong primary care presence in any health system is the potential control it can exert over secondary care costs; however, my impression from talking to NHS managers is that the government sees this control as being achieved more through PCT managerial mechanisms (i.e. managed care protocols and secondary care purchasing) than through traditional clinical gate-keeping in primary care. Thirdly, I agree with the political commentators who distinguish between theoretical enthusiasm for a primary care and real enthusiasm for general practice. Royce expresses it thus: 'In truth, many of those who are quite prepared publicly to proclaim their commitment to a primary care-led NHS … both dislike and distrust GPs as a body … disapprove of GPs' apparent lack of corporacy, regard their individualism as subversive'.[10] So my argument is that we are a central plank for the NHS, but sometimes a pretty thick one.

The cost of dyslexia

McMuffins 'R' Us

General practitioners have held a franchise to deliver government-financed health care as independent contractors since 1912, so there is nothing new in the idea of franchising. What has changed during the past decade, and looks set to change even more dramatically over the next five years, are the terms of the franchise. Like McDonald's, the NHS is straining for equity. The NHS plan is to reduce the number of practices working under traditional General Medical Services (GMS) independent-contractor contracts to 70%. Possibly by chance, 70% is also the proportion of McDonald's restaurants that are operated by independent contractors as franchisees.[11] However, unlike NHS general practice, equity of access and quality in the McDonald's organisation is unquestionable — the taste and content of a Big Mac is predictable and not negotiable. While McDonald's is very proud of the fact that the Big Mac, Filet-o-Fish and Egg McMuffin were all developed by franchisees (Jim Delligatti, Lou Groen, and Herb Peterson, respectively), the way a franchise makes one of these products is centrally decided and rigorously enforced. In the same way, individual GPs of the future may be allowed to contribute to the development of guidelines but clinical governance arrangements are designed to ensure that both local guidelines and centrally determined national service frameworks are delivered with equal rigour by all franchisees — or they lose the franchise. One commentator from the United States recently put it thus: 'each practice must see itself as one of a group of interdependent franchises for the Primary Care Trust (PCT), working to common approaches'.[12] And these 'common approaches' are going to be centrally set and rigorously monitored. As Peter Preston was quoted as saying in *The Guardian*, 'every bone in New Labour's body affirms that public targeting and constant monitoring is the only way to run vast public service operations like health'.[13]

Not the Primary Care Trust

The mechanism devised for running both the 70% GMS and the 30% Personal Medical Services (PMS) primary care services anticipated in the NHS Plans are the PCTs — the managerial element of fundholding retained when the Labour government abolished 'two-tierism' in 1997. This organisational structure would have much to recommend it (allowing GPs to manage primary care services at a local level and promoting equity of provision, by encouraging groups of practices to work closely with each other and with local social services) if managing primary care services was its main remit. Instead, PCTs are being set up as American-style Health Maintenance Organisations (HMOs), with a combined primary and secondary care budget and a remit to manage hospital services. The cost pressures on hospital services are intense and HMOs in the United States have a reputation for instituting regional systems of guideline-dominated 'managed care', for suffering from severe problems of staff morale and low recruitment, and for becoming insolvent.[14] Julian Tudor Hart argued persuasively some time ago that the strength and international reputation of UK primary care derived from the separation of primary and secondary care budgets in 1948.[15] Although our professional negotiators are trying to 'ring fence' the primary care element of PCT budgets, the main focus of PCTs will inexorably shift towards secondary care. Long-term pressure, both to shift resources from primary to secondary care. (or to allow growth only in the secondary care sector) and to pre-define acceptable 'care pathways', will be intense.

Where are we now?

Morale and recruitment

The letter pages of the GP and national press are full of gloom and despondency — 'the greatest problem with the NHS is poor morale affecting both staff and patients', wrote a GP from Scotland in a letter to *The Times* early last year.[16] 'All the spin cannot hide the destruction of the morale of health workers who are drowning under an ocean of paperwork and with no obvious improvement in patient care', was a further comment from another correspondent on the same page.[17] The recent BMA GP survey (which achieved a 51% response rate) reported the depressing fact that more than two-thirds described their morale as 'fairly low' or 'very low', most saying it was worse than five years ago. Whereas only a handful of GPs would have considered retiring before the age of 60 when they entered the profession, nearly half (46%) now plan to take early retirement.[18]

Up until now, the expressions of doom and gloom appear to have had little impact on the government, partly because recruitment to general practice appears to have held steady and partly because they are training substantially more doctors than ever before. In the ten years to 1996 the achieved number of GP registrars matched overall vacancies.[19] However, recruitment is becoming increasingly problematic, with the latest Department of Health recruitment survey showing a substantial increase in the proportion of unfilled vacancies and difficulty attracting applicants of sufficient quality.[20] Of the 599 vacancies sampled, 147 (25%) were not filled by the end of the survey period, with 50 remaining outstanding for more than one year. Practices surveyed in deprived urban areas reported the most difficulty; 64% stated that they could not attract applicants of sufficient quality, with a number of jobs remaining unfilled for over two years. As a recent commentary states clearly, 'simply educating more students provides little guarantee that, in the long term, adequate numbers will choose general practice instead of the alternatives, particularly as the literature suggests that general practice is not an attractive career for graduating doctors'.[21] Harris *et al* have looked specifically at the issue of recruitment of doctors to general practice vocational training in inner London; they also reported that recruitment was becoming more difficult and the standard of applications was falling. Difficulties in recruitment were attributed to low morale and status, poor working conditions, and the specific problems of inner-city practice (violence, poor schools, and high-cost housing). Only 28% of the registrars surveyed intended to practice in inner London on completion of their training.[22]

Doc-in-a-box

The equality agenda has also, paradoxically, promoted the commercialisation of general practice. This may appear odd for a socialist government intent on improving access for all, but it reflects the pre-eminence of the Private Finance Initiative (PFI) as a mechanism for financing new premises for general practice and other new primary care facilities, such as walk-in clinics. The General Practice Finance Corporation (formally a statutory non-profit-making organisation) was privatised by sale to the Norwich Union in 1988 and since that time loans for premises to medical practitioners have increased approximately tenfold to over £1 billion, with the proportion of loans to commercial companies (property developers and health care companies) rising from zero to 60% and the average size of the loan from about £200 000 to £800 000.[23] The latter change is explained partly by 'the complexity of property negotiations and project building deterring GPs already overladen with admin duties from ownership' plus the new acceptability of diversification into commercial operations (business plans frequently involve leasing part of the premises to pharmacists, opticians, and other 'health related' activities). However, many of the health care companies are planning to offer primary care services other than general practice (e.g. 'one-stop' shops), replicating commercial services already available in the United States.[24] The adverse consequence for quality of professional life, and ultimately for quality of care, of commercial expansion — fuelled by economic incentive and then tightly controlled with 'managed care' — is amply demonstrated in The United States and documented in the *New England Journal of Medicine*[25,26] (and in one paper characterised by the memorable headline 'Move over Jack, here comes Doc-in-a-Box'[27]). The other key implications for general practice is the proportion of the limited primary care revenue budget that is required to meet the PFI repayment costs (£4.4 billion by 2007) — the example of NHS hospitals suggests that, again, short-term gain may cause long-term pain.[23]

Is there a cure?

A cure for mural dyslexia?

I can start to answer this question on an optimistic note, because I can cite clear evidence of cure already. In January 2002, the RCGP is joining with the Universities of Leicester and Manchester in hosting a national conference on managing poor performance in general practice. It will bring those responsible for managing poor performance in PCTs together with the General Medical Council, NHS Patient Safety Agency, National Clinical Assessment Authority, and members of the RCGP's working party on *Good Medical Practice*. Having recognised the importance of inequality of provision, the RCGP shows encouraging signs of trying to work with PCTs to provide strong professional leadership. The extent to which GPs of the future can avoid the yoke of central control will depend above all on the extent to which they can identify and eliminate poor practice, not only by themselves but by colleagues. This will not be a popular or easy agenda. It requires open and constructive professional dialogue, which is not easy in a blame-and-shame culture. But if the agenda is shirked, general practice as we know it will undoubtedly be replaced by managed care (as the Americans know it) by the end of the decade.

A cure for inequality?

As Douglas Black realised, medicine provides important understanding of the mechanisms for health inequality, but inequality in primary care provision is not the primary explanation of inequality in health. The limitations of preventive medicine are the cultural constraints of the society in which we live (hence the substantial differences between nations in the distribution of risk factors for disease such as obesity), and the relatively small impact of doctors on the environmental determinants of public health (i.e. wealth, housing, sanitation, transport, food).[28] We need to be careful not to be drawn into ineffective, centrally driven 'health promotion' initiatives which are attractive to governments as a means of deflecting the need for effective public health policy (e.g. on transport and food).[29] However, there are major opportunities for effective public health action in the UK general practice and to seize a public health agenda set out by two young and enthusiastic practitioners in response to the Black Report in 1985![30] A recent paper in the *New England Journal of Medicine*, describing the impact of vaccinating children on excess winter deaths in the elderly, highlights both the huge impact which simple public health interventions such as vaccination can have on public health and our need to link policy to scientific understanding.[31] However, the key message is again that the creation of PCTs, with their expanded population base, provides general practice with an excellent and unprecedented opportunity to grasp the equality agenda.

A cure for McMuffinism?

It seems obvious now that independent contractor status offers little protection, and may actually be an obstacle, to the maintenance of professional autonomy. Many commentators argue that the only escape from tight franchise control is for GPs to step away from individual patient care towards management of an increasingly multidisciplinary team, with most frontline work delegated to nurses working mainly to protocol.[12] This advice is misguided and reflects an American perspective. The political strength of primary care comes from two sources — individual patient contact and effective gatekeeping. We need to be explicit in making clear to NHS managers how gatekeeping works — it works because general practitioners shoulder risks. These risks are shouldered, not from economic incentive, but from a strong professional ethos of personal advocacy — protecting the patient from unnecessary anxiety and investigation. The benefit of having the most highly qualified and highly trained professional in the front line is that they will shoulder risk and do not feel constrained to work to an algorithm. The complexity of any care decision is well characterised in a recent *BMJ* series.[32] In the face of complexity, decisions made on an algorithmic basis are unlikely to be optimal and will almost certainly be risk adverse. The cost of withdrawing GPs from the front line will be loss of the gatekeeper function and low-risk algorithmic referral to secondary care. The key to preservation of the gate, in the context of pressure from consumers for better explanations and from lawyers for risk minimisation, is surely better access for GPs to diagnostic services and more consultation time with patients to allow shared and informed decision making about assessed risks.

Working in the front line, providing high quality medical care, and working as an advocate for equality at the coal face is rewarding. If it was explicitly valued and supported, then this would in itself do much to reverse the current downturn in morale and recruitment. But how can this be achieved in the present political climate? James Mackenzie was a thoughtful man who would have loathed the triumph of spin and the plethora of politically inspired initiatives that plague the delivery of high-quality patient care. He craved thoughtfulness and understanding. At the age of 65 he founded the first primary care research institute to explore the impact of the environment on the presentation and prognosis of illness.[33] He epitomised the positive and symbiotic relationship which can exist between clinical practice and academic medicine, and which today is in great jeopardy. To its credit, the Department of Health has a strong and positive strategy to develop the evidence base in primary care — the difficulty is that the NHS is becoming an increasingly hostile environment for general practice-based teachers and researchers. The government-enforced division between service, teaching, and research does not exist at practice level (in a recent regional survey of 1058 practices, the majority (55%) were involved in either teaching or research and 15% were involved in both).[34] The present government appears particularly blind about how this stunning integration and academic infiltration was achieved and how it has underpinned the undoubted quality of care which still exists in UK general practice. At the grass roots, high quality practice, teaching, and research co-exist and thrive. We must work together to protect this legacy of quality, but we will do this most effectively if we simultaneously admit our past mistakes and explicitly grasp the government's agenda of eliminating inequality.

Conclusion

As a GP you would have to be blind or illiterate, not just dyslexic, to have failed to notice the web of bureaucratic control that is enveloping the profession — the rising tide of government guidelines and 'initiatives' is matched only by the intrusion of management committees and meetings. Time for patients and for professional reflection is being eroded. The freedom to think and respond intelligently to the complexity of medical practice is under threat. And we are mainly to blame. We mistook independent contractor status as a way of avoiding central control. We ignored the problem of inequality and enthusiastically supported a fundholding approach that further exacerbated inequality and encouraged the new government to institute a managed care system to control costs. In the new quest for equity we now face a reduction in quality of care and in quality of recruitment until we attain the lowest common denominator.

But all is not lost. The creation of PCTs, with their wider population base, provide not only an unprecedented threat but also an unprecedented opportunity. We can use this opportunity to deal more effectively and efficiently with the issue of poor quality care. We can seize the public health agenda and ditch the plethora of senseless health promotion initiatives for an evidence-based and pragmatic strategy to provide effective preventive care. We can achieve better access to modern diagnostic facilities and develop specialist interests. We can actively seek different staffing solutions, realising that other health professionals may perform some of our traditional tasks better.

However, you can't have a general practice service without general practitioners to staff it. The international reputation of UK general practice, the RCGP quality initiative, the outstanding quality of GP vocational training, and the envied effectiveness of the risk-bearing gatekeeping function are all built on the fact that a substantial proportion of the UK's best medical students have always opted to be general practitioners. This is no longer the case: many of my best colleagues are seeking retirement in despair and those whom I would expect to replace them are shaking their heads. The government must stop and ask themselves why. They must try to understand. If I have a simple message for them from this lecture, it is that McMuffins are not us. It is our freedom to act as personal advocates, assessing and shouldering risk in a reflective environment, and in pursuit of the professional ideal of high quality care, which both underpins the gatekeeping function and attracts many of the best doctors in the UK to work in general practice. If I have a simple message for us, it is a quote from the Berlin Wall — in translation, 'He who wants the world to exist as it is, does not want the world to exist at all'.

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