

# The NHS at 60: time to end the fairy tale

*'Mirror, mirror on the wall,  
Who's the fairest of us all?'*

In *Snow White and the Seven Dwarfs* there is a magic mirror that flatters all who look into it, saying there is none as fair as they. The NHS has a similar effect, reflecting our best ideas and wishes for free health care, treatment according to need, personalised service, fairness, and so on. But while everyone has been admiring themselves in this mirror, the world has moved on.

The organisation can still be seen at its best in the handling of medical emergencies when the best care is brought to bear with the resources that are available, irrespective of who the patient is or the cost of treatment. Other cardinal features have been the list system in general practice, providing complete population coverage and access, with very little duplication; and the gate-keeping role of general practice, providing huge efficiencies for the service as a whole.<sup>1</sup> Most importantly, the NHS has been a way of paying doctors and other staff so that, unlike many countries, money has been taken out of the consultation. It is a privilege for health professionals to care for patients in such circumstances.

One of the most glowing features of the NHS, valued by both patients and professionals, is the consistently high level of trust in GPs that is expressed by patients. This trust is based (we like to think) on patients' experiences of familiarity, continuity, and fair dealing.

Principal credit for these features of the NHS is due, not to the altruism and good intentions of people working in the service, or of the organisations that represent them, but to the architect of the NHS<sup>2</sup> who knew precisely what he was for and against, and who ensured that its structure would enshrine these progressive functions.

Two major changes since 1948, however, are the ageing population, with its need for long-term care involving continuity and coordination, and the development of so many effective clinical interventions.

Although their effects can be to reduce the severity and slow the progression of established conditions and risks only, their mass application has been an important contribution to improving population health and longevity.<sup>3</sup> The converse is that if such care is not delivered equitably, the NHS becomes a producer of inequalities in health<sup>4</sup> and part of the explanation of why inequalities are widening. This is a new dynamic that needs to be addressed.

The persistence of the inverse care law — providing good medical care in inverse proportion to the need for it in the population served — is an affront for all those who see the NHS as an instrument of social justice, and has three main components. First, as described in Julian Tudor Hart's original paper, and extant in many so-called civilised societies, there is the effect of market forces and financial barriers on the provision and uptake of health care.<sup>5</sup> Second, there are the processes by which many interest groups, including the professions, are better able than others to pursue and protect their interests. Third, and crucially, inverse care needs to be seen, not as a 'law', but as the result of specific NHS policy.

For most of the history of the NHS, access to GPs has been rationed in the same way eggs and butter were in World War II. Across the distribution of socioeconomic status, there is a virtually flat distribution of GPs, despite a 2.5-fold increase in the prevalence of poor health.<sup>6</sup> Now that good medical care depends so much on continuity and coordination, this simple concept of access is no longer adequate as a basis for addressing patients' complicated and long-term needs.

Complete population coverage and access have been huge social achievements, albeit with larger list sizes in poorer areas. When GP earnings were based largely on capitation, this could be lucrative, but changes to the contract involving payment by results, plus the retirement of a generation of Asian doctors who largely worked in such areas,<sup>7</sup> has led

to areas that are underperforming and under-doctored, prompting new types of providers in primary care.

As Allyson Pollock has documented — almost single-handedly and while most professional organisations have been asleep — legislation has been introduced in the last two decades, at Brussels and Westminster. This legislation not only enables, but also requires developments in the NHS to be opened up to commercial competition.<sup>8,9</sup> Thus, the wolf that Julian Tudor Hart warned about is no longer an external threat, but has entered the fold.

The principal arguments against commercial providers in primary care are that they take money out of the system that could be better spent on services, and that they have no track record (in this country or abroad) of providing for many what they generally provide for selected groups. Supporters of the new order need to give evidence of the ability of commercial providers to provide coverage, continuity, commitment, relationships, trust, and local leadership — the active ingredients of effective primary care.<sup>10,11</sup>

The challenge facing new providers in primary care, as well as profit-driven organisations of GPs and Lord Darzi's 100 new practices in deprived areas, is not just to fill gaps in the service, or to provide a better short-term alternative in areas where traditional general practice is run down — it is to transform the most time-poor part of the NHS where both patients and professionals are hard pressed, and necessarily used to lower levels of expectation.<sup>12</sup>

The neglect of general practice in deprived areas has allowed some wild flowers to bloom, but these are exceptions and, although their examples show what is possible, they do not solve the problem of how such services can be delivered across the board. For many, probably the majority, the commitment of these pioneering doctors goes beyond the call of duty. Traditional general practice, with its variability, disaggregation, and perverse

choices between personal income and service development, can only be part of the solution.

Addressing the inverse care law is made difficult by three other problems: first, the front line of this part of the NHS is largely hidden from external view, as a result of its geographically scattered nature, the lack of evidence, limited nature of routine clinical information, and the rarity of analyses aggregating practices according to the nature of the populations they serve.<sup>6</sup> Second, current orthodoxy on inequalities in health, maintained largely by doctors, researchers, and policy advisers without clinical contact or insight, does not generally support policies to increase the volume and quality of health care in poor areas. Third, the challenge affects only a minority of doctors and practices, whose populations' needs tend to get short shrift when the needs and interests of the wider profession are an issue. In summary, despite plentiful rhetoric about addressing inequalities, there is a dearth of well informed, influential, and powerful champions to address inequalities in NHS primary care.

To its credit, the Quality and Outcomes Framework (QOF) engaged almost 100% of practices, at substantial cost, with improvements in information and organisation that will continue to be beneficial. Although the QOF largely ironed

out social gradients in incentivised quality markers, it did little to change gradients for markers that were not incentivised.<sup>13</sup> In general, the new contract offers little to address inverse care<sup>14</sup> and is likely to be more divisive as its targets become more demanding.

If Bevan were in charge of the NHS today, with its new circumstances and challenges, would he not argue that the service should be seen at its best, and that professional careers and rewards should be most attractive where needs are greatest? That is a challenge, not only to our generosity as a society, but also to our ability to imagine structural solutions to the inverse care law.

The NHS fairy story is that all interests are part of the solution; none is part of the problem, but the careful statistics of the Registrar General tell a different tale.

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## Your general practice environment can improve your community's health

The vast majority of GPs believe that they can achieve excellence in their practice when they have developed the optimal mix of knowledge, experience, skills, attitudes, and effective consultation techniques. Unfortunately, what many GPs appear to forget is that the consultation, the very heart of their clinical practice, happens within a physical space.

Not surprisingly, given the traditional emphasis on the aforementioned more

'practical' clinically-focused attributes of general practice, a gap exists in understanding the life-enhancing potential of physical space. However, this gap is now beginning to close. The recently conducted research by Rice *et al*' (published in this issue) highlights several of the vitally important practice improvements that the sensitively designed physical environment can contribute.

This new investigation by Rice *et al* must be commended for its intention to begin to close a gap in the research literature. Specifically, this research makes three important and very practical contributions to the literature. Firstly, it describes a range of tangible outcomes that the physical environment can be used to improve, as well as describing the actual environmental elements that were used to achieve these improvements.