Cuts and the NHS:
be honest about what's possible and address inequity

'In a dark time, the eye begins to see.'
Theodore Roethke (1908-1963)

Reading McShane and Smith's *BMJ* article[1] on a simulated exercise on how to cut expenditure, what becomes clear is how successive reorganisations of the NHS in England have created a creature of great complexity. The Department of Health, strategic health authorities, acute trusts, medical schools, primary care trusts, community health organisations, private companies, social care, commissioning and monitoring organisations, National Institute for Health and Clinical Excellence, and the Care Quality Commission are probably the main players. It's tempting to be cynical and satirise,[2] but the tragedy for patients, NHS staff, and the taxpayer is that making decisions in this melee on any rational basis is well nigh impossible. We are smaller in NHS Scotland, but alas no simpler. This may be the most financially challenging time for the NHS since its inception in 1948.

So no magic solutions but here are four suggestions.

The BMA, after discussions with all the key medical players should offer a voluntary doctors' pay freeze for 3 years for all non-training posts over a certain income level. This puts us on the front foot, saves some NHS resource, and gets us some sorely needed good media coverage.

It's a cliché but also true that financial crises are often an opportunity to address bureaucracy. In our practice (7500 patients), we have kept our staff numbers steady since 2004 over the time of the introduction of the nGMS contract despite growing demand and throughput. The NHS has not, partly because of the proliferation of organisations described above, and partly because a frequent response to poor performance at administrative and managerial level is to employ still more staff.

Start having an honest debate about what the NHS can and cannot do. On Radio 4 last week, I heard two successive features on the need for more bariatric surgery (doctor led) and more funding for services for those with multiple sclerosis (patient led). Who speaks for those unable to get an interview with John Humphrys? The usual response from medical leaders on this is that politicians can't engage with this agenda. GMC, College presidents and chairs, especially our own, need to be much more assertive on the rationing issue and lead, rather than respond to the debate both with government and in the media. If the GMC's purpose is 'to protect, promote and maintain the health and safety of the public by ensuring proper standards in the practice of medicine',[3] then a renewed focus on how these resources are allocated as well as on how individual doctors use them, would be helpful for patients and the public.

Currently, patients have a 'queen' role in the NHS, at least in the rhetoric, and attention and funding for both individual patients and diseases often follow demand rather than need. This has led to persistent and unaddressed inequity in the NHS.[4] If the medical profession uses the crisis to lead a national discussion on rationing and equity in the NHS, we will have achieved something.

John Gillies

REFERENCES

1. McShane M, Smith R. The NHS in the simulator. *BMJ* 2009; **339:** b4868.
2. Oxman A, Sackett D, Chalmer I, Prescott T. A surrealistic mega-analysis of redisorganisation theories. *J Roy Soc Med* 2005; **98:** 563–556.
3. GMC. About us. http://www.gmc-uk.org/about/index.asp (accessed1 Feb 2010).
4. Watt G. The inverse care law today. *Lancet* 2002; **360:** 252–254.

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Quis custodes ipsos custodiet?

There is little doubt that cuts are on the way. It is up to us as a profession to guide and support the incumbent government. If we don't, be reassured that they will, and that 'they' in this instance will be US 'management consultants' overseen by rapacious lawyers. I propose three main areas that could stand considerable pruning for, as gardeners say, growth follows the knife. First, all private finance initiative (PFI) activity must cease; second, rational prescribing rigorously enforced; and third, we must regain control of our profession before the lawyers destroy it. To avoid medical bias, I give an example of lawyers in action: the government tried to outlaw sham marriage. The high court decided that to make these illegal would infringe the couple's civil liberties. I recently had dealings with an Independent Mental Capacity Advocate. My experience (27 years) and that of our very able nurses was as nought compared to someone who had done a weekend's course and was not with the patient (client?). The Modernising Medical Careers debacle, Medical Training Application Service, Mental Capacity Act, Postgraduate Medical Education and Training Board (PMETB), Independent Complaints Advocacy Service, and revalidation have all been overseen by lawyers. Need I say more? The GMC appears as a rabbit in the headlights in their fear of the law; the colleges even worse. Does anyone know what PMETB has achieved for us?

The first of these would be easy. PFI must be replaced by government-funded projects, unequivocally on a not-for-profit basis. The savings potential here runs to billions (in my trust alone, £700 million).

We need to move to rational rather than emotive prescribing, centralise drug budgets, and run a national formulary with a rigorous approach to pharma. For instance, prescribing statins in those whose life span is measured in months is hard to justify on any grounds, let alone

clinically. Dialysis likewise. A charge of ageism would need to be defended but taking a robust stance, rather than the current mealy-mouthed one, would make this possible. The savings would run into billions.

To take charge of our profession would empower us once more to do the job we love and, er, are pretty good at. Who wants to devote hours to revalidation rather than see patients? Surely a 'catch 22'; those who are good at revalidation almost certainly spend the least time on the shop floor. So, to keep the lawyers happy we are de-skilling our workforce. We must fight back before it is too late. We have to take back our profession from the men in wigs. How? Solidarity would help and this means a return to a militant BMA who talk to us and not *Kaiser Permanente*. The GMC and the colleges must take up the fight rather than being the fight. Abandon PMETB as not fit for purpose. Our battle cry must be re-professionalisation, not revalidation. The savings? Beyond measure.

Neil A Hedger

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'Our battle cry must be re-profession-alisation, not revalidation.'

Little things mean a lot

The discussion about healthcare costs in the US — reducing it, controlling it, getting it to the right places — focuses on big ticket items like cardiac catheterisation, end-of-life care, and transplants of all types. Since family doctors don't do transplants or cardiac caths, we avoid the glare of the cost spotlight, mostly.

I recently saw a patient with a sore throat. I didn't feel that the patient's symptoms or risks required a strep test. But it was too late, in the new 'efficient' system for primary care reengineering, the nurse did it before I got into the room and results were already in the chart.

We all understand that antibiotics for a strep throat do not shorten the course of the illness, and that the purpose of giving antibiotics is to prevent rheumatic fever and poststreptococcal glomerulonephritis (PSGN). Studies show that the adherence of patients to a 10-day course of penicillin is about 50%. Changes in serotypes, social and living conditions, and other factors have changed the epidemiology and the reality of rheumatic fever and PSGN. In the past 10 years, my state, with a population greater than Denmark, has had six cases of rheumatic fever. The trend cannot be traced to antibiotics.

The larger question is why should we be treating strep throats in Wisconsin at all in 2010? One could ask that same question in the rest of the US.

Our academic department runs a large network of practices. In a 12-month period, we had 435 000 patient visits and did 35 000 rapid strep tests. Multiplied by the cost per test, the result came to $1.4 million. That works out to one rapid strep test every 12 visits and about $3.80/visit. This cost is for a disease that occurs once out of 1 million citizens yearly. Assuming the rest of the US was to behave like we do as a Department, we are spending billions of dollars yearly for strep tests.

This $1.4 million could be seen as costs to patients and insurance plans or as revenues for our clinics. Most doctors, including us, are paid on the basis of what is called 'production' calculated through a complex billing formula developed in the last century by druidic health policy wonks working in Washington DC. More tests make more relative value units (a misnomer if there ever was one) and make me more money.

If we look at any number of 'simple' office lab tests with an evidence-based eye, we would likely find more billions to be saved. There is a butterfly effect at the most fundamental level of general practice that initiates the chaos of the system.

Lessons learned. First, we better sweep our own back porch before we sweep off someone else's. Second, don't link income to volume of anything except real and measurable quality. Third, any change, even in the little things, will require all of us to act together or it will collapse, as in, 'Well Dr Smith always does a strep culture on me, why don't you?' Finally, the medical-industrial complex is at work in every GP's office, not just the high-end hospitals. LOTS of people make money on unnecessary stuff — doctors, office testing companies, drug companies, and advertising agencies. To change that requires everyone taking a financial hit and America is not ready for that. Yet.

John Frey

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'Who speaks for those unable to get an interview with John Humphreys?'
(Gillies, page 224)