

would rocket upwards.

The NHS exists to ameliorate the fear of illness, injury, suffering, and death; the preventative and public health elements are subsumed within this. It does not have to do everything for everyone all the time.

Taking the consultation as the starting point, proper assessment and advice about anything, any time, anywhere, for free — in person, by phone, by email/SMS, by Skype, or whatever — is the first requirement. People access health care because they do not have the answer to a concern. The access points must be immediate, effortless, ubiquitous, and 24/7. It has been my experience that when patients know that an immediate response is a button press away, they are apt to relax and use the system to best effect of their own accord.

Consider the 'pyramid of care'. There is a vast stratum of minor and self-limiting conditions for which, after proper assessment, no treatment or self treatment is appropriate. The NHS should not bear the cost of any of this treatment. In time, the high street pharmacy would become the first port of call for much of this morbidity, thus freeing primary care to focus further up the pyramid. The savings in prescriptions would be vast and the funds released can percolate up the pyramid, easing the pressure on funding high tech, high cost treatments. With the high street pharmacy shouldering the greater part of minor and self-limiting morbidity, that part of pharmacy which is of the greatest direct value to primary care should be fully integrated with it. All primary care teams should have a resident pharmacist and dispensary that can optimise all aspects of therapeutic usage in real time and on site.

Further up the pyramid are those common non-red-flag conditions, for which treatment can be more appropriate, but which may lack objective confirmation of significant pathology. In the absence of this confirmation, treatment should rely on self treatment, private prescription, and/or lifestyle change. Where there is

objective confirmation of significant pathology then the NHS should start to pay for treatment.

Malignancy is subject to populist political exploitation (2-week waits and cancer funds, for example); this must stop. We need to move away from any wait at all for those with confirmed or suspected malignancy. Faced with the possibility or reality of life-shortening illness, most people would be prepared to drop everything immediately and travel from Lands' End to John O'Groats within the hour if it would help — and who is to say it wouldn't?

Every county should have an immediate, same hour, referral service for all suspected or confirmed new cases of malignancy. In such a unit, all protocols would be fully up to date and instantly initiated with physical, psychological, and social support given. Appropriate baseline investigations would be performed at first attendance, including all imaging modalities, biopsies, and endoscopic assessment. Follow-up appointments or admissions would be organised. Why not?

The pernicious impulse to eliminate variability must be recast as a determination to promote properly exercised clinical autonomy while eliminating feckless eclecticism. The tabloid mania over postcode lottery treatment must be deflected by permitting variation in service by area when it has the informed consent of the affected population.

The bottom line is that unless all the involved professions assert themselves decisively and coherently, the NHS is lost. You asked for a bolder and more imaginative approach — this is my offering in outline.

Steve Ford,
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Competing interest

In 2008, at the age of 55, I retired from general practice, primarily to register the withdrawal of my consent from what has been and is being done to the NHS. I stood as an Independent in the 2010 general election, with health as one of the main elements of my campaign: I got 1974

votes, coming 28th in the UK among Independent candidates.

REFERENCE

1. Jones R. The White Paper: a framework for survival? *Br J Gen Pract* 2010; **60**(578): 635–636.

10.3399/bjgp10X532440

Professor Jones believes that the White Paper ignores the 'funding crisis'.¹ Nothing could be further from the truth. The White Paper proposes that GP consortia will hold a budget for purchasing care for the population covered by the consortia. If a consortium fails to meet its responsibility to break even, its commissioning responsibilities will be taken over by the NHS Commissioning Board or assigned to a third party. This provides a powerful incentive to focus on the cost of services being provided or purchased. GPs are responsible for the vast majority of decisions relating to this expenditure, and they will now be directly accountable for these decisions.

The White Paper, therefore, proposes a powerful incentive to manage financial costs that has not existed since GP fundholding. The level of funding required to deliver a service with high quality outcomes can only be addressed once the incentives to achieve the desired outcomes are in place. The case that funding from general taxation is both fair and efficient has been comprehensively made by Wanless.² This is and still should be the policy of the Royal College of General Practitioners.

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2. Wanless D. *Securing our future health: taking a long-term view. Final report.* London: HM Treasury, 2002.

DOI: 10.3399/bjgp10X532459