The NHS's 50th anniversary

Something to celebrate

The Bevan legacy

Michael Portillo

At the conclusion of the second world war Britons wanted a new order of things. Medical care had made big advances in the war, and soldiers had been offered a higher standard of care than they were likely to encounter after demobilisation. Civil servants and politicians discerned these currents long before the war ended.

Following the war, therefore, Britain would almost certainly have created a national health service without Aneurin Bevan, and even without a Labour government. Bevan had to work with the conditions he inherited and he accepted much that had been planned during the wartime coalition government. He made relatively few big decisions, but those that he made have had a profound effect on the way the service has developed.

Bevan held fast to the principle of a service funded by the taxpayer, and essentially by no other source, and his resignation from the cabinet on the issue of health charges had the effect of raising that principle to the status of a dogma. That has been an important cause of the strain experienced by the health service ever since. It has been refused sufficient funds from the taxpayer, and has never had anywhere else to turn for money. Worse, sensible discussion of alternatives has been made almost impossible ever since Bevan turned the National Health Service into a party political battleground.

Summary points

After the war Britain would probably have created a national health service without Aneurin Bevan. He made relatively few big decisions, but those he did make had a profound effect on the way the NHS developed

His decision to nationalise the hospitals led to the government supplying virtually all health care as well as paying for it

His biggest principle was that the NHS should be funded entirely by tax. This has led to underfunding

Bevan also politicised the NHS in a way that has locked politicians in a perennial dread of change

Aneurin Bevan: the man and his decisions

Few politicians are as well, or as affectionately, remembered 50 years on as Bevan, and rarely is a politician's name so inextricably linked to a particular achievement as his is to the creation of the NHS. This is especially remarkable, because at the time Bevan was far from popular. He had long been viewed by many—even in his own party—as a wild man, who had risen in part thanks to the intemperance of his invective. He was a fierce critic of his party's leadership and had got himself expelled from the party in 1939. During the war, while his senior Labour colleagues held leading positions in Churchill's coalition cabinet, Bevan railed against the prime minister and the conduct of the war in tirades that even his colleagues felt were close to treasonable. When he entered the Attlee cabinet as minister of health in 1945, he could count on the hostility of the deputy prime minister, Herbert Morrison, the chancellor, Hugh Dalton, and the foreign secretary, Ernest Bevin—and he developed more enemies as he went along.

So, as Bevan set about making the decisions that were to shape the NHS, several of his colleagues were looking out for reasons to accuse him of making a terrible mess of the preparations. Bevan supplied them with ammunition, first by refusing to discuss his plans with the medical profession until after first reading of the parliamentary bill and subsequently by becoming involved in a bitter and protracted feud with the BMA, which seemed to risk failure for the whole project.

Luckily Bevan retained a high opinion of himself, and this was largely shared by the civil servants working for him. He impressed them by an early display of decisiveness, when he nationalised the country's hospitals. Previously, there had existed municipal hospitals, which tended to be quite good, and voluntary hospitals, which were of varied quality and already overwhelmingly dependent on taxpayers' money. All the wartime plans made before Bevan's appointment had assumed that the local authorities would take over all hospitals; indeed it was assumed that local authorities would be the foundation of the health service as a whole, employing general practitioners and supplying community health services too. However, those planners had not worked out how they would

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75 Davies Street, London W1Y 1FA
Michael Portillo
cabinet minister, Conservative government 1992-7
mportillo@kmg.com

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Bevan turned the NHS into a party political battleground

overcome the voluntary sector's predictable protests at being absorbed by the local authorities. Bevan solved that problem by bringing all the hospitals under the control of national government.

Bevan's decision to nationalise the hospitals provided an early demonstration of independent thought and display of power, which left him free to be unexpectedly flexible in other respects. He was convinced that he needed the hospital consultants on his side and so gave them the right to have private patients and allowed pay beds in NHS hospitals.

To general practitioners he conceded something which had not been on offer from Bevan's wartime Tory predecessor, Henry Willink: their self employed status, with payment mainly through capitation fees. Nevertheless, the BMA waged a long campaign and extracted further concessions. The bad publicity which that campaign caused Bevan gave the government the first warning that the BMA can seriously damage a minister's political health. But it also gave his own party the impression that he was determinedly implementing socialist policies, when in many ways he was not. With all his concessions Bevan created a health service which was less socialistic than that planned by his Tory predecessor. Bevan was prepared to make so many concessions because he cared about a central principle and was willing to cede territory elsewhere to protect it. The principle was a free health service available to all. For Bevan, that meant that it should be funded from taxation.

An unusual NHS

The idea of an NHS paid for almost exclusively by the taxpayer has so deeply penetrated our national psyche that it is worth remembering that it was not inevitable. The most obvious alternative was one based on compulsory national health insurance. This principle had been established by the Lloyd George reforms at the beginning of the century and was the model endorsed by the Beveridge report, the foundation of most postwar welfare reforms.

Labour welcomed the Beveridge report on its publication. But Bevan had always opposed the contributory principle. He thought that a free health service should be accompanied by a redistribution of wealth through the tax system. Bevan's way of proceeding was also in marked contrast with practice elsewhere. According to Rivett, "few other countries, outside the Eastern bloc, followed the same route" that Britain took.[1] Yet Britain embarked on an uninsured health service with apparently little debate about the principle involved, or its sustainability.

It was a decision of inestimable significance, which owed nothing to previous British practice or experience, was little discussed at the time, and has been rarely queried since. Bevan convinced the British people that the NHS was the best system in the world. You might say that ever since then vested interests have tried to convince us that underfunding has made it the worst. But in both cases we have tended to be insular: few know about other countries' systems.

Following the creation of the NHS, there was almost immediately debate about what was meant by a "free health service." The issue of health service charges was to lead to Bevan's resignation from the cabinet. His adversary was the new Labour chancellor, Hugh Gaitskell, who believed that Bevan had taken too far his idea of a free health service, that it should not extend to providing things like spectacles and false teeth which were not linked to illness, and that prescription charges were needed in order to suppress unnecessary demand. The cabinet even considered charges for hospital stays.

At the time of his resignation, Bevan had failed to convince either the cabinet or the left wing of his party of the matter of principle which mattered enough to him to sink his own career. In an extraordinarily bad tempered speech he increased resentment against him by referring to "my health service." According to Tony Benn's diaries, "He shook with rage and screamed. . . .The megalomania and neurosis and hatred and jealousy he displayed astounded us all."

Such reports make it really quite surprising that it did become widely accepted that Bevan was the father of the NHS, that his resignation had been on an important matter of principle, and that a completely free service was the defining principle of the NHS.

I think the explanation for that change is partly that the 1945-51 Labour government, despite all its reforms, was a disappointment to the Labour party itself. The government lost momentum and compromised more than its zealots would have wished. Following the split in the party Labour mythology built up the NHS as the outstanding socialist achievement.

A sacred, and underfunded, NHS

The effects of that mythology have been with us ever since. The principle of a free health service has not since been breached any more deeply than it was by the cabinet that founded the NHS. Charges to patients today make up less than 3.5% of NHS revenue. By his political martyrdom, Bevan made the NHS sacred in the form he had created it.

In the years since Bevan, there has been an important development in Labour's general political outlook which logically should have led it to rethink its stand on the NHS. Labour has abandoned its commitment to redistributive taxation. We are thus left with a commitment to fund the NHS almost exclusively out of taxation, without any policy to increase the amount of tax available to pay for it.

The paradox is that the Bevan model has led to very tight restriction of health expenditure. There has been little to choose between the political parties. Over the years the treasury has kept the lid screwed down tightly, and the NHS has had nowhere else to turn for money. The signs are that our low level of expenditure is not just a demonstration of our efficiency: Britain is actually spending too little on health.

Too much weight on a single back

I am not saying that Britain would do better if it had a different healthcare system. My point is that while there is ultimately only one source of money in a society—its people, who end up paying one way or another—it none the less helps to raise revenue in a variety of ways. Putting nearly all of the burden on taxation makes it difficult to bear, especially since many more people on low incomes pay income tax now than in Bevan's day. Another change is that both the main political parties now favour low taxation. And governments may favour other programmes such as education ahead of health.

Some combination of taxation, private capital, national insurance, charges, and private insurance might made the burden on the public more tolerable, enable the nation to spend more on health, enable people to be treated more quickly, and provide the NHS with more secure sources of funding.

In the Netherlands nearly 68% of total health expenditure comes from social health insurance and nearly 14% from private insurance. Only about 10% comes from taxes. In Germany just 14% comes from the government. In the United Kingdom 85% of health spending comes from public expenditure.

Logic and concern might dictate that we should pursue every avenue to increase the monies available for health care. But we don't, because to suggest any private contribution or any change in funding produces a hysterical reaction.

People who make provision for insurance themselves have received little encouragement. That is curious since even Bevan himself saw that private practice could make some small contribution to funding the NHS. He allowed hospital consultants to earn money beyond their NHS salaries as a way of securing their services in the public sector without having to pay them private sector fees. It brought the NHS quality at a cheap price. The private patient was recruited to subsidise the NHS one.

Because relatively so little health care is available in Britain, we have a disgraceful situation where how rich you are really does make a difference to the health care that you receive. Our queues and our queue jumping are no cause for pride or complacency, nor any reason for us to patronise other countries. The shortages and inequality are a paradoxical outcome of one of the most socialist looking systems in the world. But the answer to queues and queue jumping is not to cut back on private insurance, but rather to increase by every means what the nation spends on health care.

Private capital

Bevan's decision to nationalise the hospitals produced an effect that was not challenged for many years. It meant that not only would the government, using taxpayers' money, pay for health care, it would also be responsible for supplying it all. We take that for granted now, but it was not inevitable: it was an unexpected choice and it is not what a number of other countries chose to do. In Britain, the independence of the municipal and voluntary hospitals was put to an end. The decision brought advantages of integration, but uniformity is the enemy of innovation. Diversity can lead to the emergence of novel good practice which can then be learned by others.

It is perfectly possible for government to pay for services—so that they remain free at the point of delivery—without owning those services. If the government did not own all the facilities from which it buys services, it would not need to find capital for their construction and improvement.

Recent attempts to introduce private finance into the NHS have met with only limited success. Fundamentally this is because as part of the Bevanite legacy we cannot detach ourselves from the idea that the government should control the hospitals as well as pay for them.

The NHS in three parts

Bevan's decision to take all the hospitals, voluntary and municipal, under government control also had the effect of creating a health service in three parts: hospitals, general practitioners, and community health. Since then these three have existed in separate columns like silos that have almost nothing to connect them. Bevan was right to believe that the local authorities were in no condition to take on such heavy responsibilities. But the NHS has lived with this lack of integration ever since. In particular, it has proved difficult to develop a cadre of bright professionals who think about and drive policy for the NHS as a whole, rather than just for their silo.

Political football in the NHS

A political development of lasting significance was the decision by Bevan to make party political capital out of the NHS. In 1948 the prime minister, Clement Attlee, proposed to make a broadcast to the nation about the NHS hailing it as a national (rather than a government or party) triumph. Bevan was incensed and persuaded


Evening Standard

The National Health Bill is out. It will cost £152,000,000 a year

STATE TAKE OVER DOCTORS, HOSPITALS AND DENTISTS

'Free for all'—1948

PRIVATE PRACTICE STAYS, BUT NEW DOCTORS DIRECTED

FIGURES

PLANE DIVES ON SCHOOL

200 children at play: All safe

Can they stay outside?

HAMBURG WITHOUT BREAD

Mr. Claude de Bernales

JOHN FROST COLLECTION

Attlee that since the Conservatives had voted against the bill at second and third readings, he should claim the credit for Labour and use the NHS as a stick to beat the Tories.

In party political terms I am sure that this was sensible. The Labour party has had a permanent advantage over the Conservatives ever since, and although much more of the NHS's extraordinary advance and development has occurred under Conservatives than Labour (since Conservatives have been in office a good deal longer) still the NHS is associated with the Labour party, and the slogan that the Tories cannot be trusted with the NHS continues to resonate with the public.

So Bevan was politically shrewd. But the politicisation of the NHS has been greatly to the harm of the service itself. Rational debate has become very difficult. Every sort of change, including the replacement of old hospitals by new ones, has been presented as an attack on the service. It has made the Tories timid about reform—and it has made the Labour party cling to the Bevanite dogma of a health service financed only from taxes.

It is not just politicians who politicised the NHS. The BMA campaign against Bevan used a number of lies about his intentions designed to scare the public and embarrass him. We have seen similar campaigns since. Since the earliest days, most groups in the NHS have thought it in their interests to depict the NHS as being on the brink of collapse in order to obtain more money from government. Again this has become so much an accepted part of the scene that we have to remind ourselves that most service organisations do not try to paint the worst possible picture of themselves to their staff and customers.

Conclusion

At the end of the NHS's first 50 years, we can be proud that people in Britain do not live in fear of medical bills they cannot afford. We can congratulate those many thousands of health professionals who have given brilliant service to the sick and pushed so wide the boundaries of medical care. We can celebrate longer life and healthier living.

But we cannot give three cheers when so many who work in the service are themselves depressed. Our celebrations must be tempered by the thought of all those who suffer because they cannot have today, or perhaps even this year, the treatment that would bring them relief from pain and a better quality of life.

The gap between what we spend on health care today and what we "ought" to spend is large, and no party is going to make it up from taxation. That the parties are so coy in speaking about health is mainly down to Nye Bevan. He made the NHS sacred and untouchable. He may have freed the patient from fear of medical bills, but he has locked the politician in perennial dread of change.

1 Rivett G. *From cradle to grave: fifty years of the NHS.* London: King's Fund, 1998.

As I recall

David Morrell

14 Higher Green, Epsom, Surrey, KT17 3BA

D Morrell
former professor of general practice

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At the end of half a century of general practice in the NHS it is interesting to reflect on the enormous changes that have occurred in this branch of medicine. My qualifications for doing so are that I entered medical school in 1947, graduated in 1952, entered general practice in 1957, and retired in 1993. I was active in the College of General Practitioners from its earliest years and in academic general practice from its inception. I have worked with most of the leaders in general practice over this time. From this very personal perspective I attempt to review the evolution of general practice in the NHS.

The early years

I have no personal experience of general practice before or immediately after the introduction of the NHS. To get a feel for the benefits and difficulties that the NHS brought to the lives of general practitioners it is necessary to turn to anecdotes from doctors living through that time, leading articles and letters in medical journals, and a limited number of biographies.

The one great financial benefit that the service conferred on many general practitioners was to relieve them from the burden of bad debts and the need to employ debt collectors. Although general practitioners had traditionally tried to provide care to those in need, irrespective of their financial resources, the new service gave welcome support particularly to those working in poor and deprived areas.

Summary points

- The NHS introduced free access to primary care services to the entire population, and in operating the new service general practitioners and their patients were confused about their roles
- Research in the first two decades of the NHS clarified the diagnostic methods appropriate in managing illness in primary care, and the training and organisation needed to fulfil this role
- After the family doctor charter in 1966, research and training in general practice and the reorganisation of primary care flourished
- The changes introduced in 1990, compounded by cultural changes in the population and the profession, now challenge the role of the general practitioner as a provider of personal and continuing primary medical care

During the early years of the service many complaints were recorded in the journals, of inappropriate demands for medical care—particularly out of hours—of unrealistic expectations of patients, and of the regulations covering certificates for sickness benefit and the need for prescriptions for eye tests, corsets, and similar items.

It is difficult to show major changes in general practitioners' workload as a result of people's direct access, free at the time of demand, that was introduced by the service. In the first few years, NHS data on workload in general practice came from the annual survey of sickness, which was based on home interviews with patients. These were reviewed by Logan and Brook in 1957,[1] and it was estimated that the average consultation rate per patient per year rose from 4.8 in 1947 to 5.6 in 1950. By the time of the first national morbidity study in 1956[2] it seemed to have fallen to 3.8 consultations per patient per year, and home visits accounted for 25% of these. It is difficult to compare data that were recorded in a variety of circumstances and use a variety of definitions, but it seems that by the end of the first decade of the NHS, consultation rates differed little from those recorded 30 years later. The high number of home visits probably reflected the fact that at that time few patients possessed their own telephone or car.

In 1950 Collings, an Australian doctor who had worked in New Zealand, Canada, and the United States, carried out a survey of general practice in the United Kingdom.[3] He reported that the overall state of general practice in England was bad and deteriorating. Inner city practice he described as at best unsatisfactory and at worst a public disgrace. It must be borne in mind that the countries in which he had worked viewed "socialised medicine" as a serious threat to the medical profession. The contribution that Collings made to general practice in this country was to provoke anger in the profession, which in due course led to research and reform. An early response came from Taylor,[4] who was at the time conducting a survey of general practice for educational purposes. He concluded that one quarter of general practice was very good indeed. About one half was good, sound, and reliable, but one quarter was unsatisfactory, with poor premises and equipment, and no medical records.

A young man's view

In 1957 I became the third partner in a practice that provided care for 8500 patients from a converted house in the centre of a country town and three branch surgeries in surrounding villages. The only paramedical support we had was one receptionist. Entry into general practice at this time was difficult, with up to 100 applicants for good partnership vacancies. Interviews for a post always included the doctor's wife, and few women applied at that time. In many practices the doctor's wife became an integral part of the organisation. Partnership agreements usually offered parity of income with the existing partners after about 12 years. As was common for the incoming doctor, I was asked to live above the surgery and answer the doorbell outside working hours.

When I entered general practice, I had experience as a house officer in medicine, surgery, obstetrics, and three years' experience as a physician in the Royal Air Force. My vocational training lasted about three days during which I sat in with one of the partners, was taught to write prescriptions and certificates for sickness absence, and learnt how to obtain access to the lock up surgeries.

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The early weeks and months in the consulting room were confusing, and I was filled with feelings of guilt. The knowledge and skills acquired in hospital just did not seem relevant to the many problems I encountered, and when a proper hospital type patient presented, there was never time to carry out the type of examination that I had learnt in hospital posts. I was not aware of the political battles over general practice at the time, but was simply conscious of my own inadequacies and people's constant demand for care. Domiciliary maternity care, which was common in general practice at that time, was satisfying in human terms but demanding, and my practice was then delivering about 50 patients each year in their homes.

General practitioners responded to this situation in different ways. Some became desperate and depressed at the demands being made on them, which differed so much from their expectations and training. They complained: "This is not the medicine for which we were trained." They were right, of course, but they assumed that it was the medicine which was wrong and failed to realise that it was the training which was at fault. Many emigrated to Australia, Canada, or the United States, where the terms and conditions of service were more attractive. Others became overwhelmed or demoralised and accepted that they were functioning as second class doctors, a label that had been applied to them. Others accepted the challenge and tried to do something about their problems.

Understanding general practice

In 1952 the College of General Practitioners was established by a group of doctors who had responded to the challenge of providing good general practitioner care in the NHS.

The college encouraged energetic and able general practitioners to get together and not only to counter the pervading gloom but also to challenge specialist opposition, which was not just neutral to general

practice but in some cases actively hostile. It set up faculties in local areas throughout the country that became centres for change. These were largely apolitical and concerned with education, research, and improving patient care.

This was an exciting time to be in general practice. The terms and conditions of service precluded any radical initiatives to improve the service, but a spirit of inquiry was everywhere, and early research into the content of general practice was beginning to provide facts on the basis of which general practitioner care could be developed.

On reflection it is easy to see the difficulties facing general practitioners at that time.

Diagnosis—Doctors were trained in teaching hospitals. They were taught that a diagnosis could be reached as a result of taking a detailed medical history and undertaking a full physical examination, supported where necessary by relevant laboratory and radiological tests. They learnt about the probability of disease in response to symptoms presented at the level of secondary care, and their textbooks were written by doctors who worked in this setting. The situation in general practice was different. Patients had direct access to primary care and presented symptoms of illness that was often self limiting and often at a very early stage in its natural history. They also presented symptoms that reflected not disease but the human response to a variety of social and psychological problems. The works of Hodgkin,[5] Fry,[6] and myself[7] began to clarify the difference in diagnostic probabilities of disease in symptoms presented at primary, compared with secondary, care. This work also indicated that diagnosis at the level of primary care must include consideration of the many factors—social and psychological—that lead patients who have symptoms of illness to consult a doctor. Important research by sociologists such as Mechanic[8] began to permeate the thinking of general practitioners and to clarify their problems. Before this general practitioners were attempting to apply the diagnostic methods they had learnt in hospital to the problems presented in primary care. These methods were often unnecessary and unproductive, and doctors did not ask the questions that might tell them why this particular patient also presented with this particular problem at this time. They also usually did not have access to laboratory and radiological facilities.

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Doctors were trained exclusively in hospitals

Staff and facilities—Traditionally, general practice had been carried out from the doctor's home. The doctor was usually a man, and his wife was expected to provide support in the day to day running of the practice. In the 1950s a receptionist often provided the only extra resource. District nurses and health visitors were employed by the medical officer of health and were answerable to the local authority, not to the general practitioner for whose patients they were providing care. If doctors employed extra staff to run their practices, such as nurse or a secretary, they did so at their own expense. As a result general practitioners were carrying out tasks that could have been better conducted by less qualified staff. Swift and McDougall,[9] and Hockey[10] some years later showed the advantages of attaching local authority nurses and health visitors to general practices.

Clinical problems—The problems of inappropriate training and staffing presented just two of the challenges faced by general practitioners in the first two decades of the NHS. Many clinical problems coexisted. Pulmonary tuberculosis was still taking young lives; poliomyelitis was a constant anxiety in the summer months. There was no effective treatment for hypertension, schizophrenia, asthma, or depression, and the management of peptic ulcer was bedrest, alkali, and, very often, surgery. The management of heart failure depended on digitalis and painful injections of mersalyl, and rheumatic heart disease was still responsible for many being crippled by cardiac failure. Obstetric care was still largely in the hands of general practitioners and midwives, partly from tradition but also because there were not enough obstetric beds in the hospitals to cope with the postwar baby boom. Most women expecting their first baby were expected to have normal deliveries and had home births. Toxaemia of pregnancy was still a common problem and eclampsia a source of anxiety.

Things begin to change

In 1961 the standing medical advisory committee of the Central Health Services Council set up a special subcommittee to advise on the future field of work of the general practitioner. This was chaired by Gillie and reported in 1963.[11] It described general practice as a cottage industry and pointed out many of the features described in the preceding paragraphs of this paper. In response the government set up a working party headed by Sir Bruce Fraser, to review all aspects of general practice except remuneration. As a result the then minister of health, Sir Kenneth Robinson, entered into negotiations with the BMA, which resulted in the family doctor charter in 1966. This produced changes in the way in which general practice premises could be improved, ancillary staff remunerated, and vocational training introduced. Most importantly, the Treasury provided new money for these developments.

It was a pleasure and privilege to work in general practice during the decade after the charter. So many of the hopes and ambitions, particularly of young general practitioners, had been frustrated by the terms and

conditions of service. Suddenly doctors were able to improve their working conditions, to employ secretaries to type their letters, receptionists to organise appointment systems, and practice nurses to undertake delegated tasks in the surgery. As a result, morale improved and general practitioners began to feel that they were respected by both patients and hospital specialists. Academic departments were established in a number of universities and medical schools, and significant research began to explore in more detail the role of the general practitioner and the knowledge, skills, and attitudes needed by those who aspired to a career in this branch of medicine.

As organisational and clinical advances occurred, it became clear that if full advantage was to be taken of them, a period of vocational training, as described and advocated a decade earlier, would be essential for new entrants to general practice.

Experiments in vocational training, combining hospital and practice appointments, had commenced as far back as 1952 in Inverness and were later developed in Winchester and subsequently in Ipswich and Canterbury. As these courses evolved it became apparent that many of the skills of particular importance to general practitioners, such as communication skills, could not be taught by traditional methods. Led by the now Royal College of General Practitioners and the new academic departments of general practice, research was devoted to studying new teaching methods, and general practitioners became widely accepted as leaders in this academic field. As a result, properly funded vocational training developed rapidly. After considerable debate, the Royal College of General Practitioners introduced an examination for membership, which provided an academic objective for those training for general practice and gave evidence of their achievements.

Research in general practice developed rapidly at this time. In 1976 Hicks documented 420 references to research in general practice that had been published in the preceding decade.[12]

Perhaps the most important development in general practice during these years was the disappearance of competition for patients and its replacement by a spirit of cooperation. This led to the development of rota systems between practices to cover for care out of hours, and also to cooperation in education and training.

At this time rapid advances were made in medical science. Immunisation against poliomyelitis, measles, and tuberculosis were major breakthroughs affecting clinical care in general practice. In ophthalmology the management of glaucoma, cataract, retinal detachment, and diabetic retinopathy was improved. Reconstructive orthopaedic surgery developed apace; hip replacement was followed by knee replacement. Arterial surgery, pioneered in the 1950s, now became commonplace, and early diagnosis by the general practitioner of such conditions as coronary artery disease, aortic aneurysm, and peripheral vascular disease were rewarded by advances in management and prognosis. At the same time gastric surgery was replaced by drugs that were effective in the management of peptic ulcer. Advances in the understanding of immune disorders improved not only the management of diseases but also the outcome of transplant surgery. In psychiatry, the use of depot injections of phenothiazine revolutionised the management of schizophrenia. Cancer, despite advances in surgery, radiotherapy, and chemotherapy, continued to present serious management problems in general practice, and some of the most important advances in the care of patients with terminal disease came from research carried out in the hospice movement.

TOPHAM PICTUREPOINT

The protagonists of the GP Charter of 1966, Sir Kenneth Robinson (far left) and Dr James Cameron (second from right), at a meeting of the Ministry of Health and the BMA

The treatment of many diseases, however, became more complex, with the advent of a multiplicity of drugs for the management of hypertension, ischaemic heart disease, asthma, Parkinson's disease, migraine, and psoriasis, to mention just a few examples. At the same time general practitioners had the satisfaction of being able to manage an ever wider variety of disorders.

General practice comes of age

Many in my generation look back on the late 1970s and early 1980s as some of the happiest years in general practice in this country. We understood our role, and research and education had helped us to solve many of the clinical and organisational problems. Many practised from purpose built premises with teams of other primary care professionals. Recruitment to the discipline was attracting some of the most able graduates.

During this time, the medical schools were becoming increasingly aware how important general practice was in undergraduate medical education, and almost all the universities had appointed a professor of general practice. In many, students were introduced to patients in general practice in their earliest years of training, and in all schools there were clinical clerkships in general practice. Members of academic departments were increasingly involved in curriculum planning, and some chaired the education committees in their schools.

During this decade, research in general practice focused on such issues as the relationship between doctors and patients, consultation skills, the use of time

in general practice, screening, and health education. The need for greater cooperation between primary and secondary care in the management of many chronic diseases such as diabetes was recognised, a variety of experiments in integrated care took place, and the outcome was measured.

Despite all the optimism in general practice, by the end of the 1980s thunderclouds were on the horizon which were to burst with unexpected ferocity in 1990.

The health service reforms

In 1990 a government with a large parliamentary majority introduced major reforms in the ways in which hospital, community, and general practitioner services would be delivered. The thinking behind these reforms was complex. The need for reform was stimulated in part by the increasing cost of the NHS. A combination of technological and pharmaceutical advances and changes in the population was leading to a rapid increase in the cost of maintaining the service. There was also the ideological conviction in government that the introduction of market forces into the service might resolve this problem. The introduction of the split between purchasers and providers—between those providing hospital and community care, and the health authorities and general practitioners purchasing it—set the scene. It was envisaged that trust hospitals, each with a chairman and chief executive, would compete with each other in seeking contracts with the purchasers and thus lead to a reduction in costs.

The reforms in general practice reinforced this concept, with greater emphasis on the importance of capitation payments, in the belief that this would introduce an element of competition for patients. In addition, generous payments were offered for some preventive services, health education, and screening, on the assumption, presumably, that this would introduce a competitive element into primary care. At the same time general practitioners became accountable for many of the services they provided, and this was ensured by regular returns to the health authority, medical audit, and detailed practice plans provided on an annual basis. Some of the larger practices were allowed to elect to be fundholders and were provided with a budget to contract directly with the trust hospitals for secondary care for non-acute services. The budget was also calculated to cover the costs of prescribing and the employment of ancillary staff, including a practice manager. Overall, the reforms reflected the government's general distrust in the profession's self regulation, and this resulted in an enormous increase in paperwork. There was some justification for this distrust because although most general practice in the United Kingdom was of a high standard, some practices were still providing an inadequate standard of care. Unfortunately, neither the profession nor the health authorities had the courage to remedy these defects. New powers devolved to the authorities by the reforms made this possible.

The results of the reforms were variable. In large centres of population, trust hospitals were often in a competitive situation, but as contracts were negotiated on an annual basis, it was impossible for these hospitals to develop strategic plans. In small centres of population, where only one hospital was available to provide secondary care, they found themselves in a monopoly.

For decades general practitioners had had little say in the provision of hospital services, and the new arrangements seemed to offer them an opportunity to identify their priorities. In contracting through health authorities, the situation at first changed little. Fundholding doctors were, however, able to manipulate contracts to the benefit of their patients. Many interesting initiatives were reported, but in some cases these led to a two tier system of care in which patients of fundholding doctors benefited at the expense of others.

In the reforms of general practice, although the government spoke freely about evidence based medicine, they paid scant attention to evidence in planning their reforms. The concept of increasing the importance of capitation payments to encourage competition in general practice was an example. In 1990 most general practitioners were seeking smaller lists in order to improve the services they provided. Few of the screening and health education projects proposed in the reforms were supported by research evidence,[13] and many of them were very expensive and were abandoned within three years. The accountability that was demanded of general practitioners greatly increased the management costs. These were not the only costs, however. The reforms angered a whole generation of senior general practitioners, who, with limited resources, had spent their professional lifetimes attempting to improve general practice. Many began to seek early retirement. The reforms also seemed to deter new recruits, who up to this time had been numerous and of high quality. Above all they destroyed the good will between the government and the profession, hard earned over three decades.

Then and now

It is easy to look back 40 years nostalgically and through rose tinted spectacles. I suspect that I and many of my contemporaries entered general practice with the expectation that we would settle with our families in one area where we would live out our professional lives. Doctors frequently became an integral part of the community and enjoyed many privileges. We came to realise, and some of us to demonstrate by research, that diagnosis, prognosis, and the management of illness in primary care were concerned not just with scientific knowledge, but with understanding the way in which people who have the symptoms of illness respond, and why and when they consult a doctor. We became convinced of the importance of the relationship between doctor and patient and the importance of continuity of care.

Today the situation is very different. Medical graduates no longer see their lives stretching ahead of them in an individual practice in a certain part of the country, seeing a particular population until retirement. The increasing number of women graduates entering general practice demands more flexible working patterns, and this demand is now being echoed by male graduates. The materialistic philosophy of our time challenges the relation between rights and responsibilities. This permeates not just our patients but the

profession itself. The mobility of people, the breakup of families, and a rapidly ageing population are changing the cultural behaviour of our country.

In this situation, can the doctor-patient relationship and continuity of medical care survive? Can electronic machines replace the diagnostic skills that are based on the accumulated knowledge retained in the God given computer in the general practitioner's brain, or the facility for communication in the consulting room that is based on familiarity and mutual respect?

I often refer to myself jokingly as a dinosaur of general practice. As I reflect seriously on this in the context of our current medical and social culture, I am beginning to believe that it is true. The research we carried out and the training we devised in the last quarter of this century may be largely irrelevant to the general practitioners in the new millennium. There is no doubt that doctors will be more comfortable, have more free time and less emotional involvement with their patients, and be protected by their electronic databases. Their patients, however, may sometimes look back nostalgically to the days of the dinosaurs.

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The BMA and the NHS

Charles Webster

Charles Webster is official historian of the NHS. We invited him to look at the relationship between the BMA and the NHS since the NHS's beginnings

All Souls College, University of Oxford, Oxford OX1 4AL
Charles Webster, *senior research fellow*

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The inauguration of the National Health Service and its main anniversaries have been marked by solemn declarations of commitment by the main parties, but these figure less prominently in the collective memory than episodes of dramatic confrontation and interminable negotiations. Still fresh in the memory are the rows with Kenneth Clarke over the 1990 contract and the internal market reforms. Klein called these events "the biggest explosion of political anger and professional fury in the history of the NHS."[1] This was certainly the biggest of the many skirmishes that took place during the recent, eventful 18 years of Conservative government.

The radicalism and controversial character of the government's policies undoubtedly merited strong reaction, but it would be dangerous to conclude that the tangles with Kenneth Clarke were on an unprecedented scale. Indeed, it is arguable that the BMA possesses an unenviable record for assaults against the government of the day on matters great and small. Even periodic pay disputes, such as the one in the mid-1950s that led to the Pilkington commission on doctors' and dentists' pay, or the one resulting in the 1966 contract, were associated with menacing demonstrations of force on the part of the BMA.

Taking the past 50 years as a whole, it is arguable that the most concerted attack by the BMA occurred during the term of office of Barbara Castle, who in 1975 was embroiled in confrontations over pay, both the consultants' and junior doctors' contracts, and, most potent of all, the phasing out of pay beds. On one occasion the secretary of state was kept at the negotiating table from 4 pm to 7 am the next day, a marathon event surely meriting an entry in the NHS book of records.[2]

Summary points

Since the beginning of the NHS the relationship between the BMA and successive governments has been characterised by battles

Over the life of the NHS the BMA has turned full circle, to the point where in the 1990s it vigorously defended the system it rejected 50 years earlier

Now the BMA finds itself in genuine agreement with the government's general approach and most of the necessary conditions for a working partnership now exist

Inauguration of the NHS

None of the above examples bears comparison with the events preceding the "Appointed Day." Kenneth Morgan rightly pointed out that the conflict between the BMA and the government over the shape of the future health service lasted longer than the second world war.[3] The assault by the BMA on the government's plans began in earnest in 1943, and the ceasefire was not declared until a few weeks before the NHS began in July 1948.

As they became adept at shooting down the plans of successive ministers and increasing their control of events, the aggressive appetite of the BMA leadership became ever more difficult to satisfy. This accounts for their fury when Aneurin Bevan came on the scene. He

not only evolved an entirely new plan for the health service and proceeded with the relevant legislation without consultation with the negotiating parties but, after the NHS Act was in place, he proved a determined negotiator, capable of dealing with critics from the many quarters objecting to his plans.

By 1947 Bevan had successfully overcome opposition from the local government associations, the voluntary hospitals, many groups among the consultants, the Socialist Medical Association, and even from enemies within the Labour cabinet. Of the major interests, only the BMA remained unpacified. Although the gap between the two parties narrowed, their relations deteriorated, until in the opening months of 1948 both sides resorted to abuse on a level not witnessed before or since. In parliament Bevan called the BMA leadership "raucous voiced" and "politically poisoned," and he accused them of engaging in organised sabotage of the NHS Act.[4] The BMA leaders responded in like manner, and they were supported in a huge tide of distracted letters, large selections of which were included in the *BMJ* and the *Times*. In these letters Bevan was habitually portrayed as a totalitarian dictator. Similar passions were stirred up on the other side. Weary negotiators from the Ministry of Health showed every sign of shell shock. One of them recorded that the chief negotiator (and future permanent secretary) thought that "the present leaders of the BMA are like Hitler, utterly evil, and that any concession would merely confirm their hold on the profession."[5]

Events soon disproved this gloomy prognosis. The combatants speedily settled their differences, and the health service began on 5 July 1948 in an atmosphere of tranquillity. Overnight Bevan was transformed from totalitarian monster to charismatic leader, and everyone was keen to be impressed. This reputation has persisted, and such miscalculations as his tactless handling of the BMA have now been largely forgotten.

Fifty years of mutual distrust

Looking back on the acrimonious negotiations of the 1940s, it now seems incredible that trivial differences over the extent of availability of the basic salary, the legal status of partnerships, or arrangements for disciplinary tribunal appeals could ever have justified the fury of the reaction orchestrated by the BMA leadership. One is forced to the conclusion that the parties were separated by more genuine and deep seated differences, for which these technical issues acted as surrogates in dispute. This mutual lack of confidence has plagued the NHS ever since its inception.


Evening Standard

The BMA ballot result shows an overwhelming majority against the Bevan plan

THE DOCTORS SAY 'NO'

'NOT SO MUCH A LANDSLIDE AS AN AVALANCHE'

86pc are against serving: 89pc against present plan

Noreen Winkless leaves police HQ

STATE JOBS— £293,350

Attlee records salaries of nationalisation chiefs

Royal silver wedding at St. Paul's

Elizabeth and Philip in car crash

JOHN FROST COLLECTION

The sources of these deeper tensions are best manifest with respect to the status of the general medical practitioner, always one of the main focal points for medicopolitical conflict. The BMA has tended to fear that governments are motivated by a hidden agenda; accordingly, their natural reaction is to adopt a defensive posture and divine sinister motives behind any scheme emanating from official sources. For its part, the government has generally regarded the independent contractors as anomalous players, liable to run away with the scarce resources of the health service, and therefore treated them, at best, as potential delinquents. This atmosphere of mutual suspicion has, of course, not been conducive to the best interests of the health service, and until recently it has prevented the development of primary care achieving the priority it deserves.

The discord of the 1940s left its direct mark for more than a generation. The sources of tension are not difficult to detect. For example, the chairman of the BMA Council in 1948 accused Bevan of trying to establish a "whole-time State Medical Service," and he confirmed that the BMA was unrepentant over its advocacy of a health service based on the old National Health Insurance system.[6] Bevan took the BMA at its word, and the government's plan for unifying the health service in each locality was scrapped: under the executive councils of the NHS, independent contractors were allowed to continue the National Health Insurance form of administration, but at the price of isolation from the rest of the health service. General practitioners were thereby dispatched into a professional wilderness, and morale suffered accordingly. The Ministry of Health preoccupied itself with punitive controls, and for no sound reason it even imposed a moratorium on such potentially constructive developments as health centres.

It was therefore entirely predictable that general practice would drift into a state of crisis. The breaking point duly arrived in the mid-1960s. On this occasion, greatly to the credit of the BMA leadership and the health department team led by the minister Kenneth Robinson, a new accord was reached. The family doctor charter and the 1966 contract satisfied basic grievances and included sufficient inducements to provide general practitioners with a new sense of professional purpose.

Reorganisation of the NHS, which also reached the agenda in the 1960s, offered a second chance for the BMA to play a more constructive role. On this occasion, however, the doctors again became the victims of their bunker mentality. Although it had helped to launch the whole reorganisation process by its participation in the Porritt exercise, the BMA first lost confidence in the Porritt proposals and then attacked them when they emerged in the form of the 1968 green paper on NHS reorganisation. For the remainder of the reorganisation process, the BMA played a predominantly negative role, as in the 1940s, attacking each scheme for reorganisation as it came along. Predictably, following the course of 1948, the

BMA successfully resisted local government control of the health service or the functional unification of health authorities at the level of a locality. With respect to England and Wales, the BMA secured perpetuation of the National Health Insurance form of administration and, thereby, the continuing isolation of the independent contractors under the new family practitioner committees.

This issue exposed a split between London and Edinburgh. The Scottish BMA, which was by this time completely relaxed about integration, willingly abandoned the protection of a separate family practitioner committee. The detrimental effect of the English and Welsh arrangement for the health service generally and for primary care in particular was highlighted by a variety of reports, most influentially by the Harding committee[7] and the Merrison royal commission.[8]

By this stage most of the traditional fears concerning a state medical service were largely irrelevant, but the regional and area health authorities of the 1974 structure were subject to the same kind of demonisation. Consequently, when the Merrison royal commission on the NHS came down on the side of widely supported demands for assimilation of family practitioner committees and area health authorities in England and Wales, this was contested by the BMA and its allies.[9] On this occasion, to its discomfort, the Conservative government conceded to the BMA and agreed to even greater statutory separation of the family practitioner committees, which represented the course of events followed in the 1980s. This victory confirmed that Bevan's state medical service could be completely stripped of its threatening features and be rendered innocuous, even congenial, to the BMA.

The wheel turns full circle

During the 1980s the BMA had even more reason for satisfaction on account of the immunity conferred by the family practitioner committees against such draconian measures as cash limits and the Resource Allocation Working Party. However, the BMA had merely constructed a fools' paradise. From 1979 onwards it was evident that the ramshackle bureaucracy of the health service represented a compromise at odds with the ideology of a government that had fully absorbed the BMA's discarded hostility to a state medical service. To their cost, neither the BMA nor the medical profession more generally took sufficient account of warning signs of the Thatcher government's hostile intentions towards the existing health service. The BMA and its associates undertook no prudential defensive measures. They neither mounted an equivalent to the Porritt exercise nor any other plan for sustaining the crisis ridden health service.

Their input into the government's confidential review of the health service in 1988 was therefore minimal. Indeed, this exercise was treated with a degree of complacency that is now difficult to understand. It seems that the royal colleges of physicians and general practitioners even failed to make submissions. The other medical submissions were characterised by complacency concerning the maintenance of the status quo. The BMA was, in fact, one of the more energetic petitioners. Its evidence discussed the merits of the internal market, but it failed to address the issue of self

TOPHAM PICTURE SOURCE

Former and future ministers for health: Aneurin Bevan and Barbara Castle in 1951. The BMA battled memorably with both

governing hospitals or most of the other major changes which the white paper *Working for Patients* advocated.[10] With respect to the behaviour of the BMA, the review process closely followed the pattern of the past. As with the overhauls of 1948 and 1974, the government was left to take the initiative, but its schemes were treated with suspicion and subjected to a campaign of destructive criticism.

Paradoxically, over the life of the NHS, the BMA has turned full circle to the point where, in the 1990s, it has vigorously defended the system that it had decisively rejected some 50 years earlier, just as in the 1940s it defended the National Health Insurance system that it had rejected in 1911.

This ideological shift possesses singularly fortunate consequences for the current Labour government. For the first time in the history of the modern health service, the BMA finds itself in general agreement with a government's general approach towards overhauling the health service. Both sides reject the internal market and seek a return to the broad principles of 1948. For the moment, the BMA detects little evidence of a sinister unstated government agenda, while the government has taken the unprecedented step of placing primary care professionals in the driving seat of the new system. For the first time this century the BMA and government have established most of the necessary conditions for a working partnership. If this could be consolidated, the NHS looks set to approach the millennium in a better sprit of harmony than has existed in its entire existence.

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As others see us: views from abroad

A rational bureaucracy in a civilised society

Christian M Koeck

Koeck, Ebner, and Partners, Parkring 12A/4, A-1010 Vienna, Austria
Christian M Koeck, *president*
ckoeck@compuserve.com

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Psychoanalysis is among the most important contributions to civilisation made by Austria. Sigmund Freud's theories about the structure of the human psyche and the unconscious have changed the way we look at ourselves and society. Among the most central concepts of his theory is the notion of ambivalence. This is probably the best word to use to describe how the NHS is viewed in Austria; the spectrum of opinion on the NHS ranges from praise to harsh rejection depending on whom you ask.

On one end of the spectrum are the average doctor, health policy maker, and professor in a medical faculty. Ask them about the NHS and you will most likely hear critical remarks—ranging from stories about poor care, long waiting lists, a lack of access to care, and a shortage of advanced technology to outright rejection of the NHS model, based on claims of inhumane rationing and the exclusion of the elderly and the very sick from the benefits of modern health care. The factual basis of these judgments is not entirely clear. It is most likely that stories such as those about child B (an 11 year old girl with myeloid leukaemia who was denied a second transplant operation by the local health authority) and about age limits for treatment options such as transplant operations and dialysis have left (independent of the actual facts and circumstances) a lasting impression among doctors and health policy makers. They have come to view the NHS as a system which is in desperate need of extra money and compassion for those who most need care.

Arguments about comparable health outcomes and lower costs will, not surprisingly, make little impression on the critics. Explicitly withholding care from patients is not acceptable in Austria. It is not that rationing does not happen here; it happens here as much as anywhere. However, and Freud again offers useful explanations for phenomena like these, the mechanism of collective repression is at work. After all Austria is one of a few countries which—at least in the eyes of the public and the health profession—still (and in my view wrongly) believes that access to optimal health treatment is a right which societies should offer regardless of cost. The notion of rationing as inevitable and as it occurs in reality is widely ignored, and attempts to discuss these issues in public are futile, even though rationing is acknowledged and discussed privately.

HULTON GETTY

Rational, communal, civilised

Summary points

- Sigmund Freud's concept of ambivalence best characterises Austrian attitudes to the British NHS
- The average Austrian doctor thinks of an NHS of inhumane rationing and exclusion of elderly and very sick people from the benefits of modern health care
- Health economists see the NHS as a successful attempt to deliver a scarce resource in a rational, communal, and civilised way
- Despite (or perhaps because of) its centralisation, major change in the NHS is implemented remarkably swiftly

At the other end of the spectrum are the health services researchers and health economists. Ask them about the NHS and you will get a very different picture. In their view, the NHS is one of the most exciting and successful attempts organised by a government to deliver a scarce and crucial societal resource in a rational, communal, and civilised way. The architects of the system understood that access to high quality health care should be a central goal of society. But they were also realistic and wise enough to understand that there are limits to what a society can offer. The provision of health care is only one of many competing political goals, only one of many benefits that society should offer, although it should be a high priority. With increasing costs, the opportunity costs (that is, the cost of using resources for a certain purpose measured in terms of the benefit lost by not using them in a different way) of spending on health care increase as well. If our societies are also to achieve other goals (such as education, protection of the environment, or retraining unemployed people) a universal right to whatever health care is technically feasible is neither possible nor desirable. Financing the British system through taxation and making spending decisions part of the general budgeting process has allowed Britain to design and implement a healthcare system which, at least in theory, provides a useful structure for strategic planning, goal setting, policy implementation, and healthcare delivery in an open and transparent way within strict budgetary limits. Together with this organisational structure come many other desirable features of which other countries should be envious,

such as gatekeeping, the central role of the general practitioner in providing health care, population based financing, and a strong emphasis on primary care and public health.

As a student of organisational behaviour, I am also interested in another important characteristic of the British system: the centralisation of decision making. While many other countries, such as Austria, have been struggling for years and sometimes decades with healthcare reform, the NHS has undergone dramatic change within a very short time. The speedy implementation of internal markets and the split between purchasers and providers, in a system that has always been viewed as centralised, bureaucratic, and—in the eyes of our colleagues in the United States—the best example of socialised medicine, has surprised observers around the world. Independent of an individual's assessment of the outcome of reforms to the NHS the swiftness of their implementation was stunning and proof of the fact that a central and strong political bureaucracy is necessary to achieve such swift and major changes.

Where does this leave us in the Austrian assessment of the NHS? Those of us who believe that access to care is easier in Austria are probably right. It should be easier. Austrians spend about 40% more of their gross national product on health care than Britons, although we do not know what additional benefits we get. Those who feel that the NHS is a wonderful example of a communal effort to organise the distribution of a scarce resource in an accountable and open way are also right. It is a system that is able to address crucial issues in a timely fashion such as rationing, how to measure outcomes, how to practise evidence based medicine, how to manage competition, and how to implement spending limits. Most of all the NHS has been a wonderful laboratory for healthcare reform and experimentation in healthcare delivery. In a field that is rapidly changing and where far too often yesterday's answers are given to tomorrow's questions, one can only admire the optimism and entrepreneurship displayed in the running of the NHS. In the past few years it has been one of the leading influences on the restructuring of health care in developed countries.

But most importantly with the existence of the NHS Britain passes a crucial test for any civilised society; in psychoanalysis maturity can be defined as the ability to see and deal with reality as it is. Scarcity of resources and the inevitability of rationing are facts no nation can ignore. Some governments have chosen to repress questions of rationing, others have made the individual responsible by privatising the financing of health care or the financial risks of disease. Britain has stood by its choice to accept the public's responsibility for offering health care to all within financial limits agreed on through a democratic process. The NHS has proved that it is an organisation able to handle such a formidable task. One can only congratulate the NHS, wish it a happy birthday, and wish it good luck in the next 50 years.

A great leap for humankind?

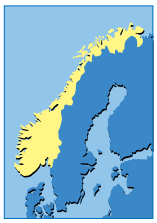
Steinar Westin

Technological milestones, like Neil Armstrong's first step on the moon, are easily visible and readily celebrated. This is not so with the introduction of new ideas, such as the ideas and political thinking behind the British National Health Service. Fifty years on, is it worth celebrating and is there enough left to celebrate? Here is a view from Norway.

We need to consider whether the Beveridge plan and the War Cabinet's ideas leading up to the 1948 NHS reforms were unique to Britain. Of course not, although the idea of a publicly financed health service available to all according to need, was truly a revolutionary thought, possibly of greater importance to most people in Europe than Armstrong's step on the moon. Universally available health care was soon to become a cornerstone of the emerging welfare states in postwar Europe, not only in Britain. Indeed, some of the well reputed Dutch health services can be traced to measures implemented by the Germans during the occupation. The political ideas on how to provide health services were "ripe" at that time, some would say as a result of the labour movement's influence during the 1930s, softened and mellowed by wartime sufferings.

Summary points

- A publicly financed health service available to all according to need grew out of the labour movement earlier this century, and examples were implemented in several European countries after the second world war
- Views of the NHS from abroad include high professional and intellectual standards in spite of meagre resources
- The spirit of British general practice continues to influence doctors and healthcare providers worldwide, even the recent decision in Norway to move to a list based system
- In spite of recent turmoil, some traditional NHS values seem to remain deeply rooted in the thinking of British doctors, so let us celebrate these 50 years



Department of Community Medicine and General Practice, Norwegian University of Science and Technology, Medisinsk Teknisk Forskningssenter, N-7005 Trondheim, Norway

Steinar Westin, *professor*

steinar.westin@medisin.ntnu.no

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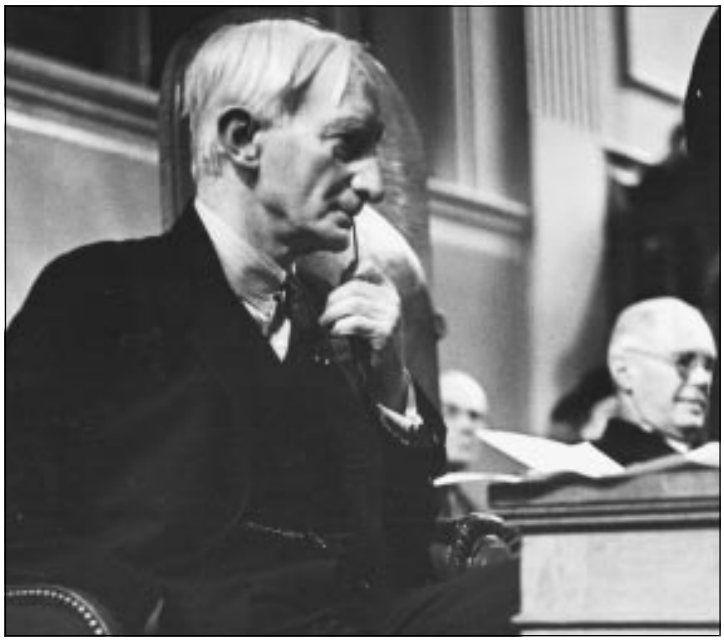
Setting the standard for primary care

Yet, there has been something special about the NHS, even when seen from abroad. The vigour with which the reforms were introduced certainly inspired the Scandinavian countries (although we have heard that there were British doctors escaping to Australia to avoid them). Three features have been part of our



HULTON GETTY

Sir William Beveridge, architect of Britain's welfare state

beliefs about the NHS: a high professional and intellectual standard amidst rather meagre hospital resources, the lasting principle of providing health services "free at the point of use,"[1] and patient registration with general practitioners. The last two features are obviously interrelated and make Britain one of three European countries—the Netherlands and Denmark being the others—to practise a personal doctor system at the primary level.[2] Iceland, too, may be seen as part of this "premier league" of general practice, since all other European countries have less strictly organised health services, with patients often "shopping" between doctors and many specialist health services being in the first line of care. Among internationally oriented general practitioners there is general agreement that, for exemplars in education, research, quality, and professional standard in general practice, you look to Britain (or to Denmark or the Netherlands).

In fact, there have been some good opportunities to do so. The British television series *Peak Practice* proved to be another of those well acted British series so loved by Norwegians. Dr Jack Kerruish and "the country doctors" (its Norwegian translation) at Cardale have provided some deep insights into what general practice is all about, as well as an update on what might happen in a practice subject to healthcare reforms. Some of us learned a lot about fundholding and British general practice as part of the NHS in these colourful, dramatic, and humanely warm episodes. (By coincidence, the American series *Chicago Hope* has also been shown and shows a strikingly different approach to health care at all levels and, to me, provides another reason for celebrating the values of the NHS.)

There are, of course, other countries to be inspired by. But seen from Norway, the ideology underlying the British NHS and British general practice has had a longstanding influence and is one factor behind the recent parliamentary decision to move to a list based system in Norway.[3] Indeed, registration of patients with a general practitioner may be coming in vogue again, since, apart from providing continuity of care, it seems to be one way of curbing the uncontrolled rise in healthcare costs.[4] It may certainly be a better alternative to what we see in other parts of the world, where rising healthcare costs have caused governments to throw in the towel and leave the problems to market forces.[5] Needless to say, the market just isn't nice to the poor, and the NHS is still a model for providing universal health services according to need rather than according to wealth.

Challenges to the system

However, there have been alarming reports to the contrary.[6 7] The fundholding reforms of the Thatcher government made some predict the end of the seasoned ideological foundations of the NHS. "Where there were formerly one hundred nurses, there are now one hundred economists," was a saying heard among British doctors, and the relatively low administrative costs of the old NHS have indeed been replaced by increasing costs for negotiations, managing contracts, etc.[7 8] Market thinking and the metaphors of commodity production seem to have entered the health services on a large scale, and Julian Tudor Hart, the internationally known general practitioner and thinker, wrote about the two paths to health services—either to look at health services as a public responsibility and a human right on which any other market driven economy can flourish, or to let the market transform patients to consumers and health services to market commodities and thereby return to a more primitive state of civilisation.[7 9]

However, in spite of the internal market reforms, the principle of providing free care at the point of use has not been affected. We have read in the *BMJ* that, however tempting it might be to introduce user charges in a grossly underfunded healthcare system, British general practitioners declined to "become the unpaid tax collectors for a government too cowardly to do the job itself."[1] This is in contrast with what often happens in Norway: when negotiations between the government and the medical association over fees and salaries become difficult, it is agreed to bleed the third party not present at the negotiating table, the patients, with increased user charges,[3] rightly characterised as another "tax on the sick and the poor."[1] Hence, there are still some traditional NHS values deeply rooted in the thinking of British doctors.

It is also true that when the NHS is subject to any major changes, as with the internal market reforms, it is watched with interest in other parts of the world. In Norway it inspired a debate some years ago, in which phrases such as "refreshing views," "new solutions," "modern management," etc, were used. It may be that Norway was too slow to really catch the ideas. New Zealand, Sweden, and some other countries did, with questionable results.[10 11] Recently, the former Norwegian minister of health, Dr Werner Christie, summed up the present state of Norwegian health care as having become modern again by "not changing to narrow ties."[12] He predicted that the vogue for competition and the internal market may already be in decline, and managed cooperation, somewhat like that in the NHS in the old days, may again become fashionable.

That is Norway, however. Tony Blair will have to deal with these issues in Britain. Whatever he does with the NHS, it will be carefully watched from abroad. In the meantime, we join our British colleagues with our congratulations: the NHS is certainly worth a celebration.

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The importance of social context

Judy M E Lim

The NHS is in a reflective mood today and rightly so. The comprehensive "cradle to grave" care envisioned by the architects of the NHS in 1948 has been called the most socialist achievement of the Labour government of that era. Indeed, being 85% funded from taxes, free at point of use, and accessible to all, it may be seen as the part of Britain's welfare system that goes the furthest in the direction of welfarism.

In May 1981, the then Minister for Health in Singapore declared that a cradle to grave health system was not for Singapore; K H Phua surmised that the "objectives of the restructuring programme were to avoid the problems of a welfare state system such as the British NHS."[1] In his 1996 National Day speech, Prime Minister Goh reiterated this point: "People often want the government to assume the full burden of the cost of medical care and provide treatment free to Singaporeans. Because of the painful lessons learned in other countries we have not done this. All the countries which have done this—Britain, France, Germany, Canada, and Communist China—have failed. Their systems break down as people overuse so-called 'free' health care, which they actually pay for indirectly through higher taxes. Their health services deteriorate. Waste and inefficiency become endemic. Now these countries are forced to cut back on services, introduce cost controls, and reform the system."

Has the NHS had an influence in Singapore?

The NHS depends on the collective role of society, whereas the emphasis in Singapore is on individual responsibility, coupled with government subsidies to keep basic health care affordable.[2] The main tenet of the NHS is to make available a comprehensive health service on the basis of need and not the ability to pay; Singapore's main concern is that an ostensibly "free" health service promotes overuse and escalating healthcare costs. To move away from the welfare model, Singapore encouraged both free market strategies and individual responsibility. The former led to the development of private hospital care and the corporatisation of government subsidised hospitals. The second point, individual responsibility, is the cornerstone of Singapore's system.

Summary points

If the NHS depends on the collective role of society, the emphasis in Singapore is on individual responsibility

Singapore's politicians worry that an ostensibly free service promotes overuse and rising costs

Singapore therefore relies on compulsory savings to fund health care, together with copayments, in a system that rewards patients for staying well

In 1983 Singapore implemented a compulsory savings model extending Singaporeans' contributions to the Central Provident Fund, a national savings plan for retirement, to the payment of medical services. The Medisave programme consists of 6-8% of employers' and employees' mandatory contributions to the Central Provident Fund. People can use their individual accounts to pay for health care in both the public and private sectors. Medisave contributions are tax free and can be passed on to one's heirs. People are encouraged to use their Medisave funds wisely, as it is their own money. They can also utilise the funds to cover spouse, parents, and children. Copayments and deductibles ensure that there is a considerable up-front payment.

Rewarding the individual for staying well decreases state expenditure on health care and also reduces the unnecessary provision of services because patients have a direct stake—what is not spent remains in their own accounts—unlike third party insurance premiums. Administrative costs are minimal, as the infrastructure for the savings programme was already in place; the overhead costs of the Central Provident Fund are less than 2%. This compares favourably with the estimate of 5% for administrative costs in the NHS.[3] With each generation paying for its own bills, the intergenerational problems associated with tax based funding would be largely eliminated as well.

Medisave has further evolved to include a component of insurance for catastrophic illnesses and long term treatment called Medishield. Every citizen or

Economic Development Board, 250 North Bridge Road #24-00, Raffles City Tower, Singapore 179101

Judy M E Lim, *healthcare services adviser*

judylim@pacific.net.sg

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permanent resident can choose to opt out of this scheme. The premiums are low as they are purchased by the government on behalf of the population and paid for directly from the individual's Medisave account. In addition, to provide a safety net for those who fall through the cracks of the scheme, each public sector hospital has access to a tax based fund called Medifund. Interest from the fund is dispersed in cases evaluated by social workers when Medisave has been exhausted and patients cannot pay. Most cases are approved.

In contrast, the NHS has been committed to a medical service that is free at point of use, although it has deviated from this in a few important ways. The establishment of prescription charges is the clearest example. A symbolic one shilling payment in 1979 is now one of 5.5 pounds. Though most patients are exempt, and 80% of prescriptions dispensed free of charge, many people find it cheaper to buy their prescription drugs over the counter.[4]

There is also a key difference in the provision of health care by private and public sectors in the two systems. The NHS provides almost all the primary care, which functions as the gatekeeper to secondary and tertiary care. When Singapore achieved independence in the 1960s it had other nation building priorities, such as public health, defence, transport and communications, building and construction. Although the government still operates polyclinics to meet the need for primary care in lower income groups, the private sector has been encouraged to grow and develop and now accounts for 75% of all primary care.

For inpatient care in Singapore, patients select private hospitals primarily because of a particular specialist or the more personalised service available, rather than because of longer waiting times in public hospitals. The different classes of wards in public sector hospitals attract different levels of subsidy which correspond to different levels of amenities such as room size, number of occupants, and air conditioning. Similar services are provided in the wards, except for a few highly expensive, non-essential procedures which are not subsidised and thus available only in wards of the highest class. Clinical treatment is of the same quality, regardless of class of ward. Luxury of choice based on ability to pay has been criticised in Britain but it is a fact of life in Singapore.

TOPHAM PICTUREPOINT

The NHS is the part of Britain's welfare system that goes the furthest in the direction of welfarism

Aspects of rationing

Rationing is another area that concerns planners in both countries. Singapore has continually emphasised the concept of a basic medical package, explicitly excluding non-essential services such as cosmetic surgery and in vitro fertilisation. Similarly, these are not covered by some health authorities in Britain.

Rationing is inevitable if both systems are to survive. Singapore accepts rationing as a bald necessity. The NHS continues to debate the form that rationing should take even while rationing on a massive scale. Donald Light has observed that the NHS rations by delay to get on waiting lists, and on the waiting lists themselves, and then with the further wait after an appointment has been made.[5]

Rationing the supply of medical staff is something that both countries do. Studies have shown that countries with more doctors, especially specialists, tend to spend more on health care. The Singapore government regulates the overall numbers of doctors and specialists. It also plans the total number and proportion of beds to be built in subsidised hospitals and regulates the mix of private and subsidised hospitals. Such central control is also exhibited by the NHS, which rations by undersupplying staff and facilities. The near monopoly of the NHS limits the consumers' choices for optimum care, which may explain the growth of the private healthcare sector in Britain. The greater latitude of the Singapore system allows individuals to use their Medisave accounts in both the public and the private sector.

Singapore's system is working well

The Singapore model has worked for Singapore. With healthcare expenditure at 3% of gross domestic product,[2] health outcomes are comparable with those of other industrialised nations, as is patient satisfaction. There are caveats, however: Singapore's favourable economic situation, rather than specific policies, may be the primary reason for its success in health.[6] Though it is difficult to compare figures on consumption and expenditure for countries with widely differing systems, Singapore's system is clearly working well in its unique social context of strong family support, a savings mentality, and low unemployment.

With 50 years of history behind it, the NHS is moving with the times and re-inventing itself for relevance in the new century. NHSnet, which promises to link hospitals with general practitioners and pharmacies, is an important step. A city like Singapore that aspires to be totally wired up in the next millennium would do well to take the cue from the NHS in tapping the power of information technology for better health care.

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Justice and health care in a caring society

Grant Gillett

Summary points

The ideal of access for all to excellent health care marks a society that accepts a role in caring for its citizens

The principle of liberty is tempered in a welfare liberal society by a "principle of difference," which moderates the advantages to privileged individuals by ensuring that any change also improves the lot of the least advantaged

Thus whatever the inequities of society, the NHS ensures access to health care as a basic right

Publicly funded health care in New Zealand is under threat from a belief that health care is a private good, not a community good

Department of Neurosurgery, Otago Medical School, University of Otago, PO Box 913, Dunedin, New Zealand

Grant Gillett, *professor in medical ethics*

grant.gillett@stonebow.otago.ac.nz

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Concept of a national health system

The NHS was founded on the idea that every person, regardless of wealth or position, would have access to excellent health care. The ethical position expressed in this idea is the kind of commitment that one finds in a society that accepts a role in caring for its citizens. This ethical intuition we could call the "caring imperative," recognising that it is the hallmark of a civilised society. When we look at the underpinning of such a commitment in political philosophy it is found to rest on a judicious balance of liberal concern for individual autonomy and property and a Marxist concern for social justice.

Such a liberal position on welfare accepts the liberal economic principle—respect for personal choice and the right to disposal of income according to individual preference—but also accepts that the individual owes some dues to the community as a whole. One might justify this attitude by appealing to the fact that a society is given its character by the participation of all those who share in creating it, however small their contribution may be. In fact, most of us want to live in a society where the caring imperative operates and the good health of the citizens is thought to contribute to the wellbeing of all. Health care, from this view, is a public good in that its benefits are shared rather than exclusively individual or private (although they also directly benefit the individual). Without a national health service the burden of illness falls on those who suffer the unpredictable vicissitudes of life, and the implicit laissez-faire attitude to the resultant suffering both represents a deterioration in the overall quality of society and exposes individuals to the risk of being caught out by the cruel chances of disease and injury.

Holidays, housing, and health

The principle of liberty, whereby an individual is maximally free to pursue his or her own projects to the extent that they are compatible with the projects of others, is, according to John Rawls, tempered in a welfare liberal society by a "principle of difference," which has the effect of moderating advantages to privileged individuals by ensuring that in any change in a system the lot of the least advantaged individuals is also improved.[1] This tends to cause changes to be tolerated because all allowable changes advantage, to some extent, the least advantaged individuals. That tolerance is going to vary, however, according to the area of social justice involved. In relation to exotic holidays, poor individuals may tolerate huge inequities, but we would expect less tolerance of inequities of housing such as to cause real suffering and even less tolerance of gross inequities in health care. The idea that the children of poor families would die in circumstances in which the children of rich families would live is deeply unacceptable to a wide range of people. The NHS has an important role here in that the treatments made available by its centres of excellence are, ideally, dispensed without favour in terms of wealth or privilege. That means that, whatever inequities exist in society, the access to treatment for genuine and pressing health needs is treated as a basic right of all.

The erosion of such a system occurs when the caring imperative is overridden by ideology. Such an ideology might emphasise the need for a nation to make progress—for example, in military-industrial terms—and not dissipate its wealth by attending to expensive individual healthcare needs. It is more common in the Western, post-Thatcherite, scene for the caring ethos to be eroded by an ideology that espouses narrow economic individualism and loses sight of the idea that health is a public good. The social and public health horrors of the 19th century are a direct result of such economic individualism.

We can also note with some satisfaction that the conduct of research and the development and careful assessment of innovative treatments are enduring features of an adequately funded public health system but are somewhat less reliable as a source of unbiased knowledge in private or economically driven enterprises. The reasons for this are not difficult to discern. A publicly funded system generally offers less in the way of pure financial rewards to those who work in it, and it trades to some extent on their moral commitment to good health care. Such individuals are likely to seek other satisfactions, such as those arising from academic and professional achievements. It is this motivation that lies behind impartial research and the careful assessment of innovative treatment. It is a virtue of the NHS that ordinary people can see and be treated by some of the foremost international experts in the diseases that affect them. This alone is worth fighting for and can come about only by continued adequate funding for research and development and the striving after excellence throughout the service. Some of these

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Balancing concern for individual autonomy with a concern for social justice

aspects of NHS care are directly threatened by recent funding initiatives.

This internal ethos itself, however, sometimes poses a problem in that academic and professional motivations may become divorced from the caring orientation of medicine so that the NHS can present a very daunting face to those for whom it cares. Individual concern and continuity of care are, on occasion, swamped by the impersonal structure and sheer size of the healthcare enterprise. This can lead some patients to opt for an alternative type of health care that is associated with the idea that health is a private good.

Public-private mix

The coexistence of two tiers of health care is often a bone of contention among healthcare theorists. It is argued that it is intrinsically unjust for wealthy individuals to have access to a level of health care that is denied to those dependent on public provision. But this is a hard claim to press, because it implies that whereas we would allow a person to purchase a bigger car, a home entertainment set, or a trip to the Bahamas, we would not allow them to spend the same amount of money on a hip replacement. In fact, the expenditure on health care from private funds tends to ease the lot of those dependent on the public system and produces an advantage for all, and so its prohibition seems to violate both of Rawls's principles of justice. There are, however, some reasons to worry about a two tier system. Firstly, the vocal and educated middle class need not rely on a public system, and this could result in a gradual erosion of standards compared with the private system. This would be particularly worrying if the members of government and those entrusted with the funding and conduct of the public system were to rely widely on the private system; perhaps policymakers should be required by law not to have private medical insurance. Secondly, the experienced specialists who could work in both systems might be induced, by greater financial rewards in the private sector, to allocate their time in an unjust way. Thirdly, the availability of new and expensive treatments in the private but not the public sector may mean that an intolerable gap does open up between the health care available in each system.

How to destroy a health system

Publicly funded health care in New Zealand is currently under a very real threat from ideologically driven government bodies. These bodies are obsessed with the idea that our publicly funded health system, despite delivering care comparable to care anywhere else in the world at a very low level of funding from the gross domestic product, is inefficient and constantly threatens to consume more and more of the tax dollar. The further political agenda seems to be a conviction that health is, in fact, a private good and not a community good and should be funded in the same way as other commodities. This is combined with a heavily bureaucratic and managerial system of healthcare administration, which wrests decision making out of the hands of its traditional guardians —elected boards and experienced healthcare professionals.

No evidence exists at all that this experiment in healthcare delivery has improved the health of the population beyond the levels that would have been achieved in any event and some evidence exists to the contrary. A recent major public inquiry has identified funding policy and hospital management policies as having a major role in a number of deaths in one of the country's largest public hospitals.[2] Despite this, the ideologues driving the "New Right" changes in healthcare delivery seem to be undeterred. The guilty parties are unable to see beyond the dogmatic application of heavy handed, top down management and strict financial accountability for all healthcare interventions. These have several effects. Firstly, they demoralise senior healthcare professionals and strip them of any elbow room to make careful clinical judgements about the vast range of different situations they meet in practice. Secondly, they tend to standardise treatment at a barely adequate level and stifle attempts at innovation that do not wear their budgetary credentials on their short term sleeves. Thirdly, they devalue the services that are hard to quantify, such as community based care and preventive care.

It is to be hoped that these dangers are seen and avoided before Thatcherite changes destroy the equitable high quality healthcare services that a system such as the NHS has fought hard to put in place.

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A social experiment that keeps adapting

Peter J McDonald

Australia's health system has its historical origins in the United Kingdom. Up until the implementation of the NHS, the Australian healthcare system mirrored the British system. The General Medical Council of Great Britain accredited Australian medical schools until the Australian Medical Council was formed in the 1980s; Australian postgraduate medical training is provided through "royal colleges"; the Australian Medical Association emerged out of the BMA in the 1960s; the public health and hospital systems of Australia are modelled on their British counterparts; and the overall organisation of health services revolves around the pivotal role of the general practitioner.

Formation of the NHS was a defining event for Australian health because of the Australian decision not to follow Britain into a nationalised health system. Though Australian health systems are built on the British model, they have evolved into an Australian version that is currently known as Medicare. The principles of Medicare are similar to those that underlie the NHS—namely, equitable access of all citizens to government funded quality health care—but the current Australian systems of healthcare organisation and funding bear little resemblance to the NHS. In Australia most medical services are provided by private general practitioners and specialists on a fee for service basis that is indemnified by Medicare; public hospitals provide open access to all citizens at no cost beyond the universal taxation levy for Medicare; there are "private" hospitals for those who have private health insurance (about 30% of the population); and pharmaceuticals are supplied at marginal cost to the citizen through a government subsidised pharmaceutical benefits scheme.

Why the systems are different

Given that Australia has a British health heritage, it is interesting to speculate on why the British NHS and Australian Medicare systems of health care delivery are so different. The NHS was established under a socialist Labour government as a strategy to promote access to essential health services, particularly primary care; the NHS was firmly driven by government. At the same time as Britain was creating the NHS, Australia entered the Menzies era of liberal-conservative politics and unprecedented economic and population growth. Health in Australia was largely left to the medical profession. In this era Australia gained "independence" from British health by establishing "Australian" training colleges, an Australian Medical Association, and an Australian health orientation that increasingly turned to the United States for postgraduate training, research, and guidance in development of the health system.

Much of this Australian independence was promoted among the medical profession by a desire to avoid the NHS style of social health, which brought the perceived evils of capitated payments, budget holding, and government rationing. Migration of doctors from Britain to Australia was a critical factor in establishing the excellence of Australian training and education systems and also provided an opportunity for refugees from the NHS to participate in shaping Australia's health systems. Doctors rather than politicians were responsible for shaping Australia's health systems in the 1950s and 60s and all was well (for the doctors) until Australia elected a socialist labour government in 1975. This socialist government introduced a national health system that followed the same principles that underpinned the NHS but chose to fund practitioners on a fee for service basis and allow citizens the freedom to select their provider without needing to register with any particular gatekeeper. Australia is now facing a

Summary points

- Australia did not follow Britain into a nationalised health system
- The priniples of the Australian Medicare system are similar to those that underlie the NHS: equitable access for all citizens to government funded, quality health care
- Doctors, rather than politicians, shaped Australia's health system in the 1950s and 60s; they sought to avoid capitated payments, budget holding, and government rationing
- Renewed interest in the NHS arises out of the need for reform of health care in Australia
- Privatisation and commercialisation have been used to force efficiency and reform in the public health system, with varying success and limited savings

SA HealthPlus,
PO Box 65,
Adelaide, SA 5000,
Australia
Peter J McDonald,
director

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Promoting access to essential health services: a tram advertises Glasgow's campaign against TB


News Chronicle
LATE LONDON EDITION
RED ARMY GRIP TIGHTENS ON 20 TRAPPED AXIS DIVISIONS
Insurance for All: £2-a-Week Pensions: Free Medical Care
10,000 Gestapo Spies Watch Italians
A NEW MINISTRY
ALLIES REACH COAST NEAR GABES, AXIS LINE CUT, SAYS RADIO
JOHN FROST COLLECTION

Britain's welfare state was designed while Britain and her allies were fighting their way through the second world war

health crisis in terms of costs, effectiveness in delivering outcomes, and difficulties in coordinating multiple services around patients' requirements. These problems are compounded in specific populations (indigenous Australians, poor socioeconomic groups) who have been disenfranchised in the current system.

An NHS for Australia?

As Australia considers its health care delivery options for the future there is increasing interest in the NHS. The current NHS appears to be providing accessible quality health care to the population at a lower percentage of gross domestic product than in other industrialised countries, including Australia. The dilapidated hospitals that were the training ground for many Australians are being replaced with attractive new complexes and general practice is being reformed around multi-funds and practitioner networks that provide a more satisfying professional experience than the constrained fee for service treadmill that has emerged under Australian Medicare.

This renewed interest in the NHS arises out of the imperative for healthcare reform in Australia and a consideration of the various options that present on the international scene. A common problem of health systems in industrialised countries is managing to implement health promotion strategies in the face of increasing burdens of illness. Most countries have approached the burgeoning costs of health care by introducing business practices to increase the efficiency and reduce costs of service delivery. In Australia a simple panacea has been to embrace privatisation and commercialisation as a mechanism for forcing efficiency and reform in the public health system. This has occurred with varying degrees of success in the different states. These measures can deliver only limited savings. To gain improved population health and financial outcomes, early intervention and health promotion are needed to control the demand on illness management services. The recent evolution of the NHS seems to be establishing a framework that can deliver improved population health.

An Australian perspective is that the NHS started as a social experiment that has successively been modified to ensure that quality health care is available to all. The current directions of the NHS are consistent with the type of health care organisation that would suit Australia, particularly the role of general practice. In Australia it is extremely unlikely that a health reform like the original NHS could be implemented. The responsibilities for health care in Australia are split between commonwealth and state governments, and it has been almost impossible to get agreements on funding of health care and overall directions for health reform. Australia is vitally interested in the future of the NHS.

Fifty years ago

The new NHS: Message to the medical profession from the minister of health

On July 5 we start, together, the new National Health Service. It has not had an altogether trouble-free gestation! There have been understandable anxieties, inevitable in so great and novel an undertaking. Nor will there be overnight any miraculous removal of our more serious shortages of nurses and others and of modern replanned buildings and equipment. But the sooner we start, the sooner we can try together to see to these things and to secure the improvements we all want.

On July 5 there is no reason why the whole of the doctor-patient relationship should not be freed from what most of us feel should be irrelevant to it, the money factor, the collection of fees or thinking how to pay fees—an aspect of practice already distasteful to many practitioners. Yet it has been vital, if this is to be the new situation, to see that it did not carry with it either any discouragement of professional and scientific freedom or any unfair worsening of a doctor's material livelihood. I sincerely hope and believe we have secured these things. If we have not we can easily put that right.

The picture I have always visualized is one, not of "panel doctoring" for the less well-off, not of anything charitable or demeaning, but rather of a nation deciding to make health-care easier and more effective by pooling its resources—each sharing the cost as he can through regular taxation and otherwise while he is well, and each able to use the resulting resources if and when he is ill. There is nothing of the social group or class in this: and I know you will be with me in seeing that there does not unintentionally grow up any kind of differentiation between those who use the new arrangements and those who, for any reason of their own, do not. Let this be a truly national effort. And I, for my part, can assure you that I shall want vigilantly to watch that your own intellectual and scientific freedom is never at risk of impairment by the background administrative framework, which has to be there for organizing purposes, but in which your own active participation is already secure.

In this comprehensive scheme—quite the most ambitious adventure in the care of national health that any country has seen—it will inevitably be you, and the other professions with you, on whom everything depends. My job is to give you all the facilities, resources, apparatus, and help I can, and then to leave you alone as professional men and women to use your skill and judgment without hindrance. Let us try to develop that partnership from now on.

It remains only to wish you all good luck, relief—as experience of the scheme grows—from your lingering anxieties, and a sense of real professional opportunity. I wish you them all, most cordially.

Aneurin Bevan (3 July 1948, p 1). (See also editorial by Gordon Macpherson, 3 January 1998, p 6.)

Looking forward

The NHS: feeling well and thriving at 75

Donald M Berwick

Summary points

A look back from a possible future shows not-impossible developments in health systems

The turning point for the NHS came shortly after the 50th anniversary celebrations in 1998, when eight principles for progress guided crucial adjustments in NHS strategy

The cost, clinical excellence, and universality of the NHS prove that a nationally organised, publicly funded, total system of guaranteed health care is an excellent policy option for a developed nation

This article is based on a talk given to "The NHS: All our tomorrows," the 50th anniversary of the NHS conference, London, 1 July 1998

Institute for Healthcare Improvement, 135 Francis Street, Boston, MA 02215, USA

Donald M Berwick, *chief executive officer*

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It is a thrill and an honour to welcome you to the 75th anniversary celebration of the NHS. Time flies. It seems only moments ago that many of us here were assembled in 1998 for the glorious 50th anniversary celebration. That meeting, at the close of the last millenium, marked, as you know, a turning point for the NHS. We recognised and celebrated the achievements of the last half of the 20th century, but we also set the stage for the enormous leaps that we have made in the 25 years since.

A lot has changed since 1998. Who could then have anticipated that durable peace would finally settle not only on Ireland but also on the Middle East and the Balkan states? We could not then have known for sure that measles would now be eradicated, river blindness brought under control, and the worldwide epidemic of multidrug resistant tuberculosis stopped through unprecedented international public health collaboration. In the United States, where health care costs reached 22% of the gross domestic product in 2015, real reform finally took hold, beginning with President Whoopie Goldberg's famous call, paraphrasing Ian Morrison, that the United States become, "At last a nation where health care is a right and carrying a semi-automatic machine gun is a privilege, instead of the other way round." Today American health care is administered under a single, government sponsored insurance scheme, with public accountability not at all dissimilar to the NHS. For the first time in nearly a century, American healthcare costs are falling (they are now only 50% higher than Britain's), the population's health is improving, and all Americans can get the care they need, regardless of wealth or race. Laser surgery has been performed remotely at the European Union's colony on the moon under the control of a world class surgeon in Manchester; cystic fibrosis has been conquered by gene therapy; and the NHS has thrived. As Lord (Anthony) Blair said, recovering from his recent cataract surgery, "The care was so good, and the service so prompt, I can hardly wait for my next operation."

Of course, you already had a lot to be proud of in 1998. The NHS had its flaws, but its cost, clinical excellence, and universality proved that a nationally organised, publicly funded, total system of guaranteed health care was one of the best public policy options for a developed nation. Nevertheless, in typical British fashion, your leaders self critically pointed out problems where they existed, such as long waiting times, poor service, technical variation, and rationing of effective care.

You remain self critical, but even the harshest among you must take note today of the enormous progress you have made. Today, unlike in 1998, the NHS is almost wait-free. At a cost that has been held for 20 years at 7% of gross domestic product, your citizens can get the help they need, day or night, when they need it. Whether by phone or internet, in hospitals or in community health centres, NHS patients and their families can expect dignified, customised, and even cheerful responses from any NHS employee they encounter. Wasteful and hazardous geographical variations in care are nearly gone: doctors, hospitals, and community health services have moved steadily toward scientifically supported, evidence based best practices as their norm, and they engage in steady and respectful dialogue to reveal differences in practice as they emerge and to help them to reduce those differences methodically, reporting their progress to the public as they go.

Progress like this in part characterised the NHS from its inception. But you and I know that, shortly after the 50th anniversary celebration in 1998, the NHS reached a historic turning point as the secretary of state, the NHS Executive, and the royal colleges (including the Royal College of Nursing) settled wholeheartedly on a new set of eight principles for progress, to undergird and, in a few cases, to revise and replace the principles and vision set out in the 1998 white paper.[1] These eight principles—sometimes called the Langlands Eight—guided some crucial adjustments in NHS strategy and have remained more or less intact for over two decades. Every school child can recite the Langlands Eight but let me recite them again, with brief explanations for their rationale.

1: Improvement comes from knowledge

Since it began, the NHS has invested in transferring knowledge about how to organise care. For example, the NHS developed standardised models for community based primary care, public health, and specialty care in hospitals. By 1998, however, you had begun to understand how much you could gain from finding and spreading your own best practices—the best you could find within the NHS—in clinical care and management. As one NHS executive stated, "If the NHS fails to use our own internal best practices as our standard, we lose perhaps the only significant advantage of being large." Or, to quote another, "If we only knew what we knew, we would be geniuses."

Before 1998, systems in the NHS defaulted to the status quo—that is, without enormous efforts to introduce changes, time honoured approaches were taken as the standard. In the first few years of the 21st century, you decided that thenceforth the status quo would not be the standard; instead, the best known practice, adapted to local use, would be the standard—whether in clinical care, such as the best approach to treating depression, or in managerial practices, such as the best system for scheduling doctors' time or the smoothest use of operating theatres.

Until then, you had been sitting on a gold mine, but not mining it. Here are the words of the then incumbent president of the Royal College of Physicians in her inaugural speech in the year 2001: "If we know that someone—anyone—in the NHS has achieved a level of care or outcome that outdistances the rest of us, we have not just an opportunity, but a sacred duty, to put that example to use everywhere as our new standard of practice, or go it one better. Let physicians never confuse professionalism with insularity. The NHS is our close and welcome partner in finding, documenting, and helping us to learn from the best among us." The other royal colleges followed.

To accomplish this transfer of technical knowledge as a core activity—that is, to make the best practice the NHS standard—required major changes in the structure and capacity of the NHS itself. You began with the formation of the National Institute for Clinical Excellence and the Commission for Health Improvement, but over the next few years you learned more about effective technology transfer. The most successful model eventually came from, of all places, the United States, from its Agricultural Extension Service, which throughout the 20th century developed, refined, and operated one of the best technical exchange systems ever seen. The Agricultural Extension Service continually bridged the gap between innovators, universities, and developers, on the one hand—sources of great, new ideas for better farming—and the field. It placed in the hands of farmers, in usable forms, innovations that might otherwise have taken decades to diffuse into practice.[2]

Today, the NHS Extension Service, managed in cooperation with the royal colleges and other professional groups, has three key measures of success: the speed with which sound advances in care and service spread throughout the single NHS; the speed with which information about the best sites for specific areas of clinical and service performance become known to all NHS caregivers; and ratings of helpfulness given to the NHS Extension Service by its main customers: doctors, nurses, and managers in delivery sites.

HULTON GETTY

A nationally organised . . .

The usefulness of today's technology transfer activities in the NHS could not develop fully, of course, until the second of the Langlands Principles was adopted.

2: Measurement for improvement is not measurement for judgment

In 1998, with well meaning naivety, you were perhaps a bit taken in by a common but incorrect belief—namely, that the principal use of measurement of performance in the NHS was to increase accountability, to make judgments. You thought that measurement would facilitate improvement by supporting market selection, rewards, punishments, and selective accreditation. You were only partially right.

The problem, of course, is that measurement alone does not hold the key to improvement, any more than measuring my daughter's errors in playing the Minute Waltz improves her piano playing. It is not possible to learn without measuring, but it is possible—and very wasteful—to measure without learning.

For a while, the NHS got it wrong. You overemphasised accountability and you underemphasised learning. You invested heavily in onerous processes of inspection and accreditation, and you developed snazzy, nearly useless "report cards" for public consumption, copying wasteful practices from the United States. We Americans could have warned you about the price you would pay for fostering a psychology of conflict around measurement in the NHS, inducing the measured parties to fight back with defensive criticism of the measurements themselves. We could have told you about healthcare organisations that, faced with an accreditation survey, bury the evidence on their own errors and flaws, instead of revealing and studying it in the service of improvement.

Gradually, you came to realise how costly this negative "name and shame" approach really was. Leaders came to recognise that measuring could be an asset in improvement if and only if it were connected to curiosity—were part of a culture primarily of learning and inquiry, not primarily of judgment and contingency. Today, reports on performance on important dimensions of care are eagerly awaited by many in the NHS, so that best practices can be found and the learning can begin.

3: Make control over care as local as possible

As the century turned you experimented briefly with rather large primary care groups as the most promising level of aggregation for improvement of care. Nice try, but you aimed a little too high. You found that you needed a slightly more sophisticated view of the problem of scale: to assign to large aggregates, like the primary care group, only those aims and tasks that could not be accomplished within smaller units, such as arranging for highly technical specialty services. The

solution, you learned, was to focus control over resources and encourage innovations in care at a level of aggregation large enough to transfer resources rationally from, say, one care programme to another, but small enough to recognise and involve patients and their families as individuals.

For some aims in public health and population based care, the primary care groups created new opportunities for rational, effective programmes of care. But for many other aims the best unit of control and accountability is smaller, and you therefore returned in part to the idea of the fundholding general practice as an ideal unit of organisation.[3] By studying the most successful fundholders, like Dr John Oldham in Glossup, you learned, for example, about how groups of five to 20 doctors entrusted with the care of communities of 10 000 to 20 000 could sensibly manage the associated resources while avoiding both anonymity for patients and bureaucracy for themselves. Primary care groups as originally conceived were just a shade too big to accomplish many of the needed improvements in personal health care.

To make list management work, however, you had to make a major shift in training the doctors and nurses who were to care for those lists. With the full support of both your academic centres and the royal colleges, you defined a new set of skills that had to be mastered as a condition of medical and nursing qualification These skills equip today's NHS doctors, nurses, pharmacists, physiotherapists, and other clinicians much better to manage limited resources and, even more important, to be constructive in improving the systems of care in which they work. Among these skills are knowledge of systems, mastery of cooperation and negotiation, understanding finance at the organisational level, skills in local measurement and tracking of outcomes of care and satisfaction of patients, and the ability to conduct and learn from local, small scale trials of change in the search for improvement.[4]

Equally important, NHS managers and authorities realised quickly after 1998 that they needed new skills and more training just as badly as others did.

4: Improvement requires cooperation among disciplines

In the NHS you had long spoken of cooperation, but your deeds did not always match your words. Until the end of the 20th century, doctors and nurses, for example, rarely trained together, and "cooperated" mainly by avoiding each other's territory. It was even worse between clinicians and managers, the former often judging the latter harshly, and the latter, perhaps in defence, usually failing to confront doctors with the needed changes in their behaviour.

You would never have achieved the success you have today if you had perpetuated this tribalism and fragmentation. As the presidents of the Royal Colleges of Physicians and Nursing stated in their joint address at the 20th annual meeting of the Academy of Health Care Professionals Royal Colleges last year, "It is hard to recall, and even harder to justify, the irrational conviction of separateness that for so long kept us from the fullest possible cooperation in continually refashioning care in the service of our patients."

HULTON GETTY

. . . publicly funded . . .

The NHS of today is so much more the jointly led endeavour of the many professional groups who work together—not separately—to provide care and protection to the people of Britain. Today, young doctors, nurses, and managers train together as they will work together, and their former disrespectful images of each other are now seen as unprofessional.

5: Waste is poor quality; removing waste is improvement

Perhaps because of the tribal separation of clinical from managerial leadership, many NHS leaders attending the 50th anniversary celebration in 1998 would still have distinguished between "quality"—by which they would have meant the technical and interpersonal properties of care given to patients—and "efficiency"—by which they would have meant decreasing the level of resources invested to produce that care.

Today, you have unified those ideas. Today, you see "cost" as a "quality" of a system of care—a variable to be improved just as you can improve levels of morbidity, mortality, dignity, or pain control. In the unification of professional perspectives around the core aims of the NHS—in teamwork—you have also found that every discipline has an opportunity to contribute toward every aim. You now regard it as the duty of lay managers to understand and help improve clinical outcomes. Equally, doctors and nurses, along with their professional societies, now understand their key role and responsibility in helping to achieve continual reductions in the cost of care, not by withholding services but by discovering and eliminating waste in all its forms. Formerly, clinicians would have seen the pursuit of wise cost reduction as "management's job." Now, they share in that pursuit willingly and as a matter of professional pride.

6: Waiting costs more than it saves

In 1998, the most significant defect in the NHS from the public's point of view was its waiting times. Queues were everywhere—for appointments, for elective surgery, in clinics and offices, on the telephone. The "New NHS" white paper made efforts to change this by proposing, for example, a 24 hour telephone advice line. But concessions to waits were still apparent. Take

the 1998 proposal of guaranteed access to specialist consultation within two weeks for women with suspected breast cancer—two weeks of anguished delay as a woman who has been told she may have cancer waits to find out if she does, while, in technical terms, the answer could be known in a few hours. And you called that "service."

This turned out to be an error. You assumed that delays were inevitable in a system of constrained resources—that delays helped you cope with those constraints. In fact, as you now know, delays often reveal inefficiencies; they point out mismatches between supply and demand. By reallocating the supply of services to better match demand, by shaping demand cooperatively with patients and families, and with innovation in the design of the care itself, you learned to reduce delays substantially with the same or fewer resources.[5] You found out rapidly in 1998 that simply calling for reductions in waits was far from sufficient; in fact, it just made hard working caregivers angry. To reduce waits required not exhortation but redesigning the processes of care themselves.

You found clues about how to do this within the NHS, back in 1998. Looking carefully for best practices, you identified clinics and specialists whose waiting times were substantially lower than the norm even though they relied on the same or fewer resources against the same or larger demand. You helped others throughout the NHS to learn from these leaders.

You learned, as well, from industries outside health care. By 1998, innovators in other industries had developed approaches—sometimes referred to as "lean production" or "just-in-time" methods—that smoothed flow and reduced both costs and delays.[6] The relevant science bases are in queuing theory, operations research, and statistics, and by using these sciences to design care, you now achieve substantial reductions in delays even while you conserve resources. You mastered the theory and practice of lean production, adapted the methods to health care, and produced better results for both patients and caregivers.

In the NHS of today, a women with suspected breast cancer gets a firm diagnosis if she wants it within four hours of the first suspicion, day or night, so you can begin planning treatment if she has cancer and limit the psychological pain if she does not.

TOPHAM PICTUREPOINT

. . . system of guaranteed health care is still an excellent policy option

7: Service is at the core of our work

Before 1998, you underestimated the importance of service in your own health care. The problem lay in mentally separating "care" (the technical procedures used by healthcare professionals) from "service" (the experiences of patients and their loved ones). In the late 20th century, all healthcare systems tended to treat the former as their core work and the latter as an amenity. That framing was incorrect.

In 2023, we now fully understand that the experience of the people we serve, as they judge that experience, is intimately tied into the basic effectiveness of care itself. The way we interact with people (with properties like respect for individual preferences, promptness of reply, dignity, privacy, completeness of communication, involvement of loved ones, and attention to comfort) affects not just their level of satisfaction but also their physiological, functional, and psychological outcomes. Diabetic patients who are coached to ask their doctors questions assertively rather than remaining passive attain lower glycated haemoglobin levels than patients not so counselled.[7] Surgical patients carefully educated about their conditions and care before their operations are less likely to develop postoperative fevers than patients not so instructed.[8]

The NHS of 2023 understands far better than it did before 1998 that dignity, privacy, individual respect, and communication are not frills; they are care, every bit as tied into the clinical, health status mission of the NHS as are giving the proper drugs or making the correct diagnosis. In its fullest form, this understanding leads to the eighth principle.

8: Patients and families can care for themselves

Powerful as the first seven principles are, they pale in impact when compared with the eighth. More than any other, the principle that patients and families can be their own caregivers transformed the costs, outcomes, and shape of the NHS between 1998 and 2023.

There is, of course, a technical dimension to this. As electronic connectivity grew in the late 20th and early 21st centuries, health care was slow to recognise how this technical revolution could extend its impact. It took us all a while to realise that expertise could move at the speed of photons, and that the very best knowledge could be available almost anywhere at almost any time. Today, you can and do still offer patients the warm human touch and personal presence when they want it, but you also offer, and they accept and value, direct, electronically facilitated access to the knowledge, words, voice, and picture of caregivers who in decades past they could never have reached. Doctors help doctors this way too. Instead of waiting weeks for a consultation with a distant specialist, general practitioners, like patients, are now only minutes from whatever world class help they wish.

But that is only part of the story. Not only do you now know technically how to give patients the knowledge they need, you have also given them more control over their own care. By the late 1990s you began drawing on the example of such doctors as Larry Staker from Intermountain Health Care, who trained his diabetic patients to measure their blood

sugar and adjust their insulin doses, achieving far better control than when the doctor was making the insulin adjustments.[9] You learned from Dr David Sobel at Kaiser Permanente in America, who trained chronically ill adults to provide care and education to other chronically ill adults, achieving better health status outcomes and lower cost for both teachers and students.[10] You built your programmes on evidence of the benefits of patient self care in studies of asthma treatment,[11] hypertension treatment, and self diagnosis of urinary tract infection.[12]

By the early 21st century, the NHS was becoming a truly patient centered clinical care system. The emphasis today is on helping people with acute and chronic illnesses to become experts in their own care whenever they wish, able to participate fully in their own diagnosis, treatment, and monitoring. Shared decision making, incorporating every patient's values and circumstances, is now the norm.[13] NHS patients today write in and read their own medical records, receive much of their care in their own homes, and remain fully connected with their loved ones and communities.

At first, your doctors resisted this trend—fearing, perhaps, that it would relegate them to second fiddle, demean their expertise, and perhaps subject patients to undue hazards. Instead, this reformulation of the respective roles of doctor and patient has helped everyone—giving patients and their families the chance to establish control over their own lives and giving doctors, nurses, and other healthcare professionals the chance to focus their time and energies on exactly those technical, pastoral, and humanitarian tasks that they are in the best position to pursue.

These principles endure. You are not by any means finished. As in 1998, and as it will be in 2048, you in 2023 seek the continual improvement of an NHS full of knowledge, taking the best as its norm, growing its capacity as a full and integrated system of shared effort, wasting little, and respecting every patient as an individual. You continue to know that you started off right in 1948, and with some important midcourse corrections, you remain well on track. Maybe some day healthcare leaders in the United States will catch up. I am sure you will help them if they ask.

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Clinical governance and the drive for quality improvement in the new NHS in England

Gabriel Scally, Liam J Donaldson

A commitment to deliver high quality care should be at the heart of everyday clinical practice. In the past many health professionals have watched as board agendas and management meetings have become dominated by financial issues and activity targets. The government's white paper on the NHS in England outlines a new style of NHS that will redress this imbalance.[1] For the first time, all health organisations will have a statutory duty to seek quality improvement through clinical governance. In the future, well managed organisations will be those in which financial control, service performance, and clinical quality are fully integrated at every level.

The new concept has echoes of corporate governance, an initiative originally aimed at redressing failed standards in the business world through the Cadbury report[2] and later extended to public services (including the NHS). The resonance of the two terms is important, for if clinical governance is to be successful it must be underpinned by the same strengths as corporate governance: it must be rigorous in its application, organisation-wide in its emphasis, accountable in its delivery, developmental in its thrust, and positive

Summary points

Clinical governance is to be the main vehicle for continuously improving the quality of patient care and developing the capacity of the NHS in England to maintain high standards (including dealing with poor professional performance)

It requires an organisation-wide transformation; clinical leadership and positive organisational cultures are particularly important

Local professional self regulation will be the key to dealing with the complex problems of poor performance among clinicians

New approaches are needed to enable the recognition and replication of good clinical practice to ensure that lessons are reliably learned from failures in standards of care

NHS Executive (South and West), Westwood House, Lime Kiln Close, Stoke Gifford, Bristol BS34 8SR
Gabriel Scally, *regional director of public health*
John Snow House, Durham University Science Park, Durham DH1 3YG
Liam J Donaldson, *regional director, NHS Executive (Northern and Yorkshire)*
Correspondence to: Dr Scally
gscally@doh.gov.uk

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in its connotations. The introduction of clinical governance, aimed as it is at improving the quality of clinical care at all levels of healthcare provision, is by far the most ambitious quality initiative that will ever have been implemented in the NHS.

Origins of clinical governance

Although clinical governance can be viewed generally as positive and developmental, it will also be seen as a way of addressing concerns about the quality of health care. Some changes in healthcare organisations have been prompted by failings of such seriousness that they have resulted in major inquiries. Variations in standards of care between different services have been well documented. Under the previous government's market driven system for the NHS, many felt that the quality of professional care had become subservient to price and quantity in a competitive ethos. Moreover, some serious clinical failures—for example, in breast and cervical cancer screening programmes[3]—have been widely publicised and helped to make clinical quality a public confidence issue.

What is clinical governance?

Clinical governance is a system through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish

Clinical quality has always engendered a multiplicity of approaches. Universally accepted definitions have been difficult to achieve, and some have even considered the term too subjective to be useful.[4] The World Health Organisation is helpful in exploring the idea of clinical governance.[5] It divides quality into four aspects:

- Professional performance (technical quality)
- Resource use (efficiency)
- Risk management (the risk of injury or illness associated with the service provided)
- Patients' satisfaction with the service provided.

These dimensions of quality are taken a stage further in the components identified in the new NHS white paper as being the attributes of an organisation providing high quality clinical care. The development of clinical governance is designed to consolidate, codify, and universalise often fragmented and far from clear policies and approaches, to create organisations in which the final accountability for clinical governance rests with the chief executive of the health organisation—with regular reports to board meetings (equally as important as monthly financial reports)—and daily responsibility rests with a senior clinician. Each organisation will have to work out these accountability arrangements in detail and ensure that they are communicated throughout the organisation.

Quality improvement philosophy

At any one time, the organisations making up a health service show variation in their performance against quality criteria (fig 1). Quality improvement must address the whole range of performances. Failures in

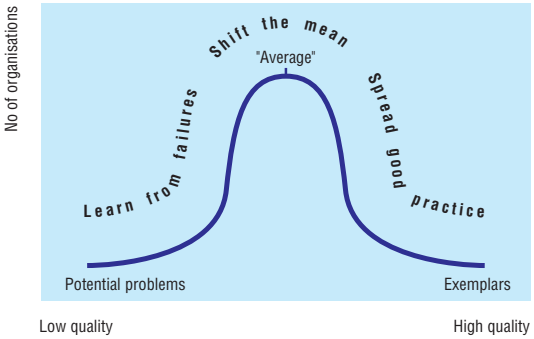

Fig 1 Variation in the quality of health organisations

standards of care—whether detected through complaints, audit, untoward incidents, or routine surveillance—represent one end of the range. Organisations that are exemplars represent the other end. At present once good practice is recognised, the scope for more general applicability and methods to transfer it both locally and nationally are not well developed.

The process of learning lessons from both exemplar and problem services has never before been tackled systematically in the NHS. However, a major shift towards improved quality will occur only if health organisations in the middle range of performance are transformed—that is, if the mean of the quality curve is shifted. This will necessitate a more widespread adoption of the principles and methods of continuous quality improvement initially developed in the industrial sector and then later applied to health care.[6] Generally these involve an organisation-wide approach to quality improvement with emphasis on preventing adverse outcomes through simplifying and improving the process of care. Leadership and commitment from the top of the organisation, team work, consumer focus, and good data are also important.

In the NHS a key part of establishing a new philosophy of quality improvement will be to decide how clinical audit fits in to an integrated approach. Although the concept of peer review is well established in the United Kingdom, the implementation of clinical audit in the NHS is not a complete success. Concerns have focused on the failure of audit processes to detect and moderate significant clinical failures; on incomplete participation (table 1); on the lack of connection and flow of information to those responsible for managing services; on substantial declines in the amount of regional audit; and on the value for money for what amounts to a significant annual investment.[8]

Table 1 Percentage of questionnaires returned in the 1994-5 national confidential inquiry into perioperative deaths[7]

Region or country	Surgical	Anaesthetic
Anglia and Oxford	73.9	81.7
North Thames	68.6	64.2
North West	75.6	75.3
Northern and Yorkshire	80.8	84.1
South and West	80.6	88.5
South Thames	75.1	74.3
Trent	77.8	72.8
West Midlands	74.2	74.1
Wales	75.0	72.8
Northern Ireland	82.3	80.7

Two new external bodies will facilitate and reinforce the local duty for quality in the NHS. The style of working of the Commission for Health Improvement and the National Institute for Clinical Excellence will be important, as will the way in which they are viewed by local services. Any external body can add value in different ways: inspecting, investigating, advising, supplying expertise, facilitating, accrediting. The role of the two new bodies could contain elements of all these functions. However, it will be important that they establish an overall philosophy which will be based (at least in their initial approach to local organisations) on facilitating improvement and encouraging evaluation. Health organisations must not be defensive if the full benefits of these important additions to the national scene are to be realised.

The case study (box) describes an imaginary hospital (Gridstone) that is ailing as an organisation. Conventional indicators of performance—for example, response times and budgetary control—are showing up badly. Other indicators, such as general practitioners' referral preferences and the inability to fill vacant posts, suggest that all is not well with the quality of care provided. It is obvious too that the relationship between doctors and management is dysfunctional. Clinical governance offers the opportunity for the hospital to look at itself afresh and start to rebuild its quality ethos—a fact that is recognised by the new chief executive.

Case study: Gridstone Royal Infirmary NHS Trust

Gridstone Royal Infirmary NHS Trust has advertised for a new medical director with specific lead responsibility for developing clinical governance in its hospital, which serves a small city and its surrounding county population. The hospital has had a troubled past four years: a recurrent financial deficit has increased each year; targets for inpatient waiting times agreed in annual performance plans have repeatedly not been met; and members of the senior medical staff have regularly used the local newspaper to criticise decisions by the trust's management. The hospital has a higher number of medical posts filled by locums than any hospital in the region. A confidential survey of general practitioners' opinions conducted for the community health council showed that many were referring to hospitals outside the county because of concerns about standards of care in some of the local hospital's clinical departments. There have been two chief executives in the past four years. The current, newly appointed chief executive is the first woman senior manager ever appointed to the hospital's staff. She states that the key to creating an organisation with a reputation for high quality is successful implementation of clinical governance.

Culture, leadership, and teams

The feature that distinguishes the best health organisations is their culture. The applicant for the medical directorship of Gridstone Royal Infirmary at her interview recognises that an organisation that creates a working environment which is open and participative, where ideas and good practice are shared, where education and research are valued, and where blame is used exceptionally is likely to be one where clinical governance thrives (box next page). The challenge for the NHS is the active creation of such cultures in most hospitals and primary care groups of the future. However, evidence on how to define a "good" culture and on the methods required to promote one is largely lacking in the healthcare field. The fact that those leading health services do not traditionally think along these lines perhaps explains the initial scepticism of some of the panel members at the medical director's interview at Gridstone. But although the management literature deals with such subjects extensively, uncertainty exists about how best to appraise it critically.

Most observers would identify leadership as an equally important ingredient in successful organisational change. However, leadership too is a rather vague concept. Among professionals it is often based on a model of wise authority rather than of authority conferred by virtue of position. The introduction of clinical and medical directors in NHS trusts has changed this approach dramatically. Posts may well be publicly advertised and are invested with significant responsibilities and authority. Although this change has taken place, little effort has been expended in developing leadership skills among members of the professions expected to take on these posts. Moreover, many who hold such posts (as in the Gridstone example) will find themselves leading clinical governance strategies within their organisations. Medical directors of NHS trusts may recognise that they have skill deficits, but although these may be addressed when someone is in post, a proactive approach would undoubtedly be preferable.[9]

New approaches to undergraduate medical education, such as the introduction of problem based learning and joint education with other professional disciplines, should in time improve teamworking skills; the importance of teamworking has been emphasised by the General Medical Council.[10]

One of the strongest statements in the recent NHS white paper for England was that a new era of collaboration would begin. Competition, a feature of the previous eight years, was to be ended. The strength of the working relationship between senior managers and health professionals will be at the heart of successful clinical governance. Other partnerships will be important too. Day to day and longer term developmental progress will depend on effective partnerships with universities, local authorities, patients' representative groups, and voluntary organisations.

Evidence and good practice

The evidence based medicine movement[11] has always had a major influence on many healthcare systems of the world. Accessing and appraising evidence is rapidly becoming a core clinical competency. Increasingly, neither clinical decisions nor health policy can any longer be comfortably based on opinion alone.

The NHS research and development programme has helped with the production and marshalling of the evidence needed to inform clinical decision making and service planning. Clinical governance will require a greater emphasis at local level, where currently the infrastructure to support evidence based practice is not always in place. The most obvious is information technology to enable access to specialist databases (such as the Cochrane collaboration). However, libraries, for example, are a basic requirement for access to professional knowledge, and a recent review in one English region has shown wide variation in funding for and access to library services.[12]

Although presenting evidence, or providing access to it, is a necessary condition for adopting new practices,

A consultant rheumatologist is an external applicant for the post of medical director of Gridstone Royal Infirmary NHS Trust. If she is appointed she will be expected to take the lead on implementation of clinical governance. Here is an extract from her interview

Q: In your vision of clinical governance will our doctors be more accountable than they are now?

A: I think the scope of professional responsibility will be much broader than at present—covering commitment not just to delivery of a safe and effective service but to the quality goals of the organisation as a whole and to the clinical team.

Q: Isn't clinical governance just a more formal way for us to weed out the poor performers?

A: No, I think the concept is much more fundamental than that. Certainly, it is vital that poor performance is recognised and dealt with better than it has been in the past. That's what people mean when they talk of local self regulation. We need to identify problems of poor performance much earlier, through mechanisms like making sure everyone takes part in effective clinical audit, and having more open communication within teams. But we must also try to prevent many of these problems. This will mean learning where possible from failures in standards of care—for example, by looking at our record of complaints and untoward incidents. It will also mean having better data to review quality in each clinical service; ensuring that clinical teams work more effectively so that individuals are taking fewer decisions in isolation; being clearer about the skills and competencies needed in each area of service; and being willing to change things to make them better.

Q: Okay, you've convinced us that there's more to addressing poor performance than sorting out the bad apples, but you say there is also more to the concept of clinical governance?

A: Yes, I see the first and most important task as an organisational one—to create the kind of service where high quality is assured and improvement takes place month on month, year on year.

Q: Sounds a little "mother pie," doctor, doesn't it? I mean, how could you possibly suggest anything else?

A: I think you mean "motherhood and apple pie," don't you? I know that you and the chairman run private companies. You are surely not going to tell me that establishing the right leadership and culture are not keys to successful organisations are you?

Q: Okay, could you be a bit more specific? How will we recognise a good culture in the hospital if we see it?

A: It is because the leadership and the culture have been wrong that you have had so many problems over the past four years. I see a positive culture as one in which doctors, managers, and other healthcare professionals work closely together with a minimum of hierarchies and boundaries. It would also be one with an environment in which learning and evaluation are encouraged and blame is rarely used. This will be brought about only through the leadership of the chief executive and the board (including me as medical director if I am appointed), by the clinical directors of each service, and by individual team leaders in every clinical area. A safe, high quality service for patients attending your accident and emergency department depends just as much on the leadership skills of the staff nurse in the department as it does on the clinical skills of the trauma surgeon or the management skills of the medical director at trust board level. That is why I emphasise leadership and culture and why I will eat "mother pie" if I am wrong.

Q: Are there any other points about clinical governance you would like to make? Time is short, and we do want to ask you about your attitude to consultants having reserved spaces in the car park.

A: There is a great deal more I could say, but just two points for now. Firstly, it is vital that the right infrastructure is in place for clinical governance: information technology, access to evidence, and education and training, as well as some protected time for individuals and teams to think about the quality of their services, review data, appraise evidence, and plan improvements. Secondly, we must find ways of involving patients much more than we have in the past—they are, after all, the people we are doing this for.

it is not sufficient. The field of behaviour change among health professionals is itself developing an evidence base, through which it is becoming clear that single measures (such as general feedback) are not effective and multifaceted strategies are needed—using techniques such as input from a respected colleague, academic detailing, and individual audit and feedback.[13]

Much of the evidence based work to improve clinical decision making has centred on specific interventions and clinical policies. However, clinical governance is also expected to address how good practice can be recognised in one service and transferred to others. Where whole services—for example, a community diabetic service or a service for women with menstrual problems—are concerned, it is much more difficult to identify the benficial elements and replicate them elsewhere. A new major strand in the NHS research and development programme—addressing so called service delivery and organisation—is intended to tackle this problem.

Changes to the NHS complaints procedure in 1996 reduced the fragmentation and inconsistency of previous arrangements as well as introducing more openness and lay participation.[14] The health service has yet to develop a simple way to allow the important, generalisable lessons to be extracted from the extensive analysis, information gathering, and independent judgment which now underpin the handling of complaints. Moreover, a wealth of other information on clinical incidents which are the subject of internal and external inquiries is generated, but there is no obvious route for this information to be channelled to prevent similar errors from recurring. Clinical governance has the opportunity to address this weakness—requiring organisational as well as individual learning.

Dealing with poor performance

Poorly performing doctors and other health staff are a risk not only to patients but also to the organisation they work for. Though relatively few in number, their existence, and the tenacity with which the problem is addressed, is very important to the standing of the NHS and the healthcare professions in the eyes of the public. The controversy generated by this subject can lead some to believe that the sole purpose of clinical governance is to sort out problem doctors (see interview (box)). A small proportion of hospital based medical staff are likely to have sufficient deficiencies in their performance to warrant consideration of disciplinary action.[15] The introduction of new performance procedures by the General Medical Council has signalled a change in approach—away from a reluctance to do anything that might be seen as criticism of a fellow professional. It would be wrong, however, to rely on a body such as the General Medical Council to deal with most problems. Local professional regulation needs to be developed so that satisfactory and timely solutions can be found to what can be complex problems. The test will be whether such cases can be dealt with in a sympathetic manner which, while correctly putting the protection of patients first, will also deal fairly with experienced and highly trained professionals.

Professional development

The staff of a healthcare organisation will be the key to how it rises to the challenges of the new agenda. Firstly, good recruitment, retention, and development of staff will make a major contribution. Secondly, staff must be supported if they are to practise well: skills training, modern information technology, access to evidence are all important. Thirdly, staff must participate in developing quality strategies and be encouraged to look critically at existing processes of care and improve them. Finally, valuing staff and letting them know that they are valued—easily espoused but often overlooked—is a common feature of organisations that show sustained excellence in other sectors[16 17]

In the NHS the development of educational consortiums has for the first time given NHS trusts and health authorities direct control over the type of training received by large numbers of professional staff. The alignment of this new system to the goals of clinical governance will be essential. Systematic reviews are beginning to inform the design of training and continuing professional development programmes for doctors.[18] Designing programmes that help to advance the quality goals of every organisation and which draw on an evidence base will also be part of the principles of good clinical governance.

Data quality

The importance of clinical record keeping is well established. The collection and analysis of routine patient data has been a central part of the health service's planning and administration. At the outset, the internal market in the NHS (which operated between 1990 and 1997) was seen as highly dependent on the exchange of data about the quality of care provided. However, the emphasis in data collection was on the number of treatments, length of stay, and costs of care. There are substantial failings in the completeness of some of the vital clinical data (table 2). A renewed commitment to the accuracy, appropriateness, completeness, and analysis of healthcare information will be required if judgments about clinical quality are to be made and the impact of clinical governance is to be assessed. These issues are so important and have been so unsatisfactorily dealt with in the past that they will need to be addressed nationally not only locally.

Table 2 Percentage of hospital episodes in which the primary diagnosis or primary operative procedure is unknown, England 1995-6[19]

Region	Primary diagnosis	Primary operative procedure
Northern and Yorkshire	4.2	2.0
Trent	21.9	0.7
Anglia and Oxford	2.4	1.8
North Thames	3.2	8.4
South Thames	3.5	1.8
South and West	1.7	0
West Midlands	2.2	0.2
North West	1.9	0.4
England	4.5	2.1

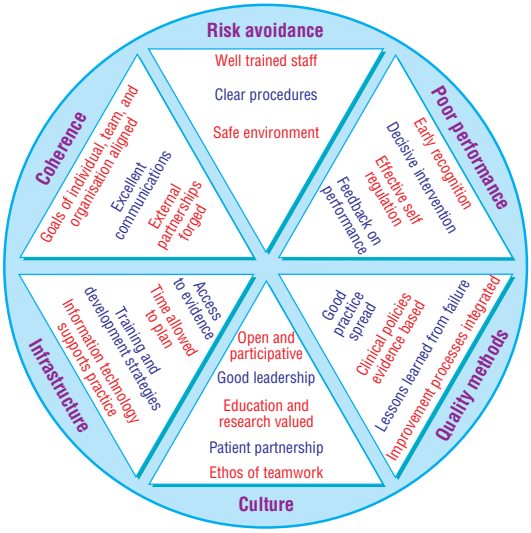

Fig 2 Integrating approaches of clinical governance

Conclusion

Clinical governance is a big idea that has shown that it can inspire and enthuse. The challenge for the NHS—health professionals and managers alike—is to turn this new concept into reality (fig 2). To do this requires the drawing together of many strands of professional endeavour and managerial commitment into a cohesive programme of action in each healthcare organisation in England. This will need leadership and creativity. If this challenge is met the beneficial consequences will flow to every hospital, practice, and patient in the country.

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Will the fudge on equity sustain the NHS into the next millennium?

Nicholas Mays, Justin Keen

Health Systems Programme, King's Fund, London W1M 0AN
Nicholas Mays, *director*

Department of Government, Brunel University, Uxbridge, Middlesex UB8 3PH
Justin Keen, *research fellow*

Correspondence to: Mr Mays N.Mays@kehf.org.uk

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The NHS was established as a compromise between key parties; it allowed those patients who could afford it to have access to both private health care and the NHS and it permitted consultants to have access to income from private practice while working in the NHS. This safety valve for excess demand was developed contrary to the founding principles of equity, but it has been a feature of health care in the United Kingdom ever since; it allows more affluent patients to circumvent the periodic funding crises in the NHS while maintaining their support for health care funded by taxes. However, the share of total healthcare spending contributed by the private sector has risen steadily. This trend has led some commentators to argue that the NHS is not sustainable, primarily because funding through taxation will lead to an increasing gap between the demand for and supply of health care. Alternatives to the NHS would involve requiring a larger private contribution to the costs of health care but such systems require complex regulation and seem to produce inequities that reveal the specific interests of their proponents. In contrast, expanding the funding of the NHS in line with increases in the gross national product is affordable and broadly equitable.

Whether the UK compromise between public and private interests will be sustained cannot be predicted. Recent developments suggest that major change may occur unintentionally through the cumulative effects of small or unplanned changes, or both, or result from applying policy thinking from other fields of welfare, such as social security reform.

Summary points

- The advent of the NHS did not lead to the abolition of private finance for or the private provision of health care in the United Kingdom
- Shares of total healthcare spending and healthcare provision contributed by the private sector have risen steadily since the end of the 1960s
- Several recent policy developments may cumulatively lead to a radically different balance of public and private finance and insurance
- Alternatives to the NHS that involved a larger share of private financing would require complex regulation and would be less equitable than current arrangements

Health care was rationalised, not nationalised

There is a tendency in commentary on the NHS to discuss it as though it is the only healthcare system in the United Kingdom but this has never been an accurate reflection of the situation. The early history of the NHS shows clearly that the newly nationalised service did not represent a clean break with the past even though it rapidly consigned private health care to a residual role that served a small minority of the population.[1] Rather, it was a partial rationalisation of what existed, conditioned by a need to reassure and encourage, rather than coerce, a number of conservative professional interest groups to participate. Thus from the outset the NHS was entangled in a wide range of relationships (with both private finance and those who supplied health care and related goods and services privately) which compromised its goal of ensuring that health services were available exclusively on the basis of need.

Over the 50 years some of the large scale features of this compromise have remained remarkably stable, both within the NHS and in its relationships with the private sector (box next page). Thus the 1946 act which founded the NHS represents a long term compromise between the interests of the state and the interests of professional, commercial, middle income, and upper income groups. This compromised fudged the equity principle in the 1946 act by permitting, and at times encouraging, private health care to develop alongside the NHS as a safety valve for people with the resources to make additional provision for themselves. The question now is whether the compromise will continue to protect the NHS into the 21st century.

Continuity and change

Despite successive funding crises threatening the comprehensiveness and sustainability of the NHS, an increasing level of criticism of its apparently poor performance, and the tolerance of private health care by successive governments the main developments in NHS policy since 1948 have done little directly to undermine the fundamental principles of the NHS as being predominantly funded by taxes and providing universal access to services. Instead, changes in policy have attempted, as in the case of the internal market,[2] to improve efficiency and responsiveness to patients' needs within a publicly funded system.

Over time there have been shifts in the perception of what is possible and desirable in the future. Perhaps the biggest change has been in the perception that there is a widening gap between what the NHS might be able to provide with more resources and what it can provide at current levels of funding. For example, the increasing numbers of high cost drugs that the NHS is required to purchase lead to contentious priority decisions and fuel the demand for more spending. One result of this perceived gap is that successive government changes to the NHS have not reduced the

Public-private ties established with the founding of the NHS

- General practitioners work as independent contractors, not salaried employees
- Specialist doctors and other professionals can maintain both NHS and private practices
- NHS pay beds (essentially private beds in NHS hospitals which allow the trust to charge for the bed and consultants to charge separately for services)
- Prescription and other charges to users for NHS services
- Patient access to both NHS and private treatment, sometimes for the same condition; access to private treatment on the basis of ability to pay rather than need
- Reliance of the NHS on pharmaceutical and other industries to develop new products with the NHS contributing resources to development and testing

attraction of private health care. Far from private practice diminishing as the NHS has grown, the private sector has become steadily more important both in financing and supplying health care, but this has not threatened the founding principles of the NHS.[3] The box below summarises some of the main trends in the balance between private and public finance and the provision of health services.

Arguments for changes in the NHS

The NHS continues to have high levels of public support. Seventy seven per cent of the population support the principle of a health service available to all, although this does not necessarily mean that they oppose people having the choice of paying for private health care.[8] Although it is difficult to believe when you are on an NHS waiting list, people are more satisfied with arrangements in the United Kingdom than are people in either Canada or the United States.[9] The United Kingdom also compares favourably internationally in terms of fairness of funding, equality of access, and efficiency.[10]

Nevertheless, arguments persist that a higher share of private funding in a mixed economy of public and private care is inevitable and desirable. Critics tend to argue that a publicly funded system, particularly one funded through general taxation, cannot provide the volume and standard of health care that an increasingly affluent, aged, and sophisticated population wants (despite the fact that we cannot determine objectively what level of spending is correct). The main difference between the United Kingdom and other comparable countries lies not in the amount of public funding for health care but in the lower level of private funding. There is a clear gap between NHS resources and demand, shown particularly clearly in the provision of expensive new drugs such as interferon beta. Yet more public spending is not an option if the United Kingdom is to remain internationally competitive in increasingly global markets, and additional spending is political suicide for any government. If more affluent people are only able to spend more of their money on health care provided outside the NHS then, inevitably, the private sector will and should grow to meet the unmet demand in the public sector.

Governments, including the current one, have responded to this argument by vowing to keep taxes and public spending down which further encourages the suspicion that institutions like the NHS are unsustainable and that more private finance is the only alternative. A range of solutions to the perceived financial unsustainablilty of the NHS has been proposed. For example, Hoffmeyer and McCarthy[11] propose a model to replace the NHS and meet increasing demand with a guaranteed package of health care for all; their model comprises competing health insurance agencies, compulsory insurance, premiums based on income and (health) risk, a central fund designed to share the costs of high risk groups, safety nets for individuals unable to afford or find insurance, providers competing for the business of insurance agency purchasers, and a prohibition against insurers excluding whole groups of patients or insisting on unreasonable terms to avoid risk.

This model has something in common with the different forms of insurance that were available in the United Kingdom before the formation of the NHS. The central ideas are that patients can choose between different packages and insurers, and more affluent patients can insure themselves for higher levels of care, which would increase the level of funding for health care beyond that permitted by successive parsimonious governments. Behind the scenes the government would attempt to ensure that each insurer had roughly equal funds in relation to the requirements of those enrolled in their plan.

But is it the case that we cannot afford the NHS, and would it be a good thing to abandon the basic architecture of health care in the United Kingdom for something new? Analysis indicates that given even conservative estimates of economic growth the United Kingdom can continue to pay for the welfare state and the NHS through taxation, if it chooses.[12] Whether we should spend more is a separate question to which there is no objective answer.

As to whether the United Kingdom should opt for a more explicitly mixed system with much more private finance and a basic publicly subsidised sector

Trends in the mix of public and private financing

- Total spending in the NHS and in the private healthcare sector rose from 3.9% of gross domestic product in 1960 to 7.1% of gross domestic product in 1992[4]
- The private sector's share of total spending on health care rose from around 3% in the 1960s to 14% in 1985 and to 16% in 1992[3]
- Public and private expenditure on private hospital care and private nursing home care increased from 9.9% of total healthcare expenditure in 1986 to 19.9% in 1996[5]
- The number of subscribers to private heath insurance policies increased from 2.45 million in 1986 to 3.17 million in 1996[6]
- Payments by patients for NHS services rose from £35m in 1960 to £919m in 1996[7]
- Investment in new hospitals under the private finance initiative announced since 1 May 1997 was £660m (Department of Health press release 98/123)

for the less well off, 40 years' experience from all over the world cautions against it.[13] Such systems, like that in the United States, tend to perform poorly in terms of public satisfaction, health outcomes, efficiency, access, and equity of finance, and are difficult to manage and regulate. They do, however, tend to increase expenditure, jobs, and incomes in the health sector. For this reason, they are supported by providers and private insurers. They are also attractive to upper income taxpayers since they enable such people to benefit at the expense of poorer people, because user charges and the cost of private insurance impose more of a burden on those who are poor and who are more likely to make higher use of services. The greater the reliance on private finance and the less the reliance on taxation or social insurance, the greater the opportunity for people to purchase more services for themselves without having to pay to support a similar standard of care for everyone else. Since those in need in any one year will be a small proportion of the population—and they will be disproportionately elderly people and those with chronic illnesses, who are least able to pay—private finance tends to improve access to care for those who are least likely to need it. Healthcare financing changes in the United Kingdom would thus have profound consequences for the equitable distribution of resources.

The shape of things to come

Irrespective of the merits of these arguments—and they have made little headway in most countries that have systems providing universal access to care—there is little doubt that a more mixed economy is emerging in the United Kingdom (box), albeit not always as a direct result of explicit reform of health policy. Further changes could occur simply through the accumulation of seemingly separate smaller scale changes which would further reduce the contribution of publicly funded health services; the box summarises a few of these changes.

Change may also come about unintentionally if the proposals contained in the government white paper *The New NHS*,[14] which sets out Labour's plans for the abolition of the internal market, are acted on. One theory is that the unwitting combination of the new primary care groups (groups of practices responsible both for commissioning hospital and community health services and developing general practitioner services) in England and the use of the private finance initiative (a scheme under which private finance is used to build hospitals which are then leased back to the NHS) will lead to something akin to an American style system developing in the United Kingdom; general practitioners might in effect function outside the NHS and this could possibly trigger an unplanned shift to a system in which patients choose to enrol with a range of competing primary care based total healthcare plans using vouchers from the NHS together with private insurance to cover additional services.[15]

Some of the changes would emphasise more strongly the difference between the privately insured haves and the publicly subsidised have nots, along the lines of the American model,[16] which could undermine the current majority support for the NHS. However, this does not seem to be the intention of the government, which has signalled that its priority is to support the NHS and to reduce the likelihood that people will use the private sector by making the reduction of NHS waiting lists a priority.[18] Like its predecessor, this government's aim seems to be to improve efficiency within the publicly funded system using management techniques borrowed from the private sector.

Developments that are altering the mix of financing for health care

- Charging for eye tests on the NHS
- Moving NHS dental care into the private sector
- Commercial funding for all major NHS capital schemes
- Changes in social security leading to a requirement for personal insurance against accident and sickness
- Plans for compulsory private insurance for long term care
- Proposals from some NHS healthcare trusts for additional contributions from local people
- Government plans to charge insurers for the full cost of NHS treatment of motorists and passengers involved in road accidents

HULTON GETTY

Public and private have always coexisted in the NHS: an early general practitioner deputising service

Conclusion

The overall position at the moment is one where most of the main elements of the 1946 compromise settlement remain in place—for better or for worse. The fact that the compromise was not simply between public and private interests but was more complex has made it difficult to change. Gazing into a crystal ball is rarely rewarding but it seems that the NHS may move in one of at least three different directions. In the first scenario key elements of the 1946 settlement, including the privileged position of consultants, will be renegotiated, with sources of finance staying broadly the same. The rapid evolution of the debate on clinical self regulation, particularly following the case in Bristol in which three surgeons were accused of continuing to operate despite high mortality,[19] suggests that this may already be happening. The second scenario is of more

radical change, whether planned or unplanned, with a far larger role for private finance. Some of the signs suggest that this is not out of the question. The third scenario, which tends already to be the outcome of the periodic crises in the NHS, is that it will continue to muddle through, with its current least worst settlement largely in place. As time goes on and if the private sector continues to grow this third path may become less likely, since an increasing proportion of the population will come to rely on the private sector for more of its health care.

Maybe the most important development will be in our sensibilities. Having been told for so long that change is inevitable, the prospect of change does not seem quite so alarming, even though the evidence that it will solve the enduring problems of health care in the United Kingdom is lacking.

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Change and resistance to change in the NHS

Diane Plamping

The NHS is 50 years old. Every government since 1948 has re-invoked its founding principles, but there is less agreement about how services based on these principles should be organised. Alongside remarkable stability in the espoused purpose of the NHS there has been almost constant structural change. Health action zones and primary care organisations are the latest offerings. There is a paper mountain of advice on reforms, restructuring, and managing change. Yet many behaviours do not change. The puzzle is why the NHS has been so unchanging, given the barrage of attempts to "reform" it.

Some things have changed, of course, in as much as complex systems can be changed from outside. Bits have been knocked off and elements have been downsized or re-engineered, but these changes have been resisted by most "insiders." These insiders have been successfully self ordering so that much of what happens in the NHS is unchanged in nature, if reduced in quantity. During all this investment in managing change, most insiders have not come to want the NHS to be different.

In this anniversary year it may not be enough simply to restate values and purpose. A more fruitful approach may be to focus on the behaviour of this complex system and to try to understand what creates the internal dynamics and maintains enduring patterns of order and behaviour.

Commonly, change is understood in terms of top-down plans. The centre has a strategic "map," and this is translated into organisational structures that are designed to fit, like the pieces of a jigsaw. But this has only a limited influence on the way that individual staff work with patients. Another approach is to look for guiding principles that are compatible with both the purpose of the NHS and the daily decision making that takes place in millions of patient contacts. If we could describe what gives rise to the behaviour patterns of the NHS this might help us decide what we want to retain and what we want to adapt to take us through the next 50 years. We can hypothesise that, if there are guiding principles that shape behaviour in the NHS, then the NHS can be reformed only by engaging with and changing the principles themselves.

Summary points

Despite considerable structural change and numerous attempts at "reform," the underlying nature of the NHS has remained remarkably stable and many behaviours have not changed

This stability could be explained by the stability of the guiding principles that shape behaviour in the NHS—"Can do, should do," "Doing means treatment," "Treatment should fix it," and "I am responsible"

These principles, though once appropriate, may now be reducing the NHS's adaptive capacity

To allow proper reform of the NHS, we have to engage directly with these guiding principles and change them, rather than simply changing the organisational structure

Urban Health Partnership, Primary Care Group, King's Fund, London W1M 0AN
Diane Plamping, *codirector*
wws@dial.pipex.com

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Principles that shape behaviour

Can we describe the principles that shape the behaviour which we identify with the NHS? Are they still useful? May they now be reducing the NHS's adaptive capacity, although they were once useful? What are the appropriate guiding principles for a modern, publicly funded, national health service? We have identified some principles that we believe, taken together, can describe current patterns of behaviour in the NHS:

- Can do, should do
- Doing means treatment
- Treatment should fix it
- I am responsible

Can do, should do

This reflects the way in which the original statement of purpose that the NHS provide a comprehensive health service is converted into everyday meaning that the NHS should provide health care on the basis of "what can be done should be done" (personal communication, M Flatau, Complexity and Management Centre, University of Hertfordshire). In 1948 this principle made sense: there were postwar shortages of everything (so more was better), far fewer available treatments, and a widespread belief that science produced unalloyed benefits. Fifty years later the same conditions do not apply: the range of possible medical interventions could swallow a huge section of our gross domestic product (GDP), we are more wary of technology,[1] and treatment can be seen as unkind, unnecessary, ineffective, inappropriate, or unethical.[2]

Cochrane suggested that the NHS should provide all effective treatments free of charge.[3] But does this mean do everything that is effective or does it mean do everything that is appropriate? Or, since there can surely be no guarantee that the NHS budget will be allowed to match that level of service, does it mean do everything that is on the authorised list of NHS treatments?

The introduction of purchasing in the 1980s has revealed that there may be two self ordering systems within the NHS—crudely, one represented by clinicians and patients and one by managers and public health practitioners. "Can do, should do" is a principle based on rights. For individual therapeutic decisions it probably still provides a reasonable basis for action, although "Can do, should be available" might be closer to the balance required between advantage and risk. In contrast, the public health principle of do what produces the maximum health gain with the available resources is founded on a goal based interpretation of distributive justice. This is not a dilemma when one or other horn presents the best solution. It is a paradox in which resolution requires the adequate expression of both elements.

From this perspective it may be time for the NHS to limit "Can do, should do" to a set of interventions recognised by all as effective and necessary for social cohesion and guaranteed to be universally available without delay. Any additional spending on health care would then be governed by the principle of maximising the health gain for the population.

TOPHAM PICTUREPOINT

The NHS's concentration on treatment allowed it to ignore determinants of health such as poverty and ill housing

Doing means treatment

In the 1940s the NHS was part of the creation of the welfare state, perhaps even its flagship. The motivation for change was not the unequal standardised mortality ratios of different social classes. The motivation was to make medical care available to everyone, which has become internalised as "Doing means treatment." For practitioners and managers, equity has come to mean equal treatment rather than the agenda of redistributive social justice of the 1940s.

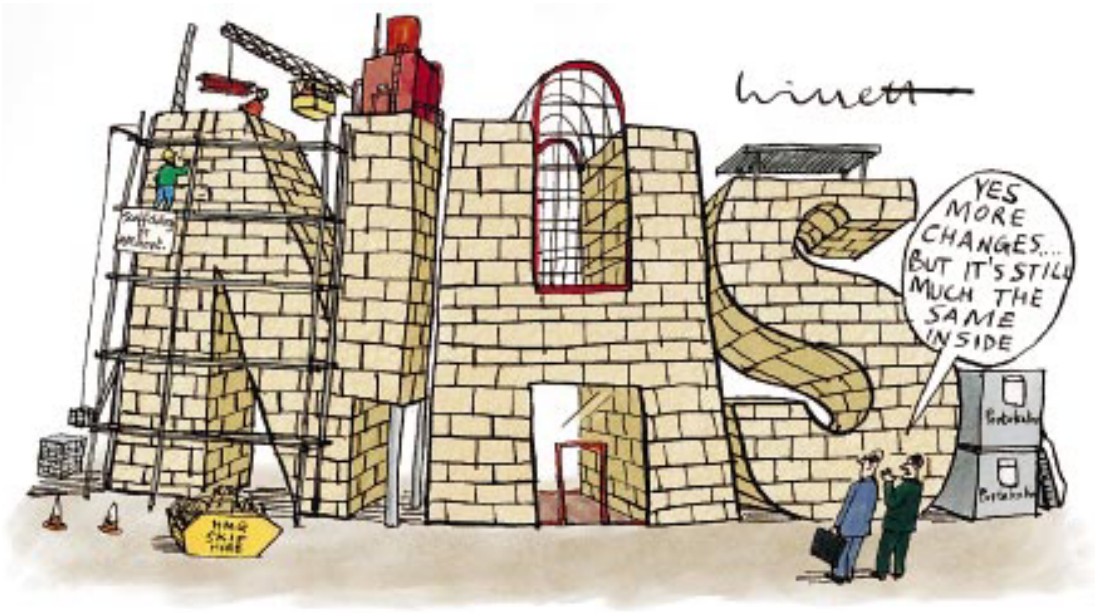
There is no lack of evidence linking poor diet and poor housing, for example, to poor health,[4 5] but this has little impact on behaviour in the NHS. The potential benefits of disease prevention and health promotion are uncontested. The principle of "Doing means treatment" has allowed preventive therapies and health promoting activities to be accepted at a personal level. But this principle may be responsible for the fact that 50 years later the NHS has not tackled the major determinants of ill health that require collective action. How will the NHS respond to today's agenda from the Social Exclusion Unit and the government green paper *Our Healthier Nation*?[6]

Treatment should fix it

Most healthcare professionals are motivated to make people well. The hope that they can do so leads to the belief that treatment should fix it and, thus, that the product is cure. In 1948 there was a legacy of ill health that had never been treated. It was reasonable to assume that once treatment got under way the population would become healthier. Fifty years later this principle is no longer advantageous if the system is designed to deal with acute illness but still deals inadequately with chronic illness. The application of this principle over the years has resulted in relative underinvestment in caring and rehabilitative services. It is no accident that the Cinderella services remain Cinderellas.

I am responsible

Part of the "genetic code" of professional identity is the principle "I am responsible." Professionals have to be able to decide and act autonomously. In 1948 many



interventions could be handled by a single professional, and if that professional took responsibility the job would be responsibly done. Fifty years later the "I" can be a problem when it excludes others from sharing that responsibility. As technology has advanced and specialisation progressed, interprofessional working has become the norm. Responsibility has to be shared with patients too, many of whom are looking for a partnership with clinicians in deciding their treatment and care. And now the white paper *The New NHS* proposes something called "a duty of partnership" on all organisations in the NHS.[7]

When "I am responsible" leads to many different individuals struggling for dominance, team working and interagency cooperation become fraught. So called solutions turn out to have more to do with ownership than collaboration, which may go some way to explaining the NHS mania for reorganising control structures. How would it work if this principle were replaced by "I am responsible in partnership with others"? This would support working across boundaries to build relationships and other sorts of management activity. And we might see mainstream money, not just peripheral budgets, linked to working in partnership. What would it mean for professional interactions with patients, and with other professionals, to be guided by the principle "The system is responsible and I will behave responsibly"? For a start, we might expect a new emphasis on co-providing, in which professional-patient interactions would be seen as meetings between experts where the knowledge of experience is valued alongside professional expertise.[8]

Conclusions

Management of change in the NHS often consists of attempts to control behaviour by changing the organisational structure. I suggest that order, in contrast with control, may arise from guiding principles that reflect the meaning and purpose people ascribe to their work in the NHS. Changing to a new pattern of order may be achieved by engaging directly with these guiding principles.[9]

People are exploring ways of working that allow intervention at this level.[10] These include, but are not limited to, large group interventions,[11] and they share several key features:

- People come together from a range of different perspectives
- People spend enough time together to move beyond first impressions
- People engage in conversations that generate possibilities but don't start with problem solving.

You can start the process yourself by talking about "Can do, should do" over a cup of coffee with somebody you don't usually work with.

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Getting research findings into practice

Making better use of research findings

Andrew Haines, Anna Donald

This is the first in a series of eight articles analysing the gap between research and practice

Department of Primary Care and Population Sciences, Royal Free and University College London Schools of Medicine, London NW3 2PF

Andrew Haines, *professor of primary health care*

Department of Epidemiology and Public Health, University College London Medical School

Anna Donald, *lecturer*

Correspondence to: Professor Haines a.haines@ucl.ac.uk

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There is increasing interest in implementing research findings in practice both because of a growing awareness of the gap between clinical practice and the findings of research and also because of the need to show that public investment in research results in benefits for patients. Improved understanding of the reasons for the uptake of research findings requires insights from a range of disciplines. In order to promote the uptake of research findings it is necessary to identify potential barriers to implementation and to develop strategies to overcome them. Specific interventions that can be used to promote change in practice include using clinical guidelines and computerised decision support systems, developing educational programmes, communicating research findings to patients, and developing strategies for organisational change.

Interest in how best to promote the uptake of research findings has been fuelled by a number of factors including the well documented disparities between clinical practice and research evidence of effective interventions. Examples include interventions in the management of cardiac failure, secondary prevention of heart disease,[1] atrial fibrillation,[2] menorrhagia,[3] and pregnancy and childbirth.[4] In the United Kingdom the advent of the NHS research and development programme has led to greater involvement of NHS personnel in setting priorities[5] and to the establishment of a programme to evaluate different methods of promoting the implementation of research findings.[6] The concept of pay back on research[7] has also been developed, resulting in a framework that can be used to assess the benefits arising from research.

Relying on the passive diffusion of information to keep health professionals' knowledge up to date is doomed to failure in a global environment in which about 2 million articles on medical issues are published annually.[8] There is also growing awareness that conventional continuing education activities, such as conferences and courses, which focus largely on the passive acquisition of knowledge have little impact on the behaviour of health professionals.[9] The circulation of guidelines without an implementation strategy is also unlikely to result in changes in practice.[10]

Health professionals need to plan for rapid changes in knowledge, something that is likely to persist throughout our professional lifetimes and which encompasses not only diagnostic techniques, drug treatment, behavioural interventions, and surgical procedures but also ways of delivering and organising health services and developing health policy. Many health professionals already feel overburdened, and therefore a radical change in approach is required so that they can manage change rather than feel like its victims. A number of steps are necessary in order to support this process.

Summary points

- Reasons for failing to get research findings into practice are many and include the lack of appropriate information at the point of decision making and social, organisational, and institutional barriers to change
- All people within an organisation who will have to implement the change or who can influence change should be involved in developing strategies for change
- Better links between clinical audit, continuing education, and research and development need to be developed
- Evidence of the effectiveness of specific interventions to promote change is still incomplete, but a combination of interventions will probably be needed
- The pressure for more effective and efficient implementation of research findings is likely to grow

Keeping abreast of new knowledge

Health professionals need timely, valid, and relevant information to be available at the point of decision making. Despite extensive investment in information technology by the NHS the rapid delivery of such information is not widely available. Relatively simple prompting and reminder systems can improve clinicians' performance[11]; the price of useful databases such as *Best Evidence* (which comprises *Evidence-Based Medicine* and the American College of Physicians Journal Club on CD ROM) and *The Cochrane Library* is little more than the cost of subscribing to a journal. There are an increasing number of journals, such as *Evidence-Based Medicine,* that review important papers rigorously and present the results in a way that busy clinicians can rapidly absorb. The NHS reviews and dissemination centre in York compiles systematic reviews that are relevant to clinicians and policymakers. Nevertheless, many clinicians still do not receive such information,[12] and more needs to be done to provide a wider range of high quality information that is usable in practice settings.

Librarians' roles are changing rapidly; in North America, for example, some librarians are involved in clinical practice through programmes such as literature attached to the chart (LATCH).[13] In these programmes, hospital librarians participate in ward rounds and actively support clinical decision making at the bedside. Requests for information are documented

in the notes, and articles are subsequently delivered to the ward. Similar programmes could be introduced elsewhere after appropriate evaluation, but information support is also needed in primary care settings. In the United Kingdom many health professionals, such as nurses, may not be permitted to use their hospital library since they are not formally affiliated with the (medical) body that funds them.

Implementing knowledge

Research findings can influence decisions at many levels—in caring for individual patients, in developing practice guidelines, in commissioning health care, in developing prevention and health promotion strategies, in developing policy, in designing educational programmes, and in performing clinical audit—but only if clinicians know how to translate knowledge into action. The acquisition of database searching and critical appraisal skills should give health professionals greater confidence in finding and assessing the quality of publications, but this does not necessarily help in applying new knowledge to day to day problems.[14] Much attention has been paid to the use of best evidence during consultations with individual patients—that is, using evidence based medicine derived largely from epidemiological methods.[15 16] However, organisational change is often also necessary to implement clinical change. Even a step as simple as ensuring that all patients with a history of myocardial infarction are offered aspirin requires that a number of smaller steps are taken including identifying patients, contacting them, explaining the rationale, checking for contraindications, and prescribing aspirin or advising patients to buy it over the counter. Furthermore, health professionals have their own experiences, beliefs, and perceptions about appropriate practice; attempts to change practice which ignore these factors are unlikely to succeed. Awareness of these pitfalls has led to greater emphasis on understanding social, behavioural, and organisational factors which may act as barriers to change.[17]

A wide spectrum of approaches for promoting implementation has been used. These approaches are underpinned by a number of theoretical perspectives on behavioural change such as cognitive theories which focus on rational information seeking and decision making; management theories which emphasise organisational conditions needed to improve care; learning theories which lead to behavioural approaches involving, for example, audit and feedback and reminder systems; and social influence theories which focus on understanding and using the social environment to promote and reinforce change.[18]

Clearly these approaches are not mutually exclusive. For example, the transmission of information from research to single practitioners or small groups of health professionals through educational outreach has a strong educational component but might also include aspects of social influence interventions[19] in pointing out the use of a particular treatment by local colleagues. The marketing strategies used by the pharmaceutical industry depend on segmentation of the target audience into groups that are likely to share characteristics so that a message can be tailored to that

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group.[20] Similar techniques might be adapted for non-commercial use within the NHS. The evidence for the effectiveness of different approaches and interventions is still incomplete and will be reviewed in a subsequent article in the series.[21] In many cases a combination of approaches will be more effective than a single intervention.[22] No single theoretical perspective has been adequately validated to guide the choice of implementation strategies.

The study of the diffusion of innovations—how new ideas are transmitted through social networks—has been influential in illustrating that those who adopt new ideas early tend to differ in a number of ways from those who adopt the ideas later. For example, those who adopt new ideas early tend to have more extensive social and professional networks.[23] Much of the medical literature has a bias towards innovation and the underlying assumption is that innovations are bound to be beneficial. However, in health care the challenge is to promote the uptake of innovations that have been shown to be effective, to delay the spread of those that have not yet been shown to be effective, and to prevent the uptake of ineffective innovations.[24]

Steps in promoting the uptake of research findings

- Determine that there is an appreciable gap between research findings and practice
- Define the appropriate message (for example, the information to be used)
- Decide which processes need to be altered
- Involve the key players (for example those people who will implement change or who are in a position to influence change)
- Identify the barriers to change and decide how to overcome them
- Decide on specific interventions to promote change (for example the use of guidelines or educational programmes)
- Identify levers for change—that is, existing mechanisms which can be used to promote change (for example, financial incentives to attend educational programmes or placing appropriate questions in professional examinations)
- Determine whether practice has changed in the way desired; use clinical audit to monitor change

Important characteristics of the message

Content

- Validity
- Generalisability (settings in which the intervention is relevant)
- Applicability (the patients to whom the intervention is relevant)
- Scope
- Format and presentation (for example, will there be written or computerised guidelines, will absolute and relative risk reductions be presented)

Other characteristics

- Source of the message (for example, professional organisation, Department of Health)
- Channels of communication (how the message will be disseminated)
- Target audiences (the recipients)
- Timing of the initial launch and frequency of updating
- Mechanism for updating the message

Although different people can promote the uptake of research findings—including policymakers, commissioning authorities, educators, and provider managers—it is largely clinicians and their patients who will implement findings. A number of steps need to be taken in order to get research findings into practice (box previous page). The characteristics of the message should also be considered; they may influence the degree to which the message is incorporated into practice (box above).

The choice of key players—those people in the organisation who will have to implement change or who can influence change—will depend on the processes to be changed; in primary care, for example, nurses and administrative staff should be involved in many cases, in addition to general practitioners, since their cooperation will be essential for organisational change to be effective. If the innovation involves the acquisition of specific skills, such as training in certain procedures, then those who organise postgraduate and continuing education are also key players.

The identification of barriers to change and the development of strategies to overcome them are likely to be of fundamental importance in promoting the uptake of research findings. Some examples of barriers to the application of research findings to patients are given in the box on the next page. A future article will propose a conceptual framework for analysing and overcoming barriers.[25] Since some of the strongest resistance to change may be related to the experiences and beliefs of health professionals, the early involvement of key players is essential in identifying and, when necessary, overcoming such impediments to change. Barriers need to be reviewed during the process of implementation as their nature may change over time.

Interventions to promote change must be tailored to the problem, audience, and the resources available. Educational outreach, for example, may be particularly appropriate for updating primary care practitioners in the management of specific conditions because they tend to work alone or in small groups. Guidelines based on research evidence may be developed and endorsed by national professional organisations and adapted for local use as part of clinical audit and educational programmes.

Linking research with practice

There need to be closer links between research and practice, so that research is relevant to practitioners' needs and so that practitioners are willing to participate in research. While there is evidence that some researchers can promote their own work,[26] in general researchers have not been systematically involved in the implementation of their own findings and may not be well equipped to do this. In the United Kingdom, the NHS research and development programme is seeking views about priorities for research through a broad consultation process.[5] Better methods of involving those who are most likely to use the results of research are needed to ensure that research questions are framed appropriately and tested in relevant contexts using interventions that can be replicated in everyday practice. For example, there is little point conducting trials of a new intervention in hospital practice if virtually all of the treatments for a particular disorder are carried out in primary care settings. Contextual relevance is particularly important in studies of the organisation and delivery of services,[27] such as stroke units, hospital at home schemes, and schemes for improving hospital discharge procedures to reduce readmissions among elderly patients. If unaccounted for, differences in skill mix and management structures between innovative services and most providers can make it difficult for providers to have a clear view of how they should best implement findings in their own units.

Interaction between purchasers and providers—In the NHS, purchasers as well as providers should be involved in applying research findings to practice. Purchasers can help create an environment conducive to change, for example, by ensuring that health professionals have access to information, that libraries are financially supported, and that continuing education and audit programmes are configured to work together to promote effective practice. Purchasers could also ensure that the organisation and delivery of services takes into account the best available research evidence. However, it is clear that the degree of influence exerted by purchasers on the practice of providers is limited,[28] and that priority must be given to helping providers develop the capacity to understand and use research findings.

Making implementation an integral part of training—For many health professionals, involvement in implementation may be far more relevant to their careers and to the development of the NHS than undertaking laboratory research, yet pressures to undertake research remain strong. Greater encouragement should be given to clinicians to spend time learning to use and implement research findings effectively.

Conclusion

Learning to evaluate and use research findings in daily practice is an important and lifelong part of professional development. This requires not only changes in educational programmes, but also a realignment of institutions so that management structures can support changes in knowledge and the implementation of changes in procedures.

There are major structural difficulties that need to be overcome in the NHS. For example, better coordination at national, regional, and local levels is required between the education and training of health professionals, clinical audit, and research and development. This type of coordination should be a priority for the proposed national institute for clinical excellence in the United Kingdom.[29]

It has been suggested that financial considerations, rather than the potential for gaining useful knowledge, affect general practitioners' choice of continuing education courses.[30] One of the aims of continuing education should be to ensure that practitioners stay up to date with research findings of major importance for patient care and change their practice accordingly. Continuing education activities need to take into account evidence about the ineffectiveness of many traditional approaches. To develop a more integrated approach to promoting the uptake of research findings, health systems need to have coordinated mechanisms that can manage the continuing evolution of medical knowledge.

The advent of research based information that is available to patients[31] and the increasing accessibility of information of variable quality through the internet and other sources suggests that doctors have the potential to act as information brokers and interpreters for patients. Doctors could also work together with user groups representing patients or their carers, a number of which have demonstrated an interest in and commitment to providing quality research based information to their members.[32] The pace of change in knowledge is unlikely to slow. As health systems around the world struggle to reconcile change with limited resources and rising expectations, pressure to implement research findings more effectively and efficiently is bound to grow.

Potential barriers to change

Environmental

In the practice

- Limitations of time
- Limitations of the organisation of the practice (for example, a lack of disease registers or mechanisms to monitor repeat prescribing)

In education

- Inappropriate continuing education and failure to connect with programmes to promote better quality of care
- Lack of incentives to participate in effective educational activities

In health care

- Lack of financial resources
- Lack of defined practice populations
- Health policies which promote ineffective or unproved activities
- Failure to provide practitioners with access to appropriate information

In society

- Influence of the media on patients in creating demands or beliefs
- Impact of disadvantage on patients' access to care

Personal

Factors associated with the practitioner

- Obsolete knowledge
- Influence of opinion leaders (such as health professionals whose views influence their peers)
- Beliefs and attitudes (for example, a previous adverse experience of innovation)

Factors associated with the patient

- Demands for care
- Perceptions or cultural beliefs about appropriate care

Factors which in some circumstances might be perceived as barriers to change can also be levers for change. For example, patients may influence practitioners' behaviour towards clinically effective practice by requesting interventions that have been proved to be effective. Practitioners might be influenced positively by opinion leaders.

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