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The disalienation of the NHS

The thirtieth anniversary of the NHS has brought predictable self-congratulatory noises from the Department of Health. The volume of Government spending on the Health Service has doubled since 1948, says the anniversary booklet,[1] and developments such as renal dialysis and EMI scanners "have been made available to many people who could not otherwise have afforded them." These platitudes ignore the realities: Britain provides treatment for end-stage renal failure for a smaller proportion of its population than the French, the Dutch, the Scandinavians, or the Australians[2]; children die while waiting for over a year for admission for investigation of suspected congenital heart disease[3]; and hardly a week passes without newspaper headlines of hospitals closed or threatened by militant union action. In 1948, the NHS may have been an example to the rest of the world, but 30 years later it measures poorly against many alternative methods of providing health care, and its medical and nursing staff are disillusioned and depressed.

Yet only ten years ago the same staff were enthusiastic and optimistic. There is nothing wrong with the concept of the NHS, and it has substantial advantages when compared with some forms of health insurance. So on this anniversary we should ask two questions. What has gone wrong? And how can we get things right?

Two experienced commentators, one Sir Francis Avery Jones, a clinician, and the other Professor Rudolf Klein, an academic, offer their own explanations in this week's *BMJ* (pp 5 and 73). The reorganisation of the NHS was, they agree, a mistake: it put too big a distance between administrators and clinicians, breaking up the partnership between those working in hospitals and those running the service. As a result, DHSS plans are now seen to be remote from bedside experience. As Sir Francis says, "Doctors have been faced with three major documents—*RAWP*, *Priorities*, and *The Way Forward*—written mainly by economists, senior civil servants, and administrators who have had no recent clinical contact." Yet the unanimity of clinicians' misgivings and doubts about these proposals has had no obvious impact on the Department's thinking. For too long now the people concerned with treating patients have felt harassed and frustrated by the growing army of non-clinical administrators and experts. The proliferation of consultative committees has so slowed the process of taking decisions that many doctors look back with nostalgia to the days of benevolent despotism by medical superintendents.

Nevertheless, we have no chance of turning back the clock, for the second important change has been the growth of industrial-style disruption of hospital work by discontented and militant trade unionists. Outside medicine, in almost every occupation there is a growing demand among unskilled and semiskilled workers for their voices to be heard in management decisions, and the NHS has been no exception. Within medicine some of the militant outbursts have been the consequence of successive pay policies superimposed on already low pay levels, others the result of inadequate staffing. Whatever the reasons, however, many disputes have been compounded by bad and sometimes frightened management. Furthermore, in the NHS the inevitable conflicts have been made more bitter by the added factor of political beliefs about private practice (encouraged by members of the Government who have done nothing to help) and by the autocratic attitudes of some doctors.

The combination of an administration remote from practical realities and abrasive labour relations has made our health service more vulnerable to the stresses of the current decade than that in some other countries. All over the world medical services have been struggling to reconcile economic stagnation with a period of remarkable technical and pharmaceutical innovation, and Britain has coped poorly with the need for decisions on priorities to be made quickly and firmly. If any future historian is looking for objective evidence of the failure of the current administrative structure of the NHS he will find it in the delays and procrastinations in decision-making—a major cause of the low morale in the Service.

Most thoughtful people agree on the defects of the 1974 reorganisation, but no major revision is likely before the report of the Royal Commission. Some action is needed more urgently than that, however, if the downward spiral is to be halted; and here Professor Klein makes some valuable suggestions. We need, he says, to create a working environment in which all concerned—doctors, nurses, and ancillary workers—have to live with the consequences of their decisions. This would mean replacing the present cumbersome system of long-distance management by small units which are (so far as possible) self-governing and self-contained—in the same way that a group practice is an accountable unit. Such a move would be in sympathy with current social trends towards decentralisation—but it would also depend on some means being found to measure and monitor performance. In an era when every change is seen as a concession, the offer of local autonomy in exchange for a system of audit of process and outcome might well prove acceptable. Nevertheless, any proposal for decentralising the NHS has to take account of fears among doctors (and others) of a return to the worst features of the local authority hospitals in the first half of this century. Their third-rate medicine, practised on the cheap, dominated the thoughts of medical politicians in 1948 (see p 28), and clearly national decisions on policies and priorities will still be necessary if groups (such as the mentally handicapped) with little political muscle are not to be neglected. Here, says Professor Klein, the NHS can learn from industry and enable its workers (of all professions and

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grades) to participate with its management in framing national policies. It would then be up to the unions and professional associations concerned to persuade and if necessary require their members to conform with those policies. The reshaping of the steel industry is evidence that draconic decisions can be carried out if they have been agreed as necessary by both unions and management.

The NHS is a public service. So how can the public help to improve it? By strengthening patient participation, by everyone taking a much closer interest in the local running of the Service than now—all the time, and not just when closures are threatened or services break down—and by providing more voluntary help, particularly in the community health services. More local autonomy for the NHS should, in any case, facilitate such changes, which would shift the balance of power towards the patient. But in the present climate of conflict and dissent national public opinion could do much to persuade NHS staff that strikes in the Health Service are an unacceptable face of unionism. Perhaps the professional organisations such as the BMA, the BDA, and the RCN could use their collective prestige and skill to launch a publicity campaign to this end.

More than anything else everyone in the NHS needs to see some light at the end of the tunnel. Despite the promised wealth from North Sea oil there is little prospect of any substantial increase in Government spending on health; and technical innovation on the one hand and the public's insatiable appetite for pastoral care on the other will ensure that there will always be more demands than there are resources. Shortage of money is a potent source of conflict, but a sense of common purpose is an equally potent means of averting dissent. Morale can be restored and the service improved (Sir Francis Avery Jones believes that increased morale can raise productivity by 10%) if doctors and other NHS staff become convinced that their efforts will bring results that are self-evident. Possibly another 10% could be saved by better prescribing, more selective use of laboratory and *x*-ray facilities, changed staff rotas, and other economies—but only if the benefits are visible in the form of new buildings, new paint, new equipment, or extra staff. This point has been made so often by people of all political persuasions and concerned with all aspects of the NHS that we wonder why it continues to be ignored. Could not the DHSS celebrate this 30th anniversary by showing an "earnest of its intent" (to use that phrase beloved of all politicians) and starting a pilot scheme of refunding money saved to the area or district that is responsible for saving it?

Even so, the change in attitude needed for any successful innovations will require more than administrative circulars: it will require a restoration of faith in the non-material rewards that come from caring for patients in an environment free from internal dissension and outside interference.

[1] *NHS and Social Services: Thirtieth Anniversary*. London, DHSS, 1978.
[2] *Renal failure: a priority in health?* London, Office of Health Economics, 1978.
[3] *The Guardian*, 15 June 1978.

PUVA

The initial enthusiastic report on treating psoriasis by the oral use of 8-methoxypsoralen followed one to two hours later by high-intensity long-wave ultraviolet radiation (UVA) appeared four years ago.[1] In the past year or two hardly a week has gone by without some further paper on PUVA (psoralen-UVA) treatment. Neither the psoralen nor the UVA is fully effective when used alone. There can be no doubt that such treatment is very, sometimes even dramatically, effective[2-4]: in one large American series of 1308 patients, 88% were cleared by the treatment.[4] PUVA has another great advantage in that it can be used for such difficult problems as generalised pustular psoriasis,[5] unresponsive to conventional treatment. When, however, the potential hazards are added to the cost it is clearly not the treatment of choice for psoriasis of mild-to-moderate severity.

PUVA is also effective in some other skin diseases. It may prove to be the treatment of choice in early mycosis fungoides,[6] though probably not in the late tumorous stage. Some bad cases of atopic dermatitis have been helped, but rather large doses and prolonged courses are required.[7] Lichen planus[8] and urticaria pigmentosa[9] have recently been added to the list. PUVA is not effective in acne,[10] which it may even induce,[11] and is disappointing in vitiligo. This diversity of responsive diseases poses interesting problems as to how PUVA works and how the diseases are caused.

There must be real misgivings that such an apparently effective and acceptable treatment is not being used even more than it is. The short-term side effects are mainly very minor if care is taken—most units monitor urine, blood count, blood urea, and liver function tests. The risk of ocular damage seems to be small, but dark glasses must be worn not only during the treatment but for eight hours or perhaps longer after the drug has been taken; not all dark glasses are equally effective.[12] Nevertheless, the drug has been taken for many years in sunny climates for the treatment of vitiligo without serious mention of ocular damage.

Nobody knows the long-term side effects of PUVA. Some premature aging of the skin is likely (as with ordinary sunlight), but this seems an acceptable risk. The rodent ulcers and squamous carcinomas that may arise in light-damaged skin should not prove too great problems. The risk of melanomas and other malignancies is more worrying and is being tested by careful laboratory work. There is still some doubt about the mutagenic potential of 8-methoxypsoralen in the dark. Until these problems have been sorted out—and with the added problem of the difficulties in accurate formulation of the drug—this treatment has not yet been given general approval by the Committee on Safety of Medicines and has no product licence. When PUVA is prescribed it is on a named patient basis. Nobody wishes to repeat the early troubles with radium. How much explanation of these potential hazards amounts to informed consent (which should always be sought) and what are the legal implications?

At present, therefore, the dosage of radiation should be kept as small as possible. Schedules have been suggested,[2 3 13] but accurate measurement of the radiation is important and far from simple.[14] Small UVA units are available or can be home-made to treat localised or resistant areas. The use of topical psoralens and UVA is an attractive idea which preceded the oral use of the drug. This regimen can be effective, and it poses very considerable problems,[15] but may well come to be of considerable importance.[16] The trials comparing PUVA and conventional dithranol treatment have not yet been completed, and many questions remain unanswered, in particular about maintenance treatment. Should we aim to give more modest doses than those recommended to achieve complete clearing and be satisfied with less than a 100% success? Should we clear the psoriasis and then try to treat subsequent relapses with conventional local applications—a regimen successful in some departments? Should dithranol be used to clear the psoriasis and then PUVA used to maintain clearance? Should the treatments be combined? Most patients who have experienced the antisocial features of dithranol and the attractiveness of PUVA therapy are reluctant to use dithranol, and more evidence is required before pressure can be brought to bear.[17] The combination of tar with PUVA apparently has little virtue.[15] Corticosteroids have become less popular for the long-term management of widespread chronic psoriasis. Short treatment with a strong topical steroid may reduce the number of PUVA treatments required, but the evidence on the rate of relapse is conflicting.[17 18]

Until these questions have been solved there is much to be said for following the Task Forces on Psoriasis and Photobiology of the American Academy of Dermatology[18] in recom-