Britain and the Netherlands have been at the forefront of these developments, followed closely by Germany. In the Netherlands the Dekker Report of 1988 has led to the introduction of competition between both insurers and providers. The aim is to establish a system in which patients may choose between insurers who in turn will contract selectively with providers. These changes are being implemented over a period of years and it will take some time before they come fully into effect.

Viewed in the Dutch context, the pace of reform in Britain seems reckless in the extreme. An alternative interpretation is that the existence of a majority government has provided Margaret Thatcher and now John Major with an ability to act, which their European counterparts observe with envy. From this position, British policy makers have been able to act decisively to tackle weaknesses in the financing and delivery of health services, and their experience is being followed closely throughout the developed world. In this respect, the NHS has become a laboratory for other countries, acting as a test bed for the grafting on of competition to a managed system.

The unanswered question is, will the experiment prove a success? We don't yet know. As the OECD's analysis is right to point out, although there are some encouraging signs, there is as yet insufficient experience and evidence on which to make a firm judgment.

Even more important, whatever the long term benefits of managed markets, there may well be a price to pay in terms of reduced access to care and greater inequity in service delivery. These are the inevitable trade offs involved in designing health care systems. There are also limits to which supply side reforms can be expected to compensate for underfunding.[3] To this extent, the cost containment policies of the 1980s may have tackled one set of problems only to have caused others. The puzzle is how to combine the control of expenditure at the macro level with real incentives for efficiency at the micro level. The country that is able to solve this puzzle will indeed be the envy of the world

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Open access upper gastrointestinal endoscopy

Popular, but is it right?

Demand for open access endoscopy, the investigation of dyspeptic symptoms in patients directly referred from general practitioners to endoscopy clinics without prior hospital screening,[1] is growing. Current estimates suggest that such services are available in about half of Britain.[2] Consultant gastroenterologists being appointed around the country are charged with setting up these services, and the investigation is popular with general practitioners, particularly fundholders. Its economic appeal is obvious: bypassing outpatient departments probably cuts the cost of referral by half.[3]

But is it the right thing to do? Our understanding of the pathogenesis of dyspepsia, one of the commonest symptoms, is poor, and our management mainly empirical.[4] Clinical assessment and some form of investigation are mandatory in many patients, but investigation reveals only relatively trivial underlying disease in most.[4] Attempts have been made with computer based questionnaires, ultrasonography, serological testing for *Helicobacter pylori*, studies of gastric acid secretion, acid perfusion tests, pH monitoring, oesophageal manometry, and gastric emptying measurements to separate out subgroups, but mostly to no avail. Endoscopy is undoubtedly the most sensitive tool we have to investigate the upper gastrointestinal tract[5-7]: it is more accurate than even a double contrast barium meal examination and permits direct visualisation and biopsy, confirming inflammatory changes, neoplasms, or *H pylori* infection. But even so it is not necessarily the right first line investigation for all patients, given its expense, risks, and inconvenience.

Studies have suggested various benefits for the investigation.[8 9] In the largest published series, Gear and Wilkinson reported that endoscopy progressively replaced barium meal studies and was popular with general practitioners, which led to more referrals.[10] The case has been made for using this technique primarily to identify early gastric cancer,[11] and its use to exclude cancer in dyspeptic patients presenting over the age of 40 is easy to justify.[4 11]

But others have been less enthusiastic and found its benefits less clear cut. Holdstock *et al* did not find that more ulcers and gastric neoplasms were detected, and attempts to improve diagnostic accuracy by using a scoring system had only limited success.[12 13]

No evidence currently exists for initially investigating all dyspeptic patients endoscopically. The widespread introduction of endoscopy before proper evaluation would therefore seem to be a classic example of how market forces distort patterns of medical care. Deciding on the proper role of this procedure would seem vital. Other screening tests also deserve evaluation to decide whether they are preferable to endoscopy in the initial management of patients with dyspepsia.[6]

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