

The fairy godmother has spoken

One of the occasional complaints voiced by UK GPs is that the planners and policy makers award so little attention to primary care. However, policy statements from the Department of Health have, in the recent past, often contained unwelcome surprises, and the prospect of a new policy statement is likely to cause very mixed feelings. So, the predominant response to the White Paper *Our health, our care, our say: a new direction for community services*¹ is likely to be a sigh of relief. General practice, as it is currently practised, receives a qualified vote of praise. The document is concerned with poor primary care provision in some areas of England and Wales, and for some groups of people, and proposes new methods for dealing with them. This has to be welcomed: such failures of conventional general practice have long been acknowledged and the difficulty of provision for disadvantaged groups is a stain on the face of UK primary care. Even the qualifications result in what are, for the most part, familiar recommendations and many of the so-called innovations are already in place in many practices. They include a repetition of access targets, a commitment to nurse triage, and better use of IT. Even in the section dealing with longer opening hours, the Department has begun to realise that extended hours are not compatible with personal continuity, which the public consultation has, again, identified as both a key strength and feature valued by patients. All the UK GPs who have been responsible for such innovations in the past few years may experience passing irritation at the Department of Health claiming ownership of their ideas, but they know a form of flattery is working here.

The proposals to deal with the provision of primary care in under-doctored areas will alarm some. The opportunity for the independent sector to bid to provide services in such areas is specifically encouraged, and there will be some concern that this is the first step in

opening up the whole of NHS primary care in England and Wales to be managed by US health corporations; and, as others have commented, we all know how efficient US health care is. However, the White Paper assures us that the tendering process will be fair. I have argued that UK primary care is phenomenally efficient, so good that outsiders cannot quite believe how good it is and paradoxically we always undersell ourselves; so I would welcome a real competition between the model of what we provide here and how an outside corporation would do it — but the emphasis is on the word 'real'.

Beyond the world of general practice there are proposals covering lots of different aspects of primary care. There is predictable rhetoric about people being responsible for their own care, about responsiveness to public demand, and about end-of-life care. There is a surprising commitment, after so many years of decline, to revitalise the community hospital sector, with the hope of providing all kinds of care closer to patients' homes. There is an equally surprising statement, since it has been around already for many years, to providing named midwives for pregnant women. There is a very serious attempt to grapple with the problems of care for the increasing numbers with complex, long-term needs. There is (again familiar) talk of integrating health and social care, discussion of the needs of carers, and of the need to provide incentives for general practice.

The integration of health and social services for people with long-term problems holds out the promise of major health gains and it is probably the most important section in the White Paper. However, there will be numerous difficulties before success is guaranteed. The health and social care sectors in the UK still work in very different ways, and there is a lot of mutual suspicion. For all the talk of 'integrated packages of personalised care', there is a touching faith that such management approaches

will make a real difference; so the most welcome part of this section is the plan for demonstration projects to work out a solution. Second, there is the risk of losing sight of this important project amid the numerous other bits and pieces, included in response to the public consultation, such as the life checks, that existing evidence indicates is likely to be of marginal value. Third, there is a curiously utopian air to the whole White Paper. There is an acknowledgement that some of these developments will cost real money, but no indication where the additional resources will come from. Given recent publicity about the astonishing deficits being accumulated by Trusts and PCTs in different parts of the country, one has to wonder whether the authors of this White Paper have spent the last few months in purdah, insulated from the realities of the NHS.

This air of unreality pervades the whole document. Take, for instance, the proposals to shift care from hospital outpatient to community settings. Evidence published in these pages came up with the unsurprising conclusions that getting specialists to offer consultations in community settings is welcomed by patients, but costs more.² Even where the cost may be neutral, there has to be a consideration of the opportunity costs. There are, for instance, optimistic claims for the likely benefits of practice based commissioning. Whatever benefits accrue, there will certainly be opportunity costs associated with the time doctors and managers will spend in negotiating and managing contracts. Our difficulty is that there is still a taboo in the UK on any discussion about rationing. Every so often the topic surfaces, but those who want to replace the NHS with privately funded solutions have an interest in portraying rationing as an avoidable feature of socialised medicine, so the left feels it cannot open the debate. However in a mature democracy citizens have a right to be engaged in an honest debate, and while the Department of Health is right to consult the public to find out what

people want, it is surely part of their duty to tell the public in return which of the activities requested are worthless, and which cannot be afforded, at least at this level of funding.

Whenever commentators want to criticise some initiative as too interventionist they invoke the overworked metaphor of the nanny state. But real nannies habitually told their charges that many of the things they wanted were not allowed. Here we have the Department of Health telling the public that they can have anything they

want, regardless of cost. It is government as Fairy Godmother. It is unsustainable, and in the end dishonest. No doubt we should all like to go to the ball, but I want to know who is going to pay.

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REFERENCES

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Prescribing antibiotics to patients with acute cough and otitis media

The question of unnecessary antibiotic prescription is still in focus, both in Europe and other parts of the world. Studies have demonstrated that there is more than a threefold difference in prescribing rates between countries, without any good reason to explain the variation.¹ Respiratory tract infections (RTIs) are the reason for 60% of all antibiotic prescribing in general practice and seem to be target conditions where antibiotics can be reduced most without increasing complications. Guidelines emphasise the need both for total reduction and increasing use of narrow spectrum antibiotics. A close relationship between use of antibiotics and resistance has been demonstrated for the most common airway pathogens, especially pneumococci.^{1,2} The dilemma in clinical practice is this: we know that we generally overprescribe and that's bad for everyone. At the same time we know that a small number of patients with RTI or otitis media will, if given antibiotics, benefit with shorter illnesses, and a tiny number potentially with fewer complications. So far there is little evidence of how to select patients for whom we should be prescribing.

EPIDEMIOLOGICAL CLUES

Fleming *et al* demonstrated a fall both in respiratory tract infections (of 48%, winter; and 38%, summer) and antibiotic prescription (by 34%, winter; 21%, summer) in the UK between 1994 and 2000.³ It is debatable whether this is due to a lower incidence of RTIs in the population or a higher threshold for help-seeking among patients. Norwegian data in the same period suggests a stable incidence of respiratory tract infections of 14% of all general practice consultations, but also a significant fall in patients seeking help for otitis media of 30%.⁴ Data indicate a similar situation in Holland⁵ (T Verheij, personal communication, 2006). The fall in consultation rates in patients with otitis media is confirmed in the study by Williamson *et al* in this Journal.⁶

DIAGNOSTIC CLUES

The uncertainty of distinguishing between acute bronchitis and pneumonia and between bacterial and viral causes based on clinical clues have been demonstrated in many studies.^{7,8} Use of near patient tests such as C-reactive protein (CRP) has been expected to improve this

situation in general practice. CRP is widely used in Nordic countries and has a good ability to exclude bacterial infection, but it is still open whether it can contribute to lower antibiotic prescription.⁷ Hopstaken *et al* showed that CRP was capable of separating infections with no serological response versus viral/bacterial infections with response.⁸

OTITIS MEDIA AND OTITIS-PRONE CHILDREN

In acute otitis media it has been concluded that otitis-prone children (defined as having three episodes last 6 months and four episodes in the last 12 months) are susceptible to complications, and should be treated with liberal antibiotic use.⁹ Few countries have guidelines for this subgroup of children, and when they exist they don't show a consistent approach. Little *et al* demonstrate in their study in this issue that delayed antibiotic prescription is not likely to have adverse longer term consequences. However, otitis-prone children are more likely to have poorer outcomes. Other studies with liberal use of antibiotics to otitis-prone children