

Health checks and screening:

what works in general practice?

I know that prevention is better than cure but it's still the bit of general practice I have always enjoyed least. It's hard to be motivated by something not happening. It's easier to be motivated by screening, where the aim is to detect early-stage disease and there is often compelling evidence for the effectiveness of treatment. But GP enthusiasm for prevention has been dampened by ill-conceived NHS policy initiatives since at least 1990.¹ Dalton *et al*² are not the first to ask whether NHS Health Checks are defensible when measured against World Health Organization screening criteria.³

MORE EVIDENCE AGAINST HEALTH CHECKS

Enthusiasm for health checks will be further dampened by two other studies in the *BJGP*. Caley *et al*⁴ reported that they have surprisingly little impact on the recognition of undiagnosed diabetes, hypertension, chronic heart disease, chronic kidney disease, or atrial fibrillation. Koekkoek *et al*⁵ point out that the evidence favours targeted stepped interventions, which avoid investing scarce resources in the worried well. And the evidence from all three articles is consistent with the Cochrane meta-analysis which makes it quite clear that promoting health checks in unselected adult patients has limited impact on cardiovascular risk and no significant impact on cardiovascular mortality.⁶

However, it is important not to throw out the baby with the bathwater. Many of the constituent elements of health checks (for example, smoking advice, blood pressure management, and statin prescribing) are trial-proven effective interventions. The studies by Korhonen *et al*⁷ and Gil-Guillen *et al*,⁸ as well as Caley *et al*,⁴ confirm that population screening in primary care can detect undiagnosed cardiovascular risk. So what is going on here? Why is the evidence inconsistent?

WHY IS THE EVIDENCE INCONSISTENT?

The first half of the answer to this question is straightforward. We have known for more than 20 years that those at highest risk of cardiovascular disease are the least likely to attend for health check screening.⁹ We have known for even longer that identifying risk does nothing but harm if you don't go on to manage it effectively. Effective

management is less likely in programmes that try to deal with multiple rather than individual risks; for example, smoking cessation advice is less effective when given in the context of multifactorial health checks.¹⁰

The second half of the answer is more nuanced: context is usually more important than content in determining the effectiveness of a complex intervention so trial evidence is time and context specific. The pioneering North Karelia community-based programme of cardiovascular disease prevention (begun in 1972) provides a good example. The initial trial evidence showed no significant reduction in smoking or weight and a significant reduction in cholesterol only in males and not females.¹¹ The programme was nevertheless rolled out to the rest of Finland and subsequently associated with a fall in coronary mortality of 80%.¹²

LESSONS FROM STANFORD AND NORTH KARELIA

This is not the only important lesson from North Karelia. The most effective element of the initial intervention was the one in which primary care played the greatest role: a 46% reduction in the number of people with dangerously raised blood pressure (defined as a diastolic blood pressure >100 or systolic blood pressure >175 mmHg).¹¹ However the subsequent fall in mortality has been attributed much more to changes in diet and tobacco use achieved through government legislation, fiscal policy, and mass education rather than personalised intervention; even the major reduction in blood pressure was achieved less by identifying and treating those at very high risk than a shift to the left of the population mean.¹² Similarly in the Stanford project in the US (the other major cardiovascular prevention project in the 1970s), the initial impact of personalised care by health practitioners was transient in the context of wider community education and major secular change and was not thought to have had sufficient impact to be included in

the main five-cities programme.¹³

So what can we learn from this historical evidence? Personalised health interventions tend to be swamped by other factors influencing secular trends in health behaviour. This does not mean that GPs should play no role in primary prevention: patients notice that their GP doesn't smoke and medical opinion as a whole is an important element of the political context, which makes legislative and other changes possible. But it does mean that giving lifestyle advice in primary care is seldom cost effective. We concluded in 1990 that GPs:

*'... should be careful not to absolve the government of its public health obligations by substituting unproved preventive interventions aimed at the individual patient.'*⁹

This is as true now, as we consider how to respond to an epidemic of obesity, as it was when written 24 years ago.

WHEN GOVERNMENTS FAIL

However, governments often don't act effectively and primary prevention fails. In this situation, we can't escape from picking up the pieces through secondary prevention. As already cited, the North Karelia project demonstrated that primary care can do this task of secondary prevention very effectively.¹¹ But the key to effective secondary prevention is recognising that case finding and subsequent clinical management are essential but separate components. Both components need to be actively managed and quality-assured. In terms of case finding, Koekkoek *et al*⁵ draw attention to the greater effectiveness of stepped screening programmes, with the first step being identification of patients most likely to benefit from a resource-intensive face-to-face appointment. They also echo Lindemeyer *et al*¹⁴ in stressing the importance of proactive patient and community engagement to increase the attendance for screening of those at

"...we can't escape from picking up the pieces through secondary prevention."

“... let's look forward to moving from health checks to facilitated self-checks ...”

greatest risk. In terms of clinical care, Dalton *et al*² imply that when risk factors such as hypertension or hyperglycaemia are identified by screening we have a responsibility to manage them with the same attention and quality control as premorbid conditions identified in other national screening programmes such as breast cancer.

Lindemeyer *et al*¹⁴ give a practical example. One important reason for diabetic case finding is that blindness from microvascular complications is preventable. Diabetic retinopathy screening uptake apparently varies between practices from 55% to 95%. Although three contributory factors are beyond our control (social deprivation, ethnic diversity, and transport access), GPs can substantially improve screening uptake by contacting patients and encouraging them to attend, integrating screening with routine care, and facilitating good communication with regional screening teams. Preventing blindness seems a particularly compelling argument for action but these common-sense observations must apply to most other national screening activities, all of which are supported by trial evidence of their effectiveness. They also apply to vaccination. The variation in vaccine uptake between practices, and the key role GPs can and should play in maximising compliance, has been discussed in this journal many times before, most recently in the context of influenza vaccination for at-risk children.¹⁵

SO WHAT WORKS?

So to return to the title — what works in general practice? The answer is simple: secondary prevention. Secondary prevention certainly includes identification and management of patients with high blood pressure, high blood sugar,

hyperlipidaemia, or renal insufficiency. It also includes advising people to stop smoking (it's secondary prevention because it's only necessary when failure of primary prevention means people start smoking in the first place). And in each case, it involves case finding, but not through NHS Health Checks. This NHS preventive flagship merits scuttling because it's unfit for purpose. It's inefficient at case finding, strays into primary prevention, and lacks an adequate quality-assurance mechanism to ensure subsequent treatment is effective.

In designing a better programme we should give thought to the damage we have caused by unnecessarily medicalising another important NHS prevention programme: the provision of contraception. Not everyone has the ability and motivation to self-care, but surely we should not only be involving patients in self-recognition of risk but should also be delegating to them as much responsibility as possible for its subsequent management. Patient self-monitoring may not only be more convenient for them, it may also be more effective.¹⁶ And 'fire and forget' may sometimes be a more efficient and cost-effective prescribing strategy than ongoing clinician monitoring in primary care. So let's look forward to moving from health-checks to facilitated self-checks; and for cardiovascular disease, to a more targeted, quality-assured, and evidence-aware programme.

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Achieving earlier diagnosis of symptomatic cervical cancer



Gynaecological cancers have a combined annual incidence second only to breast cancer among women in the UK. Cervical cancer is the third most common cancer after uterine and ovarian cancer with approximately 3100 new cases and just under 1000 deaths annually in the UK. It is the most common cancer in women aged <35 years, and over 75% of UK cases are diagnosed in women aged <65 years. Cervical cancer survival is higher among women diagnosed at a younger age. The 5-year UK survival percentage is 67% overall, and almost 90% for women <40 years of age.¹ However, poorer outcomes in the UK compared with other western European countries have been well documented, and there is increasing evidence that earlier diagnosis of cervical, uterine, and ovarian cancers could contribute to a reduction in the survival gap between UK and European averages.²

SYMPTOMATIC PRESENTATION

Uterine and ovarian cancers are known to mainly present symptomatically, however, the UK's long established cervical cancer screening programme has led to a widely-held belief among both patients and some primary care providers that the vast majority of cervical cancers are identified via screening and before symptoms develop. Cervical cancers are, indeed, identified through screening programmes, however,

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a study by Lim and colleagues in this issue of the *BJGP* clearly shows that many women with cervical cancer do present with symptoms, such as vaginal bleeding, vaginal discharge, and abdominal pain. Their interview study examines the determinants of diagnostic delays among young women with symptomatic cervical cancer, and reports that a significant proportion (31% in this study) were diagnosed after a symptomatic presentation.³ Furthermore, even among their participants diagnosed via screening, more than half (56%) also reported symptoms prior to screening, and almost half of these patients had previously reported these symptoms to a health professional (although in retrospect many may not have been associated with the cancer). Of the patients diagnosed after symptomatic presentation, 28% reported patient intervals (from first noticing a symptom to first presentation)⁴ of >3 months, and 60% reported provider intervals (from first presentation to diagnosis)⁴ of >3 months. Delays in presentation appeared to be primarily due to the nature of the symptom, suggesting it was due to a less serious condition or normal biological change, as well as lack of awareness of cancer symptoms. Delays in primary care were partly due to non-visualisation of the cervix, and coexisting genital infections.

NATIONAL RELEVANCE

These findings have relevance not only to the UK but also to international clinicians and policy makers, particularly in low- and

middle-income countries without established population-based cervical screening programmes, where most cervical cancers are diagnosed after symptoms develop. Hence, developed and less developed countries have much to learn from each other. For instance, patients with cervical cancer in many Asian and sub-Saharan countries are known to report late for health care, experience fewer treatment benefits and have poor outcomes.⁵ While few studies have explored patient experiences, a recent Ugandan study interviewing healthcare professionals identified that primary care providers, often lacking adequate education, facilities, and access to pathology and specialist care, could erroneously diagnose and treat infection before excluding cervical cancer. Furthermore, a number of patient and sociocultural factors influence time to diagnosis for symptomatic cervical cancer including beliefs that cervical cancer is not curable with modern medicines and fear of cancer diagnosis.⁶

IMPROVING TIMELY DIAGNOSIS

What steps can be taken to improve the timely diagnosis and management of symptomatic cervical cancer in the UK?

First, public health and community awareness-raising approaches, such as the Department of Health's 'Be Clear on Cancer' campaigns, can incorporate clear and appropriate information about the most important symptoms such as vaginal bleeding, vaginal discharge, and abdominal

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pain. Such messages can also be integrated into the materials used as part of cervical screening programmes, and the materials used as part of HPV vaccination programmes and treatments. As gynaecological symptoms are very common and the vast majority are not due to a malignancy, the information could be targeted at specific age and higher-risk groups to offer personalised information for pre- and post-menopausal women, women during pregnancy, and those using hormonal forms of contraception or hormone replacement therapy. Awareness-raising campaigns can also dispel myths and stigma, and encourage discussions among women about their symptoms and what is ‘normal’ or appropriate for their time in life.

Lim and colleagues described a number of barriers to presentation in primary care including finding it difficult to get an appointment, worrying about not seeing a female doctor and about what the GP might find, and not wanting to waste the GP’s time;³ hence these campaigns could also tackle the more general issue of how to seek help from general practice in a timely, appropriate, and acceptable way. Similar barriers have been described in many studies exploring barriers to help-seeking, and not only for cancer symptoms. Issues around embarrassment and the privacy of symptoms, particularly in minority and ethnic groups, may require a more sensitive approach for symptoms of cervical cancer. Recent similar campaigns for symptoms of colorectal and lung cancer have resulted in more consultations, investigations, and referrals, however, at present there is very little evidence that cancer awareness campaigns have any impact beyond the short to medium term.⁷

Second, GPs could target their female patients with similar age- and higher-risk group-appropriate information. A study published recently in the *BJGP* showed that most GPs would be agreeable to this sort of targeted information and promotion of earlier detection of gynaecological cancer.⁸ However, while GPs are generally supportive of cancer awareness-raising activities in primary care, they remain reluctant to engage in specific activities because of concerns about the potential negative impact

on patients, lack of incentivisation, practice workload, and the availability of secondary care services.⁸

Third, GPs should examine all women presenting with symptoms of gynaecological cancer, and the NICE referral guidelines for suspected cervical cancer recommend a speculum and pelvic examination for symptomatic women.⁹ However there is little evidence for the value of visual inspection of the cervix in women who present to primary care with abnormal vaginal bleeding.¹⁰ Although there is also little evidence for the usefulness of cervical cytology as an aid for cervical cancer diagnosis in symptomatic women, even among women aged <25 years for whom cervical cytology is no longer recommended, new research may modify this recommendation. Even when examined as normal, it is important that all symptomatic patients are given appropriate safety-netting advice, such as how long to monitor symptoms, any new symptoms to prompt further help-seeking, and how to make appropriate follow-up appointments.¹¹

Fourth, practice nurses could play a far greater role in the primary care management of women with vaginal symptoms. They now undertake the majority of cervical smears and, therefore, the routine adoption of a systematic approach to all women presenting with cervical symptoms is feasible. This could include visual inspection of the cervix, plus swabs, and cervical smear test if not previously performed within 3 years.

In conclusion, a more systematic application of current guidelines and management practice could achieve earlier diagnosis of symptomatic cervical cancer in primary care. Improved management on first presentation with gynaecological symptoms may lead to reduced time to diagnosis and initiation of treatment, and possibly improved outcomes for the patient. The medium to long-term effect of any awareness campaigns to promote symptom recognition and subsequent action remain to be fully elucidated.

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Burnt out or fired up?

Helping recovery in distressed patients can increase our own resilience

INTRODUCING RESILIENCE

Burnout has become a major concern in general practice in the UK, with high levels of exhaustion, depersonalisation, and low levels of personal effectiveness. A study in 2011 suggested that burnout was allied to pessimism.¹ With the major systemic problems in general practice in the NHS, such as shifts in funding, pay cuts, staff wastage, and contractual chaos, the need to be resilient, to foster better coping and creative solutions, has never been more pressing.

Resilience is a concept from materials science representing the ability to return to a previous state of resistance without deformation or loss of elasticity. Psychological resilience is similar, but additionally encompasses the concept of growth from stressful experiences, 'bouncing forwards', to become more resilient in the future.

EMPIRICAL EVIDENCE

In psychological research the effect of resilience on growth and optimism under stress has been shown to be strongly mediated by frequency of access to positive emotions.² There are a number of cognitive enhancements that are associated with the experience of positive emotions, including cognitive flexibility, creative and detailed problem solving, better working memory, and increased prosocial behaviours, such as compassion and generosity, increased social inclusion, and ability to focus effectively on negative information.³ Relevant studies conducted with medical students and physicians showed that increasing positive emotions (receiving an unexpected reward such as a small gift or praise) increased diagnostic skills, problem solving, and a sense of vocation.⁴

The experience of positive emotions can become a self-sustaining positive feedback loop due to these cognitive enhancements, increasing positive social feedback through parasympathetic networks that signal approach(ability) to others, while building a sense of mastery. Memory of this sense of mastery builds a sense of personal effectiveness and positive self-esteem, which buffers the person from future stress.⁵ Conversely negative emotions, perceived danger, failure, or social isolation increases activity in frontal regions related to sympathetic activity, and can cause a

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state of withdrawal, resulting in a narrowing of cognitive abilities.

POSITIVE EMOTIONS AND RECOVERY

Depression is a condition characterised by low positive emotions and cognitive impairments that inversely reflect the cognitive enhancements from positive emotions, therefore increasing access to positive emotions is a promising way to reduce depression. Additionally, as the cognitive enhancement correlates of positive emotion have all been demonstrated in general populations, increasing positive emotions can not only aid recovery in those who are depressed, but also have a beneficial impact on the wider population, including stressed health professionals, building resilience, and reducing vulnerability to stress and depression.

Rewards that raise positive emotions can be praise, appreciation, love, gratitude, affiliative gentle touch, or humour. However, sometimes personal or working circumstances overwhelm our positive reserves. Individuals with depression definitively cannot access positive emotions. Promising new avenues of investigation have emerged in recent research, looking at the interaction of positive emotions, depression and recovery. The mode of processing your thoughts can be ruminative (thinking; 'why can't I do better?'), which is self critical, unconstructive, and correlated with depression vulnerability, or, alternatively, decentred, which can involve visualising how an event proceeded or focusing your attention on some internal process (breathing) or an external image and 'letting

go' of your thoughts.⁶ Accessing decentred processing facilitates re-interpretation of events in a non-judgemental way and boosts positive emotions in students with depressed mood (A Dobbin, unpublished data, 2014). Visualisation practice is helpful, as are other body/mind techniques such as breathing or relaxation training.

AN OPPORTUNITY FOR GPs

In 1985 one of the most comprehensive studies into depression was carried out, a multicentre study comparing four therapies: antidepressants, placebo, cognitive behavioural therapy, and interpersonal therapy. These were all delivered with clinical or psychological support for 16 weeks. The primary outcome was recovery at 16 weeks and 18 months. Surprisingly all groups experienced equal recovery, the most effective predictor of recovery was the patient's expectation, mediated by the relationship with the therapist. It has been established that non-specific treatment effects (placebo/expectancy) account for at least 75% of the effects of antidepressant medication, similarly in other conditions and possibly in all psychotherapy.⁷ There is huge potential for upskilling GPs to use their position of trust and respect to maximise expectation and therapeutic alliance and help their patients with psychological therapies. This can be done through GP guided self-managed materials and can be cost effective.⁸

The understanding of the neurobiology of emotions, the biopsychosocial model of distress and the mind/body link is poorly covered in medical schools, despite its huge

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“... you are your most important patient; by understanding the neurobiology of distress, resilience, and recovery and integrating this into your clinical practice, you can learn to communicate this model ...”

relevance to all fields.⁹ Thus we end up with thousands of graduates who can (hopefully) recognise a medulloblastoma (obviously important but extremely rare) but have little idea about the origins and ramifications of distress, which, as GPs particularly, they will deal with every day. GPs are further marginalised by initiatives such as the Increasing Access to Psychological Therapies (IAPT) programme, where, rather than engaging with psychological treatment of patients with common mental health disorders, their sole purpose is seen as referral, which can also deter from clinical involvement in innovative treatment ideas. The recent figures for uptake and outcomes of this programme show the lack of patient engagement with a referral-based programme in primary care, and strengthens the case for devolvement to, and encouraging innovation in, the front line.¹⁰ The most damaging outcome of this exclusion is that if you do not have the skills to help your patients, you do not, *ipso facto*, have the skills to help yourself. You must practice the alleviation of distress to understand it, the most important thing is to give your patient a credible model and explain how this will assist their recovery. The more you enable recovery in others the more you enable it in yourself. This is a concept I have called ‘therapeutic mirroring’. The Buddha said ‘*you are the person most deserving of your compassion*’. Similarly, you are your most important patient; by understanding the neurobiology of distress, resilience, and recovery and integrating this into your clinical practice, you can learn to communicate this model and commence a process of increasing resilience thereby aiding recovery for your patients and yourself.

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The future funding of health and social care in England

These are embarrassing times for baby boomers. As beneficiaries of the Attlee settlement, we have enjoyed affordable health care, decent housing, free higher education and a generous welfare state. Notoriously, these are blessings that could be denied the next generation.¹

The NHS is facing yet another funding crisis and social care is under increasing strain. The confusing border between the two has long been a source of administrative waste and frustration for users. Patterns of ill health, life expectancy, family structures, and medical technologies have changed considerably since 1948 when Beveridge and Bevan established the current system. A King's Fund commission, chaired by the economist Kate Barker, proposes a new settlement fit for today's circumstances.²

An interim report used five criteria to assess future options: equity, transparency, efficiency, the split between collective and individual responsibility, and affordability.³ The evidence suggests that the present arrangements fail on all of these criteria.

SYSTEMIC FAILINGS

The contrast between a health service free at the point of use and a social care service that is means tested and publicly funded only for those with heavy needs, means that the type of ailment you have determines the financial support you receive. Compare the personal cost consequences to our patients of developing cancer or dementia. The outcome of this 'lottery' is inequitable; similar needs do not receive equal treatment.

The current lack of funding for social care is little understood by the public; greater transparency is badly needed. Sir Andrew Dilnot's proposed reforms to the funding of social care, due to be implemented in 2017, are a step forward.⁴ The higher threshold for the means test will allow people to keep £118 000 of assets, rather than the current £23 250, and still receive local authority funding. Above that, however, those who can will still have to meet the first £72 000 of the cost of their social care.⁵

Efficiency is hampered by a lack of organisational integration, health is run by the NHS and social care by local authorities, with the two commissioned separately. The price of this failing is well illustrated by some 3000 hospital beds occupied each day by people needing social care funding

"The outcome of the present lottery is inequitable; similar needs do not receive equal treatment."

or assessments. If anything, in recent years care has become more fragmented despite numerous initiatives to promote integration. The ill-fated £3.8bn Better Care Fund is a further example of what Ben Ramalingam in another context calls 'best-practicitis': the short-term, localised modelling of technical fixes that don't work.⁶

While the NHS is often perceived as monolithic and unchanging, there have been a number of shifts in the boundary between public and private funding in the post-war period. In general, these have restricted free access to social care and increased private payment for health care. Large amounts of Continuing Healthcare have been moved out of the NHS. More social care is now provided by unpaid carers.

UNIFICATION IS POSSIBLE

The commission proposes moving towards one ring-fenced budget for health and social care, with a single commissioner and within which entitlements are much more closely aligned. Bringing the Attendance Allowance into this budget would create a more graduated pathway of support. The key issue is that of affordability.

Many believe that the health costs of the rising number of older people are simply unaffordable. In fact, it is largely advances in medical knowledge and technology that have raised costs in the health service. Ageing itself is less significant, with healthcare costs still concentrated in the last 18 months of life. And while there is a worry about old age dependency (that is, too many old people compared to workers) the proposed rises in pension age and greater participation of older people in

work are changing this ratio favourably. Spijker and MacInnes, have shown that the 'real' old age dependency ratio is lower than previously predicted as older people are increasingly 'younger' than previous cohorts.⁷

Furthermore, all pensioners are no longer poor pensioners. According to the Institute for Fiscal Studies (IFS), median pensioner incomes are now similar to those of the working-age population. Thirty years ago, more than 40% of pensioners were in the bottom fifth of the income distribution as compared with 10% today.⁸

Currently, more than one-quarter of GDP is spent on pensions, health, and social care; items chiefly consumed by older people. Recent estimates from the Office for Budget Responsibility suggest that in 2062–2063, health, social care, and pensions could together absorb almost 50% of public spending and almost 20% of GDP even on the basis of current entitlements.⁹ Health costs will continue to rise but, as income levels rise, people choose to spend more on health care (above a certain level of spend, health care is what economists call a 'luxury good', not a 'need').

The commission's figures imply that health and social care are not, currently or in the foreseeable future, either unaffordable or unsustainable. Spending on them, as the economy grows, is a matter of political will and individual choice, expressed both by how much people choose to spend themselves, and by which politicians they choose to elect.

Regarding entitlements, the broad choice is whether to align social care more closely with health, or the other way around. Social care could be aligned with health by making

"The commission's figures imply that health and social care are not, currently or in the foreseeable future, either unaffordable or unsustainable."

Box 1. Possibilities for paying for the new settlement

- Productivity improvements
- Revamped prescription charge
- Better targeting of winter fuel payments and TV licences
- Means testing accommodation costs for Continuing Healthcare
- Ending NI exemptions for pension age workers
- 1p increase in NI for over 40-year-olds
- Wealth and asset taxes, for example revisions to inheritance and property taxation

more of the most acute end of social care free at the point of use; for example, care for advanced dementia, Parkinson's disease, or end-of-life care.

Health care could be aligned more closely with social care by applying the Dilnot principles to the NHS. Individuals would be covered for extreme expenditure but they would pay an appreciable amount in contributions for health as well as for social care. An annual cap for a range of charges could, for example, be set at £500 or £1000. Depending on exemptions, that could raise billions of pounds in additional funding. The Dilnot reforms to social care were expected to generate a stronger insurance market to cover costs up to the cap; charges for health could do the same. However, this approach would be administratively complex and involve extending existing charges and/or introducing new ones.

These two approaches are not mutually exclusive but to move in the directions the commission suggests will require some combination of higher taxation, new charges, or cuts in other areas of public spending.

Effective change is going to require more than better integration and improved productivity.

DIFFICULT CHOICES

A new settlement needs to provide better value for money but its costing is not straightforward. Barker proposes making critical and substantial care needs free at the point of use for older people in the first instance.² This would cost nearly £3 billion initially and £14 billion by 2025; some £5 billion more than currently projected expenditure.

Spending on social care is inevitably going to rise whether it is funded from the public purse or privately by those unlucky individuals with high needs and their families. However, as the economy grows, it should be possible for health

and social care to take a larger share of a much larger cake. More generous provision would raise expenditure on combined care to between 11% and 12% of GDP by 2025. This compares with the 11.2% spent by France and 11.9% spent by the Netherlands in 2010 on health care alone.¹⁰

The core of the final report examines how the settlement could be paid for (Box 1).² Most readers will be relieved that the commission did not find in favour of introducing new charges for health care, for example, for GP visits or outpatient attendances. The sums raised would be relatively small and such charges could adversely impact on the health of the poor. Hypothecated taxes are also rejected.

Not unreasonably, 'as a matter of equity and inter-generational fairness', today's older people are targeted for the greatest contributions. They are both better off than their predecessors and will be the first beneficiaries of any new settlement. Scaling back existing benefits and ending exemptions from National Insurance (NI) contributions when people work past pension age could raise £2 billion. A revamped prescription charge of £2.50 without exemptions ('the price for a posh coffee') could raise an additional £1 billion. Full implementation of their proposals will require new wealth and asset taxes, for (yes, you've guessed) scrapping those tax-free pension lump sums.

The proposed reforms would necessarily have to be phased in over the coming decade, but the report sets a direction of travel. The notion that health and wellbeing boards could evolve into the single commissioners at a local level will raise eyebrows. That the boards 'would need strengthening' is a felicitous understatement.

CAN WE AFFORD TO DELAY?

Will a newly-elected government wish to embark on such fundamental reforms? The electoral risks are considerable. Not all pundits will feel as optimistic about the economic projections presented here and some of these proposals will be unpopular. Short-sighted politicians, already facing financial shortfalls in both systems, will be tempted to kick this report into the long grass.

Unsurprisingly, the response of the main political parties has thus far been muted. However, no government can indefinitely ignore the hard choices needed to prevent a decline in England's health and social care. Squeezing the grey vote may be perilous, but perhaps we berated baby boomers can yet exonerate ourselves.

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