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Working for patients — a journey into the unknown

THIS is an historic time in the development of health services in the United Kingdom. Proposals put forward by the government in *Working for patients*[1] are radical in their intent and breathtaking in the likely speed of implementation. The changes envisaged in the white paper have a direct bearing on all aspects of health care and will impinge on every consultation between the doctor and the patient. As they stand, the proposals are stated only in broad terms and the precise way in which they will be implemented awaits the publication of a number of working papers and further negotiations between the government and representatives of the health professions. It is difficult therefore for general practitioners to know how to respond. The government's stated aims are to give patients better health care and a greater choice of health services and to give greater satisfaction and rewards to those working in the NHS and those who successfully respond to local needs and preferences. Better health care is a laudable aim but are the proposals likely to achieve this?

The intention to implement medical audit should be generally welcomed; requiring all doctors to be involved in quality assurance activities is a sensible first step in ensuring that standards of care are maintained and improved. In referring to the College's 'quality initiative',[2] which advocates the implementation of performance review activities in general practice, the government has accepted the view that medical audit should be based on peer review and self-audit. There is a considerable body of experience within general practice about the assessment of quality. Practice activity analysis,[3] the assessment of trainers and training practices[4] and the 'What sort of doctor?' initiative[5] show the way in which internal and external monitoring of performance can be combined. Baker has recently reviewed the principles of quality assessment in general practice and has indicated the ways in which medical audit can be implemented.[6] The white paper sensibly places the responsibility for medical audit in general practice, with family practitioner committees and with general practitioners themselves. There is considerable scope for experiment and initiative in the methods used in different localities and the profession should grasp the opportunity to demonstrate the quality of the services they provide. Medical audit not only monitors the performance of doctors, it also reveals areas where there are inadequate resources and so enables the case to be made for improvements in the services.

This government gives a high priority to the breaking down of restrictive practices and seeks to give individuals as much choice as possible in their use of services. The white paper contains a range of proposals which are relevant to this aim, but they are a curious compilation, owing to the restricted room for manoeuvre which resulted from the promises made during the last general election campaign. 'The NHS is safe in our hands' has been translated to mean a health service which is funded from general taxation and free at the time of use. From this starting point and from the white paper's remarkable endorsement of general practice as the central plank on which the rest of the health service is built, the ways in which choice for an individual patient can be enhanced are limited. Will the proposals be effective in actually improving patient choice? We are told that there will be new simpler procedures for patients who wish to change general practitioners and that capitation

fees will make up 60% of the total remuneration of a general practitioner. The aim of these changes is to encourage general practitioners to take on new patients and so compete with other doctors in their locality. Linked to these changes are the intentions of the government to take direct control of the entry of new doctors into general practice and to allow doctors to advertise the range of services which they offer. This is a coherent logical approach to increasing choice for patients but experience in the early 1950s does not suggest that improved patient care results from intense competition between general practitioners.

The government's policy assumes that increasing choice for patients will improve health care. To suggest otherwise appears unfashionably paternalistic. Many aspects of health care, however, are not immediately popular, for example health promotion, and responding to demands rather than needs may lead the NHS even further into being a sickness rather than a health service. Most of the patients seen by general practitioners are suffering from self-limiting disorders and efforts to shift the emphasis in general practice towards prevention could be undermined by the proposals on patient choice. The white paper's proposals may also damage the coordination of general practice and community services. An effective primary health care team requires at least rough comparability in the territories covered by individual members. This point was strongly advocated in the report of the community nursing review.[7]

The choice of hospital care will be more problematic in future than it is at present. At the moment general practitioners have the right to refer their patients to any specialist. Geographical inconvenience and waiting lists modify this open system but costs do not intrude directly into the decision making of the doctors or of the patient. Hospital costs dominate the health budget and although the government is reticent about the financial implications of their proposals, 'value for money' is the *leit motiv* which runs through the whole white paper.

Budget management and competition are the means envisaged to achieve value for money in the health service. The unique arrangements set out in the white paper will create an internal market within the NHS, with money following the patient and both general practitioners and hospitals encouraged to manage their own budgets. This system is so novel that no one can predict the consequences. Some see the proposals as damaging the doctor–patient relationship by placing a price tag on the decision making of the doctor. Supporters of the government see it as a way of directing resources to the services which are successful in meeting the needs of patients in a locality. The only certainty is that there will be an increase in administrative and accountancy staff and that the NHS will be a magnet for health economists from all over the world who will wish to observe the service as it grapples with this massive experiment in health care.

Some of the uncertainties about the future of the health service may be reduced by the publication of the promised working papers but, whatever the outcome of the detailed negotiations, health care in the United Kingdom is journeying into unknown territory. Optimistic general practitioners who work in areas where fierce competition is unlikely should remember that cost limits are being applied to primary care for the first time. Pessimists should remember that in the past 40 years general practitioners have been improving the care they provide to patients while working to a contract which penalizes investment of time and equipment for better patient care. Our contract and the terms and conditions of our service do have a major effect on the care we provide in general practice but our professional responsibility is to act at all times in what we believe to be the best interest of the patients we serve.

E.G. BUCKLEY
Editor of the Journal

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Quality of care in general practice — lessons from the past

SINCE 1911, general practice has evolved under three policy regimes: the panel system (1911–48), the early National Health Service (1948–65) and the family doctor charter (1965 onwards). With negotiations now under way for a new framework of policies and economic incentives, the time is right to examine what these developments in general practice show about policy choice. It may be unwise to look for lessons about specific areas, but the historical record may give some guidance on broad issues such as the relative effects of professional as against economic incentives.

Family doctors are clinicians, but they also have to be businessmen. Their clinical commitments have been affected by their ability to attract and use resources. In this respect it was the panel system rather than the NHS which represented the real break with the past in providing improved rewards for initiative. Recent research covering both the panel system and the period since the family doctor charter has looked at the decisions which doctors faced and how they reacted to incentives.[1]

The panel system was based on the state health insurance scheme that was introduced by the national insurance act of 1911 and came into effect in 1913. The panel doctor was paid a capitation fee for providing services and drugs to panel patients. Initially the act covered wage earners aged between 16 and 70 years employed in manual labour or in non-manual jobs with an income less than £160 a year, although the limits were made less restrictive over time. Dependants and the better off were not covered. It was in effect a two-tier system with half the population covered by the panel system and the rest having to pay