But if doctors are to fulfil this role, it was agreed, working practices must change. The trend to reduce doctors and other healthcare staff to industrial workers whose (simplistically measured) output is subject to scrutiny and potential censure by non-medical staff has damaged professional morale and discouraged doctors from using their professional judgment. It has not been good for patients either. Healthcare managers and administrators need to understand that their decisions have a direct impact on patient care and that they are part of a medical team, not guardians of an industrial machine. At the same time, doctors need to know more about healthcare management and participate more in debates about health policy.

The meeting concluded that if the experience of the past 10-15 years has shown anything it is that the rapid adoption by countries of broadly similar philosophies and healthcare reforms has been misconceived. Nevertheless, the experiences gained have been valuable, and what information there is on the development and effects of different strategies needs to be widely shared.[2]

This should help countries to develop policies that better reflect their diverse history, culture, traditions, and health needs. Where the national balance lies between public and private provision is probably not crucial, provided the core values of a public health service are respected. What is important is to encourage entrepreneurial provision in both sectors, flexibly tailored at national and local level. "That, and going slowly," said Dr Miguel Gonzalez Block, a health policy analyst from Mexico who is setting up a health reform network in South America. "This debate has left me more convinced than ever of the need to pilot all initiatives and proceed on the basis of evidence, not ideology and anecdote."

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1 The Ljubljana Charter on Reforming Health Care. *BMJ* 1996;312:1664-5.
2 *European Health Care Reforms: analysis of current strategies*. Copenhagen: World Health Organisation. Regional Office for Europe, 1996.

Specialist rehabilitation after stroke

Effective in the short term, but more work needed in the long term

See p 1642

The era of nihilism about stroke rehabilitation must surely have ended with the publication of a recent overview showing that patients cared for in specialist stroke units are significantly less likely to die than those cared for on ordinary wards.[1] Organised stroke care lowers mortality without increasing the number of dependent survivors, since the reduction in the combined endpoint of death or institutionalisation is even greater (34%) than the reduction in mortality alone (21%).[2] A decrease in odds of 34% is equivalent to an absolute reduction in risk of about 10%—far greater than the accepted benefits of thrombolysis for heart attack.

But these and other overviews[3] raise several issues. Firstly, if a cumulative meta-analysis of the trials had been undertaken as they were published convincing evidence of benefit would have emerged at least 10 years earlier (P Langhorne, unpublished data). Secondly, the trials used different techniques for measuring their main outcome measure, disability, which has hampered meta-analysis. Thirdly, the overviews could not examine depression and other emotional sequelae of stroke because these were rarely measured, despite their great impact on the quality of life. Any effect of stroke units on depression, although plausible, is not known and probably never will be since further trials of stroke units are unlikely to be carried out. You cannot find by analysis what was lost by design. Fourthly, we do not know what it is in the "black box" of a stroke unit that is effective because the trials did not systematically measure the interventions. Fifthly, trials using unblinded assessments of outcome probably overestimate the effect of treatments[3].

Stroke units generally only deal with a small part of the long term process of rehabilitation, and several studies have examined the efficacy of later interventions. In this issue of the *BMJ* (p 1642), Young and Forster report on an evaluation of input from a specialist stroke nurse after patients were discharged from hospital.[4] Other trials have compared domiciliary and hospital based rehabilitation,[5 6] and evaluated leisure therapy,[7] occupational therapy,[8] and physiotherapy.[9] All of these trials were properly randomised and used valid and sensible outcome measures. Most have indicated some sort of positive result. None of these trials is convincing on its own due to small numbers, and in some cases the positive results come from analysis of even smaller subgroups.

The past has taught us the need to ensure that our evidence database is constantly updated. The Cochrane Collaboration now collates the results of all randomised controlled trials in stroke management, and so information from new trials can quickly add to the sum of knowledge.[10] This promises a great step forward towards evidence based medicine, but greater progress might be achieved by prospective collaboration. For practical and financial reasons small trials in single centres rather than multicentre mega-trials are likely to remain the norm in rehabilitation research. Nevertheless, these single centre studies could be coordinated in a collaborative framework. The broad questions and subsidiary hypotheses could be agreed in advance so that each study has a defined place within the overall structure. There could be a common core protocol and a common set of measures of case mix, process, and outcome. This kind of preplanned collaboration is termed prospective meta-analysis in the United States[11] and epi-analysis[12] in Europe.

These issues are now being addressed by the Collaborative Stroke Audit and Research (COSTAR) Group, an open collaboration set up with support from the NHS research and development programme for cardiovascular disease and stroke, which all potential stroke rehabilitation trialists are invited to join. Agreement has been reached on some of the "burning issues" in stroke rehabilitation, and these broad questions provide a framework within which individual trials can be fitted, so that epi-analysis can be performed. One such epi-analysis will compare "social-environmental", physical, and psychological approaches to rehabilitation in the community (the trial from Bradford reported here would fit into the first of these categories) aiming to reduce long term misery after stroke. Agreement has already been reached on basic methodological criteria for trials of rehabilitation, and a standard core dataset has been drafted. The next major task will be to reach a consensus on a common clini-

cal language to describe and measure the contents of the rehabilitation black box. With such a collaboration organised on a prospective basis, there is a good chance that we will not have to wait another 30 years for the next major advance in understanding and evaluating stroke rehabilitation.

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Primary care: restoring the jewel in the crown

Britain's government is at last listening to general practitioners' concerns

From the mid-eighties onwards, a succession of government documents[1-3] and policy decisions heralded a radical transformation of British general practice. The new contract was imposed in April 1990[4] and the NHS reforms were implemented a year later. The secretary of state for health, Stephen Dorrell, speaking in January, described the last few years as "a period of bruising management change," in which "huge amounts of time and effort have been consumed in reorganising the management of the service."[5]

This agenda of constant change and policies imposed on an unwilling profession have caused a sense of powerlessness, loss of independence, and demoralisation, which have contributed to increasing numbers of early retirements and a recruitment crisis in general practice.[6] By its actions, the government showed that it no longer valued its partnership with the profession.

However, the sense of alienation felt by general practitioners has been slowly assuaged over the past six years, and such recent developments as the changed arrangements for out of hours care,[7] for complaints,[8 9] and for health promotion [10] have shown both a regaining of professional control and a new sensitivity to the profession's needs.

In 1994, the government began to promote the concept of an NHS led by primary care,[11] with the aim of bringing decision making and service delivery as close as possible to patients. Stephen Dorrell has repeatedly talked of general practice as "the jewel in the crown of the NHS." In October last year he announced a debate on the future of primary care, in which the minister for health would tour the country, listening to what people involved in the delivery of primary care had to say.[12] Many doctors were cynical about the extent to which true listening would occur, partly provoked by some government statements which seemed to pre-empt the outcome of the exercise.

However, now that the government's consultation document *Primary Care: The Future* has been published[13] we can assess how sensitive the minister for health and his advisers have been to the real problems of those working in primary care. That assessment produces a surprisingly encouraging answer.

The document recognises five key objectives. Primary care should provide continuity, be comprehensive, be properly coordinated, be the gatekeeper to secondary care, and address the health needs of local communities as well as individuals. The listening exercise also identified five principles for the planning and delivery of primary care services: quality, fairness, accessibility, responsiveness, and efficiency. Finally, seven possible areas for action are specified: resources; partnerships in care; developing professional knowledge; information, involvement, and choice for patients and carers; securing the necessary workforce and premises; better organisation, including information technology and management support; and local flexibility.

Perhaps the most heartening overall feature of the document, however, is the openness of the future agenda. In his foreword, Stephen Dorrell describes it as "the essential first step in clarifying how primary care services should be developed and identifying the action needed to do so" but continues by stating that "the government has no preconceived idea" about how change can be achieved and is not "seeking to impose a single template." Rather, the process of listening and consulting is set to continue over the summer, with the intention of clarifying policy intentions in a more definitive publication later this year.

General practitioners believe that any transfer of care from secondary to primary care must be evidence based, planned, explicitly agreed in advance, and adequately resourced so that it does not undermine the core activities of general practice.[14] The cynical may therefore fear that the government's second document will promote the unresourced dumping of unwanted work into general practice—more involvement in the care of severe mental illness, of minor injuries, and in rehabilitation—and will enthuse over total purchasing as the preferred organisational model.

However, there are great opportunities for the profession at a time when the government does seem far more willing to listen to their concerns. *Primary Care: The Future* does recognise their problems: low morale, excessive workload, low levels of recruitment and retention, and poor and inadequate resource allocation. And the document does show awareness of some of the essential solutions: more flexible contractual options, increased and equitably distributed resources, more appropriate professional and financial rewards, the preservation of the role of the clinical generalist, the definition of core services, evidence based medicine, more time with patients, commissioning led by general practitioners, teamworking, reduced bureaucracy, and patient education.

The concept of a primary care led NHS is a vote of confidence in those who work in primary care. It is also a policy founded in the reality that over 90% of patient contact in the NHS takes