OFFICE OF HEALTH ECONOMICS

The Consumer and the Health Service

Proceedings of a Symposium

held at

The Royal College of General Practitioners, London

27 January 1968

Edited by: John McKenzie

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Contents

(*Discussion is included between contributions as appropriate*)

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Introduction

MANY of the general public and the medical profession have strong views on the current and possible future shape of medical care. However, all too frequently each group is unaware of the basis or nature of the other's problem. To bring members of each of these groups together the Office of Health Economics held a Symposium on *The Consumer and the Health Service*, on Saturday, the 27 January, 1968, at the Royal College of General Practitioners. It was attended not only by General Practitioners and representatives of consumer groups, but also by professional social scientists and social workers and members of the other branches of the medical profession and its auxilliary services.

The Conference had three primary objects; to try to foster an increasing awareness and understanding of the attitudes of different groups, to consider the type of service which might satisfy both consumer wants and clinical needs, and to identify areas requiring further research. In this publication we represent the formal papers and some of the ensuing discussion.

Our thanks are due not only to those who gave papers and to our Chairmen, Mrs Mary Adams and Dr John Hunt, who handled the meeting so admirably, but also to the many speakers from the floor who contributed so much to the success of the meeting. We are only sorry that limited space has precluded the publication of all but a few of the interesting comments following each paper.

JOHN McKENZIE

Patient Needs

DR F. M. MARTIN

THOSE who plan or provide public services are often accused of misguided paternalism. They are told that their own notions of what is good or what is appropriate for various groups in the community are unrelated or imperfectly related to real needs, and planners of services are often recommended to find out what the people for whom they are planning really want. This has led to a fair amount of consumer research in a variety of fields, ranging from the use actually made of different rooms in council houses to patients' attitudes to general practitioner and hospital care.

It would be very pleasant and very satisfying to be able to turn to the excellent studies of public attitudes to Health Services that we have had the good fortune to see carried out in the past few years, and say that from these there emerges a clear picture of the way in which medical services should be run and should be delivered so as to produce maximum consumer satisfaction. But I do not think it is really possible to do this. I do not think we have yet exhausted the potentialities of this particular approach. We have not said the last word in the field of consumer studies. Particularly I think in the future it would be illuminating to see a certain shift away from the basic questionnaire studies which provide the essential ground plan so far and towards the greater exploitation of, say, depth interview techniques. But so far it must be said that the results of the studies which have been carried out although full of interesting and important features, are significant mainly for the curious light they shed on the limitations of the entire approach.

What emerges most clearly, is the picture of the patient as an undiscerning, undiscriminating, over-tolerant consumer. I do not want to exaggerate this, of course. Criticisms are expressed, and these come out very clearly in Dr Cartwright's admirable studies, which are the most important source of information on both hospitals and patients. Hospitals, patients tell us, do sometimes keep you waiting around; there is sometimes a bit less privacy than you really like; doctors do sometimes seem a bit impersonal if in hospital or rushed in general practice. But all of these criticisms—or so it seems to me—are buffered by spontaneous statements of explanation, understanding and justification, and they are more than neutralised by a remarkable respect and trust which above all seems to characterise the attitudes to the health professions of the British public in general. This is not, of course, universal. There are exceptions—disaffected intellectuals in particular are, I think, a special and important case, but I suspect that intellectual chaos ensues if we allow their attitudes to be extrapolated for the general population.

I am sad to say that much of the love is unrequited, and indeed it is instructive to contrast all this warmth and goodwill with the distaste which I think runs through a lot of the attitudes of doctors to their patients. (There are some major international differences here, which may be summed up loosely by the saying "American patients hate their doctors; British doctors hate their patients".) Specifically, one is very struck by the conservatism of the patient as consumer, by his cheerful endorsement of the arrangements which happen to be familiar to him. Thus we see that patients of doctors who have appointment systems seem to be for the most part in favour of appointments; patients of doctors who have not got round to appointment systems tend to think they are not necessary. Patients of single-handed doctors are fairly enthusiastic about solo practice; group practice patients have clear views of its advantages. We know that patients rarely change their doctors, except when they move, in spite of the fact that they chose them in the first place with what seems to be a remarkable lack of discrimination. We know, too, that although the complaint procedures that exist in the Health Service are the source of much irritation to many practitioners, nevertheless the actual use made of those procedures is extraordinarily slight. British patients seem to be dominated by acceptance and a lack of litigiousness. This phenomenon does require some explanation, and I think that in fact several different factors do contribute to it. It would take too long to analyse all of these in detail, but I will mention a few of what I think are interesting components. I think there really seem genuinely national characteristics in this. There is a tendency to self-effacement and a reluctance to express criticisms openly, so that if you find yourself in a hospital out-patient department with thirty-nine people, all given appointments for nine o'clock, the one patient who starts to protest is likely to be much more unpopular with the other patients than the doctor who started the bad system in the first place. We do have this curious distaste and horror for making our-

selves conspicuous. I suspect I could not really document this though, that there is another characteristic in the form of a somewhat fatalistic attitude to illness which tends to make us pitch our expectations lower and to be perhaps inordinately grateful for any improvement or relief in our situation. I think, in this respect, the British contrast quite remarkably with Americans, who do not seem to accept illness any more fatalistically than they would, say, a curious noise in the engine of their cars; the right sort of technician will tell you what is wrong with the engine; and the same principle is thought to apply whether the body or the big end is at fault. This, of course, is a special aspect of the general American concern for the pursuit of life, liberty and happiness, which accounts for so much of the basic optimism that characterises American life.

Then there are other contributory elements which are perhaps more historically conditioned. There are in our medical and many other public services residues of attitudes of patronage and attitudes of charity, which have been handed down from a past period in which they were more relevant. On the patients' side I am inclined to think these are reinforced by the fact that most patients assume they are getting something for nothing. I do not think this in itself constitutes a sufficient argument for a system of direct payment, but I strongly suspect, if such a system did exist, it would almost certainly have the result of stimulating a more critical—not necessarily more intelligent—attitude on the part of the patient as consumer. Of course, he does pay as a taxpayer and as an insurance contributor, but this does not seem to enter into his thinking most of the time; he feels he is getting favours. And finally, in the long run, there is the sheer problem of the lack of technical knowledge, lack of ability to make a technical meaningful judgment which must limit the capacity of the patient—even the generally intelligent and thoughtful patient—to be a discriminating consumer. If patients were really a thoughtful, discerning, discriminating, group of consumers, they would provide a potenially valuable feed-back mechanism for the Health Service. I find it difficult, however, to see how this can be built up other than gradually. We are likely to see some growth in awareness, discernment, and sharpness of judgment, as a gradual side effect of the general rise in the level of education, in standards of living generally, and enlargement of the horizon of expectation. Personally I am doubtful whether it would be desirable to force the pace by too deliberate an encouragement of specific consumer education. I suspect that if patients are encouraged to think of doctors as 'They' against whom 'We', the patients, must somehow band together, we will have lost something quite important. At the present day patients' attitudes may be over-trusting and naïve, but if I were faced with a choice, I think I would be sorry to see them replaced by attitudes of suspicion and calculation. Maximum good faith on both sides seems to me an absolutely essential feature of a productive doctor-patient relationship.

Perhaps the implication of what I am saying is that the onus must be squarely on the professionals, on physicians and those who work with them in training doctors, in planning health services, in organising the delivery system. A resort to populism does not, I think, provide a solution. We can not rely on patients to tell us what their needs really are. Perhaps in the end there isn't any escape from paternalism but it has to be informed paternalism, free from patronising, and based on the respect for indivdual dignity which is not always sufficiently obvious in professional circles. I do not refer only to the medical profession; I suspect this is a general criticism. It should be based also on a systematic study and awareness of human needs. Now, these needs cannot be inferred simply and directly from studies of likes and dislikes, from collections of complaints. We can, however, learn something about human needs, partly by a process of empathy, and partly also from a wide range of social and psychological studies. Thus we know there is in almost everyone a need for privacy and a need for involvement with others, and that the varying balance between these needs requires usually a rather delicate appraisal, made more delicate and complex by the impact for sickness. All this has implications for the planning of hospital accommodation, though even here we need more information—not so much attitude-type information, but rather sympathetic and subtle observational studies of hospital patients and their objections.

Again, we know—whether we like to admit it or not—that an awful lot of our medical care programmes are designed on the assumption that medical and professional time generally is infinitely valuable and patients' time is, so to speak, infinitely expendable. We probably also know that the latter assumption, at any rate, is quite false, and we also do have sufficient operational knowledge to strike a very much more equitable balance. Again, although we know the conventional phrases about patients being people, about treating the person and not the disease, about illness affecting the family as well as the individual, we have still a long way to go before the platitudes are translated into systematic knowledge of the lives of sick patients and the consequences of illness, especially of chronic illness, on personal and domestic life, and of the complex adaptations required. There is a long way to go before they are translated into concrete acts and attitudes on the part of more than a smallish minority of practitioners. My point is, even if the patients themselves cannot directly express very fully and accurately what their needs are, there are a variety of sources from which we can learn a great deal about these. We already know quite a lot and there are ways in which we can learn more. What is important is that we devise ways of putting this kind of understanding into a practical context, and this I take it is what this meeting is about. These considerations take us far beyond the specific tasks of design of hospital wards or of planning appointment systems, although these obviously are essential elements: no one should under-estimate them.

They take us, of course, to crucial and recurring questions, questions which everybody here is involved in discussing, the general practitioner particularly, and which must be resolved if we are to be satisfied with our health services, and in such a way that the patterns of patient care and attitudes that we hint at can take on some reality, some meaning, for the practitioner. These considerations take us also to perhaps even more basic questions of medical education in the widest sense, not only in terms of the specific training that is given, and the relevance and implications of this training for particular professional rôles, particularly rôles which are practised within the community, but also medical education in

a wider attitudinal sense, the sense of professional identity, the ability to comprehend the manifold problems of patients' lives and the social and psychological aspects of disease, which receive comparatively little systematic attention in a great deal of our present-day medical education.

We cannot really find out about patients' needs simply by asking patients what they like and what they do not like. We can learn a great deal, but our basic questions can not be answered in this way. Patients are remarkably accepting, remarkably tolerant—obviously far too much so. If they are not discriminating there is even greater responsibility on the professional. It is far too easy, and far too dangerous, to move to the conclusion that as they are easily satisfied it is not worth going to any great lengths to provide improved services. We should perhaps see this the other way round. If patients are not discriminating, if they respond positively to a wide range of practices, good or indifferent, perhaps they are capable even of appreciating what we might do for them at our professional best. They might even like that at least as much as they like the second-rate services they all too often receive.

Discussion

MRS A. WILLIAMS

IN the last ten years we have got used to the idea of probings and questionings into the standards of consumer goods and services. In addition we are beginning to get used to the idea of guides on such varied things as good food and good schools. I am not advocating a 'Guide to good doctors'! But we could do better by providing more material so that the consumer can make a wise and informed choice. I am thinking about a fairly easy explanation of the basic material which you need when choosing a doctor. Most people do not know that a list of G.P.'s is available at Post Offices. What is there in this so-called 'Guide'—The name of the doctor, his qualifications in professional gibberish, meaningless to most people, whether he has got an appointment system and his hours of opening. This is no adequate basis for an informed choice. How do people really choose their doctor?—by word of mouth, talking to a neighbour, choosing the one who gets through the patients in his surgery the quickest? I maintain, then that we could easily have tabular presentations in these guides. The sort of thing I would like is an easy indication of sex [at present initials are for men, full christian names for women]; let's have date of birth; any children of his own; has he attended any courses of retraining since graduation; has he any special interests—the elderly, diabetics, alcholics, obstetrics; does he immunise; has he laboratory facilities; has he ancillary help, such as a health visitor; what about car parking facilities? All this could quite easily be put down in tabular form.

My second point: we need to look much more closely at methods of mass communication. People just do not know. Whose fault is it they do not know? We need to debase our professionalism by taking a look at the methods eminently successful methods, of advertisers and salesmen, in promoting a product and a service. We need to look at new ways of getting things over to people; for telling somebody once is no good; we have Home Help organisers going round telling elderly people what jobs a Home Help may or may not do—but they cannot remember in spite of an explanatory leaflet. We need to have a multiple approach—written, verbal, promoted by television, and radio—repeated and repeated in different forms, and sometimes popularised. Such things as comic strips are acceptable to many people, maybe the only thing they read. We need to have a new look, to work with advertisers to see if we can get over in a more presentable form this necessary information. I feel this might well lead to more general acceptance of rights, and duties. I am not maintaining that we need to produce any idea of a British Standard doctor with a Tel Tag round his neck, but I think we need to have a clearer conception of rôles, and this can only be done by consumer education. I do feel quite strongly that we must look very closely at these methods of mass communication. Cure can depend on communication.

DR J. M. LAST

I would like to begin by agreeing with everything Mrs Williams has just said. As I am myself a consumer of medical services, I think there ought to be some way in which the consumer can obtain this amount of basic information about the doctor that he or she may choose to see. There should be something done to educate the public about what they could expect of their doctor. The American Consumer Association, in its monthly journal gives a very sophisticated account of the criteria which could be used by members of the public for estimating the quality of the medical care their doctors are providing. With respect to the question of discrimination by patients I think there is some evidence of variation in the level of discrimination in different communities in Britain. Some data I collected in 1961, revealed that the number of patients who did change their doctors in the North of England in one town was twice as high as in two other towns which were pretty much the same otherwise. One other interesting difference between these towns is that the doctors in the town with the high rate of turnover did not on the whole seem to think quite so favourably of the patients, as judged by the kind of questions I was asking, as did the doctors in the other two towns.

MRS U. MILLER

Dr Martin brought up a point on patients who ought to be more discriminating in the choice of their doctors. Well, it is terribly difficult to find out the quality of a doctor, moreover, very often it is not a matter of good or bad, but of compatibility. It is the same as marriage: sometimes two very nice people do not get on together. The difficulty here is that once a patient is on the doctor's list and he feels he would like to change it is very difficult to find another doctor who will accept him without the reason being given that you have changed your address—'would you like to take me on? I would like to change my doctor.' Usually the answer is, 'No, thank you.'

DR E. TRIMMER

You read quite a lot about this business of people having operations, and people in hospital, not really knowing what is going on. Until about two or three years ago I really believed this was

true, but a couple of years or so ago I took on a rather interesting job of Medical Adviser to a large firm of publishers in this Country, and I receive every week something like a hundred letters from readers of our magazines. Yesterday I spent a long time going through these with regard to this question of operations and hospital treatment. I went through nine hundred letters yesterday, and only in forty-two was there any criticism of this aspect of the Health Service. This is not many when you consider that about ten per cent of these letters were concerned with general sexual problems of the most elementary nature. Ten per cent were problems which really concerned the simple physiology of menstruation. Another surprise was that only about forty people were writing about psychological problems. I am led to believe that this is not one of the great "icebergs" in general practice which nobody ever talks about.

MISS B. WELLER

Just two points. Perhaps doctors are in a majority here today, but there is a tremendous need of understanding in relation to the patient and the nurse in the hospital. The other point I would like to mention is about patients being told something. In my experience as a ward sister I know that I have to tell patients the same thing again and again and present it in different ways, and despite this occasions still arise where a patient complains of not being told. We fail to recognise that illness so interferes with the understanding of the patient that they will believe they have not been told.

DR P. DRAPER

I would like to reinforce that point. In a study of gynaecological patients, the patients were asked at a follow-up clinic in outpatients whether anyone had explained to them the operation that they had had. Very often the answer was 'no'. The doctor then showed them a diagram that he himself had drawn in the case notes. 'Don't you remember my drawing this for you?'—vague recollection. Obviously we need more communication and doctors and nurses have to learn the skills to communicate effectively.

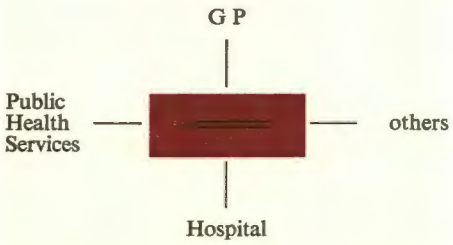
The GPs View of the Consumer

DR JOHN FRY

WHAT I want to do is to start from base and take a look at what general practice is, say something about the consumer and about the attitude between the two in relation to one another, and then perhaps look and see where any improvements might be made.

Table 1 indicates the various components of the Medical care system. The consumer should be very pleased to see the patient in the middle. What are some of the special features of general practice in relation to caring for the patient? The first feature of general practice is that the patient—the consumer—has direct access to the doctor.

Table 1
Components of Medical Care System



This is quite different from most of the other services in the National Health or any other service of medical care. He is also the doctor of first contact, the first medical man who sees the patient. He works in a relatively small and static community, and he provides longterm care, and because he works in a small community his spectrum of disease is quite different from all other doctors. He also works as a private entrepreneur: he has to provide his own premises, and work his practice and his staff in the way that he feels necessary.

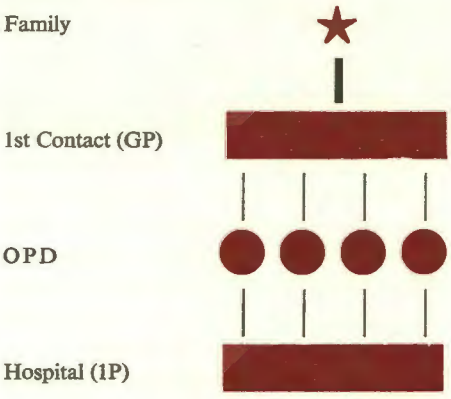
If one just looks at it a little bit differently now to stress one point, that is, that in our system of medical care the patient has a single portal of entry into the National Health Service, and this applies to the whole family. The family can only get into the main stream of medical care through their family doctor (Table 2). This does not exist in other forms of medical care, American, Russian, and others. This single portal of entry through the GP leads to the out-patient department or to other hospital departments.

We are living in a changing world where the consumer is much more educated than he has ever been before, not only in relation to medicine but to other matters. Because he is educated he is much more expectant. We have already heard one needs a guide to various parts of the medical services. This is what is coming to pass—the fact that we are dealing with an expectant public, a public which is expecting quality and service, who are being informed about the various opportunities of specialised medical services.

One rarely gets discussions about the first level services—the general practice services—on the television, but one gets a lot about cardiac transplants and other growing points, the dramatic specialised examples in medical care. The consumer is left with the idea that medical care has limitless capabilities to achieve cure. He is not, unfortunately, told that most diseases are incurable in the true sense of the word.

The Service is by no means a free service because, on average, each one of us pays £25 a head a year. What do the consumers really want out of the

Table 2
Flow of Medical Care



GP? As far as one can tell from the various studies that have been carried out, they want personal and individual service. They want availability and access. These are all service measures. They want a kindly listener, and only fourth or fifth in the list of priorities is that he should be a good doctor. This also suggests that the consumer is not very good at discriminating quality of medical care in relation to the specifications of medical techniques provided. They want a good kindly human being, a good bedside manner: this ought to be considered. As far as one can tell from Ann Cartwright's and other studies, the relationships from the consumer's point of view with the doctors are very good.

Recently I had the opportunity to look at a study on GPs carried out by OHE. Four hundred and sixty or so general practitioners were questioned, and some of the questions were related to whether they thought the National Health Service was working in a satisfactory manner; and the second group of questions in this particular

section related to whether they felt that the service was being abused. Only 55 per cent thought the National Health Service was working in a satisfactory manner. This compared with 75 per cent in 1962 and 62 per cent in 1964. The degree of satisfaction in relationship to the functioning of the National Health Service is declining and the general practitioner, presumably, is becoming less satisfied himself, too. When they were asked, 'How do you think you could improve the Service?' the main suggestions were—fewer patients, more doctors, make the patients pay, re-introduce prescription charges, and improve the efficiency of the whole service. A quick look at these answers shows that the GP is concerned in protecting himself, perhaps by fees and prescription charges, and trying to get more time, by having fewer patients and more doctors. But the implications are that we cannot do anything about some of these things; we cannot have more doctors or fewer patients at the moment. Some of the doctors also thought too much time was wasted seeing trivia; they were having unnecessary requests for home visits, and there was also a degree of malingering, trying to get put off work without the need arising. When they were asked what they should do about it, fee and prescription charges were mentioned, and 'educate the patient,' whatever that means. One small group said 'It's up to the doctor to deal with these patients as he thought fit.'

Now this is just a small look at what the mood of general practice is today, and it's a very mixed mood. It shows that not only are the general practitioners dissatisfied with their relationships with their patients, presumably because they are not happy, but the fact is that other evidence shows a high figure for possible abuse of them by their patients.

Now for some more detail. Let's just look at what trivia are. The accompanying tables indicate the type of illness and the number of cases GPs will see in any one year (Table 3). But we don't quite finish here, because the GP is also dealing with the social pathology of the community and this does not go into the standard text-books of medicine. There are the illegitimate births, the juvenile delinquents and broken homes, the forty odd families where one or other parent is missing (Table 4).

Table 3

Annual morbidity experience in average British General Practice of 2500 persons (i.e. numbers of patients suffering from the diseases that the doctor may expect to see each year).

MINOR ILLNESS (ILLNESS OF SHORT DURATION OR MINIMAL DISABILITY).

Condition	*Number of cases*
Upper respiratory infections	500
Emotional disorders	250
Common digestive disorders	200
Skin disorders	200
Acute otitis media	50
Wax in ears	50
Acute backache	50
Acute urinary infections	50
Migraine	15
Hay fever	12

MAJOR ILLNESS (ILLNESS OF SEVERE DEGREE, OR MARKED EFFECT ON LIVING).

Condition	*Number of cases*
Pneumonia and acute bronchitis..	50
'Anaemia' (Hb. 70 per cent or less)	40
Coronary heart disease (new cases 5)	15
Severe depression	12
All new cancers:	
lung, 1	3
stomach, less than 1 (0.74)	
breast, less than 1 (0.75)	
cervix, less than 1 (0.22)	
Acute appendicitis	5
Glaucoma	3
Killed or injured in road accidents	17

CHRONIC ILLNESS

Condition	*Number of cases*
Chronic arthritis (all forms)	200
Chronic emotional illness	60
Chronic bronchitis	50
Hypertension	35
Asthma	25
Peptic ulcer	25
Stroke	15
Rheumatoid arthritis	12
Epilepsy	10
Diabetes mellitus	10
Pulmonary tuberculosis	5
Pernicious anaemia	5
Parkinsonism	3
Multiple sclerosis	2
Mental deficiency	2

Table 4

Sociomedical problems in an average General Practice of 2500 persons during a year.

Condition	*Number of cases*
Persons receiving National Assistance	100
Aged over 75	100
Lonely old persons (living alone)	50
Broken homes (children under 15 living with only one parent)	40
Severely deaf	25
Problem families	5–10
Registered blind	5
Juvenile deliquents (known)	4
Chronic alcoholics (known)	4
Illegitimate births (known)	3
Disabled and unemployable	2
Divorce	1
Adult committed to prison	1
Male homosexuals	?

Table 5

An estimate of undiagnosed diseases present per 2500 persons.

Condition	*Number of cases*
Chronic bronchitis	200
Anaemia	200
Staphylococcal, nasal carriers	200
Hypertension	120
Depression	110 (6 will attempt suicide)
Bacteruria	100
Obesity	60
Diabetes	12
Cancer of cervix	2-3 positive cervical smears annually
Pulmonary tuberculosis	2 (to be assessed)
Cancer of lung	1 picked up every two years on MMR

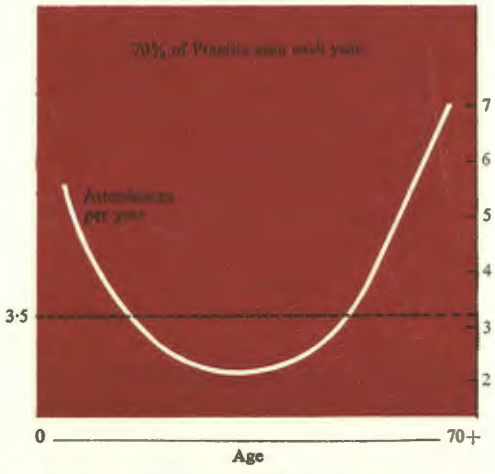
These are some of the trivia which some of my colleagues are complaining about. They feel it is trivia perhaps because they have been trained in Medical Schools where these things are not considered appropriate to be talked about or dealt with. Their attitude to general practice starts perhaps on the wrong foot. There is also another group — the undiagnosed diseases. (Table 5). Do we need to do anything about them or not? The GP sees on average seventy per cent of his patients at least one a year, and ninety per cent of all family households at least once a year—on average each person about four time a year. These are the age groups; chiefly the young children and the old people during his year of contact with his patients, so he does provide continuity of care, and he does see his patients very

frequently, and in fact he has opportunities to do quite a lot of things for his patients.

Table 6 represents all the service in the community and all the people who have symptoms at any one time. Of these only one in four takes the obvious step of consulting a general practitioner. Why do these 25 per cent take this step? It obviously depends on a whole lot of variable personal factors. It depends on the tolerance of patients with their symptoms, what they can put up with; on their understanding of what is normal and what is abnormal. Should we take any steps to try and educate patients into the normal and the abnormal, before they take the first step. Professor Butterfield and others in community studies have shown that many more patients when they have symptoms go to the chemist rather than the doctor. But it also depends on the patient's attitude as to the curability of diseases. The emphasis now is that we are able to cure and correct a lot of the things from which we are all suffering: this is an unfortunate myth. With the emphasis on cervical smears the patients feel that there are a lot of preventive opportunities with early diagnosis. Is this so? I very much

Table 6

Whom does the GP see?



doubt whether we ought to go on encouraging this, at this stage. It is still not proven.

How should the general practitioner work? How should he provide his care for the 70 per cent of his patients who he sees at least once a year? How efficient and how effective are the ways in which we are working at the moment? Has the solo general practitioner disappeared, or has he still got a place? What about the health team at this first level of care? Here again until we have more comparative studies we only know so much of what is the attitude of the consumer. whether to the old-fashioned solo type of doctor or to the health team. However, it seems that as far as doctors are concerned, they say they want fewer patients or more doctors: this is impossible. How can we make ourselves more effective and efficient? Obviously by making better use of all the available services, and it must mean that one's got to bring in the health visitor and the other ancillary medical helpers, the nurses and the others, to fit into this team. One does not know how best to employ and deploy these people. What are we left with? How do we begin now to look into the future to try and provide optimal care.

First of all, one needs a better understanding of each others problems. I do not mean inside the profession; I mean understanding of consumers' problems by the profession, and understanding of professional problems by the consumers. The image of the doctor and the way he works is still shrouded in mystery. It has not perhaps got across to the consumers that medical care—the diagnosis, the management, and the assessment, is a highly difficult art. It is still much more an art than a science. Second, we ought to try and do something about defining our own rôles within the medical care system. These are very vague because, to take the health visitor, these were introduced a hundred years ago for a quite different purpose. Their rôle in modern medicine is, presumably, very much different from what it was a hundred years ago, yet many of the foundations of the training is still based on those old days. What I am really trying to say is that we have got to take a fresh look at the modern way of doing things, within the medical care system, and how to use these roles to make the best of available resources. To do this one needs to experiment, but the opportunities to do so are not very easy to come by. This country has the oldest traditions and it is most difficult to alter traditional concepts to fit the modern age. It is very much easier in Russia with a history of fifty years, and relatively easier in America with a history of a hundred years. It is very much more difficult with our history of five hundred years, even a thousand years, and perhaps this is one of our problems.

The last point, the most difficult of all—assuming we decided that changes are required—what are the techniques of really working and producing these changes? And this is the sixty-four thousand dollar question.

Discussion

DR R. SMITH

FOLLOWING on John Fry is always a difficult task because he can deal with a subject of this nature with a knowledge, and I would say a skill unique amongst British family doctors. However, what I hope to do in these few minutes is to restrict myself to a slightly more literal view of the title, 'The GPs View of the Consumer'.

We had from the first speaker this morning—Dr Martin—that shattering comment, 'British doctors hate their patients'. What is the general practitioner's view of the consumer in the National Health Service, and really I am asking this question with this in mind—how does this influence his treatment of the patient? This is the heart of the matter. We have heard from Dr Fry that, to the patient, the personal aspect of his relationship with the doctor is very important to him, and I believe that this importance is not just restricted to the patient. It also affects the doctor, not only from the point of how this is going to affect his enjoyment or not of his work; but I believe it has an important role in how the doctor is, in fact, going to handle that particular case. I do not want to make too much of this, but I always like to remind myself that one of the greatest of the modern consultant hospital specialists, Sir James Spence, in his essays on the purpose of medicine believed that the medical consultation—this meeting of patient and doctor together in privacy—was really the essence of medicine, and everything else springs from this. It's here that the doctor/patient relationship is put to the test, and the outcome of this confrontation decides to a larger extent the standard of service that a particular doctor is capable of providing. Let us ask ourselves about our background of modern medicine, the National Health Service—our method of providing individuals with medical care on a vast scale—how much, if at all, does this devalue the importance and

disturb the doctor/patient relationship.

What do we really know about this? Well Dr Cartwright, has been mentioned this morning, and I am sure that in time her recent publication of '*Patients and their Doctors*' will be looked upon as a classic study on how to measure this relationship. In particular the chapter on 'Doctors' views of their Patients' is most revealing. She has made an attempt to measure what is really a volume of pent up frustration felt by British family doctors today. One half of them—and these cannot all be bad doctors—sincerely believe that one quarter of all their work is trivial, unreasonable and inappropriate. Equally, going to see the doctor can hide a major problem, usually of psycho-social nature. From the emotive terms used by doctors that come out in particular in Dr Cartwright's study, it is quite clear that the doctor often transfers to his patients some of the blame about what is wrong with the Health Service. This is the only way in which he can unburden his criticisms about the organisation. Yet Ann Cartwright tells us that most general practitioners enjoy their work because of the personal contact with the patient, in spite of annoyances and frustrations. They value the friendship of their patients, and they also value the respect that patients show to them. So instead of it being just a hate relationship it is more a curious love-hate relationship. I hope I am not labouring this too much, but I believe that the standard of medical care, in fact, does rise when more time is spent and more time is available to take into account the psychological factors affecting both the patient and the doctor in their contact with each other. Doctors the least troubled by trivia tend to be those who value the psycho-social content of their work, and not those practitioners more attracted to hospital work. This is an important point which John Fry has brought out. The doctor's view of the consumer does reflect his own attitude to his own particular rôle in the society. So long as doctors are trained exclusively in hospitals and wish to practice in hospitals, their frustrations with the consumer will continue to be a familiar feature of general practice in the National Health Service. So not only is it a question of organising and re-organising the way in which medical services are provided, but changes in medical education are also needed.

I am very relieved to see in recent years that this is now being accepted, so that if at some future date Dr Cartwright does another study in this field she may find the view of the doctor to be less jaundiced than it is today.

1 CARTWRIGHT, A. (1967). *Patients and their Doctors.*

DR H. LEVITT

I would like to add my congratulations to Dr Fry for a magnificent sweep in a short time, high-lighting all the problems and asking the right questions, even though he may not have produced the correct answers. The problem as I see it today in general practice is the organisation and distribution of medical care to the people who should get it; and the second question is how to evaluate the quality of medical care. If you ask one patient—any patient at random—'How do you evaluate medical care?' he would say, 'I can get my doctor quickly.' If I asked an academic person, 'How do you evaluate medical care?' he might answer, 'I would like to know he has access to a laboratory, and uses it.' Another asked the same question would reply, 'I would like to think the doctor goes to regular post graduate instruction'; and finally if you ask an elderly man who is homebound, his answer would be, 'I would like a nice kindly doctor who will come and see me, even though I don't really need him; one who would feel for me'.

Who or what obstructs the organisation and distribution of medical care? One fly in the ointment is the construction and organisation of the present-day hospital, whether teaching or non-teaching. The present-day structure in hospitals is a series of small empires with large, high walls between them. For many years the general practitioner, who has been taught in the hospital, when he goes out to the community, finds he has no access to the modern technology in the hospital for the patient. He could not, until very recently, ask for an X-ray; he was isolated, and more and more frustrated by the professional isolation from the hospital doctors. If you referred the patient for investigation in recent years you were obliged to go through the out-patient department. When the patient got into the hospital it was very difficult to find out what was going on. Can we hand over our patients to responsible medical care outside? We do not even know who is going to look after the patient. General practitioners have been driven to take the initiative by using health visitors, district nurses and others to help them in maintaining enormous demands involving social matters, family things, and clinical treatment.

My suggestion then is to offer a constructive but not highly original solution is of completely altering the system of hospital treatment. We do not need these great monoliths of empire with special beds—surgical beds, skin beds and so on. We need progressive patient care, patients to be admitted for intensive care, and then to go on to convalescent care and self-care, and so on at various stages. The doctors and the nurses outside can be brought in to assist. We know from work done recently that many patients have simple operations and do not need to spend more than twenty-four hours in hospital at a cost of £60 a week. You can stay at home in your dressing-gown as well as in the ward. I think we should look at this hospital topic, and Dr Fry has mentioned how the doctors and nurses and others in the community can be used equally effectively in and out of hospitals.

DR A. ELLIOTT

The thing that I am struck by is this: it is not the consumers who are complaining about the medical services. What the survey mentioned shows is a very great deal of satisfaction. Frankly people do not know any better. The people who are dissatisfied are the doctors, and especially the family doctors. It is very interesting to note the work done on the people who emigrated. The survey showed that job satisfaction, or lack of it, was most significant. It was not even a question of money; the important thing was lack of job satisfaction. The other interesting thing is contained in Dr Talbot Rogers' Report dealing with efforts to bring doctors back from the United States. He was the representative of the Ministry who was interviewing GPs. The point is that though people gave various reasons why they liked the United States and Canada, one thing is very important: they said they were not prepared to come back to general practice in this country. We have got to consider very seriously this situation.

The young doctor at the moment is trained by specialists to be a specialist and all his training is done in hospital. Then he is shot out into general practice for which he has not been trained. It makes them feel they are being rejected. All their training has been of this electronic, high power, scientific kind. They do not understand about questions of emotional illness, and income tax, and the mother-in-law. Therein lies the great difficulty. I believe that the solution to the question of job satisfaction lies in the very encouraging signs that we are having now on a new look in medical education. The General Medical Council is not a body which we expect to be tremendously forward looking, but their statement on basic medical education shows that there is a whole re-orientation of ideas, and that a doctor when he qualifies will not be available to do any sort of medicine but will then have to embark on vocational training and have general practice as well. I see other signs. The Royal Commission on Medical Education and others have been working on schemes of vocation training for the general practitioner which will fit into the whole general scheme. But what I want to see is teaching units of general practice associated with these hospital situations, not forgetting that half these doctors will need to go into general practice, and they are going to have two-thirds of their training in the district hospitals. If we can have units of general practice —teaching units—all over the country, we will then produce doctors who will have some association with the local hospital and at the same time will have the job satisfaction of working in the community, which I am sure we are all striving for.

MRS A. WILLIAMS

You have touched upon a point which concerns me. In my spare time I am a school teacher. In my profession we have to accept auxiliary help. I would like to know why there has not been more exploration of this idea of medical auxiliaries. Should there be a quarter of a doctor's time spent on trivia? If there is a nurse, could a doctor not make the official diagnosis and pass on the complaint to her? Then the doctor should not have to deal with an ingrowing toenail. This is a sort of rationalisation of a doctor's job and I think it would save an infinite amount of time. There should be an expansion of the nurse's job. I think it has been true, when a woman had a baby, a nurse could not take out stitches or put them in. I think this is all a lack of rationalisation.

Who Pays for Health?

GEORGE TEELING-SMITH

THE cost of ill-health falls primarily on the individual and his family. The cost of prevention and treatment of ill-health, however, must fall primarily on the community as a whole. That is an unarguable statement of fact for any advanced or developing country in the latter part of the twentieth century; the only notable exception at present, the United States, is rapidly falling into line with the pattern already established elsewhere. However, the statement of that fact is by no means the end of a discussion on 'Who pays for health'. It is possible for a small but important share of the cost of medical care to be borne by individuals rather than the community. Even although this private source of funds can only make a limited contribution to the total available it can perhaps have a significance far beyond its monetary value.

Table 1

Approximate source of funds for expenditure on health. UK 1967

	%
Central & local government taxation	81·4
NHS contributions	9·3
Direct payments to NHS	3·5
Private medicine (mainly pharmaceuticals)	5·2
Private insurance (mainly BUPA)	0·6
	100·0

At present in Britain, as Table 1 shows, more than 90 per cent of the total expenditure of some £1700 million a year on medical care comes from Government finance. It is a popular misconception that the weekly Insurance Stamp provides much of the money for the NHS. In fact this is not so; the vast majority of public expenditure is financed out of general taxation and rates. In fact, one contributes more to the NHS funds buying a bottle of whisky than buying a National Insurance Stamp. If the 37s. 6d. excise duty on the former is distributed evenly over public expenditure as a whole, about 3s. 9d. will go to the NHS. From the 31s. 8d. Insurance Stamp (excluding SET) only 3s. 4d. goes to the Health Service.

As an aside, if the whole of the working population were to drink one extra bottle of whisky a month, and the total Exchequer revenue were to be devoted to the NHS, it would provide well over £500 million extra funds for the Service. Unfortunately this painless answer to the NHS financial problems introduces some over-simplification of the issues involved, and I must return to my main theme.

Much present discussion about the comparative ways of financing medical care is confused by regarding all health expenditure as a homogeneous entity. In fact, however, it is a composition of many varied parts ranging, for example, from the supply of pharmaceuticals (including aspirin for a headache) through the routine diagnosis and treatment of acute disease, the performance of major therapeutic procedures such as open heart surgery and radiotherapy and screening for pre-symptomatic disease, to the long-term care of the elderly and chronic sick in hospital. These different aspects of medical care involve issues which in turn range over a multi-dimensional continuum, depending on their cost, their duration, their degree of medical necessity and the probable ability of the patient to meet their cost directly. Because a particular system of finance is appropriate for some aspects of medical care, it may not be appropriate for all.

In addition, we tend to forget that for many fringe areas of the National Health Service there are already more or less arbitrary decisions about what is available without charge and who is entitled to receive it. At present, in some cases, the patient and doctor between them work out which medicines (for example, analgesics, travel sickness remedies, and oral contraceptives) will be supplied under the NHS and which the patient will buy. Home help services are charged for according to a means test. Many dental treatments are available, without additional charge, only at the discretion of the Dental Estimates Board. Health check-ups are available without charge only if the local doctors have chosen to provide them. Clearly, under the NHS as it exists, some cows are more sacred than others.

Also, it was sometimes naïvely assumed that the former 'money rationing' of medical treatment had given way to a Utopia in which the 'best' medical care was available to all. Even now that we have come to accept, for example with treatments such as renal dialysis, that we still face a problem of rationing scarce resources, many people still hopefully believe that this rationing is based solely on the criterion of the greatest medical need. This is not so. Medical treatment is frequently rationed on the basis of geographical availability. It may also be rationed—like the State subsidised cheap tickets for the Covent

Garden Opera House—by the amount of time which individuals have available for waiting their turn. Finally, the present distribution of scarce medical resources is still biased in favour of the middle classes, who can apply their intelligence and contacts to increase their likelihood of getting whatever treatment they require.

Nor is it any use imagining that 'more money for the NHS' can end these forms of rationing. There will always be scarce and specialist procedures which cannot be universally available. We will never reach a situation, for example, in which every elderly chronic invalid receives the painstaking and comprehensive personal care which would be the ideal. Nor will each latest spectacular surgical technique immediately be available to all whom it could benefit.

Thus we have an imperfect situation at present and, however much this may be resented, there are strong human forces at play which are unlikely to allow existing inequalities to be diminished. It is therefore sensible to examine alternative systems of finance.

To do so, it is useful to distinguish at least five different aspects of medical care. The first is primary preventive care, including immunisation and the maintenance of as healthy an environment as possible. The second—sometimes called secondary preventive care—covers surveillance and early diagnosis, either using multiple screening tests, or periodic 'health checks' by one's own doctor. The third includes the diagnosis and treatment of acute illness and minor surgical repairs for otherwise healthy individuals. Fourthly, there are the growing number of major therapeutic procedures, such as open heart surgery, neuro-surgery, transplant operations and radio-therapy. Finally, there is the care and maintenance of the elderly and chronic sick.

As I have said, each clearly involves different, although not distinct, problems. Care of chronic sickness, which is usually associated with increasing indigence, should desirably be financed out of public funds. For the major therapeutic procedures there are conflicting issues. They are too expensive for the average person, yet they are just the type of medical care for which the more affluent are willing to pay. An insistence that they are invariably financed entirely out of public funds is often associated with the fact that they are not available for all. The same is true for surveillance and early diagnosis. In both these cases the issue is complicated—but perhaps in a way made easier—because there is a substantial element of research still involved. This raises the ethical problem of using non-paying patients in experimental situations while carrying out the same procedures selectively in paying patients. By definition, of course, such treatments must be of unproven benefit. If some people, knowing this, choose to purchase them it is debatable whether they should be prevented from doing so. There must, of course, be safeguards to ensure that the research programmes are not hindered by such provision.

The treatment of acute illness, on the other hand, can be paid for or insured against by many employed persons. It is not necessarily correct, simply because other types of medical care cannot be financed in this way, to rule it out for acute illness.

We should have a more flexible attitude of mind to the whole question. Any aspect of medical care can be financed in one or more of six essentially different ways. If it is privately provided, it can either be paid for directly, or by private insurance cover. In this country, under BUPA, for example, private medical care is frequently paid for by a mixture of the two methods. If the care is publicly provided (as under the NHS) it can be financed either by public funds or by direct levy such as prescription charges. Again, it is common to have a mixture of the two, part of the cost being met by direct levy and the rest being met out of public funds. These public funds may be raised either by general taxation or by special taxes. As the Table has shown, Britain favours mainly the former. Most other countries finance their health services more by special taxes along the lines, for example, of our weekly insurance contributions. Finally medical care and particularly health research can be financed from charitable funds.

Six alternative sources of finance—private payment, private insurance, general taxation, special taxes, direct levy or charitable funds—each available for five entirely different types of medical care would give a total of more than 40,000 alternative ways of financing health care as a whole. A more detailed breakdown between the parts of the Health Service, considering how each could be financed separately, would give many more alternatives. Obviously many combinations would be inappropriate, but on the other hand the present choice out of the many thousands of alternatives may not necessarily be the right one. I do not feel that we can afford to reject, without detailed consideration, the possibility that there are certain significant aspects of medical care which could appropriately be financed differently than at present.

Having said that, I would like to mention a number of objections both to private finance for health and to direct levies. First, there is the danger of socially unequal distribution of scarce medical resources. We should debate, however, whether this concept is as simple as it sounds. Sometimes equality for all means the provision of nothing for anyone. More seriously, 'limited resources' are often defined primarily in terms of a shortage of manpower. In this context, we must remember that at least 300 doctors a year are leaving Britain, often because they cannot obtain adequate rewards or satisfaction in this country. Private finance could be directed towards attracting these doctors to remain in Britain and thus considerably reducing the overall shortage of medical manpower.

Secondly, it is often argued that a single comprehensive health service covering the whole population ensures that middle class pressures for improvement—such as those expressed through the Patients' Association—also benefit the less articulate social classes. This is certainly a valid point, although the most effective pressures come more from social reformers than dissatisfied consumers, as for example in the case of the book *Sans Everything*. There is also the contrary point, that if better services can be bought with private money these create a bench mark against which shortcomings in the public service can be assessed. If no one can have open heart surgery or cervical cytology, for example, there may be no pressure to make them generally available. If such operations can be privately purchased by those who can afford them there may be very real pressure to make them available for those who cannot.

Thirdly it is argued that the encouragement of private finance for medical care would create two standards of medicine. This is again a real risk, but it must be seen against the fact that we already have multiple standards,

dictated by accidents of time and place, by personal status, by relationships with the medical profession, and similar considerations. Would controlled inequalities permitted by limited opportunities for the private purchase of medical care be worse than the existing inadequacies? Could those who are at present less equal than others possibly be better off if the overall standards could be raised by new sources of finance?

Finally, there is the question of the extent to which direct payments—either privately or as State levies—act as a barrier to treatment. There is no doubt that they do, and that these barriers cannot simply be removed by exempting certain classes of people from payment. Might there not, however, be some way round this problem if social scientists gave their mind to it, rather than re-stating their dogma on the evils of direct payment for medical care?

There are several reasons why it might be worth while considering alternative sources of finance for medical care. First, they can raise additional funds, by diverting private expenditure from personal consumption (for example on new cars or foreign holidays) on to personal health care. Because this does not raise taxation, it is a genuine alternative to increasing public finance. However, it is certainly wrong, in my view, to expect private finance to contribute much more than 10 per cent of the total cost of medical care, at least in the foreseeable future. It has been argued, however, that there are advantages in encouraging the public to regard their income as a means of purchasing better medical care and other social services instead of only less socially desirable consumption. For instance, an increase in salary could enable you to pay for medical services if you did not spend it on drink or holidays. Secondly payments for medical care can be used to affect the pattern of consumption of medical care. This happened, for example with dental charges, which were imposed only on non-pregnant adults, and which consequently allowed a greater proportion of the busy dentist's time to be devoted to the treatment of school children. It is suggested by the proponents of prescription charges that these also cut down unnecessary consultations with general practitioners. However, unless they are intelligently applied, the deterrent effect of private payments and direct charges are probably more often bad than good.

Thirdly, different sources of finance introduce an element of competition into the field of medical care in several senses. The unquestionably good sense in which competition is stimulated is that rival sources of finance are able to vie with each other in providing the best service. 'The medical care provided under our scheme is the best available' is a statement which is meaningless in a monolithic system of medical care; but it can be a very real spur to progress when several alternative services are available to the public. The public accept what they get, but if two or more services are available they have a choice. On the other hand, a richly endowed private sector can present an impossibly strong competitive force draining the most highly skilled manpower out of the public sector. Nevertheless it is certainly wrong to oppose a private sector simply because the public sector cannot face up to the challenge of competition which will show up its inadequacies. Remember again, in this context, that I am referring only to a 'private sector' in respect of certain limited aspects of medical care—not for the Health Service as a whole.

Finally, alternative sources of funds can provide an opportunity for innovation. This happens at present when the teaching hospitals use their endowment funds for projects which cannot obtain government finance. In a different sense it happens when the NRDC backs a new development in the health field. It certainly happens when charitable funds such as Nuffield or the Kings Fund finance projects which fall outside the terms of reference of the NHS. It happens when the Institute of Directors provide their medical check-ups for executives. I am sure that many of the greatest advances in surgery and in services such as pre-symptomatic health checks can best be developed where private or charitable finance is available.

I have not attempted to suggest in this paper where the balance of public interest lies in this intensely complex field. I hope, however, that I have stimulated some more openminded discussion of the extraordinarily intricate question of the best method for financing the different parts of the very many-sided entity which makes up our Health Service. It is certainly not a subject where simple dogma or the pronouncement of broad general principles are likely to provide the right answers.

Finally, I would like to end by restating the basic dilemma which faces all questions of social and economic policy. If we insist on equality for all, we create by definition a state of mediocrity. If, on the other hand, we stimulate peaks of excellence in any part of the service, we run the risk of creating pockets of inadequacy elsewhere. The almost insoluble challenge is to create acceptable standards of equality without stifling excellence. I have no hesitation in saying that, so far, we have completely failed to achieve this ideal in Britain. Perhaps this is only because it is unachievable.

Discussion

MR H. C. ELWELL

AS I am on the staff of BUPA I feel I have no need to declare my interest in a virile private sector in medicine. I would thus like to comment on one, very narrow, aspect of Mr Teeling-Smith's paper, in which he mentioned, as you have heard, the source of the funds coming into the Health Service from private patients. An earlier speaker dismissed very briefly the four per cent of people in this country who are covered by private medical insurance. May I ask you not to dismiss quite so summarily what is at the moment—and I freely admit this—a relatively insignificant proportion of people in this country, some 2 million people only. The reason I ask you this is that I feel it is very easy to think that because this section at the moment is so small that it is not potentially vociferous, nor in a position to influence thinking over the next few years over the whole range of medical treatment. The reason why I am so insistent about this is that, up to a few years ago BUPA was a rather introverted and a small organisation—in other words, we had a single product and said 'if anyone wants to buy it they can come along'. I think we are getting to a slightly more aspiring stage of our career where not only do people come freely to buy this product, but there are a great many other people outside in the general market interested in the product. Can we get at them; and, if so, are there the facilities to ensure that, having paid their subscriptions, they can in fact get the private treatment they insured

for? Two years ago, in an attempt to define the market open to us, we conducted a research project, which indicated that the present 'market' for people who require private treatment, protected by medical insurance, is over eight per cent of the population, the adult population—still perhaps a relatively insignificant proportion. However, if we indulged in marketing this proportion could increase to possibly between 12 to 15 per cent of the population.

Can I say straight away that we, and I think all the provident associations, view a very rapid growth in the private sector as being absolutely wrong. This is leaving aside any sociological or political aspects—we know there just are not the facilities available. An attempt to do something about this question of facilities was made a few years ago and an Organisation, Nuffield Nursing Homes Trust, was set up by BUPA to build nursing homes. NNHT now operates thirteen Nursing Homes—or rather private mini-hospitals—with over 430 beds. In terms of beds, these still cater for only a small proportion of the demand, and would go only a small way to being able to cope with what could be a vast increase in people who require private treatment. So I would like to stress here that we in the provident movement appreciate the appalling dangers of 'over-selling' in advance of production, that is facilities, and in being involved in highly complex social and political problems which are not in our sphere. We are designed to provide a service; we don't want to be embroiled in political or sociological in-fighting. Incidentally, I notice in the programme today there is no mention of the influence that politics can have on the whole future of the Health Service, although I feel that the influence it is going to have on each of us in this hall is considerable. This might have been a deliberate omission and although I think it is a very right one, I don't think we can dismiss the fact that our political masters—unless they are conditioned by what we are saying today—appear to have no intention of doing anything other than tinker with a service that is, so many people feel, increasingly inadequate—for whatever reason; and I think if they merely tinker then the whole tissue of the service will fall to the ground; we shall be in a worse position in ten or fifteen years' time than we are now.

To sum up, although a small percentage of the population is enrolled in provident schemes, the percentage is growing fast, including particularly the staffs of firms, and also politicians, from both sides of the House; as an aside, I find it particularly irritating to find an MP in the House talking about the inequalities stemming from private treatment when he goes in for it for himself. We in the Provident movement have a very large market indeed; we in BUPA are in a position to tap a large proportion of this market; we have a computer now; and, if it should be necessary, administratively we could take on as subscribers half the population of this country.

MR G. FORSYTH

There is so much to agree with in what Mr Teeling-Smith said. He does, however, raise one or two controversial issues. Health services in this country certainly do rely on one source of finance: general taxation; but we should not forget that other sources are available and used to some extent. So far as the consumer is concerned he has a very wide range of choice. Everyone has to pay general taxation and most pay the weekly insurance contribution. When the consumer has done that, he is quite at liberty to pay a private doctor or pay for a private hospital bed. In fact, the various options already available are used by the public in combinations and the various systems are very much interrelated. For example, from a recent New Society survey it appears that 90 per cent of those carrying private voluntary hospital insurance of the BUPA type are registered with National Health Service general practitioners. Again private practitioners can make use of NHS hospital direct access diagnostic facilities without charge to their private patients. The only two combinations denied to the consumer are firstly, he cannot have a private GP and have Health Service drugs; secondly, he cannot have a private pay bed in a public hospital and escape paying fees to Consultants. The first limitation is imposed by the Ministry, the second by the Consultants. One could even argue that the expansion of BUPA type voluntary insurance is not unrelated to a public taxation system which allows firms paying premiums on behalf of senior executives to charge such payments against Corporation Tax. The point is that the present system in Britain provides consumers with a wide choice of payment systems, subsidised in various ways.

Mr Teeling-Smith's proposals, it seems to me, would by implication narrow and not widen the opportunities for paying that the consumer has at present. As I understand him, he is proposing to base the method of payment on some kind of disease category. The five types of medical care he lists imply various disease categories ranging from trivial anxieties through to major chronic sickness. This might be an appropriate way to finance medical care, relating the payment to disease category. I have no objection to this in principle, but at least the practical issues need careful examination. Mr Teeling-Smith's proposal raises two important questions. First of all, who is going to decide which group a patient falls in to at any particular point in time; and secondly, what will be the administrative cost of collecting the money? On the first of these, obviously the patient can hardly be expected to decide himself which category he falls in. Is he making a trivial complaint, or is he chronically sick? The GP will have to make the decision. As Dr Fry demonstrated this morning, the GP is involved in all these stages of medical care and should be aware that patients in one category are potential candidates for another more serious one. Precisely on this point the proposal to reintroduce prescription charges is in trouble already because, quite rightly, the profession refuses to say which patient shall pay and which patient shall not. Just imagine a Doctor saying 'You must pay for this placebo Mrs Jones; it won't do you any good and you don't really need it', whereas in reality he was playing for time perhaps to sort out what really lay behind the apparently trivial complaint. As for the cost of administering any kind of system which is going to involve payments by patients, the former type of prescription charge at least had the merit of involving no great administrative cost, and it was stupid to abandon it. But can charges be applied to other parts of medical care? For example, hospital in-patients: at present 25 per cent of bed-days in general acute hospitals are consumed by those over the age of 65. The proportion is

of course higher in mental and chronic sick hospitals. These patients would find charges hard to meet. Indeed, about 20 per cent of people over retirement age are already receiving supplementary benefits from the Ministry of Social Security. To levy charges on hospital patients could mean extra clerical staff and expenditure might exceed receipts. We would all agree, I hope, that a system designed to save money should not cost more to administer than it actually saves. In any case, even were the hospitals, by levying charges, to receive a few thousand pounds extra, there is no guarantee that the Treasury would not reduce the service allocation from Exchequer funds accordingly. Which type of medical care can you charge for and show a profit? The costs of relying less heavily on general taxation should certainly be investigated.

In fact my real doubt about Mr Teeling-Smith's paper concerns whether tinkering with financial arrangements alone is really going to solve the problems. I think what we really need is new ideas at this time, particularly those which relate to new forms of organisation as much as to the injection of new funds. One of the interesting developments in Saskatchewan was the emergence of Community Clinics during a Doctors' strike in 1962. This involved groups of consumers taking insurance policies along to the Bank and borrowing money on them. They provided premises and equipment for GPs and Specialists working together. In these small Community Associations medical education was promoted in the wider sense referred to this morning by Dr Martin particularly by explaining to the public how they ought to use the services. I should have thought that Consumer Associations in this country might perhaps try something on these lines. Consumers at this Conference have made it clear that they have their expectations and perhaps they should try and undertake more responsibility themselves in seeing that GPs are able to meet them by providing the extra facilities they apparently desire. This idea of closer Doctor-Consumer co-operation is only one possible new form of organisation. What depresses me in this country is that at the moment the only reorganisation we think of is the Area Health Boards. These Boards may help, but they will not solve all our problems, and I do not see how they will help Doctors and consumers in adjusting to the fact that they are no longer in a direct financial relationship with each other. We need to be much more inventive both in using present resources and creating new ones.

In Manchester, Rutherford is remembered for two things: first, because he split the atom, and secondly, because he once called his staff together and said, 'Gentlemen, we have no money: we must use our brains'.

DR P. DRAPER

I feel the title of Mr Teeling-Smith's paper is wrong. The question we ought to be interested in is, 'What is bought in medical services anywhere'. Second, with regard to the price of care, the only systematic research into the question of whether price mechanisms can evaluate medical care comes from a survey in the United States in relation to general practice and earnings of general practitioners. This showed quite conclusively that selection of good general practitioners by price mechanism was inefficient. Additionally studies which have been used to decide which country has a better health service as judged by the proportion of the gross national income spent on it, are inadequate. What we are interested in is what is bought with these proportions. The arguments about 'private' versus 'public' care are really as dead as the dodo; they also focus attention on insignificant components—on chicken feed. The central question is, 'How can we raise medical productivity?' If you halve the provision of hospital beds in this country you substantially reduce the money that we require for health services, and the question which we should really ask ourselves is what are we doing with the money we are spending. Are we getting good value? Are we assessing medical care properly, and are we planning medical care sensibly?

Planning with the Consumer in Mind

M. E. J. WADSWORTH

FORWARD planning for health services (as opposed to the more static operations research in health services) with the consumer in mind has in the past too often been dominated by the useful, but sadly incomplete question of the average pram pushing distance. This is surprising in an age when planning has become a scientific discipline with its own large range of techniques and experts, and when the social sciences are interested in studying the philosophy of planning. Why is it then that only relatively recently the consumer has become of interest in planning?

First I want to put forward two working definitions, of the consumer and then of planning. I am using consumer here to mean the public as a whole, that is, all potential patients, and not just those persons who are patients at a point in time. For planning, although a definition is obviously difficult, Professor Eckstein, the American social scientist in his work on the National Health Service has this to say:

'The purpose of planning, in a word, is to "rationalise" the activities on which planning is imposed, to make subject to calculation what was previously left to chance, to organise what was previously unorganised, to replace spontaneous adjustment with deliberate control.'[1]

This concept of planning as something which is imposed on continuing activities is useful because it illustrates the central problem of planning, namely prediction. In medicine this is especially complicated because of the different rates of growth and change of the complex matrix of factors concerned. I want to illustrate this complexity to show why the consumer has at this point in time become of interest to planners.

During this century there have been basically two important and interlinked movements affecting medical care. Firstly, the overall changing pattern of disease and secondly the changing structure of services to manage it. The disease pattern has been influenced by the coming of the sulphonamides and antibiotics along with the developments in diagnostic techniques. These discoveries have helped to clear the obvious back-log of post war sickness and to prolong the lives of our already ageing population, thus enabling them to live on to contract chronic illnesses usually associated with the middle and late years. Professor Morris has summarised this process in a vivid way:

'Lessen physical deprivation and widespread emotional and social incompetence are exposed. Reduce physical disease and problems of mental health can no longer be ignored.'[2]

As a result the front line or primary care services, evolved as they were to cope with the pre-war pattern of acute illness, are experiencing frustration and disenchantment at becoming much more concerned with maintenance and surveillance.

Throughout this period access to medical care became increasingly easier until in 1948 it became completely free. Along with this has come the 'discovery' of the iceberg of disease—that is presymptomatic and unrecognised illness. So there exist at the same time comcomplaints of doctors being swamped with trivia on the one hand and on the other a growing interest in screening—that is in detecting presymptomatic and/or unrecognised illness in persons who do not present with the complaint sought in the screening examination. Thus we have the present interest in the consumer, the person who usually, at present, has to make his own interpretation of when and what complaints to present, and to whom to present them.

This interest in the consumer is represented in the work of clinicians, epidemiologists and social scientists, and already jointly staffed projects are being carried out. Patient's needs are changing, from infectious to chronic disease, and overall medical attitudes and interests are changing from alleviation to early detection and prevention. A great deal of clinical and epidemiological work has been, and remains to be done, in this field. I am sure that our familiarity with the range of work is sufficiently common for me to be able to summarise quite simply with three examples. Firstly, the drawing together and interpretation of data by Dr John Last and Professor J. N. Morris in their work on the 'iceberg'. Secondly, clinical epidemiological investigation in the work of Professor John Butterfield and his colleagues in the Bedford and subsequent studies of diabetes, and thirdly the work of Dr J. M. G. Wilson on the rationale of screening and the early detection of disease.

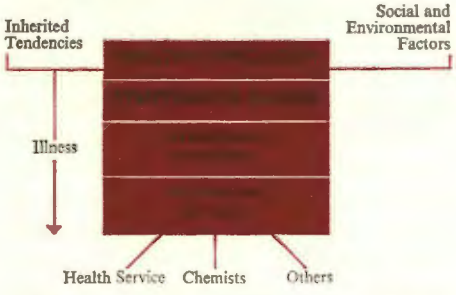
At the same time social scientists have been interested, along with clinicians and epidemiologists, in demand rather than need, for medical care. Whereas in clinical studies need is frequently defined as any measurable deviation, either symptomless or with symptoms, from the 'norm'—and of course many problems have arisen

in the definitions of 'norms'—the social scientist's interest begins when symptoms are manifest. At this stage the individual has to decide for himself whether or not to become a consumer of medical care. As Morris says 'needs have to be felt as such, perceived; then expressed in demand'. Morris also says that 'needs often are revealed and demand expressed only when services are supplied'. For the sake of argument this could be taken to mean—although it quite obviously does not—that free access to a system of comprehensive medical care would ensure the existence of a very small pool of unmet and manifest need and demand. But is this so in reality?

In 1963/64 the field work of a study was carried out from the Department of Medicine at Guy's Hospital and this investigation throws some light on the question of consumer demand for medical care. In this work, to which I shall now refer at some length, I was privileged to be a colleague with Professor John Butterfield and Dr Roger Blaney.

Table 1 shows a crude abstraction of the conceptual model which formed the basis of this study, and also helps to draw together some of the previous remarks.

Table 1



We wanted to discover every single measure and medicine taken by a random sample of persons in order to show what proportion of them were in receipt of medical care and what proportion were using other and no forms of care. What we have been trying to investigate is not the demand for medical care expressed as a figure to be extrapolated to other populations, but the sorts and numbers of complaints which in one population were self or lay treated. This is part of the source of demand for medical care. Since our concern was with the individuals decision to seek medical care we recorded the layman's interpretation of his own complaint. This was in order to remain within his frame of reference and to discover his reasons for choosing a course of action with regard to his complaint. Thus, a structured questionnaire —based very much on questions already evaluated by epidemiologists—was used at interviews in the home conducted by lay interviewers.

We found that during a fourteen day period only 4·9 per cent of those interviewed had absolutely no complaints, 18·8 per cent had had complaints but took no action for them and 76·3 per cent took action for their complaints, and in one third of cases this was medically initiated.

In the report of the study we have gone on to examine closely this situation concentrating on the complaint itself and on the individual's idea of the cause of complaint in relation to his management of it. We wanted to show whether some sorts of complaints lead more readily than others to certain courses of action taken by individuals, in order to throw some light on this problem of demand and on the notion of a threshold of consultation. We have been surprised in the analysis of our findings to discover, among other striking things, many examples of a very low standard of health knowledge in individual's interpretation of symptoms and subsequent choice of medication, amounting in some cases to not only a misguided but dangerous use of medicines and appliances. In short, we have sometimes referred to the iceberg of demand.

Whereas in the Guy's study we looked first at the overall situation at a point in time and then concentrated on the complaint itself and its management by the individual, there have been many other ways of studying this area. Probably most ambitious among these is the present cross cultural, or at any rate cross national, study of 'the influence of the organisation and financing of health services on their utilisation in general populations', and this work is under the direction of Professor Logan in this country, Professor Kerr White in the United States and Dr Kraus in Yugoslavia. Others have investigated consumer response to offers of various sorts of screening examinations, the use of self medication, the use of general practitioner and dental and student health services, and the health and attitudes towards health of low users of medical care. There have also been cross cultural studies of attitudes to specific disorders and national studies of the help and medical care seeking behaviour of small groups—for example the family—in various states of health and illness as well as work on the effect of public health education programmes, for example about cancer in all forms and about smoking.

Yet despite all this important work, it is still early days in this field. Many theories and methods are being tested and as yet in this country no single research group has consistently tackled these problems, although several as it were one-off studies have been carried out. I suggest that this may be so for three reasons. Firstly, and quite simply, shortage of money. Secondly, the difficulties involved in bringing together an inter-disciplinary team to do this—for example, the Guy's study team consisted of a physician, a research worker in social medicine, who has latterly become a medical administrator, and a social scientist. Thirdly, this may be because its practical relevance is not perhaps always immediately obvious.

But will these sort of data be useful for planners? I would suggest that they will, in view of the present trends in the medical care system which I sketched very briefly at the beginning of this paper. The general practitioner is overwhelmed with sheer numbers of patients presenting, and for obvious practical reasons it is likely to be some time before a large increase in numbers of general practitioners can be brought about. In order therefore, to make best use of present resources two courses are likely. Firstly, an increase in numbers of ancillary workers, for example, nurses, technicians, social workers and secondly a resort to the traditional industrial solution in a manpower crisis, namely technology. In medical care terms, technology could here be translated in practice as such easily used diagnostic and pathological test equipment as the Dextrostix method and the auto-analyser. As these methods are developing it is possible—and this is pure speculation on my part—that emphasis will gradually turn from the present episodic pattern of front line care, based as it is on the patient's interpretation of when and what to present, and tend increasingly towards seeking out and following up the patient, perhaps even with a routine examination service for the young and the elderly.

These postulated changes in emphasis (and whether they are right or not we can be sure that changes will take place), and even the present episodic pattern of primary care, could obviously be better planned if consumer interpretation of complaints and subsequent demand for care was better understood. This is one of the basic activities, as Eckstein says 'on which planning is imposed'. As demand is apparently always increasing and changing, the necessity for this work becomes clearer. It is hoped that such large scale investigations into total population as the Tecumseh study of Professor Eckstein and his colleagues will routinely include, along with the investigations by clinicians and epidemiologists, some component of consumer behaviour studies, since consumer behaviour is the source of demand for medical care, the basis on which the whole medical care system is imposed.

I want to end by quoting what seems to me one of the best summaries of the increasing demand situation, influenced as it is by many factors, including the way in which medicine is practised. It is an observation made by the famous Canadian humorist Stephen Leacock:

'Just think of it. A hundred years ago there were no bacilli, no ptomaine poisoning, no diphtheria and no appendicitis. All of these we owe to medical science. Even such things as psoriasis and parotitis and trypanosomiasis, which are now household names, were known only to the few, and were quite beyond the reach of the great mass of people'.[3]

1 ECKSTEIN, H. (1959). *The English Health Service.*
2 MORRIS, J. N. (1964). *Uses of Epidemiology.*
3 LEACOCK, S. (1937). *How to be a Doctor in Literary Lapses.*

Discussion

MRS M. JEFFERYS

AT this point in the proceedings, much of the speech which I had prepared is superfluous, and I wish to make only a few disjointed points. First, a point which has not been sufficiently stressed, even though it has been implicit in the previous discussion, is that the demand for services which could be met by doctors and other health service personnel seems to be infinite. If it were finite, we should have far fewer problems. We are really concerned with how to ration health services, i.e. how to distribute the limited supply of services between the competing demands for them. There are two ways in which one can do this; the first is by planning, the second by allowing the unrestricted forces of supply and demand in a free market economy determine how resources are to expended. The second alternative is no longer politically possible and hence not seriously advocated; but in choosing the former there are many degrees and kinds of intervention possible. We can, in fact, plan to allow a proportion of resources to be allocated in response to changes in demand as evidenced by the purchasing power of consumers. But we must decide how much of our limited supplies should be allowed to find its own level in this way.

The second point is that, whatever the degree of control, it is essential that there should be sufficient flexibility to allow for reallocation of resources should we have to meet unpredicted changes in the supply or demand conditions for different kinds of service. Some of our present problems arise from the rigidity with which plans have have been imposed in the past, and the subsequent difficulties of introducing change into inflexible structures or the idea of change into inflexible professional and bureaucratic brains. Paradoxically, we must plan for uncertainty.

The third point to be made is that we need to be planning health services, not for today, but for five, ten and twenty years' time. This means that we need better methods of prediction than we have at present. Prediction is difficult because the speed of technological change is so great and because so many factors, economic, social and psychological enter into the equation. The social scientists have not, so far, been very good at prediction. For example, they were taken by surprise by the increasing birthrate of the last decade, and they did not foresee the effect of changing marriage patterns on the demand for maternity and child health services. We must consider all the implications of changing population size, and of population shifts between regions, from city centres to the suburbs or to new towns, from urban to rural areas, and the consequential changes in social and economic status to which such shifts give rise for the development of health services. One of the problems from the standpoint of the community, representing both consumer and producer, is how to get agreement to plan for the future rather than for the present. This involves allocating resources with some long-term aims in mind. It takes from five to ten years to produce a doctor; it seems to be taking equally long, if not longer, to produce a sense of community and continuity in new towns. Pursuing short term aims may make longer term ones more difficult to fulfil.

I cannot give answers to all these questions which do not seem perhaps to have received much attention in the discussions so far. I think they may be equally important in determining how far the changes in health services which now seem to be merited will achieve a substantial improvement in the health of the nation—the objective which we all have in mind.

MRS M. STACEY

I was interested in a remark made about the relationship between the low standard of health knowledge and subsequent choices of medication discovered in these surveys. The point is that this sort of statement implies that there is a standard of health knowledge, a concept of health care which is absolute, which we all ought to agree to, and those who do not are lagging behind. In Swansea we are trying to investigate this sort of idea a little more. Persons have different ideas in their heads about what constitutes health; and again of the kinds and amounts of disability they can carry on with. Because of this sort of thing they make different decisions about when to go to doctors. We are starting very humbly with a few families and trying to find out under just what circumstances people do present cases. We are seeking antecedents, the stage before they visit the doctor. Some people think it is morally wrong to be ill, and some think it is morally right to get treatment. There is a great deal of lack of knowledge in this area. These investigations might help us to see why some predictions are not as accurate as we should like them to be.

MR J. B. McKINLAY

I would like to suggest that we do plan with reference to a consumer, but we usually have in mind one who is a

rational, ideal type of individual. Seldom do we recognise that there are some groups in society which, because of their structural position and because of particular experiential factors, entertain certain beliefs about and attitudes towards health and illness. They define various therapeutic situations in unique ways and for a variety of reasons perform with regard to health and illness in a manner which appears to be idiosyncratic. Certain social categories, such as unskilled manual workers and their families experience difficulty in operating with formal organisations. They are said to be unable take to the rôle of the listener; cannot express themselves easily; have no facility with form-filling and generally feel alienated. Such people do not only have difficulty in medical situations, however, but also with insurance companies, banks, building societies—in fact with most professional bureaucracies. This is a distinct and consistent cultural pattern if we can accept that there are distinct cultural systems.

I know that the idea of an equitable distribution of resources and facilities is very Utopian, but there is, it seems to me, another way and that is to plan, organise and implement services which are relevant and understandable to these unique and distinguishable subgroups of society. These facilities should be based on the organisational forms they like operating with, instead of in a very formal bureaucratic fashion. One way is to encourage and build on the individual patient/doctor type of relationship. It is vital that we do not further alienate those who are already alienated. We need a health service that is planned with these considerations in mind. In other words, we need a service which takes account of the heterogeneous subgroups of which society is composed.

Balancing Consumer Needs, Professional Requirements and Available Resources

DR R. H. L. COHEN

I MUST begin by explaining that I have been invited here not as a Ministry spokesman, but simply as someone within the Ministry and familiar with some of the problems of the National Health Service as they appear from its viewpoint. If, then, I speak largely in the first person singular it is not out of egotism but to emphasise that I speak only for myself.

I have been asked to talk about balancing consumer demands, professional requirements and available resources. I cannot deal comprehensively with the innumerable inter-reactions of these three, but will talk first about available resources in terms of medical manpower; and then against this background discuss some of the considerations which should influence consumers and the profession in making up their minds about priorities in a National Health Service. Finally, I shall describe an experiment in the hospital building programme, which aims at a better use of both financial and manpower resources.

If I have chosen to talk about resources mainly in terms of manpower rather than money, this is not to deny that money is short or that this does not impose serious limitations on our freedom of action. Nevertheless, it is true that shortage of doctors is an even more serious limiting factor on progress; and this may help to bring home to us that medical services must compete not just with other claims on society but also with each other. As in any system in which potential demand is unlimited and supply limited, new developments in medicine must mean as a rule not an allocation of uncommitted resources but a drawing away of resources from some other medical activity which may indeed be less needed. In fact, no nation could hope to offer to the whole of its population all the opportunities afforded by modern medicine and technology immediately upon their emergence at the level of technical practicability.

It may seem surprising that it is only in the last few years, during which the numbers of doctors have continued to increase not only absolutely but also relatively to population, that we have come to realise that an acute shortage exists. Unfortunately, it not only exists now but is bound to continue for a long time; for, although the output from British medical schools is rising, the extra services which the new doctors can supply will be required for the time being almost wholly for the needs of the growing population, and the increasing elaborateness of medicine calls persistently for more medical time. We must certainly do everything possible to pinpoint the causes of emigration and deal with them (and our mission to North America made some useful recommendations) and to make it more practicable for married women to work part-time but such measures, however successful, will not relieve us of the need to make the most effective use of all the doctors and other health service staff we have. Do we do this now?

I will consider first the distribution of doctors between hospitals and general practice. In 1966 there were the equivalent of some 19,500 doctors working whole-time in hospitals in England and Wales as against 11,750 at the start of the National Health Service and 15,500 a decade later in 1957 at the time of the decision to reduce the intake of medical students. In general practice, on the other hand, the numbers in England and Wales rose from an estimated 18,000 in 1949 to 22,000 in 1957, but then fell to 21,500 in 1966. Moreover, whereas the number of hospital doctors more than kept pace throughout with the increased number of hospital treatments, the proportion of GPs to population, while rising from 42 per hundred thousand in 1949 to 49 in 1957 fell to 45 in 1966. Thus the position of general practice, after improving for a decade, has been deteriorating and, although this trend has been checked, it is unlikely to be corrected so long as the role of general practice and its training requirements remain undefined or unapplied. We do not know what a proper balance would be between well-organised general practice and the hospital service in a more fully integrated National Health Service, and there is urgent need for operational research to assess the value, cost and efficiency of different patterns of medical care and the work-load at all levels in different branches of the profession. Despite the pioneer efforts of the Royal College of GPs very little is known on the latter point. The Ministry has, however, recently begun a study of the work of junior doctors in hospital and is anxious to encourage in any way it can the interest which the profession itself is now showing in the organisation and management of its work.

The second point to note is the disparity in medical staffing between different parts of the country. Although there has been everywhere since the start of the National Health Service a steady increase in hospital staff at all levels, disparities between regions have recently been widening. To take an extreme example, Sheffield has a con-

sultant for every 9150 people and an SHO or registrar for every 8150, while Oxford has a consultant for every 6350 and and S H O or registrar for every 6150. In general practice also the range is wide, from 43 per hundred thousand in Birmingham to 53 per hundred thousand in the South-Western area, and again the least well-served areas tend to be the industrial north and midlands. There has been no systematic attempt to monitor the effects of these staffing differences but it seems likely that they must effect the standard of care; and levelling up can only be gradual.

Next there is the problem of the distribution of doctors between specialties; some are over-stocked and others, as important in patient-care, for example geriatrics, anaesthetics, radiology and pathology, though the numbers in them have grown rapidly, are still short. A choice of specialty is often based on ignorance of prospects and subsequent disappointment is a frequent source of emigration. However, more attention is now being given to helping the young doctor to plan his career. The Ministry publishes yearly in the medical journals the prospects for consultant vacancies in each specialty; every region has a post-graduate dean available for advice; and the recommendations of the review body in 1966 have removed the financial deterrent to re-training.

Lastly, I want to remind you of the increasing calls on medical time that will be made in future by medical education, which has now of course, a far wider interpretation than sufficed while basic undergraduate training and a short in-service apprenticeship were enough to equip the ordinary doctor for a lifetime's career in medicine. Organised postgraduate vocational training and continuing education throughout professional life are now accepted as indispensable foundations for acquiring and maintaining a proper standard of skill in any branch of medicine, including general practice. Indeed, since some half of all general practitioners have never attended a refresher course, while changes in medicine become ever more rapid and complex, it may well be that the expansion of postgraduate education would be the quickest and surest single step to improve the quality of medical care and that its needs may have to take precedence for a time even over some service commitments.

It is against this background of the shortage of doctors, for which there can be no quick remedy, and of the need both to upgrade the basic services in the less well-staffed areas, and to provide for longer periods of training and retraining, that consumers, doctors and administrators alike must assess the new developments in medicine which make such large demands on both money and manpower. And it is at some of these developments that I want to look now.

I shall start with the early detection of chronic disease and especially with its detection in the pre-symptomatic stage by population screening. Screening is not new; it has been used successfully for a long time for special groups, pregnant women and children for example, and also more generally as in mass radiography for tuberculosis. Recently, however, the idea has come to be associated especially with the chronic diseases of middle and later life, which are relatively intractable to treatment and in countries like our own seem increasingly to overshadow the problems of acute illness.

Screening differs from other forms of medical care in searching for presumptive disease in the apparently healthy population rather than waiting for the patient himself to take the initiative when he feels the need for assistance. The concept of screening therefore raises difficult ethical issues which need to be examined critically for each individual condition for which screening is advocated.

When this is done, it is found that the value of detecting conditions early varies a great deal and that in only a few cases do our understanding of the disease process and our ability to treat it fulfil the underlying requirements for success. In high blood pressure, for example, as Dr Holland points out in his recent OHE pamphlet, we do not know at what level of pressure we should regard disease as being present or whether the course of disease is altered by treatment in the pre-symptomatic stage which it is the object of screening to detect.[1] On the other hand, we do know that anxiety, which could be precipitated by the unsolicited intervention of screening, plays a part in the early stages and that active treatment can have unpleasant side-effects. The potential disadvantages of indiscriminate screening are inconspicuous and therefore often overlooked but they are none-the-less real, not imaginary.

However, because of the long natural course of these diseases, it may, rarely, be thought right to introduce screening, as was done for cancer of the cervix, before conclusive evidence of benefit has been obtained. As part of the balance sheet before such a decision is taken, however, it is surely right to reckon the cost in real terms, by which I mean not only the total direct and indirect costs of the screening process itself but the cost in relation to the likely benefit and the alternative uses (for example, health education) to which the effort might be put if screening were rejected. And the cost is likely to be high. Screening for cancer of the cervix, if all those at risk could be persuaded to come for examination and re-examination would mean some 4 million examinations a year. And the present screening test for chronic glaucoma will throw suspicion, most of it false, on some eight per cent of the population over forty years of age with the result that, on average, every ophthalmologist in the country would be faced with giving a full examination to some 4500 people of whom only perhaps two in every hundred would turn out to have real evidence of disease. Or, to quote the second OHE pamphlet on early detection, by Mr Peter Graham, each case of glaucoma detected would consume eleven hours of an ophthalmologist's time and seventy-one hours of a technician's and secretary's.[2]

I have laboured these points because the case for nation-wide multiple screening is so persistently urged. The scope for this will undoubtedly increase in the next decade but what is needed now is much more research to provide a better basis for action. Episodic health weeks which lack evaluation based on long-term or even short-term follow-up are of little relevance in reducing chronic disease in a population or producing useful evidence as a guide to policy.

I want to turn now to the rather different problems created by the highly specialised medical developments of which intermittent dialysis and replacement surgery are topical examples and which have opened up entirely new possibilities in the treatment of a number of degenerative disorders. Developments of this nature, once their efficacy is beyond reasonable doubt,

produce new service demands which will, rightly, always have to be met. Their cost in manpower and money is, however, often daunting. It has been reckoned, for example, that intermittent dialysis requires the equivalent of at least two full-time doctors, eleven nurses and four technicians for every thirty-patient hospital unit. It seems vital, therefore, that the introduction and development of such new services should be organised economically. It was to avoid a delayed, uneven or wasteful development of dialysis that the Ministry decided to take the unusual step of trying to stimulate planned development by financing it directly from central funds on the advice of a specially appointed professional committee. My own, admittedly partisan, view is that the experiment is proving a success, and the Minister has announced that he has set up a similar committee to advise on the development of renal transplantation. There is certainly evidence that there may sometimes be drawbacks in a *laissez-faire* attitude to specialised developments of this kind. A case in point is the use of cardiac pacemakers in the treatment of permanent heart-block. In 1966 the Royal College of Physicians estimated that the need for this form of treatment was approximately 1200 installations a year and recommended that the operation should be carried out only in centres where at least fifty a year were being performed. A Ministry survey has shown, however that only just over 400 pace-makers were bought in the year between September 1965 and September 1966, and these by as many as forty-five different hospitals. In the London area twelve teaching and two non-teaching hospitals accounted for some 50 per cent of all the installations in the country. In four northern regions a total of seven different hospitals installed between them only fifty-five units. Another instructive example is open-heart surgery, with its large staffing requirements. The usual regional pattern has been for a single centre to evolve naturally from the existing thoracic surgical unit. In London, however, at least sixteen hospitals undertake open-heart surgery with extra-corporeal circulation and this means that many of them are not working on a large enough scale to get the best out of either staff or equipment.

If room is to be found, as it will have to be, for these new forms of medical care, as well as for overdue improvements to the basic medical services, the profession itself will have to feel a collective responsibility for their being organised economically and efficiently. And there will surely also have to be critical re-appraisal of much standard practice. Nearly 750,000 bed-days, for example, were used in 1964 for the in-patient treatment of varicose veins: that was an increase of 40 per cent in seven years. Following the introduction of new methods in some hospitals there was a fall of 5 per cent in the next year. Whether this was cause and effect we do not know, but how much more saving could generalisation of these new methods bring about. Again, as the Joint Working Party on the Organisation of Medical Work in Hospitals has said in its first report, the normal therapeutic regime for quite common conditions varies considerably from hospital to hospital and from one consultant to another in the same hospital. The treatment of hernia, for example, shows differences in length of stay from fourteen days to two (and over 1 million patient bed-days a year are used for patients with hernia and these patients also suffer a mean waiting time of 15·6 weeks). Yet where out-patient surgery or shorter stay is tried it seems almost invariably to be to the satisfaction of both patient and doctor.

Finally, having discussed consumer and professional demands and the resources available to meet them, I will describe the medical aspects of an experiment which the Ministry is carrying out in relation to the hospital building programme. At present hospitals take eight to ten years or more to plan and build and the cost is very high, for the ordinary district general hospital £8500 per bed on average, excluding equipment. As many of you will know, there are Ministry experimental building schemes now in progress which by economies in design and material will reduce the cost per bed considerably. The new schemes at Bury St. Edmunds and Frimley, however, which the Ministry's own staff have been engaged on for the past year, though they started out purely with the aim of reducing building costs still further, have now become also virtually exercises in area planning, setting out to explore the effect of a more unified deployment of all the medical, nursing and welfare resources of the community. The revised aim, in short, is to use the opportunity of providing these new hospitals as a catalyst to bring about an integrated system of medical care and to plan the hospitals themselves on the premise that such a system will be in existence by the time they are. They are intended in fact as a first step towards a recipe for the future and are being built to a common design which, though not applicable in full to densely urban areas, will it is hoped, have many lessons of general application. If successful in practice, they will profoundly affect the later stages of the building programme.

The overall operational policies have been based on the ideas of the new pattern of medical care which have become familiar over the past ten years: the need to bring the hospital service into closer touch with care before admission and after discharge; the opportunities which practice from a health centre or a group practice, with attached supporting staff and access to diagnostic services, can provide for the GP to work also part-time as a member of the hospital team and to take part in preventive work, to the benefit of hosptial staffing, quick and free communication between different parts of the service, and continuity of patient-care; the need for closer association with local authority nurses and other health and welfare staff.

The intention, then, is that as many patients as possible should be investigated and treated by general practitioners, with the help of nurses and health visitors, in the environment in which they live their ordinary lives; that hospital investigation should whenever possible be done in the out-patient department or, failing this, by the use of day-beds; that minor surgery, when not carried out in the health centre, should be done in the hospital out-patient department, if need be on a day-patient basis; that short-stay surgery be tried, when home conditions are good, for a wide variety of operations; that a good accident and emergency service and physical medicine department should be run; that there should be an effective hospital geriatric department working closely with local authority community services, including residences; that there should be a community based psychiatric service related to the general hospital's acute psychiatric unit and a psychiatric day-hospital with facilities for out-patients treatment; and that there should be an early discharge system for maternity

cases and a high and increasing hospital confinement rate.

None of these practices is new: all of them are generally accepted and increasingly in use. What can perhaps be expected, however, is that this preparatory period of organised collaboration and experience in joint management (which has been welcomed by all concerned—local authority, local medical committee, general practitioners and hospital staff), and the planning and provision of community facilities as an essential part of the total scheme, in step with the planning and building of the hospital itself, will enable such practices to be adopted more confidently, more intensively and more uniformly than has usually been possible.

The logical conclusion—that fewer hospital beds will be needed—has, as I have implied, been incorporated in the scheme. However, a substantial safety margin has been left and the standard adopted for duration of stay has been, on average, the same as has already been operating satisfactorily in the Oxford region. The big saving is in the beds for general medicine, general surgery, gynaecology and some of the smaller specialties, which by flexibility in bed use between specialties have been reduced by one-third from the accepted standard of three per 1000 population to two per 1000. Acute geriatric and acute psychiatric beds remain unchanged and maternity beds almost unchanged. Out-patient department, operating theatres, physical medicine, X-ray and pathology have all been maintained virtually at a level sufficient to serve the 700-bedded hospital which, on the normal scale of provision, both these hospitals would have been. Only instead of a little over 700 beds there will be about 550 and, because of good architectural and engineering design and planned flexibility in the use of space, instead of £8500 per bed the cost will be £5500; so that the total cost for providing acute hospital services will have been reduced by half—from about £6 million to about £3 million. The objective, as you see, is to erect two hospitals for the price of one. No less important, the aim is also to build and commission a hospital in half the time it takes now, in four to five instead of eight to ten years, a gain which in itself would transform the present outlook for the hospital service.

Yet there is one corollary to all this we must not forget. All this is in terms of a re-organisation of hospital work which depends at every turn upon its association with general practice. If that is to succeed, there must be a corresponding re-organisation of general practice. This is occurring sporadically but its rapid generalisation is the most important factor affecting the future of medicine in this country.

1 HOLLAND, W. W. (1967). *The Early Diagnosis of Raised Arterial Blood Pressure.*
2 GRAHAM, P. A. (1967). *The Early Diagnosis of Visual Defects.*

Discussion

PROFESSOR R. F. L. LOGAN

DR COHEN, in the opening half of his paper, gives us the facts of life, the facts of life as in any developing country. Is medicine a luxury or necessity? No country, even the wealthiest, can do the best for every patient in need; and that is going to continue as medicine advances. Then in the second half of the paper he, in fact, gave a "declaration of intent" of the Ministry, and this was one of the most exciting things I have heard. And the challenge is going to be to the profession if they can implement it. Now that really is all I wanted to say; but when I heard the confusion this morning and as I have thought of the structure of today, I felt maybe a bit of old-fashioned, economic analysis was needed. What is medicine going to get in relation to education, to housing and to transport, and after this last three weeks there is no need to discuss this any further. Then what are we going to do with what we are given?

Now this afternoon it rather struck me that we did get down to the point, as to how the GP and the public view each other. As Dr Last says, this is related to use of services and our available resources—doctors, nurses, and how hospitals and general practice are used. Mr Wadsworth examined what are the needs in connection with the doctor/patient relationship, and how are these translated into practice. Much of our discussion today has been about the demands for health services, but where are the demands coming from and how many doctors would be used in this and at what cost? And what would be the outcome of all this? The outcome, not as the economists were trying to say this morning, in terms of cash, but in terms of death and disease and life expectancy. That, of course, is the huge question mark. Now I am attempting here to bring together this kind of teaching, because it seems to me that the College of General Practitioners, the OHE and the Ministry have come together this afternoon to try to fumble their way into some kind of model—and these are very early days—as to how the profession can deliver the skills needed to be of the most benefit to the patient. How can you plan without a model? Each of us pulls out of our hair the magic solution. In this country we have got the Hospital In-Patient Enquiry—what in fact is the content of general practice? All we have is bits and pieces. When we do get some kind of systematic equation covering input of resources, the clinical work done on the caseload of each service and its outcome, then as Dr Cohen said, we can cost this. It is only when you get the circuit completed you enter into planning. This is the kind of system we have got to get into and clearly we are only at the beginning of the beginning.

DR R. SMITH

If you can inject any money at all into this Health Service to make it more efficient where is it going to be put? We have listened to Dr Cohen with a lot of interest. My past experience has taught me that the hospital part of the service, when it comes to money, is a bottomless pit; it seems never ending in its demands. I speak with some experience. We would love to put into effect what Dr Cohen is suggesting, but we find that the walls are going even higher at the moment, and that there is an ever-increasing move to keep the general practitioner out. Do not, at this juncture, put the money into the hospital service, give the general practitioner more money—then he would get his longer holidays.

There is one interesting fact in a survey from the College of General Practitioners, that whether you are a good practitioner or a bad one you still refer the same number of cases to the hospital services in the south-west.

Could I take up Mrs Williams' suggestion, one I feel that I am involved in. We can use some of the resources here and now to meet this demand; and it is our experience that a nurse can be used for primary screening of patients. We have talked a lot about trivia. Every doctor here knows that every illness is

trivial to start with; and some trivial illnesses progress to serious illnesses. We have found over a limited amount of time that the nurse can screen out quite a lot of these things. It has been suggested that this introduces a new element into practice, but we have found this is a very desirable one. It is acceptable to the consumer provided it is explained to them. Then, I suggest, the general practitioner will alter his role and become very much the leader of a health and illness team. I would like to put in a plea for expansion here and now of these services, and for the Ministry of Health to consider making funds available for the training of such nurses to be explored and expanded.

MISS P. C. L. GOULD

A suggestion has been put forward about team work and screening, and I would like to say that in some areas this is working very well with the general practitioners. District nurses, midwives and health visitors are employed in the early stages of this team work, and this takes a considerable load of work from the general practitioners. Only this week one of the staff who has fairly recently been attached to a general practitioner produced a list of forty-six cases which she had been asked by the general practitioner to visit. On analysing the results of these visits it was found that of these forty-six cases only fourteen of those seen were over sixty-five. So we are finding that the general practitioners are now realising the much wider role we can play in all cases. It is a two-sided affair: the health visitors now that they are in with the doctors are able to explain some of the cases, whereas in the past they would have said the health visitor was fussing. But she is asking for help and they give it willingly; and they equally realise they can pass some of their problems to the health visitor.

MR G. J. DRAPER

My remarks relate to those of the last speaker about using a nurse in general practice. I have been associated with general practitioners in the north-east in a study using nurses in this way. When you actually do this and look at the figures for the amount of work doctors do, the results are rather surprising. It looks as though one gets a very much smaller decrease in the load of the general practitioner than one had predicted. Whereas people expect in theory a 25 per cent reduction it turns out to be much nearer 5 to 7 per cent—possibly because the general practitioner has not re-organised his work, or is giving a better service. First, when you re-organise you do not get the result predicted theoretically, though there are advantages in other directions. Secondly when you re-organise one part of the Health Service you have to think rather carefully about re-organising the other parts.

MISS B. WELLER

This morning I heard several general practitioners mention the fact that they had received their medical training in hospitals which had big high walls, and that the type of care they needed in the districts was quite different from that which was received in their training. Before we flounder further with this problem of the nurses we should consider nurse training. We are doing exactly the same with nurses. The nurse is trained for hospital work, and yet now you are wanting to take the nurse out of the hospital situations into the districts.

Implementing Change: Public and Professional Problems

JOHN McKENZIE

IT is often imagined that recommendations for change are mostly welcomed, particularly if it is possible to demonstrate that as a result some improvement in the existing order of things will be achieved. However in fact, the strongest arguments are usually in favour of maintaining the status quo. Initiating a change normally involves a step into the unknown with all the uncertainty this brings, to say nothing of the great deal of time and effort which is usually involved in its actual implementation.

This means that unless the present position is markedly unpleasant or inefficient, people will prefer to stick with it. Thus it is possible to show that on the one hand people with an appointments system say they prefer it and on the other that the majority of those without an appointments system say they prefer that situation. Again, in a totally different area, when OHE examined doctors' prescribing behaviour, it was found that the majority always began treatment of a particular illness with the same product.

How then, assuming that change is desirable, does one overcome these strong and quite natural resistances? Let us first examine the theoretical steps we all take when we decide to change something. Three steps are normally involved. Supposing an individual wants to buy a new car. He begins by establishing an *attitude of mind which is prepared to consider a change* in this particular context. Having done this, he needs to obtain *information* about the various models which are available and from which he can choose. Lastly he will *act* to implement his choice. Such a set of criteria are equally applicable in medical matters, for example a doctor's decision to institute an appointment system, or a patient's decision to change his doctor.

However, in addition to this theoretical analysis, we need to understand the specific motivations which concern a doctor when he comes to consider implementing change in his professional way of life.

From our group discussion work with General Practitioners it has been possible to isolate some specific criteria. Firstly, he will consider the likely personal emotional impact of the proposed new situation. Secondly, he will be concerned with the financial repercussions. Thirdly, he will want to know what will be its impact on his workload. He will also wish to consider the upheaval that may occur as the change is implemented.

However, not all of the doctors enquiries will be concerned with his own position. He will also wish to consider the impact, both physical and emotional, of some of his changes upon his patients and on his relationship with the practice.

The relative significance of each of these issues will vary from one situation to another. When considering whether or not to implement an appointment system the GP will be concerned, for example, with his financial position as a result of the change, and whether or not it will reduce his workload. On the other hand, if the issue is whether or not to join a group practice then the crucial issue will be whether the GP can emotionally live with the restrictions that this will place on his independence within the practice. He may also be concerned with the impact of such a procedural change on the relationship with his patients.

In other situations, for example concerning changes in therapeutic care, these sort of issues are of little relevance. Here the crucial issues will be whether or not any substantial improvement in treatment can be achieved by implementing some new procedure, and what will be the risks involved in such a change.

In our recent research studies we have also been able to isolate key factors influencing the patients' attitude to change. It appears that the status quo is almost invariably regarded as a desirable situation by the normal patient because it symbolises the security situation which is so important in his relationship with the doctor. Basically, patients go first of all to the doctor for re-assurance; secondly, to have some pain eased; and thirdly, to obtain a cure for the condition. Thus, security and reassurance are uppermost in their mind. Anything which involves a change in relationship or procedure creates new uncertainty. If there is to be an appointment system, patients begin to wonder whether they will be able to see the doctor as easily as at present; stories circulate that they will be unable to book an appointment for a week.

The solution to such fears lies in making certain that the patient has a very clear picture of what is happening and how it will personally affect him. Thus it is necessary to ensure that appropriate information is available for use as ammunition for encouraging change. With regard to an appointment system a very effective method would be to demonstrate the recently established fact that with such a system nearly half the people who attend surgery will have to wait less than ten minutes to see the doctor and that for

the rest there is a greater chance of a speedy consultancy than where there is no appointment system. Equally it is important to establish that the information which is provided is actually absorbed by the patient. I believe we have too readily neglected evidence which is available to make our communications more efficient. For example, Lay and Spelman, in a recent study on communications with patients, were able to indicate a series of very useful rules.[1] These can be summarised as follows:—

1. Patients forget much of what the doctor tells them.
2. Instructions and advice are more likely to be forgotten than other information.
3. The more a patient is told the greater the proportion he will forget.
4. Patients will remember best:
   a) what they are told first;
   b) what they consider most important.
5. Intelligent patients do not remember more than less intelligent patients.
6. Older patients remember just as much as younger ones.
7. Moderately anxious patients recall more of what they are told than highly anxious patients or those who are not anxious.
8. The more medical knowledge a patient has the more he will recall.
9. If the patient writes down what the doctors says he will remember it just as well as if he merely hears it.

The provision of information in a form in which it can be reasonably assimilated is not only of significance to the patient or consumer. It is equally relevant for the General Practitioner. The decision to change either the form of treatment for some disease or his working structure must begin with the knowledge of the alternatives and their advantages. My own experience in discussions with General Practitioners around the country is that they are frequently remarkably uniformed, in particular in the case of the latter type of issue. However, this is not the result of lack of interest. For example, whenever I have had a group of doctors sitting round a dinner table they have eagerly asked questions of one of their number who has acted as an innovator. The person to person approach has many merits, particularly if the innovator is someone they know or at least have heard of because he lives and works in that particular area.

Nevertheless it would be wrong to believe that change is facilitated simply by ensuring there are good channels of communication. Two other crucial issues emerge.

Firstly, the views communicated must be regarded as acceptable. For many this means that the authority from which they emanate must be unimpeachable. This in itself often presents problems. The establishment are often by no means amongst the first to consider and, more important, to provide rational pronouncements on some new recommendation. All too frequently the General Practitioner may either be unable to obtain any advice on some matter or will receive a series of conflicting recommendations. The normal reaction, not surprisingly, in these circumstances is to maintain the status quo. Indeed in such cases this may be the correct view.

However, the second issue concerns occasions when a generally accepted recommendation for change has been ignored in spite of good communications. Sometimes this is because the issues have simply been stated without stress on the benefits accruing to the individual concerned and an explanation as to how any possible problems will be overcome. To develop such a campaign one needs a sound understanding of the psychology of the doctor in the terms outlined earlier and one must lay stress on the issues he will regard as fundamental in this particular area. Then, for example, the favourable aspects of a reduction in his work load can be emphasised and reassurance provided for any doubts regarding how far the change is compatible with the doctors personal demands for independence. Inevitably such techniques mean much more research.

In a way all these recommendations are not far removed from the normal marketing operation. However, their success will not be judged in terms of company profitability but in the standard of medical care provided within the community and the satisfaction derived by patients.

1 LEY, P. and SPELMAN, M. S. (1967). *Communicating with the patient.*

DR J. J. MCMULLAN

I believe strongly in the general practitioners' role in trying to help patients to adjust their aspirations to reality. This is part of helping the patient to adjust to the realities of life and a healthy environment. Another part of it I would like to suggest is responsibility. How can we develop a sense of responsibility in the use of resources, in ourselves and in our patients, the consumers? I would like to mention two points.

The first is, how far is the National Insurance Scheme sapping our patients sense of responsibility by paying for acute self-limiting illness. Would it not be more reasonable for, say, the first fourteen days not to be paid, or to be subject to some draw-back of payment.

The other question is quite a different one. Speaking of the role played by mass media, how far are they encouraging us and the patients to use the services with responsibility; and how far are they, in fact, generating a sense of anxiety? I do not mean only programmes such as *Your Life in their Hands* but programmes such as, *The Wednesday Play*, *Up the Junction*, *Dr Finlay's Case Book* — and by mentioning these particular programmes I do not in any sense wish to suggest that they are not effective—but could not they be very much more effective?

MR I. ROBERTS

May I simply endorse the theme that Mr McKenzie has put over. Our main purpose at the King's Fund Hospital Centre is to encourage good practice in hospital and other health services in the way that Dr Draper, of Guy's, quite rightly stressed this morning. One of the ways in which we try to do this is to sponsor research into staffing, administration, planning and equipment, and it has been our experience that getting research projects done is less than half the battle; and the whole process of then getting it known, discussed and considered, let alone finally applied, in hospitals and elsewhere is a far, far, more difficult task. Two points. We think it is an advantage, therefore, to have in mind, right from the beginning of the research, some of the ways in which one might see that it is made known and applied, so that you do not do your research and suddenly find you are high and dry. The second point is simply to say that this is a subject worthy of study in itself. There is in fact, at Loughborough, a unit set up not so long ago for this very purpose.

MR J. M. BEVAN

Two speakers have contended that patients almost invariably preferred the status quo. Some work of Dr Cartwright's and ours independently suggested that this need not be so. Patients' approval of the status quo, namely having or not having an appointment system, was strongly dependent on how long they waited to see a doctor. For example, those who did not have appointment systems and had to wait a considerable time were mainly against the status quo. Likewise those with appointment systems who still waited a long time were usually against the system.

A second point: we found that the extent to which people used appointment systems from the outset was positively related to the amount of care taken in introducing them to the systems.

DR A. ELLIOTT

John McKenzie did point out some very important things. I think we have already seen this morning that the demand for change does not come from patients, so therefore the change is going to be introduced by the profession, in agreement with the Government. Given the enormous changes we are envisaging over the next few years there is going to have to be real studies to ease patient concern. Every time we get a new doctor in my practice the rumour goes round, either that the doctor is dead, or has gone away. The whole question of security is involved. It presents an insecure feeling for my patients to go along and not find me there: they always think a new doctor has come. We must understand that in the inevitable changes, there will be more and more group patients having to come further to see their doctor. Moreover, there will be many other new situations and traumatic experiences for the patients.

On the question of propaganda, there has been great criticism of the Ministry's flashes on the television screens: they do not seem to have done much good. In my opinion limited propaganda, perhaps in a more limited area, does have results.

During the height of the 'flu' epidemic which hit our area before Christmas we were absolutely inundated with work. The local Medical Committee called a Press Conference. We pointed out to them certain things which the patients did not seem to know; for example, it was not essential for a patient to have to get a National Insurance certificate the first on second day off work, he could get a certificate up to six days. I am glad to say this did have an effect and did help. It is difficult to prove this, but all the local doctors agree that it did help to keep down the immediate work load.

MISS B. M. JACOB

About communication and the use of the mass media—I wonder whether we realise just how little patients actually know about the Health Service unless they come into contact with one branch of it? I think sometimes we are to blame if there is any abuse or any trivia because we are bad at telling other people about the sort of services we are trying to provide. We are also bad at telling them about health. I think this is where some of the mass media things are good. I personally think that the propaganda the Ministry of Health publishes is among the best there is. We do not think enough about the attitudes of the people. It does not matter what social class they come from. Talking recently to a very mixed social group—consisting of all social classes—I found they were all talking about the Health Service on the same intellectual plane: they knew almost nothing of the various services that could be obtained to assist them.

MR C. BROOK

On the subject of consumer attitudes, what people tend to forget, who have to administer services—whether GPs or people in hospitals or ancillary services—is how vulnerable the individual consumer really is. If you go into a shop to buy something you do not buy every day, like a stereophonic hi-fi outfit—unless you are one of those maniacs, and are well-informed on them—you are extremely vulnerable: they will sell you anything. Having reached one of these electronic centres you go in there, having made up your mind, like the ostrich, to spend £60, because you've seen other people enjoy the benefits of hi-fi. Unless you are an extremely integrated person—and I do not think doctors are more so than other people—this will cause you anxiety, and you are very likely to make a mistake or a series of mistakes, which you will not be conscious of, but you will be worried and feel insecure—and that's how the patient feels. You are dealing with people who are very soft—not soft in the head—very weak and at a disadvantage; they need help; they need strengthening; they certainly do not need to be pushed around. Information is what they need when they have been well educated; but the vast majority of the British population, although intelligent, are unfortunately virtually illiterate; so you cannot keep on pumping information out in pamphlets and booklets: they are for the literate people, the people who are educationally fortunate, and have been lucky in education. But in the two-thirds of the population who have been very badly treated by the educational mill, these are not much good. As a consumer I would urge you to bear in mind how weak the potential patient is, facing you as a specialist. A final point: I am sure you will laugh. You are seen as experts by these people who come and call on you, but just let me give you my definition of an expert—a bundle of prejudices. All citizens on a doctor's list are patients. The word patient is a social concept; a sick patient is a clinical concept. As regards prejudices, there is no human being who is free from them. The problem of life and society and medicine is how to make them compatible.

MRS M. ADAMS

A foot-note to what Mr Brook said. There are two kinds of patients; those who address their doctor by his christian name and those who address their doctor as Sir. There are two kinds of people in our social structure, and I think we have got to remember it.

Blueprint for Consumer Satisfaction I

DR MARK ABRAMS

AFTER lunch Professor Backett and I had a word as to how we would share this final session; and we agreed immediately that I would stay away from anything connected with medicine, because I know nothing about it, and try to say something about the consumer side, and the various points that have come up during the day which affects the structure, the formation, and the attitudes of people taking part in the National Health Service. Dr Backett will deal with doctors and teachers of medicine.

Going through the various notes I made during the day, it seemed to me that on the consumer side there were two main topics that kept coming up. One of them dealt with this question of the study of the consumer in terms of what he wanted, and his levels of satisfactions. Is this, in fact, a legitimate way of starting to plan the supply of a social service? Of course, we know that in commerce certainly, and in a good many other areas, this approach is a commonplace—that is, political parties providing programmes, manufacturers providing foodstuffs, do start their planning, or incorporate in their planning this process of going to consumers and trying to find out from them what they think. Surveys of this kind were referred to this morning. These surveys can be sub-divided into three types.

The first is concerned simply with attitudes: how do you feel about what you are being offered, or what you would like to be offered, and so on. The first speaker did mention there have been quite a few of these in the field of people's attitudes towards the Health Service, and they all show very much the same picture: that is, if you ask the rather simple and straightforward question, 'Are you satisfied with the Health Service?' then, almost invariably, most of the surveys show that seventy, eighty, or an even higher percentage of the adults interviewed will give an answer saying, 'Satisfied' or 'Very satisfied'. Now is this, first of all, a reliable method of discovering the degree of satisfaction felt? One can ask what is the worth of such a figure standing by itself. As a measure of people's satisfaction this is not probably terribly good. There are much more sophisticated and complicated ways of asking people if they are satisfied with a product or a service than simply saying 'Are you satisfied or not?' There are a great many intricate ways of getting them more involved in a situation and giving therefore a reply which is more closely geared to their considered feelings.

I think that, so far, most attitude studies of satisfaction with the Health Service have been superficial and have not really got below the surface. Secondly, what, in fact, do the figures mean? I think one would find that in almost any context if you were to ask consumers about the extent of their satisfaction with almost any social service or amenity you would get 60 to 80 per cent expressing satisfaction. In other words, if you were to use a control group dealing with an area outside medicine (e.g. education, television) the high score for medical services would be put in perspective. Among consumers there is a large degree of docile acceptance of what is available. This has been the experience in many industries and services which are in the public sector, and where consumer committees are set up as watch dogs—for example, the consumer committees concerned with passenger transport, agricultural foodstuffs, the fuel industries—with all these we can look at their reports year after year and see that the volume of consumer complaints they receive are negligible. I suggest then that one can discount these very high figures of 80 per cent of people saying they are satisfied with the Health Services. It is only when you turn to more detailed aspects of provision that consumers show real discrimination and reject or accept what is offered them. In more generalised assessments of most services and commodities consumers normally express satisfaction. For the bulk of the population docility and apathy seem to be the norm. Can anything be done to change this as far as the Health Services are concerned?

I think there would be no point in trying to set up a Medical Services Consumer Committee made up exclusively of consumers. I think 'watchdog' committees help consumers work most effectively where they are able to work with the co-operation of the people who stand on both sides of the fence, i.e. producers and consumers. That is, if there are going to be Health Services pressure groups, then they would probably be more effective if they were to enlist the support of medical people as patients or potential patients.

A second type of study of the consumer is one which is concerned with consumer needs. For example, you can look at people's houses and say: clearly there is a latent need here for a bath room, or for so much furniture; or, given the number of people in the family, there is a need for a minimum amount of mechanical equipment or household linens or fuel, and so on. I know of no national survey of this kind

in this country, that is studies of the total population, assessing the needs of the population in terms of the medical services that would be necessary in order to establish levels of good health. These are not easy surveys to carry out, partly because the definition of needs provided by the consumer are likely to be very different from the definition provided by the people producing the medical services. On both sides of the fence—the consumer and supplier—definitions of needs change over a time and can change quite rapidly. As far as the consumer is concerned, it seems that the higher his standard of living the higher will be his definition of what constitutes needs.

The third type of consumer study I have in mind is concerned with the problem of prediction, that is, attempting, from a study from a sample of consumers, to predict what the demand is likely to be in five, ten, or fifteen years' time. As far as I know very few studies of this kind have been carried out in the field of medical services. This is not merely a matter of extrapolation of recent trends; rather it is a problem of identifying those elements in the present situation which are generating significant trends. For example, one of the surveys carried out for the Robbins Commission on Higher Education traced the development of a cohort of children from their birth in 1940 to the time they reached adulthood. One of the facts to emerge from this longitudinal survey was that among working class children, other things being equal, children whose mothers before marriage had worked on the fringe of white-collared occupations were much more likely than other working class children to continue at school and go on to some form of higher education. In other words, the number of working class girls in white collar jobs has been a good predictor of the next generation's demand for higher education. This type of survey which examines the data with an eye to its predictive value has been carried out in the United States with the purpose of predicting the future amount and character of poverty and presumably could be carried out in the field of health.

There are, then, three types of consumer studies I would like to see: first of all on attitudes—one which really gets at attitudes and not merely generalised expression of overall satisfaction or dissatisfaction. Secondly, a 'needs' study—using perhaps a variety of definitions of 'needs' and taking account of changes over time. And, thirdly, studies which concentrate on the possibility of predicting the demand for medical services.

The second topic I wanted to comment on came to the front in Mr Teeling-Smith's paper. The multiplicities of possibilities of spending money and saving money that he described almost pointed to the impossibility of solving the question of what should be done in providing medical services. At first one's reaction might be: since the problem is so complex and contains so many possibilities perhaps what we should aim at is much greater flexibility in the services we provide and leave supply and demand to sort themselves out. My own feeling, however, is that this is not the best way to proceed where you have a situation of this kind, i.e. one where we have limited resources, a wide variety of possible demands on these resources, and where we are, for the most part, operating outside the pricing mechanism. Instead, just as we have each year a Blue Book which analyses our economic affairs and indicates where progress has been made or not made (e.g. in consumption, in investment, in savings, etc.) so it should be possible to produce each year a Blue Book which analyses our social accounts. Some of the criteria here would be obvious—a fall in the number of deaths from lung cancer, a fall in infant mortality, a decline in the number of industrial accidents, etc. Presumably one could arrive at a whole list of changes that could be regarded as gains in the budget of social accounts. Then one has, as Professor Logan pointed out, a comparatively simple cost-benefit problem to cope with. With the desired gains in mind, one can start allocating the limited resources over the whole medical field. Can a given social advance be reached most economically by expenditure on industry health services, on university teaching, on hospital expansion, on GP services, etc? The benefits sought would not be expressed in monetary terms, but in the sort of criteria I mentioned earlier. Nothing of this kind has, in fact, been done on a national scale in this country; but in America there is already quite an appreciable literature on the application of cost benefit analysis to medical services, and there is a good deal of literature on social accounts; in fact, there is a Bill before Congress now, making it part of the Federal Government's responsibilities to produce each year a social accounts budget which will pay particular attention to the Health Services.

Blueprint for Consumer Satisfaction II

PROFESSOR E. M. BACKETT

ARISING from the papers and discussions are a number of problems which, though they have been with us for a very long time, seem obstinately difficult to answer. But they must be answered if we are to make the progress towards consumer satisfaction with the family doctor services which has been talked about so much today. In the solution of most of these problems we need the help of the Sociologists, the Economists and the Epidemiologists. I shall start with one or two examples: one of the oldest of problems concerns the nature and quality of the doctor/patient relationship. A constantly recurring theme is the importance of what is gaily called a 'high quality doctor/patient relationship'—a baffling description of something so ill-defined as to impede rather than help understanding. We know very little about this relationship—of what it consists, when it occurs or how to get it. From the consumers point of view we may be sure that it is something more than just having a nice doctor who can be trusted (though that is part of it). It was helpful therefore to hear more of this relationship—of the importance of the emotional satisfactions of the doctor when treating a sick patient and of how these satisfactions are usually modified or lacking in preventive medicine—helpful in that with these insights we can better understand the reluctance of some doctors to move into preventive work and better understand the role of the personal doctor in the new medicine of today.

Another major problem of general practice is the frustration of medical skill in the face of the sometimes overwhelming mass of trivial complaints. A difference of opinion between doctor and patient as to how serious (or how medical) are the symptoms experienced by the patient is a constant source of friction between them. Here is yet another problem which demands social and psychiatric insights, health educational skills in solution and is in very large part misunderstood by patients and doctors alike.

A third problem arises from a confusion of demand and need. With a more medically sophisticated population demand approaches need (and presumably if the population were all good doctors it would equal need). But until that utopian day there is a changing threshold of pain or disturbance of some kind beyond which we seek medical care. This threshold, like most of our behaviour, is conditioned by background and education, by attitude, fear and so on. We know little about its determinants and, since it is so important to us as doctors and patients, we should know more.

Another area of questioning is less likely to lean on the social scientist for help—it is the changing relationship between hospital and general practitioner. We have all talked glibly of the importance of this contact—patronisingly for the GP, hopefully for the patient and uncertainly for the hospital doctor. Yet the two institutions are still separated by a huge chasm, unbridged except in a few places and by suggestions in a few reports. Closer contacts are possible even before the Area Health Boards arrive and their effects can be studied, on doctors and patients. In particular those in charge of episodic hospital care might correct a few complacent assumptions about the long term value of their treatments if they were in continuous contact with the results, as are the family doctors!

As a background to the changes in medical care and particularly affecting the satisfaction of doctors and patients, are the dramatic changes in the pattern of disease. Linked to disease pattern are the demographic changes which threaten us with a society of old and sick people. What we want of course is a society of increasingly *reasonably healthy* people but most of our serious chronic diseases are incurable when they are recognised and we can do little to help. Meantime our doctors wait for patients to come to them while much of this prevalent chronic disease may possibly be preventable, at least for some time. Not only is much of it likely to be preventable but the development of some at least of this chronic disease suggests that earlier diagnosis may mean better treatment—an altogether too attractive belief in medical intervention to be accepted without question. But the evidence of the value of early treatment is slim and it is even possible that for a few diseases in some patients we may do more harm than good by early diagnosis. So urgent is it that we should know in scientific medical rather than 'clinical art' terms about the success or failure of our early intervention, that this must now become a top research priority. Fortunately, at this time of greatest need for precision and measurement in medicine there has been a load of gadgets which will help. Instruments which range from portable measuring devices to massive computer storage will help the epidemiologist to answer for the first time the question 'does earlier really mean better?'. Incidentally, confusion reigns supreme when

we ask what are the criteria of 'better'. Do we mean just survival, or do we mean survival with some quality in life; an absence of pain and some modest enjoyments? How the patient dies is important too: early diagnosis may be of value in that it may mean palliative operations and death with dignity rather than a longer life and a more unpleasant death for the patient and prolonged distress for his relatives.

Next, I want to mention two features of the organisation of general practice (a recurrent theme today) where urgent change is needed. Both will benefit consumer and doctor alike.

The family doctors' records must sooner or later take part in the vast flowering of our medical information services which has been made possible by the computers. Among many things which will become possible and which should already be subjects for research are two products of linked data; the prediction of need and the prediction of recovery. By predicting medical need with reasonable accuracy the doctor will have an early warning system of great value; by predicting recovery he will be in a stronger position than ever to organise treatment.

Less spectacular but just as important is the new thinking about work in general practice by social workers and other non-medically qualified people. The work done by the general practitioner which *cannot* be done by someone else must be defined as clearly as the work which he now does but which is much better done by someone else. The case conference, with its pooling of skills can only do good in this respect and is not so time consuming as some critics would think.

So these are some of the areas of further questioning—areas of study and research where answers are on the whole readily available and where their discovery will pay dividends in satisfaction. Apart from the need for simple documented descriptions, three kinds of research method are involved: first, the clinical trial, a philosophy of enquiry as much applicable to hospital departments and general practitioner care as to drugs; next, some kind of balancing of costs and benefits (or cost-efficiency enquiries) and finally, evaluation studies of the effectiveness and quality of services. On the whole I think the doctors themselves must undertake these enquiries but they will not do so unless they want to and have the necessary skills. So we are back at training; training in epidemiological method and, perhaps even more important, in the responsibilities of medicine for social change within its own institutions.

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