



Only general practice can save the NHS

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LIFE AND DEATH Iona Heath

Only general practice can save the NHS

Why have governments been intent on undermining the morale and status of general practitioners?

The UK National Health Service is designed as an expression of social solidarity and provides universal access to health care funded through general taxation and free at the time of need. Similar systems have been developed across the Nordic countries and elsewhere but, despite frequent statements of support from all mainstream political parties, all such systems now find themselves under grave threat. Rapid advances in biomedical science are producing exponential increases in the costs and sophistication of investigations and treatments. Politicians everywhere, undoubtedly reflecting the priorities of their electorates, are unwilling to increase levels of taxation to match these increasing costs. This reluctance is easy to understand, but the identification of market forces as a solution to the worsening tension is perplexing.

Markets are motivated by the pursuit of private profit. This motivation can be used to increase efficiency and hold down wages but markets can thrive only if they can generate increasing demand for their products. Health care, despite recent efforts, is not easily packaged as a product and the relation between demand and need within health care remains intensely problematic. At what point, if ever, should demand be prioritised over need? Within a market system, how can unprofitable need, however great the suffering involved, ever be given commensurate priority?

If there is to be any hope of continuing to provide a comprehensive modern health service on the basis of solidarity expressed through taxation, resources must be allocated on the basis of need rather than demand. The current enthusiasm for market forces seems to be making this politically unacceptable and so nothing is being done about the expansionist health technology industry, which is driving demand for health care through the deliberate inflation of fear. The definitions of disease are being extended to include more people

as patients and preventive medicine pursues an ever greater number of risk factors, each of which triggers a search for more technological interventions. There are three clear trends that are mutually reinforcing: the medicalisation of normal life, the industrialisation of health care, and increasing state coercion of medicine. In the UK we see the last of these in the ever increasing surveillance of clinical practice, the apparently deliberate creation of unemployment among junior doctors, and a campaign of insidious vilification of doctors. All this is counterproductive if the hope is to sustain a healthcare system founded in social solidarity.

At its best, general practice offers highly trained clinical expertise located close to the context of the lives of individual patients. Longitudinal care over time allows general practitioners to understand how illness and disease develop and thrive in certain settings and it also enables doctors to see that technological biomedicine has enormous power to heal but also to harm. All doctors working in the UK who were trained in this country have been educated to understand the continuing necessity of balancing the needs of individuals and their families against those of the population as a whole. In general practice, this has generated instincts for caution, doubt, and frugality that have underpinned the longstanding (although now rapidly eroding) cost effectiveness of the UK health service.

General practitioners have learnt from experience the benefits, both to the individual and to society, of holding the border between subjective illness and the disease categories recognised by biomedical science; of confining people within diagnostic categories only when this will be positively useful to them; and of deliberately minimising exposure to the harms of medical technology. In this way, general practice directs both the power and the rising costs of biomedical science where it can help rather than where it harms. These instincts almost



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certainly explain Barbara Starfield's findings of the importance of a strong system of primary care to the health of populations. Many frail older people have a diminishing appetite for technological care and a proportionately increased need for sensitive, hands-on care. How can markets have a place in marking that distinction and enabling the necessary transition?

GPs can undertake this role only if they can hold the fear implicit in any presentation of illness within a framework of trust so that demand for unnecessary and dangerous health care can be held in check—this in turn allows the doctor to prioritise the identification of need. Trust is built on strong personal relationships and on levels of skill and expertise. Patients must be able to trust that the doctor working at the first point of contact will recognise the early signs of serious disease. This can be achieved only by rigorous training, not by fragmentation of the first point of contact or by delegation to those with less training and knowledge.

GPs work in the front line and deal with undifferentiated illness and distress. They undertake a highly skilled and high risk task on behalf of society and enable the cost effective functioning of the NHS. So why have successive governments been intent on undermining the morale and status of GPs and on eroding public trust in their contribution? Are patients' interests really served by doctors who are subservient to commercial or political interests? Why have doctors forgotten that patients may be best served by doctors prepared to defend their clinical autonomy and the ability to allocate their time and expertise on the basis of an expert assessment of need?

All the indications are that patients and professionals remain committed to a healthcare system based on social solidarity rather than the pursuit of profit. Can we be convinced that politicians are similarly committed?

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