General practice under pressure

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Crystal ball gazing has its problems. There is a temptation to indulge either your worst fears or your most optimistic hopes, to overestimate the speed of progress in some areas, and to completely misjudge developments in others. What you can be absolutely sure of is that you won't be right, so let's get on with the fun.

Discontented doctors

In 2015, the NHS and general practice are surviving—just. General practitioners are getting restless with their contract, and the female chair of the General Practitioners Committee is under pressure to negotiate a new one to replace the 2003 version. The quality aspect continued to be developed and was an agreed success, copied in many other countries. However, political interference and the introduction of populist measures, such as “diet MOTs” and awarding points for the standard of refreshments provided in general practices, has led to a professional outcry. This, together with continuing attempts to erode general practitioners' incomes and the government's decision to double the cost of creche payments for the largely female workforce, has brought the profession to the brink of dispute, despite the fact that the recently passed public sector legislation prevents any effective form of industrial action.

Moreover, general practitioners feel undervalued for the work they are doing in the flourishing community based resources. Patients—or customers as we are increasingly being directed to call them—are able to receive a whole range of services previously provided in hospitals. Many practices have joined together to run the centres. Others are provided by the private sector, and Tesco Health has extended its franchise with the recent takeover of the failing NHS Direct.

Competition

Hospital admissions have fallen sharply. Many district general hospitals and some teaching hospitals have closed as a result of the pressures caused by introducing the market into health care. Despite the efforts of local groups and the NHS Independence party, which doubled its number of seats at the last general election, traditional NHS facilities have found it difficult to compete with an increasingly aggressive private sector without a level playing field.

Of course, this has had a detrimental effect on customer choice. Despite the fact that, in theory, the NHS is still free, realistic choice is available only if the area has an independent sector treatment centre. Many treatment centres offer a limited selection of treatments so many patients have to travel further afield for the services they traditionally received at their local district general hospital.

Information technology

Connecting for Health is finally due to complete its programme to fully integrate the NHS's computing systems, eight years behind schedule and £25bn over

budget. Despite several legal challenges from patient groups, all patients now have to agree that their electronic care record must be available on the spine (the central repository of the national information technology system that health professionals have access to) if they wish to receive NHS care. Patients are able to amend any inaccuracies using their NHS smart cards, and patients can use these to access their records through their home computers or television sets. Similar facilities are available in general practices, walk-in centres, clinics, and hospitals.

Bigger and better practices

The nature of general practice has changed considerably. There are fewer, larger practices and many more salaried doctors. However, the predicted demise of independent contractor status has not occurred. General practitioners have shown themselves to be a real match for the private sector and have made successful challenges under the competition laws against the government's attempts to rig the market in favour of big business. Successful practices have amalgamated with their neighbours, have radically improved the standard of practice management, and expanded the range of services they offer, together with the staff to provide them. They employ counsellors, physiotherapists, and medical care practitioners and are responsible for all community staff.

Dual registration, briefly tried out in 2007 after the white paper review, has been abandoned as too costly and resulting in an undesirable fragmentation of patient care. Instead, the new generation of mobile video phones allows patients to consult healthcare professionals in their registered practice, irrespective of where the patients work. If examinations or tests are needed, the patient can visit any community resource centre, where medical care practitioners perform the necessary procedures, under the direction of the patient's general practitioner, and feed the results back to the patient's practice. Such services are also available in the early morning and on evenings and at weekends, particularly in areas with large numbers of commuters.

Culture of fear

The flu pandemic of 2007 not only ended Tony Blair's premiership but left a legacy of everyone wanting every possible protection, irrespective of any evidence that the interventions were effective. All employers are now legally obliged to provide a comprehensive occupational health service, including influenza immunisation for all workers. Similarly, the horrendous 2010 measles outbreak resulted in legislation that requires schools and nurseries to have proof that children have been immunised before they are allowed to admit a child.

Patient charges

The NHS is still, ostensibly, free at the point of use but after the valiant attempts to abolish prescription charges in Wales and Scotland had failed, the concept has been slowly eroded, and charges have been introduced for areas of care that are considered "non-essential"—not just those such as plastic surgery but for sickness certificates from the newly privatised benefits scheme and hotel charges for hospital inpatients.

The NHS is still essentially funded out of taxation but with many of the independent providers offering cut rate insurance for treatments that they provide the health divide is increasing. As Prime Minister Brown's

Vision

General practitioners, most of whom are female, feel undervalued because of eroded income and political interference

Larger practices offer a wider range of services

All practices are linked by a computer network

Video phone consultations have relieved some of the problems of access

Patients have to pay for non-essential services including hotel care in hospital

Wanless 2 report in 2009 suggested, a fully funded NHS is likely to be unsustainable in the long term. However, the Cameron government hasn't dared to grasp that nettle because it doesn't want to be seen to be the party that got rid of the NHS. We'll probably have to wait for 2025 and the next new Labour government for that.

Competing interests: None declared.

Still striving for utopia

Carol Black

My vision for the NHS 10 years hence is not far removed from the orthodox aspirations of today, but it is a considerable advance on what is often found, what is poorly reported, and what is seriously misunderstood. Of course, it is folly to imagine the utopia Aneurin Bevan once envisaged. But it would be worse to believe that we have achieved all that is possible. Health, health care, the experience of patients and their families—and of health staff—can all be made better than they are today.

The current government has set core standards describing what must be done, supplemented by developmental standards, designed to drive up quality of care.¹ By 2015, these will all have been met and we will have a service that is safe, clinically effective, and patient focused.

Changing patient priorities

The need to preserve health, protect health, and prevent or delay ill health casts responsibilities far beyond the NHS. Not only do they fall to other national and local agencies, and professionals of many disciplines within them, but individuals and families must also take more responsibilities for their health and wellbeing. Primary care will be key in supporting people to take on these responsibilities. By 2015 it will have moved a long way towards generating a level of self esteem that rejects behaviours harmful to health and makes fitness the norm.

Success lies beyond health services alone. Action will have also been taken in many domains to ensure

sound parenting, good education, confident buoyant communities, and opportunities for development that continue for life, sustained and enriched by better understanding of the need for personal responsibility for health. This will all help to ensure that the health service is truly patient led and patient centred.

Technological advances will mean that patients have ready access to reliable information and advice, presented in ways that can be widely understood. But patients will be rediscovering that possessing information is not a complete solution to questions of interpretation and judgment. They will continue to rely on their general practitioners to help them make the right healthcare decisions.

Medical professionalism will be key to ensuring patients retain trust in their doctors. As Dame Janet Smith has said: "The public ought not to even have to think about whether they trust their doctors—it should be something that they are able to take completely for granted."² That state of affairs is part of my vision too, and it can be achieved.

Medical professionalism cannot be imposed by governments or by a regulatory culture. It must emerge from and be sustained by doctors themselves. "Medicine is a vocation in which a doctor's knowledge, clinical skills, and judgement are put in the service of protecting and restoring human well-being. This purpose is realised through a partnership between patient and doctor, one based on mutual respect, individual responsibility and appropriate accountability."³ By 2015 we will have created an environment that enables those values to flourish.

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