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.

Royal College of Physicians, London NW1 4LE
Carol Black
president
carolblack@rcplondon.ac.uk

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Some other goals are scarcely utopian. It should not be an insuperable task to make sure the places where we deliver care are clean, not only in the wards and departments where it most matters, but in every passage way and waiting area. According to the Healthcare Commission the private sector manages these things better. Surely it is not an unreasonable expectation that the NHS will do so long before 2015.

Work in progress

Although in many ways the NHS in 2015 may fall short of what many aspire to, we must not undervalue how far it has come. The incremental changes that mark progress will continue. Advances in clinical science and their translation into services, practice, and care will be steps to improvement. Quality and clinical excellence will be an intrinsic part of a health service that is fit for the needs and expectations of patients. The long and deeply ingrained urge to question clinical practice and improve care will be supported by adequate investment. And at last we are beginning to see recognition and mature acceptance of a responsibility to match expectations and demands with ethical best use of the resources available. A new behaviour among public

Vision

Health care will be safe, clinically effective, and patient focused

Primary care will have enabled patients to reject behaviours that harm health

Patients will continue to rely on doctors to help them make decisions about health

Medical professionalism will ensure high levels of public trust

and providers alike, a mature conversation between clinicians and patients might seem unrealistic, but it is not beyond imagination.

Competing interests: None declared.

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- 2 Royal College of Physicians of London. *Doctors in society. Medical professionalism in a changing world*. London: RCP, 2005.
- 3 Commission for Healthcare Audit and Inspection. *Assessment for improvement. Criteria for assessing core standards*. London: CHAI, 2005.

Health policy

Improving NICE's social value judgments

Jonathan A Michaels

NICE has just published guidance on judgments relating to social values. A systematic approach to incorporating patients' characteristics in modelling could improve such judgments

Academic Vascular Unit, Northern General Hospital, Sheffield S5 7AU

Jonathan A Michaels
professor of vascular surgery

j.michaels@sheffield.ac.uk

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Discrimination between patients on the basis of individual characteristics is inevitable in clinical practice. Such characteristics are clearly relevant in determining the risks and benefits of specific treatments, and few would question the appropriateness of considering factors such as age, sex, and obesity in devising guidelines for preventing deep vein thrombosis or taking account of ethnic origin in screening for diseases that occur in particular populations. Such discrimination might, however, be considered unfair, particularly when the issue to be decided relates to cost effectiveness or if the grounds for discrimination could be seen as being a question of "deservedness."

Consistency, comprehensiveness, and specificity

The National Institute for Health and Clinical Excellence (NICE) is to be congratulated on tackling this difficult issue through the development of guidelines on social value judgments.¹ The draft document provided guidance on how such issues might be addressed in the decisions taken by NICE, particularly

in relation to the appraisal and guideline development processes, but there were some difficulties and potential shortcomings.² Several issues arise in regard to the extent to which this advice is consistent, comprehensive, and sufficiently specific for technology appraisals or guideline development.

Firstly, the apparent inconsistency between recommendations relating to different characteristics such as age, sex, and ethnic origin has been partly resolved in the final version.³ For example, in respect to age the draft guidance stated that "where age is an indicator of benefit or risk, age discrimination is appropriate"—but existing guidance, such as that relating to the use of drugs for influenza and the treatment of infertility, already sets criteria in relation to age.⁴ In respect to gender and sexual orientation, they suggested that discrimination is not appropriate "unless there are risk factors for benefits, risks or both" whereas in respect to ethnicity they stated categorically that there is no place for discrimination, and did not include a caveat in respect to differences in risks and benefits.

It is not logical to treat individual characteristics such as age, sex, or ethnic origin in different ways—an alternative would be a generic approach that deals with how such information should be used, rather than the specific nature of the information. Some forms of