LETTER FROM WESTMINSTER

Changing the script

JOHN WARDEN

This was to have been the year of the family doctor. The year when parliament would focus on the reform of primary health care. But somehow the script has been altered. It got as far as the white paper *Promoting Better Health* before we were rudely interrupted and the crisis in the hospital service took over.

The future of Britain's 30 000 general practitioners was promptly relegated to second place and the government's health showpiece on primary care was almost totally eclipsed. What had been represented as medicine's equivalent of big bang subsided as suddenly as the stockmarket did.

Likewise, events have forced ministers back to the drawing board and the primary care plan is now seen more as part of a grand design for a new health service that is still to take shape. The primary package, however, remains intact in its original form with implications for changing the face of general practice.

But while the pack has gone chasing into the hospital sector, the government has safely laired its Health and Medicines Bill, which is the legislative preliminary to the reform of general practice. The bill has come through its Commons committee stage unchanged by nearly 70 hours of debate. Last week, despite determined opposition from the BMA, it passed the hurdle of clause 13, which controversially introduces cash limits into the family practitioner service in respect of premises and staff.

Given the impact of cash limits on the hospital service, there is scope for apprehension about the same foot in the surgery door. Labour's attack, led by Ms Harriet Harman, did not miss the point: "We have seen what cash limiting has done to patients needing treatment from the hospital service. We now see cash limiting being introduced to put the squeeze on family doctors," she said.

The BMA's view is that the proposed cash limits will constrain the family doctor service, breed a cumbersome bureaucracy, and anyway are unnecessary. Since the average family doctor employs only 1.2 ancillary staff, but is entitled to be reimbursed for two, the uptake has been lower than was intended. There is an inconsistency in the government now wanting general practitioners to employ more staff with a wider range of skills while curtailing the means to do so. The BMA would rather limit the staff to two per doctor than the cash to pay them.

The government's reply came from Mrs Edwina Currie, junior health minister. She said that the present system was not working. It was arbitrary and haphazard. The best practices were excellent but the worst were terrible. With expenses paid on an average basis keener doctors lost out and those who employed fewer staff gained.

In future the family doctor would be able to seek reimbursement for a far wider range of staff, Mrs Currie said, scolding doctors for rating receptionists as more important than practice nurses, since they employed five times as many (approximately 15 000 receptionists to 3000 nurses). These figures looked to the minister to be less related to the health needs of patients than the clerical needs of doctors.

"We feel the current system is too restrictive," she said. "There is no cash at all for many things that are desirable." Apart from physiotherapists and chiropodists the new dawn could include music therapists, hypnotherapists, and indeed anyone qualified to deal directly with patients. They could be reimbursed up to 100%. Whether that happened would depend on local priorities as determined by family practitioner committees—and, of course, their cash limit. Mrs Currie pledged more money, but exactly how much more would depend on negotiations with the profession and

the success in raising £170m from dental checks and eyesight tests.

So into the boiling pot it goes, along with such topics as the family doctor's workload and the pattern of hospital referrals. Though Mrs Currie could hardly have shown the government's hand by declaring a figure, there will be disappointment that she gave no promise that cash limits would not creep into other areas. On the contrary, her message was that general practitioners had nothing to fear from the experience of cash limits in hospitals because they had had more money and staff.

Labour claimed, too, that clause 13 could pave the way for the introduction of American style health maintenance organisations, built on the foundations of the family doctor service. A high flying kite in *The Times* to that effect was termed "pure speculation" by Mrs Currie, which is notably less dismissive than the scepticism of health minister, Tony Newton, a few months ago when he doubted if United States health maintenance organisations could be applied here.

"Revenge" from the shot pianist

But that, too, was before the script was rewritten—and contributions to the script flutter in almost daily. One that it would be unwise to ignore is *National Health Crisis—A Modern Solution* (Shepherd-Walwyn, price £4.95), published this week by Mr Ray Whitney, who was Mrs Currie's immediate ministerial predecessor. He comes out strongly for the health maintenance organisation concept to place "managed health care" in the hands of family doctors and autonomous hospitals, financed by a mix of state vouchers and private insurance. It is an update of the safety net system proposed by a working party, chaired by the late Dr Ivor Jones, 20 years ago over the imprimatur of the BMA, which is rebuked by Mr Whitney for dropping an idea that he believes could have avoided today's problems.

Today's medical establishment will in turn find Mr Whitney's book hair raising, though he makes no apology for that. He wrote it because his relatively brief spell as a health minister showed to him the political Passchendaele at which the health service had not only arrived, but to which it had been inexorably driven since 1948. Freed from the restraints of office, Mr Whitney can see no salvation within the Bevanite framework of a nationalised hospital service which, he estimates, needs an extra £10 billion in funding.

That the "NHS myth" has for so long masked such a failure was largely the fault of the medical profession. According to Mr Whitney, the profession's original resistance followed by surrender sanctified the NHS and ensured that the doctors had "reigned supreme" ever since. But while accusing the BMA of a mixture of ferocity and guile unsurpassed by any trade union, Whitney sees this as ground for hope. He believes that the profession's resistance to any new thinking will again be short lived. Once a new system was in operation the profession would become its most committed and passionate defender.

Mr Whitney is entitled to his revenge, which is as much on Mrs Thatcher as on anybody: "It is always easier to shoot the pianist than to compose a new tune. . . . I write as one of the assassinated pianists." Now that the Prime Minister is being forced to compose that new tune Mr Whitney may claim to have had the last laugh.

He can also expect to be fêted by many on the Conservative backbenches—and beyond. Mrs Currie, in the context reported above, exactly echoed the Whitney thesis when she declared: "If our system is the best in the world how come nobody else in the world has copied it?"

The ministerial dynasty lives on.

Cervical screening: GMSC criticises five year interval

In January the DHSS issued revised guidance on cervical cancer screening, recommending a five year screening interval for women between 20 and 64.¹ Before the circular was issued the chairman of the General Medical Services Committee, Dr M A Wilson, had written to the chief medical officer and at its meeting last month the GMSC received the reply with disappointment. The two letters are set out below.

Dr Wilson's letter to the CMO

"The GMSC wishes to draw to your attention the conclusions of the inter-collegiate working group on cervical cytology screening, which includes a recommendation that cervical smear tests should be conducted at three yearly intervals on women between 20 and 64 years of age.

"We believe there is a continuing contradiction between, on the one hand, incontrovertible clinical

evidence on cervical cytology, and, on the other, existing public policy on screening intervals, which could be removed by a clear statement in the new health circular on cervical cancer screening. We urge you not to miss this opportunity."

Reply from the CMO

"You will know of course that the health circular on cervical cancer screening was issued before your letter reached me. We sent to health authorities, with the circular, two copies of the Intercollegiate Working Party Report in view of the useful guidance it gives on smear-taking and the interpretation/reporting of smears. However, the circular did not accept that three yearly rather than five yearly screening should be a priority at present. Indeed when considering the potential of cervical cytology screening to limit the incidence of cancer of the cervix in a population, discussion of the merit of three yearly screening as opposed to five yearly screening is largely academic until such time as a substantial majority of women between the ages of 20 and 65 are being screened regularly. We have not yet reached that position nationally and to do so will require a good deal of effort by all those involved.

"Health authorities screening a high proportion of eligible women regularly are, of course, free to increase the frequency if they feel that this is a justifiable use of resources. It is for this reason that the circular (para 3) says recall should be *at least* every five years."

In the light of the chief medical officer's reply the committee has approved the following statement prepared by Dr P F Kiely.

"In the light of current epidemiological evidence, the General Medical Services Committee, the Annual Conference of Representatives of Local Medical Committees and the Representative Body of the BMA have recommended to the DHSS the introduction of an adequately funded cervical cytology programme which offers a cervical smear test to women over the age of 20 at three year intervals, together with adequate follow up facilities. Such a programme, comparable with those of many other countries, would indicate the determination of the DHSS to reduce significantly the number of deaths each year from cervical cancer.

"At the present time, arrangements for screening in health authorities vary widely. Some authorities have introduced programmes based on

BMA council: candidates in 1988-90 election

The election of members for the BMA council is being held in one stage and the successful candidates will serve for the two year period 1988-90. The candidates are listed below. Ballot papers will be issued on 28 March in those categories where an election will be held and the results will be announced in the *BMJ* on 7 May.

In the craft elections only those BMA members in the relevant craft may vote. In the election for the regional and country seats members may vote only for candidates in their own region or country. For the election of the four United Kingdom seats the ballot is open to all members in the United Kingdom.

Craft nominees

General practice (six to be elected)

Sriramashetty Venugopal, Birmingham
Lotte Newman, London
Shirley Jane Richards, Exeter
Simon Oakley Fradd, Nottingham
John W Chisholm, Henley on Thames
Deb K Bose, Wolverhampton
Peter Enoch, Ilkeston, Derbyshire
John Bernard Lynch, Denbigh, Clwyd
Lionel Kopelowitz, London
Ian Bogle, Liverpool

Senior hospital (four elected unopposed)

Alexander Patrick Ross, Winchester
Brian Lewis, Hythe, Kent
W James Appleyard, Canterbury
John Chawner, Anglesey

Training grades (seven to be elected)

Terence James Sullivan, Mitcham
Adam Lowy, Leicester
Lindsey Anne Stroud, Cardiff
San Everington, London

Angela E Thomas, London
Christopher John Spencer Jones, Exeter
Ted Rose, Wembley, Middlesex
Jeremy Wight, Sheffield
Paul Godwin, Leeds

Community medicine or community health (two elected unopposed)

L Fleur Fisher, Macclesfield
Eileen A Wain, Linton, Yorks

Armed forces (one to be elected)

David G Jones, Ivybridge, Devon
Charles A Gauci, London

Academic (two elected unopposed)

James Patrick Payne, London
Colin L Smith, Southampton

Occupational health (one to be elected)

William M Dixon, Chalfont St Giles, Bucks
Joseph L Kearns, London

Associate members (one to be elected)

Keith Reid, Dundee
Amira Dangoor, Bristol
Andrew R Houghton, Oxford

Other crafts (one to be elected)

Frank Wells, Ipswich
Christopher J Bolt, Nottingham

Region or country

Simon Jenkins (North Western) returned unopposed
Stephen Colin Drew (Northern) returned unopposed
Mervyn Goodman (Mersey) returned unopposed
James M Dunlop (Yorkshire) returned unopposed

James Francis Milligan } West Midlands
Mary White }
Donald Andrew Aitken }
David Roberts } Trent
Tony Earnshaw }

Alan J Rowe } East Anglia
Charles Saunders }

Arnold Elliott (North East Thames) returned unopposed

Peter F Kiely (North West Thames) returned unopposed

David J Farrow } South East
Abu Tayeb Md Amzad Hossain } Thames
John Stephenson }
Jeffrey Michael Cundy }

Ewen Crighton Bramwell (South West Thames) returned unopposed

Anthony John Stanton (Oxford) returned unopposed

Vacancy (South Western)

John S Happel } Wessex
Jeremy Patrick Lee-Potter }

David Parry (Wales) returned unopposed

John Callander (Scotland) returned unopposed

S R Campbell Ritchie } Northern Ireland
Caroline Marriott }

United Kingdom

(Four to be elected)

Robert Anthony Keable-Elliott, High Wycombe, Bucks

Peter Charles Hawker, Stratford on Avon

John Godfrey Ball, Bewdley

Anthony H Grabham, Kettering

Henry Yellowlees, Basingstoke

Michael Anthony Wilson, Huntington, Yorks

Stephen John Watkins, Oldham

Dick Greenwood, Rothley, Leicester

Abdul Karim Admani, Sheffield

a three year interval, whereas laboratories in others are refusing to accept specimens more frequently than every five years. This is confusing for the public and creates difficulties for doctors in their relationship with patients. In addition, it creates further problems for the scheme under which general practitioners receive fees for tests done for patients in certain restricted categories. Already this scheme is difficult to implement and often misunderstood by both doctors and family practitioner committees. Optional flexibility and lack of clear guidance on the nature of local programmes are guaranteed to make matters worse.

"The GMSC will continue to press the DHSS for an early resolution of these problems. A clear-cut national programme compatible with parallel arrangements for remuneration will end the present state of confusion and promote the level of activity required to guarantee a significant reduction in the number of deaths from cervical cancer."

Reference

- 1 Department of Health and Social Security. *Health services management. Cervical cancer screening*. London: DHSS, 1988. (HC(88)1) (HC(FP)(88)2.)

MPs want more money for NHS and full funding of agreed pay awards

Reports from two House of Commons committees have called on the government to provide more money for the NHS and pointed out the difficulties that health authorities face in planning their budgets because of uncertainty about the full funding of pay awards by the government.^{1,2}

The Treasury and the Civil Service Committee, reviewing government expenditure plans to 1991 (22 February), criticises unrealistic targets given to government departments based on the assumption that inflation affects all departments in a similar way. It also condemns the practice of laying down advance cash limits without advising departments about the likely level of pay settlements or whether the Treasury will fund them. The report also points out that on the government's own criteria expenditure could be increased on programmes such as the NHS that might need extra funding during either the current or the next financial year.

In its report on the short term issues of funding the NHS the Social Services Committee calls for the government to commit itself to fund fully all NHS pay awards in 1988-9 to which it has agreed. In its recommendations, published below, the committee—chaired this session by Labour MP Frank Field, who succeeded Renée Short, and made up of MPs from all parties—identifies "an apparent shortfall" in NHS funding of nearly £1.9 billion. In their analysis of the NHS funding crisis Mr Field and his colleagues comment that there "is in practice no absolute data on health, here or elsewhere, by which the effectiveness of any health service can be assessed and virtually no costing of clinical procedures in the United Kingdom by which the efficiency of medical intervention can be measured." This absence of data "impedes a clear assessment of the adequacy of funding."

In discussing the reasons for the shortfall in

funding the committee quotes the chief secretary of the Treasury. He told the Treasury committee that "the presumption in the planning process is that there is no compensation for inflation or the relative price effect [the difference between the general level of inflation and the inflation in prices and pay for particular government departments] . . . we do that because we find that not indexing effectively the relative price effect is a good counter-inflationary measure and an incentive to economy."

Referring to closures of wards or hospitals, the Social Services Committee says that these are not necessarily a bad thing as planned closures could lead to a more efficient use of resources without any apparent reduction of services. In contrast, however, it highlights City and Hackney District Health Authority's possible closure of 200 local acute beds to keep within its budget for 1988-9. That would be "catastrophic" and would mean the number of empty beds at St Bartholomew's Hospital was such that it would be practicable to close the newly opened district general hospital at Homerton and move its beds to Barts.

A disturbing example of temporary ward closures or delays in treatment was the long term effects on standards of medical education and research, a warning that the Committee of Vice Chancellors and Principals had put to the committee. The committee was also disturbed by effects the day to day squeeze on cuts was having on the NHS's "main tangible asset—the estate." There was a danger of creating an insoluble financial problem because of continuing neglect of the NHS's buildings. Alarm was expressed, too, in the report on the "unacceptable policy of maintaining acute services at the expense of development in priority care in the community services already planned for 1988-9."

Social Service Committee's recommendations

● We recommend that the government, in order to enable authorities to plan their budgets for the whole of the coming year, rather than make or plan cuts not in anticipation of underfunding of pay awards later in the year, commits itself to fund fully all NHS pay awards in 1988-9, to which it has agreed.

● We recommend that the government review the overall allocations to health authorities in the light of a commitment to fund pay agreements, and calculate the extent to which the resources so far allocated will enable services to rise by 2% in 1988-9. If it appears that on the DHSS's best estimate of NHS specific price inflation in 1988-9 that 2% target will not be reached we recommend that the allocation for that year be increased to cover the costs of 2% service development (taking into account planned cost improvement programmes).

● We recommend that the shortfall of £95 million in funding of pay and price inflation in 1987-8 acknowledged to us by the DHSS be made good forthwith. In addition we recommend that the DHSS make available over the next two years a separate and additional sum, which should not be less than one billion pounds, recognising that we have identified an apparent shortfall of £1.896 billion. This sum should be allocated to specifically identified and costed priority developments, including information technology and putting right the maintenance backlog, replacing essential fabric and equipment, and developing identified service priorities for care in the community. It is not only RAWP gainers, but also DHAs which are RAWP

losers, which will require these additional funds. Taken together, and they are a package, we believe our recommendations represent, at a time when the economy is buoyant, a realistic programme which will bring the NHS back up to scratch and restore the morale of its staff—who represent the most fundamental and essential resource of the NHS.

● We recommend that urgent attention is paid to the development of improved measurement of the effectiveness of the NHS, a process to which the DHSS and all the groups working within the NHS should contribute, since the existence of such measurements would represent the most effective guarantee against recurrent funding and other crises.

References

- 1 Treasury and Civil Service Committee. *Second report from the treasury and civil service committee 1987-88: the government's public expenditure plans 1988-90 to 1990-91*. London: HMSO, 1988. (HC 292.)
- 2 Social Services Committee. *First report from the social services committee 1987-88: resourcing the National Health Service: short term issues*. London: HMSO, 1988. (HC 264.)

Prescription charges rise by 20p

NHS prescription charges are to rise by 20p to £2.60 and the annual season ticket by £2.50 to £37.50 from 1 April. Announcing this increase to the House of Commons on 29 February, Mr Tony Newton, Minister for Health, claimed that at 8% the rise was broadly in line with the increase in the cost of medicines. He also announced that from 1 June testing strips for diabetics would be issued free and reminded MPs that half the population was exempt from charges and that 75% of prescriptions were issued free. The Labour party spokesman condemned the increase as unjustified, undesirable, and wildly in excess of the rising costs of medicines. The increase will raise an extra £10 million for the government. Dental charges and charges to overseas visitors will also go up. Vouchers for helping with the purchase of spectacle and contact lenses will be raised in value at a cost to the government of £7 million.

Powers of attorney: explanatory leaflet

The criteria for assessing incapacity when power of attorney is sought are not identical with those for assessing the need for compulsory admission to hospital. This is explained in a leaflet produced by the Court of Protection in consultation with the BMA, the Royal College of Psychiatrists, and the Royal College of General Practitioners. The leaflet is available to BMA members from regional offices and from the other organisations and could be helpful to general practitioners and psychiatrists who are asked to provide medical certification in connection with the enduring power of attorney. There is no statutory or common law requirement for a person or attorney to obtain medical evidence when a power of attorney is created or when an enduring power is registered. But because of the difficulty of retrospective assessment of capacity the leaflet advises that it would be wise to obtain a report or certificate from a doctor about the person's mental condition.