raisers who can “talk the talk” but not necessarily “walk the walk.” Procedures should in an orderly fashion connect the distinct roles of the political, scientific, and administrative elements in the programme’s formulation and implementation. Once political decisions are fixed on the recently proposed general themes of the seventh research framework,¹ the key responsibility should be transferred to active, fully competent researchers from all relevant biomedical, epidemiological, and social areas. They should formulate the call for proposals’ topics within the health theme(s) and evaluate the merit of submitted projects with the administrative and technical support of EU staff. Topics should not be specified too narrowly, to allow selecting the best quality projects through competition. In health systems research, high quality studies require as much imagination and rigour as in any other kind of research: limiting the proposed European Research Council⁸—a welcome instrument to improve the scientific governance of EU funded research—to the basic sciences reflects an obsolete hierarchy of first and second class sciences that also demands urgent revision.

At the level of resources, four requirements stand out. Firstly, adequate funding—say, at least 20% of the total life sciences allocation—should be assigned to a well identified “health systems research” section of the programme. Secondly, appropriate provisions should be made for large and complex megastudies as well as for smaller, agile investigations exploring new hypotheses in which only some of the 25 EU countries participate. Thirdly, the programme should embody mechanisms to allow adequate time—conditional to positive periodical evaluations on a competitive basis—to do population based studies, usually longer than experimental or clinical studies: mechanisms such as the European Strategy Forum on Research Infrastructure⁹ may be appropriate, in particular for “life course”¹⁰ investigations of disease development. Fourthly, substantial investments in edu-

cation and training, formal and on the job, should be targeted specifically to strengthen competence in all population health sciences.

Hopefully these proposals will find a way into the new EU programmes: short of this, the EU research “for health” will miss its target and remain by and large a well intentioned misnomer.

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The future of singlehanded general practices

Recent developments put their future in doubt

Do singlehanded general practices have a future in the United Kingdom’s NHS? Singlehanded practices—those that have only one principal doctor with a contract with their primary care trust—have been dwindling in number for many years, and this decline has now become much more rapid. Between 1994 and 2003, the number of singlehanded general practitioners fell from 2959 to 2578 (from 10.8% to 8.5% of all general practitioners) in England.¹ Between 2003 and 2004, the number fell by a further 660 to 1918 (now comprising 6.1%), a larger fall over one year than in the preceding nine years. Yet singlehanded doctors make up a much larger proportion of the primary care workforce in many other developed countries. For example, in the United States in 1998, 46% of family practitioners and 34% of general internists were practising alone.²

Ever since the foundation of the NHS, singlehanded general practitioners have made an important contribution in the UK, particularly in inner city and

rural areas where recruiting general practitioners has proved difficult. These areas often have deprived populations and, in inner city areas, a high proportion of patients from minority ethnic groups. Singlehanded general practitioners have been an integral part of these communities for several decades, providing both NHS and pastoral services to their local population. In 2004, 22% of all general practices in England were still run by doctors practising solo. Why then is the future of singlehanded general practitioners now in doubt?

Over the past 50 years in the UK, general practices have gradually expanded, with both the mean number of doctors and the mean number of patients per practice increasing.³ Some of the decline therefore represents a desire for doctors to work in larger practices—in particular, those who want part time clinical work because of family or other clinical and managerial commitments. For such doctors, larger practices can offer more flexible working arrangements. Doctors may also find larger practices more attractive to work in because they reduce

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the likelihood of clinical isolation, can employ more support staff, allow scope for specialisation, and offer a wider range of services than small practices.

However, a more important reason for the decline in the number of small practices could be that they might not feature in the UK government's long term vision for primary care. Small practices are seen as less efficient and more difficult to manage by many policy makers and managers. The case of serial killer Harold Shipman, who was a singlehanded general practitioner, may also have contributed to this desire to reshape general practice.⁴ Among the recommendations arising from the Shipman inquiry was that the NHS should take steps to reduce the clinical isolation of singlehanded practitioners. Encouraging general practitioners to work in larger practices is one way in which the NHS can achieve this objective.⁵

At a conference in March 2005, a new vision of general practice was unveiled, in which primary care services would be provided by a combination of large group practices and walk-in centres.⁶ Will such a model lead to a more efficient and higher quality primary care service than one that includes singlehanded practices? Studies that have compared the quality of care in smaller practices with that in larger practices have found little relation between practice size and the quality—for example, of managing ischaemic heart disease.⁷⁻⁸

Smaller practices are considered by patients to be more accessible and achieve higher levels of satisfaction among patients than larger practices.⁹⁻¹⁰ Hence, the available evidence does not indicate that amalgamating general practices into larger units will lead to more efficient and higher quality primary care services or to increased patient satisfaction. Creating a primary care service based on larger practices also reduces patients' choice, and those patients who prefer the more personalised care they might receive in a small practice will be denied this. This is anomalous at a time when the government is proposing to increase patients' choice in the NHS.¹¹ Is the definition of choice to be confined within limits imposed by the government so that, for example, patients can choose a hospital when they need referral to a specialist but cannot choose the type of general practice that they would like to provide their day to day care?

A better approach might be to use the information on quality of care that will be collected as part of the

new general practice contract to compare the performance of singlehanded practices with that of larger practices.¹² This would provide objective comparative information on the quality of care and provide a rational framework for reducing the number of practices if singlehanded practices were found to be performing below the level of larger practices. This could be combined with making more information about practices available to the public so that patients could make informed choices. The future of singlehanded general practices would be in their own hands. If doctors continued to want to work in them, if they provided health services of comparable quality and cost effectiveness to larger practices, and if sufficient patients wished to register with them then they would continue to exist, and possibly even flourish, in the NHS. If, however, they failed on these criteria they could then die a natural death in which their fate would have been decided by market forces and patients' choice, rather than through a policy based on making general practice an entirely collective endeavour.

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Thresholds for normal blood pressure and serum cholesterol

Lower thresholds mean that 90% of people over 50 years are identified as patients

For several years, disagreement has been growing in health services about ever lower thresholds for "normal" blood pressure and serum cholesterol, the most common biological risk factors for cardiovascular disease. This was most publicly expressed in 1999, when more than 800 doctors, pharmacists, and scientists from 42 countries signed an open letter to the then director general Gro Harlem Brundtland, outlining fears that the World Health

Organization's new hypertension guidelines would result in increased use of antihypertensive drugs, at great expense and for little benefit.¹⁻² The simplistic linear structuring of many research questions and the extrapolation of research results over prolonged and unstudied time periods produce guidelines that make many doctors, and particularly general practitioners, feel uneasy about the high proportion of their patients who are being labelled as sick.