Medical advice and health policy

CMO issues challenge to community physicians

The Chief Medical Officer, Dr E D Acheson, chose the theme "Medical advice and health policy" for his address to the Central Committee for Community Medicine and Community Health on 26 April. Dr Acheson began by suggesting that the first time that medical advice had provided a crucial element in health care policy had been the implementation by the Royal Navy in 1796 that seamen should have a daily ration of lemon juice to prevent scurvy. This had been influenced by James Lind's

book published 40 years earlier based on epidemiological reasoning and a controlled trial.

The rest of the Chief Medical Officer's address is reproduced here.

Developing better relationships

The first government department to be formed exclusively with the function of dealing with health matters at national level and under the direction of ministers was the old Ministry of Health, which came into being in 1919. Previously, medical functions in government had been divided in various ways but latterly between the Local Government Board and the Education Board. The only point I wish to make about these previous arrangements is that they had involved over a period of some 70 years a series of squabbles about the relationship between administrators and doctors. Indeed this had been an issue between Chadwick and his medical advisers in 1838-48 and was again the issue that led to the voluntary retirement of Sir John Simon from the Civil Service in 1876.

Sir George Newman, who was the first chief medical officer in the Ministry of Health and who occupied the post from 1919 to 1935, described the new relationships which were developed between medical professional and administrative staff within the ministry with a good deal of satisfaction in his book *Building of a Nation's Health*.

The success of the new arrangement was based on a principle that is as relevant today as it was then—namely, that the chief medical officer should (for the first time) have right of access to ministers. This ensured:

(1) "that the chief medical officer shall in no instance be placed in the position of carrying out a policy with which he may from the professional standpoint, disagree, without having had a full opportunity or urging his views both upon the permanent secretary and the minister;"

(2) "that proposals initiated by the medical staff are considered fully on their merits and are put forward stage by stage in the ministry . . . up to whatever point the chief medical officer in the exercise of his responsibility may consider that their importance warrants."

Today, as in 1919, the chief medical officer has no executive powers and, in particular, may I say, as this is much misunderstood, has no management line which gives him authority over any doctor working in the National Health Service; and that proviso does not exclude, as you all well know, medical officers

employed by the regional and district health authorities. The influence of the chief medical officer depends upon two factors and two factors only:

- (1) the quality of the medical advice he gives to ministers;
- (2) his relationships with the institutions of the medical profession (British Medical Association, General Medical Council, Medical Research Council, etc) and with individual colleagues within the Department and within the National Health Service.

Not the exclusive channel of medical advice

Happily the chief medical officer has a great deal of help in formulating advice to ministers. Apart from a staff of full time medical civil servants, who cover a wide range of expertise including, for example, primary care, infectious disease, hospital specialist services, toxicology, and medicines, there are a number of standing committees—for example, Standing Medical Advisory Committee; expert advisory committees—for example, AIDS; and in addition he can draw on the expertise of a panel of colleagues in the profession who are available to give advice on anything from smallpox to leprosy and obstetrics to geriatrics. The chief medical officer is accountable to ministers for the quality of the advice of his colleagues in the medical civil service. So far as other advice is concerned—for example, on the reports of expert committees—he has a duty to interpret, to balance, and, if he considers necessary, to criticise. There is, however, one other important point to be made here. The chief medical officer and his professional colleagues are not and never have been the *exclusive* channel of medical advice or of communication with the medical profession for ministers. Ministers can and do take advice from whomsoever they see fit.

I now propose to draw some parallels between the chief medical officer as a full time officer within central government and community physicians as full time officers of health authorities. After all, one of the features of the work, which we have in common and which we do not normally share with consultants or general practitioners, is that we are all accountable officers.

Part of the philosophy of the [Griffiths] management inquiry is that in order to encourage a measure of experimentation and diversity so that the arrangements for management can be adapted to local circumstances there will no longer be detailed guidance about job specifications. So far as the arrangements for professional chief officers are concerned these are set out in paragraph 7 of annex C of HC(84)13.¹ I place a great deal of importance on this paragraph and will therefore quote it in full.

"Professional chief officers are appointed by the authority and will continue to be directly accountable, and have a right of access, to the authority on the provision and quality of professional advice. On matters relating to the fulfilment of the general manager's responsibility, they will be accountable to the general manager for the day to day performance of their management functions. The representative members of the district management team will also continue to have direct access to the authority."

Subsequently ministers have emphasised the importance they place on the continued provision of professional advice to the authority, and have indicated their expectation that authorities will maintain the appointment of a chief medical adviser at a senior management level whose main responsibility is the provision and quality of medical advice.

As there are no plans to enlarge on this paragraph by further

official guidance it is worthy of careful study. The first point to note is the explicit reference to the accountability of the chief professional officer to the authority and his right of access to it on the provision and quality of medical advice. The second equally important point is that there is no intention that the medical officer should be in a position to bypass the general manager on matters relating to his (the general manager's) responsibility. Quite the reverse.

It is clearly stated that on matters relating to the fulfilment of the general manager's responsibility the chief professional officer will be accountable to him for the day to day performance of his management functions (as indeed the chief medical officer is to the permanent secretary). I know the permanent secretary certainly sees it as part of his general responsibility for the Department to ensure that ministers have *directly available* to them the advice of their chief professional officers.

Challenge to community physicians

As ministers do in central government health authorities will be free to take their medical advice from many sources. There will be an appropriate medical advisory machinery at each level and at district level a representative of the consultant staff and of general practitioners also has right of access to the authority. However, the words of the paragraph "the professional chief officer will continue to be directly accountable on the provision and quality of medical advice" imply both an opportunity to health authorities and also a challenge to community physicians. This opportunity and challenge is that authorities should seek to have a medical officer capable with assistance from colleagues of commenting on quality (and I would add balance) of advice on health care policy as a whole including planning and evaluation of care. He or she should be able to speak out in terms of the needs of the district as a whole for health seen in perspective and, of course, for prevention. Such a message incidentally is not always popular with individual consultants. In the past it has been such advice from such officers that has been in large measure responsible for the establishment of a National Health Service with a balance of care of specialist services based on rational planning at regional level and in many if not all districts a reasonable balance of hospital community and preventive services in the districts. But as such a role, if it is to be executed in practice, requires professional credibility and the consent of colleagues, it cannot be secured by prescription from the centre if these prerequisites do not exist locally. However, if I may return to my own position, just as I would find it difficult to discharge my own duties if I were not a member of the Health Services Supervisory Board and NHS Management Board, so one would hope that authorities would see the importance from their point of view that their chief professional officer should be privy to the inner councils where the advice on health care policy is formulated. Responsibility for the "quality of medical advice" also implies that the chief professional officer should have an important role within his authority for the selection, training, career development, and promotion of community physicians, Mr Victor Paige, chairman of the NHS Management Board, associates himself with all these remarks.

There is one other aspect of the paragraph from the circular to which I must refer. The term "professional chief officer" implies some sort of hierarchical relationship with colleagues in the same field. I know of course that it is [the] Faculty [of Community Medicine's] policy that specialists in community medicine should be free standing consultants on the model of clinical consultants. Speaking personally, I have sometimes seen a contradiction between the role of a specialist in community medicine as a consultant in that sense and his contract as a full time officer. A difficulty might emerge in practical terms where an authority saw fit to appoint several specialists in community medicine but chose to avoid the title "district medical officer" (a title which incidentally is no longer compulsory). Would it

not be in the general interest if in such circumstances one community physician was nominated as *primus inter pares*? The influence of the specialty of community medicine within the district would surely be greater if accountability for the provision and quality of medical advice was through one officer and such an officer had access to the authority.

Balanced professional advice of prime importance

Some colleagues in community medicine have expressed disappointment to me about the number of community physicians who have been appointed to regional and district general manager posts. It is a small number, perhaps too small. I have no doubt that the community physicians who are employed in this capacity will make an outstanding contribution but I would be surprised if they ever furnish a majority of such posts. It seems to me that the more important point is that we should work together to ensure that in the future it is possible for *all* authorities to find community physicians as chief professional officers who are capable of giving balanced and dispassionate advice on health care policy on its planning and evaluation. My own opinion after my short period at the Department of Health and Social Security is that with increasing specialisation and sophistication of medical practice and increasing pressure on resources the need for such a view, and a view which at the same time ensures that prevention and health promotion in all its aspects are given sufficient emphasis, is likely to increase, not to diminish.

May I suggest, therefore, that within the specialty we should concentrate on and develop those skills which are based on and can be developed from a medical education. These include an understanding of the nature of health and illness and of its determinants, not forgetting its behavioural and social components, and special skills in measuring needs in planning and in evaluating health services. Above all of these I place the need in community medicine for a knowledge and understanding of epidemiology. As a tool in the solution of the day to day problems of my job (and this may also be true in yours), this helps me more than I would have dreamed possible.

Reference

- 1 Department of Health and Social Security. *Health services management. Implementation of the NHS management inquiry*. London: DHSS, 1984. (HC(84)13.)

THIRTY YEARS AGO

The Comptroller and Auditor General reports that in England and Wales prescriptions of proprietary preparations rose from 18% of all prescriptions in 1950 to 27% in 1953, representing 44% and 58% respectively of the total costs of ingredients prescribed in those years. In February, 1954, a sample analysis indicated that the proportion of proprietaries had increased to 29%. The monthly average cost of prescriptions, after some decrease towards the end of 1953 and early months of 1954, rose in August, 1954, to 4s. 3.73d., the highest figure recorded since the inception of the N.H.S.; in 1949 the average cost was 3s. 1d.; in 1947, under the more limited scope of the National Health Insurance scheme, it was 1s. 8d.

In reply to an inquiry whether any further steps were to be taken to reduce prescription costs, the Ministry informed the Auditor General that the main cause of the increase in average prescription costs, apart from the element of the remuneration of chemists and appliance contractors at present under inquiry, was the introduction of an increasing range of expensive preparations designed to treat conditions that in the past had not been, or not to the same extent, medically treated. (*British Medical Journal* 1955;i:46.)