such as pulmonary embolism it is necessary that at least some centres continue to have a high necropsy rate.

This work was supported by the Swedish Medical Research Council (grant number 00759).

1 Kaij K. Tromboembolifrekvensen i ett obduktionsmaterial. *Lakartidningen* 1959;56:1437-43.

2 Havig O. Deep vein thrombosis and pulmonary embolism. An autopsy study with multiple regression analysis of possible risk factors. *Acta Chir Scand* 1977;Suppl 478:1-92.

3 Rubinstein I, Murray D, Hoffstein V. Fatal pulmonary emboli in hospitalized patients. An autopsy study. *Arch Intern Med* 1988;148:1425-6.

4 Bergqvist D, Lindblad B. A 30-year survey of pulmonary embolism verified at autopsy: an analysis of 1274 surgical patients. *Br J Surg* 1985;72:105-8.

(Accepted 29 January 1991)

NHS Profile

William Waldegrave: thinking beyond the new NHS

Richard Smith

BMA NEWS REVIEW

"I can guarantee that community care is not going to slip any further—whatever the structures of local government."

RS: Doctors and managers in London are particularly depressed about the NHS changes. Mightn't the changes spell disaster for London because of the high costs and the highly complicated cross boundary flows?

ww: London seems to me to be an extreme case of how the present system doesn't work. We've got nearly a third of the beds in London closed and yet we have long waiting lists and difficult access to beds—in some parts at least. People are working under great strain and are unhappy—and I don't blame them for being so.

What the new system will do will force some decisions out of us cowardly politicians, who for 20 years have put them off. The new system will begin to bring things to a sharp crunch in a number of places. I'm not one of those who thinks that everybody knows what to do and it's just a matter of doing it. I don't know whether it's a matter of taking out one teaching hospital or whatever: I simply don't know that. What I do know is that after we have watched the flows of money becoming more explicit we will begin to get some much clearer indications about what to do.

I don't think that it is inevitable that the famous and relatively expensive hospitals will lose out. Americans will travel to famous hospitals: why shouldn't the British? What is clear is that it must be crazy to run all the hospitals in London below capacity so that none of them are working efficiently but are all semi-demoralised. It must be very depressing to work with large numbers of beds closed. In economic, morale, and organisational terms this is a poor state of affairs, and we can't let that drag on.

"...It must be very depressing to work with large numbers of beds closed. In economic, morale, and organisational terms this is a poor state of affairs, and we can't let that drag on."

The new system will bring it to a head, and whoever has to make those difficult decisions will be extremely unpopular for a time—and will be like the man who amalgamated the regiments of the British army. The equivalents of mad Mitch will be after him like nobody's business. But if he gets it right he will have helped the whole system in England.

RS: Your argument is that he or she will have the information necessary to make that decision?

ww: Yes. Firstly, he or she will be forced to take the decision, and, secondly, he or she will have much more information to make the right decision.

RS: How long is that going to take?

ww: I think that the next couple of years will bring this to a head.

RS: So it could be you having to take these decisions?

ww: I hope that it is. It would be wonderful to be involved in getting a rational health service in London.

RS: Are you confident that research and teaching are going to survive this onslaught?

ww: They must, that's a given. If things go wrong—which I don't think they will—then they will just have to be looked after. What I do say is, I don't think that it's right that the teaching tail should wag the whole dog. We should be able to organise teaching in terms of what we need for health provision for patients. The disposition of teaching facilities should not be allowed to distort the health provision.

Community care

RS: Let's talk a little about community care, which has been rather forgotten in all the fuss surrounding the new NHS. Shouldn't you move it forward again?

ww: My preference would be to move it forward, but I don't think that it's practical. It would get caught up in the reforms of local government, which are still ongoing. Equally, however, I think that I can guarantee that it's not going to slip any further—whatever the structures of local government. And the Prime Minister has reaffirmed this recently. We will put the leadership with the local authority side. My job is to make sure that from the health service side the web is seamless.

And there are some benefits to set against the delay: people will be better trained and will understand better what is expected of them. I actually find some of the most exciting papers on my desk those that are to do with greater integration of primary and secondary care and of community health with social services. There's real room for exciting developments there.

RS: So is that something you might make a priority for the future?

ww: Exactly.

Preventive care

RS: Preventive care is something else that seems to have been rather forgotten recently. Are you, for instance, doing enough about tobacco? Doctors who have been watching this for 30 years can't understand why you don't bump up the price dramatically or ban advertising.

ww: Price is the main thing, and that is a matter for the Chancellor. I've made it clear to him what we want, but

British Medical Journal,
London WC1H 9JR
Richard Smith, MB, executive
editor

BMJ 1991;302:711-4

when the retail price index is rising we tend to lose the argument. When it's falling—as it is now—then there's hope for some change.

I have in the back of my mind an increasing worry about what happens in 1992 with the single European market. We are going to have to fight very hard to make sure that there's not a reduction in tobacco tax—and it's ridiculous that the European Community is still subsidising the growing of tobacco.

“...I want to emphasise very strongly that the strategy we produce in the spring will be a genuinely consultative document.”

We have taken some robust decisions recently about labelling tobacco products—about the strength of the messages and the extension of their coverage. All I can say is that this department takes a determined stand on all tobacco issues.

RS: But what about advertising? Doesn't that lie within your remit? Couldn't you ban that if you wanted to?

ww: It's a big step to ban the advertising of a legal substance.

RS: But a step that many other countries have taken.

ww: That's true. It'll be interesting to see if the message that we've required—“Tobacco kills”—will be one that advertisers find attractive to put up on hoardings. We may see some diminution of advertising.

RS: What about alcohol? The evidence is that the harm it does is astronomical. Yet the argument about

bumping up the price of alcohol never seems to come through strongly.

ww: You're absolutely right that alcohol does a lot of damage—particularly among young men, where the chief medical officer's figures show all sorts of worrying trends. But it's a slightly different question from tobacco in that there's a safe level of alcohol but no safe level for tobacco. But, putting that small proviso aside, I agree that reasonable tax levels and controls over sales are necessary.

RS: But price again is the key. Have you put as strong arguments to the Chancellor over alcohol as over tobacco?

ww: I won't deny that cigarettes are my number one, but we made a pitch on alcohol as well.

Inequalities in health and targets

RS: You have spoken a little about inequalities in health, which is again something that concerns many doctors. WHO Europe's targets for health for all for the year 2000 begin with reducing inequalities by 25%, but at the moment we seem in Britain to be heading in the opposite direction.

ww: I'm not sure that we're going in the opposite direction. This is a difficult matter—quite apart from the debate over what inequalities are. My primary duty is to ensure that there is equality of health provision, and one of the benefits of the new NHS is that it is already throwing up areas where that question still needs addressing. But getting greater equality in health outcomes is much more difficult because it doesn't lie only—or even primarily—with health services.

We will be addressing these issues in the strategy document, which I hope to publish in the spring. The

Virtues of government organisations—the NHS?

RS: In your book you outline what should be the virtues of government organisations, and I'd like you to tell me whether you think the NHS reaches them now and whether it might in the future. Firstly, you say that they should “serve their clients at a speed and with a courtesy comparable with private enterprise organisations.”

ww: That could be one of the rubrics of the whole reform.

RS: “Should have waste controlling mechanisms that are effective and visible.”

ww: Agreed, and in so far as we are going to provide far better data about how much things cost and how to apply resources better the system should improve.

RS: And you don't think it's good enough at the moment?

ww: It's a strange mixture. People work incredibly hard and yet you can visibly see things being wasted in other places. The resource allocation system isn't swift enough.

RS: Then you say: “Pressures other than those of competition should be invented to maintain efficiency and to provide an equivalence of free enterprise's accountability to shareholders, workers, and the market.”

ww: Well, the internal market in inverted commas is trying to do just that. It isn't a market in the real sense.

RS: So it's not competition in the real sense?

ww: It's competition in the sense that there will be comparative information available. It's not a market in that people don't go bust and make profits and all that, but it's using market-like mechanisms to provide better information.

RS: So it fits with “pressures other than those of competition?”

ww: There will be competition.

RS: What are the other pressures?

ww: Peer group competition: “Why's that fellow able to produce his health care for much less than me?” The first reaction is that the manager's not doing his job properly, or perhaps it's something else.

RS: So are you arguing that the pressure will come from the new information?

ww: Yes.

RS: Finally you say, “Highly developed procedures for ensuring that they do not use the terrible power against the individual in ways against which he cannot easily and effectively appeal if he thinks himself the victim of abuse of power.”

ww: We must remember that we are part of the state, and the state has tremendous power. Ultimately the real strength of markets is that the customer is king and can walk out and say, “I'm never going to set foot in Tesco's again.” You can't not set foot in the health service again, and that is why we have always to bend over backwards to be even more responsive.

strategy will fit within the framework of the WHO health targets. We will be trying to produce—rather as the Australians and Finns have done—a set of health targets for this country that parallel the WHO targets.

RS: These then will extend beyond the remit of the health department.

ww: Yes, they will have contributions from other departments. They must. I think that the way to deal with inequalities may be to try and identify the vulnerable groups—most of them with their vulnerabilities arising from poverty—and then identify mechanisms for reaching them.

RS: Your strategy will set targets generally?

ww: The strategy will set quantitative targets and priorities for the health service—and for some other parts of government that affect health. It won't be a matter of simply predicting what is going to happen and saying that's a target.

I want to emphasise very strongly that the strategy we produce in the spring will be a genuinely consultative document. We will have a shot at targets, priorities, and strategies, but we want health professionals to contribute to a debate about whether they are reasonable—and we will be willing to change them.

At this point every lobby in the country will descend on my head, so I will need the help of serious senior health professionals to maintain some discipline. If priority setting is going to mean anything we can't include everything.

RS: So these will be priorities for health rather than health care. Will they thus say something like, "We will reduce deaths from heart disease by 10%"?

ww: They will be priorities for health, but there will also be specific targets for the NHS as well. This is the time to re-examine the mission of the health service. But there will be targets for health running across departments.

RS: So if we are talking about heart disease there will be strategies on smoking and diet and the like?

ww: Yes.

Rationing?

RS: Do you think that there is an unbridgeable gap between what can be done clinically and what can be afforded?

ww: I don't think that there's an unbridgeable gap between what should be done and what can be afforded. But there will always be unaffordable procedures. There will always be tension on resources. But I think that we can get closer towards a consensus that we are doing what should be reasonably done.

RS: Do you think that politicians should be more up front that not everything can be afforded?

ww: I do, and I think that it will be utterly necessary under the new system—because one of the things that will be thrown up will be a much more explicit demonstration of what we are and are not buying. That will cause those decisions to have to be justified—not only by politicians but also by the clinicians. The system will become more open and explicit, and therefore more argumentative. I think that must be a good thing, although it will take a little getting used to.

RS: Do you think that we might start a bottom up system like the one they have had in Oregon and have town hall meetings deciding on what the criteria are for what can and cannot be afforded?

ww: I think that the health districts should do that kind of thing in the way that the WHO city programmes have. But I think that ultimately this is a matter where scientists have to carry weight, because it

doesn't make any difference if the village votes that the earth is flat—it remains round. It is right to consult and to take people's priorities into account, but it is also right for us to say that we must back those who really do understand the subject and that sometimes they will want to do things which will not be popular in the short term.

RS: The way that the Oregon system works is that the public produces guidelines on, say, how much to match quality against quantity of life—and the clinicians then combine those general criteria with more exact data.

ww: Good public consultation can help to get consensus around some of those issues. But with the difficult ones—like heart-lung transplants—the public might say, "Stop all that and do more hip replacements." But that might not be the right decision because, although heart-lung transplantation might not yet be producing the success we hope for, it might do soon.

RS: It was of course that issue that started the debate in Oregon because some people did say that they wanted to get rid of heart transplants.

ww: I wouldn't want to cross out all of that, but I wouldn't want it all to be done by populist voting. But I'd want the public debate to be more open.

The future

RS: What about the future? You must at the moment be contributing to the Conservative manifesto on health. What kind of new ideas might there be?

"...[The NHS is] the biggest employer of women in the country, and I'm not sure that we are giving enough attention to women's issues."

ww: What there won't be is a lot of new ideas on organisational structure. What I want to talk about now is three things. Firstly, we must shift the debate on to health outcomes. Secondly, we should give more emphasis to how we as an NHS employer operate—for instance, we are the biggest employer of women in the country, and I'm not sure that we are giving enough attention to women's issues. And we have the problem of employing many low paid people. We need to be a better, more thoughtful, and more communicative employer and get a greater sense of corporate loyalty—not loyalty to me but to the service. You'll have to wait for the nuggets of the third issue.

RS: One group in your party would like much more insurance based health care. Will you be encouraging that?

ww: That's not on.

RS: I hear talk that there may be a health directorate set up in the European Commission. Is that going to have a big impact on the future of health in Britain?

ww: There are beginning to be some interesting issues in Europe now. We are very interested in raising the quality of the professional health advice that the commission gets. They are beginning to push for the extension of their competence into a number of health areas. We are suspicious about that in our usual way. We want to see that there's a real case for it, but if there is we want to see that the quality of their health advice is really good. I think that it may be right eventually to

UPPA

"There will always be unaffordable procedures."

"The system will become more open and explicit, and therefore more argumentative. I think that must be a good thing."

UPPA

have a health directorate. That may be sensible. And there are certainly areas in Europe where we should be cooperating on public health issues.

Personal

RS: A couple of personal questions. Do you enjoy the health brief?

ww: Yes. The subject is fascinating, and one cannot doubt that what one is doing is an important job. But it's a strange and vulnerable job for a politician because you are presiding over an enormous management structure. And, as Aneurin Bevan said, when a bed pan is dropped somewhere in the health service the minister of health ought to hear about it—and that was one of the things he did arrange for. So you are bombarded with individual cases, which are useful in that they give you a picture of what is going on. But the semi-

managerial role makes it unlike a normal political job.

RS: Is health something you've been interested in for a long time?

ww: I have some great health institutions in my constituency—like the Bristol Royal Infirmary—but I've never really been directly involved in health before.

RS: Do you and your family use the health service?

ww: Certainly—my mother is in a health service hospital at the moment, having broken her hip.

RS: Finally, do you think that you are going to win the next election?

ww: Of course.

RS: Would you like to be Secretary of State for Health again?

ww: I'd certainly like to stay here and see this through.

The New NHS

East Birmingham: "the great bureaucratic square dance" begins

Tony Delamothe

Expectations are not high in East Birmingham that the NHS changes will bring improved health and medical care. The district contains some of Britain's poorest people. Deprivation is rife, unemployment is three times the national average in some wards, and in one ward nearly a third of the heads of household were born overseas, mostly in Pakistan. Poor health parallels poor social conditions, and in the mid-1980s East Birmingham had the highest perinatal mortality rate among Asians in Britain.¹

East Birmingham has 58 general practices, half of them singlehanded. Many general practitioners work from poor premises, with no practice nurses or computers. A survey of general practitioners recently initiated by the district elicited a response rate of 5%. Dr Anne McConville, East Birmingham's director of public health, speaks of general practitioners' "de-motivation."

Purchasers

In 1991-2 none of East Birmingham's general practitioners will be fundholders. The district health authority's purchasing team will negotiate contracts with providers on their behalf, reflecting patient flows in 1989-90. General practitioners will be free to reproduce this pattern of referral but not to deviate from it. For example, if a general practitioner wants to send a patient to an entirely "new" consultant or to send a fifth patient to a consultant who saw only four of his or her patients in 1989-90 then the answer from the district will be a polite but firm "no," says Mrs Wai-Yin Hatton, director of corporate management. She defends her actions as follows. The district purchasing team is already holding back about 2% of its budget for extracontractual referrals. If it held back more then less money would be available for contracts with providers. If providers are guaranteed less income then Mrs Hatton would expect providers to increase their prices to compensate, meaning that her money would buy less.

Mr Alan Torbet, general manager of the Birmingham Family Health Services Authority, agrees that demands for extracontractual referrals "will test the system mightily." If purchasers decide to keep money up their sleeves the providers will be able to count only

on the proportion that has been allocated to them. By the end of the year the purchaser may have a pile of unspent money, the community a backlog of unmet needs, and the provider such trimmed down facilities that there is no way of doing anything about it.

After the year of "steady state," district health authorities will be freer to negotiate contracts where they like. How much will change in 1992-3? East Birmingham's purchasers say that they have no plans for greatly changing referral patterns. "We would need very good reasons to do so," says Mrs Hatton. Price is unlikely to be one of them—in any case "soon you won't get prices differing much between providers." Quality could be, but Mrs Hatton doubts whether they will be arguing with general practitioners about where to refer patients: "They know the clinical needs of their patients; managers don't. And one day I'm going to be on a waiting list myself."

Reducing the number of providers that a purchaser has to deal with looks attractive, but once again the status quo seems likely to prevail for at least the next few years. Having the quality specifications from many different providers to hand, however, allows the purchaser to dangle some of the better specifications in front of its more backward providers—a potent stimulus "for bringing the standards of the rest up to the standards of the best."

Mrs Hatton cuts a convincing figure as the honest broker, purchasing in the general practitioner's name. "We don't know what the public wants: it's up to general practitioners to tell us," she said. To make that easier a liaison general practitioner may be appointed to the purchasing board of the health authority. If general practitioners suggested drawing up a list of consultants to whom referrals should be honoured without question then she would be prepared to consider it. "We should be searching for whatever is going to work," she said.

The fundholding practice

Although none of the 306 general practices becoming fundholders next month are in East Birmingham, several will be buying services from East Birmingham providers. Unlike health authority purchasers, who are constrained to negotiate contracts reflecting 1989-90

British Medical Journal,
London WC1H 9JR
Tony Delamothe, MD, senior
assistant editor

BMJ 1991;302:714-8