A NEW PATH ENTIRELY

How NHS Wales could lead the world

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Based on a paper presented to a Bevan Commission seminar Cardiff, January 19 2012

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In February 1948, Nye Bevan announced in parliament the forthcoming birth of the National Health Service on 5 July. More than 80% of UK family doctors had voted against work in the new service. Most newspapers claimed it would be impossible to start on time, or if it did, that it would quickly collapse, because at zero price, demand would be infinite. He said:

> "I think it is a sad reflection that this great Act... should have so stormy a birth. I should have thought, and we all hoped, that the possibilities contained in this Act would have excited the medical profession, that they would have realised that *we are setting their feet on a new path entirely*, that we ought to take pride in the fact that, despite our financial and economic anxieties, we are still able to do the most civilised thing in the world..." (*my emphasis*)[1]

Bevan believed that once doctors and patients entered this new path, they would soon learn that healthcare can be far more effective and efficient as a social gift than as a commodity. Indeed they learned. By the end of 1948, over 90% of GPs were working in the NHS. 64 years later, 98% of GPs in their Royal College voted for withdrawal of the Conservative-Liberal Democrat coalition government's Health and Social Services bill, a law that does its best to return healthcare in England to commodity status. [2]

Four Compromises To Gain A Principle

Welsh Government Health Minister Edwina Hart appointed the first Bevan Commission in 2008. "Many things change", she said, "but principles do not. I want the NHS to remain loyal to the principles established by Nye Bevan. I want you to advise me how to achieve this within the reformed NHS."[3]

Nye Bevan seldom let principles get in the way of a better life, either for his fellow citizens or for himself. To make real progress, principles must be ranked for priority within a larger strategy. Bevan always had such a strategy – to end trade in healthcare as a profitable commodity, and develop an organised gift economy, paid for by everyone according to their wealth, and given to everyone according to their need. Sickness was a matter of chance, so in a just society, costs of care should be borne by everyone, sick or well.

Bevan faced three main opponents: the hostile organised medical profession of 1948, Conservative and parochial interests in local government as it then was, and the timidity of his cabinet colleagues. To sustain progress, Bevan made four major concessions:

1. A right of consultant specialists to conduct private practice within NHS hospitals, as well to continue trading outside them, if they chose to work part-time rather than full-time for the NHS.
2. A right of general practitioners (GPs) to operate as independent contractors to the NHS - private operators of public service.
3. As a concession to a large majority in his own Party, he left Public Health functions with Local Government. This separated preventive from treatment services, which progress in medical science had been bringing together..
4. A tacit right of both medical professionals and NHS administrators to operate as judges of their own conduct within extremely broad limits, with little control from any elected body, local or national.

In exchange for these concessions, he gained three steps toward his greater principle, the NHS as a socialising service. This could begin to rebuild human relationships within an otherwise dehumanising economy, and provide a space outside capitalism within which both staff and users could learn to think and work differently.

These three steps were:

1. Nationalisation of virtually all hospitals throughout the UK, so that a ragbag array of facilities ranging from voluntary teaching hospitals, through municipal hospitals and workhouses, to the smallest miners' and rural cottage hospitals, were all brought into nationally and regionally planned public ownership.
2. Central control of geographical redistribution of both hospital specialists and GPs, from a pattern of grossly unequal market demand to a pattern of equal staff per head of population.
3. Development of a cash-free economy throughout a public service funded from progressive taxation, and delivered as a human right according to need, not ability to pay.

Bevan believed his four compromises could be rectified later, when progressive forces were stronger.[4] They never were. Even by 1948, the tide of anger expressed by Labour's landslide victory in 1945 was receding. The socialising function of the NHS survived, but his four compromises remained. They eventually provided entry points for so-called "reforms" of the NHS, back to the marketplace.

Reformed NHS?

Edwina asked the first Bevan Commission to advise her how to retain Bevan's principles "within the reformed NHS." What did she mean?

None of the reforms imposed on the NHS since 1948 ever tried to move significantly toward local control of the NHS by the communities it serves. We have in many ways moved toward a happier, kinder, less fearful, and more imaginative culture within the NHS. This has depended not on reforms or reorganisations, but on developments within medical, nursing and social professionalism, on the sciences on which these are based, on a huge rise in demand for information and intelligent participation by user groups, and on a general shift towards a more tolerant and compassionate society, despite the dehumanising effects of industrialisation and consumerism in the global market economy. Except for the GP reforms of 1966, and the fainthearted and largely formal merger of Public Health with clinical functions in 1974, the only consistent theme of all NHS reforms, pursued by all governments since Margaret Thatcher's first administration, has been stepwise return of the NHS back toward business, away from Bevan's alternative economy and culture of social solidarity. Solidarity was the foundation for community health care as a public service, and the political foundation for the NHS Act of 1946. Apart from the two exceptions mentioned above, all "reforms" imposed on the NHS since 1948 have been retreats from solidarity, towards its opposite – consumerism, the philosophy of every man for himself.

The phrase "within the reformed NHS" could be interpreted to mean "within this ignominious retreat from solidarity". In that case the Bevan Commission would be a nonsense. Or it could be one of those minor compromises judged necessary for politicians to advance a more important principle.

Devolved Dissent

Since control of the NHS was devolved to Wales, Scotland, and Northern Ireland in 1999, their administrations have committed to elimination of the purchaser-provider split. This was the legal and economic foundation for NHS "reform" from public service to a state-subsidised business, initiated by Margaret Thatcher in 1983.

Her project was reinforced by New Labour governments after Blair's first year in office, despite an explicit promise in its 1997 manifesto to "restore the NHS as a public service working cooperatively for patients not a commercial business driven by competition."[5] The present coalition government's Health and Social Care Bill has taken New Labour "reforms" to their logical conclusion by ending central government responsibility for providing care, nominally handing power to GPs (98% of whom say they don't want it), in fact offering it to "any willing provider" – in

practice, to corporate healthcare business. Labour's shadow minister Andy Burnham has done his best to oppose the Lansley Bill within the constraints of shadow cabinet policy, but he evades any explicit commitment to its eventual repeal, or to renunciation of New Labour's commercialising policies when it was in power.[6]

The Labour Party in Wales, and all four Welsh Ministers for Health, have stuck to their guns, and silently refused to follow New Labour "reform" policies at Westminster. Open conflict has been avoided by both sides. That has minimised bloodshed, but also prevented serious public discussion and understanding.

This loyalty to public service does not depend only on principles, but also on common sense, a rare quality in recent politics. Marketed healthcare is a road to social and economic ruin, easily visible in USA. We simply cannot afford the extravagance and inefficiency of the unplanned and unplannable provision of care, promoted as a commodity for consumers, legally ensured by passage of the UK government's current Health and Social Care Bill.[7]

Wales, Scotland and Northern Ireland have more in common than their Celtic origins. Together with the north of England, they were the prime sites of imperial Britain's once mighty manufacturing economy. They provided much of her armies. Now discarded, they generated the wealth piled up in the City of London, its commuter suburbs, and its gentrified countryside, now squandered by speculation. All three are now an economic and political liability to finance capital, indifferent to all but itself. For the derelict periphery to recover, all three must lay foundations for new economies, new social agencies to support them, and new relationships between these social agencies and other industries (the economic potential of Wales NHS lies beyond the scope of this paper, but is hugely important but so far neglected subject).

Bevan envisaged a future society fundamentally different from that in which he grew up, a difference far beyond filling stomachs with burgers or minds with vicarious thrills. He had a vision of advancing, intelligently critical solidarity, shared by a large majority of Welsh people. Such expectations made the 1945 Labour landslide, and laid foundations for the NHS.[8] People had learned from their own experience, the lessons of their own history. Faced by the social and economic realities of today, we shall have to do the same, but probably in even worse circumstances. Britain is no longer an island of coal in a sea of fish. This sets an urgent agenda for the second Bevan Commission, far beyond bland platitudes.

The Glyncorrwg Project 1961-1992

I was invited to speak to this Commission because of innovative work done in the South Wales valleys in the last years of the mining industry.

Experience in Professor Archie Cochrane's Medical Research Council (MRC) Epidemiology Research Unit in 1960-61 convinced me that his approach to observational research in whole populations could usefully be applied to their primary care. Care might then be organised to pursue objectives broadly defined by Public Health, using methods based on scientific evidence. Care might thus gain both in effectiveness and efficiency, even in the worst circumstances of that time.

Cochrane's great talent was to understand the importance of including entire populations in his research. He set new international standards for response rates, and for the quality of his data.[9] He was among the first to recognise that what happened in small numbers of volunteers or among patients referred to specialists was never representative of the population as a whole, even for subsets with specific health problems. Fully to understand disease, the people doctors didn't see were as important as those they did see. He studied whole communities not in laboratories or hospital wards, but where they lived and worked. He was prepared to meet them on their own terms, in workmen's clubs, in chapels, wherever large audiences could be brought together. He welcomed active co-operation from the National Union of Mineworkers, without whom none of his original projects would have been possible.

Disillusioned by experience of the clinical medicine of his times, Cochrane had little interest in the work of clinicians, other than to subject their work to ruthless criticism, which it seldom survived. He was therefore more popular among the chairborne than those who worked with their hands, at least in his lifetime.

I was and remained a clinician in primary care, where it is easier to recognise that the evidence patients can contribute to rational care is fundamental to positive outcomes from clinical interventions. This lay largely outside Cochrane's remit, so I left epidemiology to see what might be done as a clinician oriented toward public health, working in a small team serving an accurately defined population, and measuring not only what we did, but also what had yet to be done. My wife and I applied the rules of investigative science to the routine practice of medicine, in the most difficult conditions existing at that time. This, we hoped, would ensure that our work would be relevant to others working where needs were largest and resources were smallest.

When we began to organise seriously for this in 1968, age-standardised mortality from all causes was 34% higher in the Upper Afan Valley (Glyncorrwg Urban District; GUDC) than the average for England and Wales. Relative to the country as a whole, public health indices were in decline. Infant mortality in GUDC showed the same pattern: a continued absolute fall, from 78 per 1000 live births in 1921-5 to 37 in

1966-8, but a relative rise, from 102% of the England and Wales average in 1921-5 to 205% in 1966-8.[10] Rising inequality in mortality was associated with rising inequality in incomes, living conditions, and access to effective medical care. Consultation rates in coal-mining and ex-coal-mining areas were high,[11] generally allowing consultation times averaging five minutes or less. Consultation time is the main determinant of quality in care.[12] As in any poor population, much even of this was taken up by administrative rather than clinical tasks, such as certification for benefits.[13] GPs in industrial areas worked hard for long hours and often broken sleep, but on any reckoning, their output of health gain was pitifully small. It was a demoralising situation, and many were demoralised.

Helped by my wife, who was a research assistant in Cochrane's research unit, and a growing number of nurses, office workers, trainee GPs and eventually MRC research registrars, we developed systems for what we called *anticipatory care* applied to our whole population. Starting with control of blood pressure and smoking, we sought systematically to find all the people who could benefit from early treatment of ill health of many kinds. We tried systematically to find needs, not just respond to wants. We found that for most causes of serious ill-health, roughly twice as many people were in need of care, as had actually received it. We also found that if we looked critically at the evidence, a smaller number had care which was ineffective or unnecessary.

After I retired from clinical work in 1987, Public Health staff in West Glamorgan reviewed standardised mortality and Townsend indices of social deprivation in all 55 electoral wards in the County of West Glamorgan for 1981-1983.[14] Unexpectedly, mean standardised mortality rates under 65 in Glyncorrwg ranked fourth from the best rates in this distribution. The other two wards of the Upper Afan valley, Blaengwynfi and Cymmer, ranked 36th and 32nd respectively. The Inverse Care Law states that wherever marketing cultures prevail, those most in need of good care are least likely to receive it.[15] In Glyncorrwg this seemed to be vanishing.

This encouraged us to compare standardised mortality over a longer 5-year period (1981-6) in Glyncorrwg after 20 years of planned anticipatory care, and in Blaengwynfi, where care still followed a traditional demand-led pattern. SMR was 28% lower in Glyncorrwg than in Blaengwynfi for deaths under 65, and 30% lower for deaths at all ages.[16]

If It Worked, Why?

This analysis depended on just 69 deaths under 65, though more numerous deaths at all ages confirmed an even larger difference. Much of this 28% difference might plausibly be attributed to chance, but probably not all of it.

The largest differences in disease-specific causes of death were reductions in infant mortality, respiratory disease, circulatory disease and "other causes" in Glyncorrwg, with a consequently higher proportion of deaths attributed to cancer and external causes. This was what one would expect from effective interventions of the sort we used.[17]

What else might account for our apparent success? Our first and simplest target was control of high blood pressure, the main treatable cause of stroke and vascular dementia. These were (and still are) among the most frequent, most feared causes of disability in adults. They incur high costs for both NHS and social services. High blood pressure was also a major cause of kidney and heart failure. Using thresholds for intervention validated by the US Veterans Administration studies (far less radical than those accepted today) applied to our entire local population,[18] we virtually eliminated severe uncontrolled high blood pressure within five years, despite exceptionally high local prevalence, especially among men under 40.[19]

So far as possible, while maintaining continuing detection and follow-up of high blood pressure, we applied similar methods to detection and follow-up of smoking, obesity, diabetes, wheezing in childhood, asthma and chronic obstructive lung disease in adults, and urinary tract infections in childhood. We did our best to find all the treatable ill health in our population, treat it, keep it in treatment, and monitor and measure over remaining lifetimes. This was a cumulative workload. It took at least five years to stop rising, and level off as newly diagnosed problems were balanced by deaths. As all cases were lifelong problems for containment, we had no cures. Fortunately much of this follow-up work could be done by nursing rather than medical staff, though doctors had always to be immediately available when target levels for control were not achieved, or patients presented problems outside the competence of non-medical staff. Altogether about 20% of hypertensive and diabetic patients needed medical consultations for these reasons at any one session, usually complex interactive problems.

To the extent that any of the mortality differences between Glyncorrwg and Blaengwynfi may be attributable to our proactive systems for diagnosis and follow-up, they probably derive from the Rule of Halves: the empirical finding that for almost all chronic health impairments, roughly half those affected were generally undetected, half those detected were untreated, and half those treated were not controlled (as rules of thumb).[20] In the main, we found and treated ill health more completely, with more proactive follow-up, more systematic recall, and readier recognition of the huge role of denial and other complex social reasons for drop-out

from care, especially during the first two or three years after diagnosis. Patients need time and support to become active participants in their own care.

The Rule of Halves is widely dismissed as obsolete. It is assumed that the NHS Quality and Outcomes Framework (QOF) now ensures that every practice continually searches for disease indicators, simply to tick enough boxes to stay in business. Yet again and again, when strict audits of outcome (not process) are fully applied to whole populations, omissions of similar size are found. Doubtless if data recording is rewarded, data will be recorded, but unless it is used with imagination and all the personal circumstances in which interventions must be applied are considered, and unless teams integrate rather than fragment their various specialised tasks, problems either remain unsolved, or soon revert to their initial state as patients drop out of programmes they can't understand. Very high response rates, very low drop-out rates, and excellent health outcomes can be attained and maintained, even in generally deprived populations with around 30% annual population turnover, but these depend on high clinical and social motivation and staff morale, personal responsibilities for patient care, continuity, and shared discussion of complex problems involving all team staff.[21] [22] Consequent workload becomes even greater as chronic problems like high blood pressure or type-2 diabetes are redefined to include ever higher proportions of people, without regard to feasibility or to the influence of pharmaceutical lobbyists.[23]

Once they are fully ascertained, most problems in people at or beyond middle age prove to be complex, especially in low income populations.[24] US data from 1990 suggested that about 45% of adults outside institutional care had one or more chronic health problems, accounting for 75% of healthcare spending.[25] This is the main clinical area in which a general shift of management from hospital-based specialists to primary care generalists is both possible and urgently necessary. Wherever needs are sought assiduously for a whole population, numbers found have always been too large for hospital-based specialists to manage alone. Evidence from USA suggests that continuing management of chronic disorders may be less effective[26] and often technically inferior (even for major illness[27]) when performed by specialists rather than by generalists, probably because generalists cope better with the multiple problems which most older patients actually have. [28] [29] Most problems need shared care: continuing care by a personal doctor or nurse practitioner, plus advice when required by a consulting specialist. Consultants need to be defined by what they do, not by what they earn. One of their most important functions should be to advise workers in primary care. They rarely need to take over care for indefinite follow-up. In my experience, imaginatively shared care is still a rarity in practice.

Learning From Our Own Audits, Omissions, Errors & Research

Our frequent audits were designed to measure our omissions at least as much as our achievements.[30] This essential task is impossible without listed populations at risk, traditional in UK working class practice since the 19th century, though their use for planned care is recent. This is now threatened in NHS England by elimination of practice boundaries and promotion of limitless consumer choice across communities.[31] People not seen or helped by anyone are always among those with greatest and most treatable needs.

We accepted that in dealing with complex human problems, demanding so many urgent decisions with uncertain or incomplete information, mistakes were inevitable. Our community understood this, and so did our staff. So it was possible for us to analyse 500 consecutive deaths in the Glyncorrwg practice, look for avoidable causes, and consider how they might have been prevented.[32] It has been said that death audits in small populations cannot provide significant data.[33] Small populations, and small numbers of events, need cautious interpretation and may otherwise lead to false conclusions. However, even for small units serving small populations, local research for local use is essential for team development. We know critical incident analysis is useful.[34] What incident could be more critical than death? We audited every aspect of our work, and every first time, we were astonished by the results: not that they were so good, but that they fell so far short of what we had thought we were already doing. Good results first time are always suspect.

This requires a general NHS management framework that encourages open discussion of problems, and rewards honesty rather than conformity. We were able to act with imagination because, so far as we could see, nobody in authority really cared what we did, as long as we didn't cause them trouble. In those days primary care was grossly under-managed. We need management, but from managers with real experience of the territory, pursuing aims that are shared and understood by all who either give care or receive it, and always with full regard to the resource implications of new tasks.

Our Costs

Contrary to the common assumptions of advocates for commercialising reforms, we were exceptionally concerned about possible added costs incurred by our proactive policies, and did all we could to measure them. As ours was a dispensing practice, and nearly all our referrals were to two local hospitals, we had exceptional access to data.

The most obvious possibility was that if more illness was diagnosed and treated, treatment costs would rise. In fact, when we looked at practice data in 1972 for cardiovascular medications (mainly antihypertensives) their percentage share of our prescribing costs was more than five times *less* than the Wales average, and our overall prescribing costs per patient were 20% *less* than the Wales average. On the whole, it seemed that the more we knew about our patients, the more cautious we became in prescribing interventions of any kind other than information and advice, and the more conscious we and our patients became of potential harms from treatment.

Participation in the 1971 National Morbidity survey made it possible for us to compare some of our Glyncorrwg activity rates with other participant practices. These were all volunteers, so high workload practices in industrial areas were (as always) grossly under-represented.

Table 1. Unpublished data from RCGP National Morbidity Survey 1971-2 comparing Glyncorrwg annual consultation, referral and death rates with all 44 participating UK practices and UK mean.

rates per 1,000 population	Ratios Glyncorrwg/UK rates	
Consultations (all ages)	4,844	1.50
Consultations per episode of illness	1.5	1.00
Hospital admissions	332	1.76
Out-patient referrals	948	1.07
X-ray & lab. investigations	1,908	1.75
Deaths	138	4.05

Considering our fourfold higher death rate in Glyncorrwg, our 76% higher hospital admission rate seemed not unexpected, though I suspect our deaths were more completely recorded. The similarly higher investigation rates, together with relatively low out-patient referrals compared with admissions, suggest that we were dealing in primary care with much work transferred to hospitals elsewhere.

Larger Staff And Multifunctional Primary Care

The huge volume of added work entailed by proactive care and continuing follow-up was to some extent balanced by fewer crises, and more rational demands from an increasingly educated population, mostly learning from their own experience of care. Even so, we had to work much harder and longer hours than most of our colleagues, who accepted responsibility only for their patients' wants and demands, not for seeking their needs. For the first 14 years almost all of this fell on me and my family. The 1966 GP charter helped by meeting 70% of the costs of employing two half-time office staff and two half-time nurses. Our heads only got above water in 1974, when the MRC agreed to fund a medical research assistant at registrar level, to help both with research in the practice and with patient care, to employ Mary as a research

manager, and a variable number of nursing and office staff depending on the size of projects undertaken, in collaboration with our parent unit, the MRC Epidemiology and medical care research unit at Northwick Park hospital, directed by Dr Tom Meade. Two years later we gained a little more staff time by taking on the first of many subsequent trainee registrar GPs. Finally, our practice took responsibility for teaching a continual stream of undergraduate students, mostly from London teaching hospitals (we had little interest from Cardiff). None of this undergraduate teaching had more than token funding in those days.

By the late 1970s we had developed five integrated functions for our unit:

1. Demand-led clinical care.
2. Proactive clinical care.
3. Research (for internal use and for external publication).
4. Learning and teaching (for staff, patients, postgraduate and undergraduate students).
5. Local, national and international leadership.

Because all these five functions were integrated, and because learning requires practical responsibility and experience, some of the additional staff time funded for research and teaching was available for patient care. Because the whole unit had shared aims and moral support from the community it served, staff morale was exceptionally high, staff enjoyed their work and accepted responsibility for doing it imaginatively and with personal commitment. They consequently worked more efficiently.

To regard all this as only a matter of attitude, commitment and morality is wrong and counterproductive. Sustained progress cannot depend on exceptional behaviour by exceptional people. The sort of heroism we need is not exceptional behaviour occasionally leading to honours, but the sustained collective heroism of people who know what they want to do and where they want to go, and are resourced appropriately to get there by the people they serve. The source of these resources is taxation, the price we pay for civilisation. People who regard income tax as theft from what they alone have produced need to understand that they alone seldom produce anything. They have worked (or owned) within the mutually supportive society which is a precondition for fully developed production.

No further studies have been done with the Glyncorrwg population since 1992. High staffing and equipment costs had reduced my net practice income to about half the UK mean. My successors soon discarded policies entailing ever more work for ever lower net income. Missionaries may capitulate later than mercenaries, but without proper resourcing, both converge toward a single destination, impoverished and soul-destroying work for impoverished and soul-destroyed people.

Professional Development In A Free Service

A main reason for Bevan's readiness to compromise with the organised medical profession in 1948 was his confidence that once they experienced caring led by their patients' needs rather than by search for fees, most would find their lives more rewarding in all dimensions; not just their wallets, but their hearts and minds. This confidence proved justified. Initial development of British general practice as an innovative and dynamic area for clinical medicine, research and teaching was led entirely by NHS GPs in association with a then imaginative and supportive central administration, setting global standards for this rapidly developing new field for effective innovation. Without Bevan's NHS and Kenneth Robinson's 1966 GP Charter, which resourced postgraduate education of generalists, assistance from non-medical staff, and buildings suited to purpose, the Royal College of General Practitioners would neither have been born, nor led the world in initial development of primary care generalism.[35] With experience, organised professional attitudes to the NHS have exactly reversed. The British Medical Association (BMA), which did its best in 1948 to obstruct the birth of the NHS, is now doing almost as much to resist its return to business in 2012.

Most UK doctors have learned from experience to value Bevan's liberation of clinical medicine from the marketplace. A minority (smaller in Wales than in England) still sees new opportunities in market competition, but few of these will be able to compete with the power of transnational corporations now leading the field. Even before Lansley's Health and Social Bill has passed into law, Conservative spokesmen propose to raise the proportion of funding for Foundation Hospitals raised from service to private patients from its current level around 2% to 49%.[36] Reversion to business orientation in English general practice has already led to a huge rise in numbers of medical assistants salaried to do whatever established GP principals don't want to do themselves, with no voice in practice policy or stake in development. In 2004, UK GP principals were given a new contract, relating their earnings to process output. This encouraged them to employ doctors rather than take them as partners. Between 2003 and 2006, average GP principal pay rose by 58% (from £73,000 to £114,000). Over the same period, they raised average pay for their salaried assistants by 3%.[37]

Both for young specialists and young generalists seeking employment in the NHS as a public service rather than a business, Wales could become an increasingly attractive area for innovative work, but this will depend on confidence that Wales NHS will continue to move in a new direction. A shift into primary care of work formerly done in or at hospitals is both possible and necessary, but GPs have yet to be convinced that such a shift will be fully funded and resourced. If it is not, the potential flow of professional refugees from the wreck of NHS England will never occur.

Should We Start Winding Down Nye Bevan's Four Compromises?

Bevan compromised on four major issues:

1. Continued private practice by consultant specialists.
2. Continued status of GPs as private operators of public service.
3. Isolation and subordination of some functions (mainly Public Health) from the otherwise comprehensive NHS.
4. Absence of democratic local accountability at all levels of the NHS.

For the NHS to survive in Wales as a public service, immediate steps should be considered to withdraw all four. They obstruct development and delivery of rational, sustainable and affordable care at a time when scientific knowledge is expanding and UK state funding is shrinking. They are brakes on intelligent and informed participation by Welsh people in their own public services, and they limit staff imaginations.

Take his **first compromise, consultant private practice**. It has always entailed conflicts of interest. People in Wales see specialists privately because there is a long queue to see the same specialists at an NHS hospital. In my day patients could wait 18 months or more just to see a surgeon, and then usually several months more for their operation. Non-urgent referrals to a neurologist could wait 3 years.[38] In both cases, they could be seen privately by the same part-time NHS consultant in a private facility within a week. Soon after they would be admitted to an NHS hospital, the consultant having somehow recognised the exceptional urgency of their case. This could plausibly be called bribery. Despite all target-setting, tighter management and cash penalties, waiting list problems are still concentrated in surgical specialties where part-time consultants control rates of flow (eyes, hearts, hips, and ears),[39] unless government steps in at huge expense to buy in competition from corporate private providers (often the same part-time consultants or their colleagues), as the NHS did in England during New Labour "reforms"..

It's hard to get precise information on private practice earnings. Few who know are willing to talk on the record, and independent providers are well organised to conceal and confuse. A first step could be to restore the originally large difference between NHS salaries for part-time and whole-time NHS consultant specialists. We should be aiming at eventual whole-time service (including teaching and research) throughout the NHS workforce. In this way all consultant specialists could work on the same footing, their work integrated with other specialists and with primary care to make decisions more relevant to the complex problems most people actually have.

His **second compromise was to leave GPs alone,** simply extending Lloyd George's 1911 Act to the whole population, except that through the UK Medical Practices Committee (abolished by the Blair administration) GPs were redistributed

toward proportionality to local population numbers. This was almost fully achieved by the 1970s, but then slowly reverted towards a pattern reflecting potential GP earnings from all sources, rather than population needs, largely because GP training developed disproportionately in practices with lower morbidity and workload, serving more affluent populations.[40] GP staffing proportional to local age-standardised mortality, morbidity and workload has never reached the policy agenda, though this is the only way to create in reality the level playing field for healthcare discussed in fashionable rhetoric.[41] This is a target which Wales NHS should be facing now, whenever a practice falls vacant.

Because GPs as small businessmen invested more in prosperous areas with expanding economies, than in areas of post-industrial dereliction, investment in primary care followed a similarly irrational pattern. However, because they were starting from abysmally poor staffing and premises, practices in poor high morbidity and workload areas made a bigger absolute increase in investment, and raised their standards of care relatively more than more prosperous high investors.[42] This confirms that GPs generally did their best to advance demand-led care to a decent world standard in poor areas, despite often increasingly difficult social circumstances. The splendid pioneering work done by Graham Watt's Deep End Group in Scotland is a model Wales should follow as an immediate first step to get this issue onto the agenda for public discussion, led by staff and patients with personal experience of primary care in deprived areas of high relative mortality and workload.[43]

This is probably about as far as primary care can go, while still locked within group general practice owned by its GP principals, staffed and operated at their discretion, moving forward at whatever pace their least socially minded partners impose. Fully to apply what medical science now makes possible, and to do so at affordable and sustainable cost, requires that care is planned, both nationally, regionally, and locally, to meet rationally defined needs, rather than whatever wants marketing and consumerism may promote. The aims of each practice need to be defined in public health terms, and primary care teams need to include doctors and nurses educated to integrate public health and clinical processes at local level. Judging from our experience in Glyncorrwg, this could raise output of health gain enough for both staff and local communities to recognise it as a useful advance beyond entirely demand-led care. I doubt if any of this will be consistently possible until GPs in Wales are employed and salaried by a competent planning and managing authority, as all NHS hospital and specialist staff have been ever since 1948.

No such competent planning and managing authority is visible now. Salaried service for GPs will stay off the agenda until NHS Wales has created primary care agencies of this kind, at least as an experimental model somewhere. No model for this yet exists, nor should any exist until primary care health workers have been listened to, particularly those working in areas of high morbidity and low income. Assembly

government policy is already committed to integration of specialist services with primary care, and a major shift of activity from hospital out-patient departments to primary care. Without strong primary care planning and management authorities, no such shift will be possible. However this shift is done (and certainly it must be done), it cannot depend either on the individual decisions of GP entrepreneurs, or on collective decisions by administrators without substantial and recent personal experience of work in the front line. Salaried GPs exist now, but only as voiceless assistants to GP principals, or stopgap providers where no reasonable candidate can be found for unpopular vacancies (always in areas of greatest need).

Our experience in Glyncorrwg suggested that primary care led by salaried GPs could work well, if they were allowed to develop their own styles and patterns of work, and learn from their own audited experience. The entire NHS at every level depends on trust. Bevan trusted even the socially semi-literate medical profession of his day to learn rapidly once they were freed from pursuit of fees, and exposed to the full weight of simple human needs in the world's first substantial cash-free economy. NHS administrations today should be able to trust GPs in Wales at least as much, to work out local tactics using local data and experience, to implement strategies developed by regional authorities, and do so for dignified salaries, not in response to management sticks or fee-for-service carrots.

Bevan's third compromise was to limit the scope of the NHS to demand-led clinical medicine, even though he had emphasised the comprehensive nature of the service. Public Health, including Chest Clinics for tuberculosis and clinics for sexually transmitted diseases, immunisation and maternity clinics, were all left with Local Government. These functions were brought within the scope of the NHS in 1974, but Public Health never reached the driving seat, where logically it belonged. Ever since commercialising NHS reforms began in the 1980s, the once leading role of Chief Medical Officers has diminished.[44]

Comprehensive care is a simple concept which could be understood by the public, but it is a responsibility which few if any health ministers since Bevan have encouraged or wanted, least of all "reformers" of the NHS, all of whom have done their best to limit rather than extend its scope. Many functions important to healthy lives remain either outside the NHS, or painfully astride the fence still separating the NHS from charity, most importantly palliative care and care of the long term sick, disabled or very old.

Bevan's NHS promised comprehensive care for everyone from the cradle to the grave. That commitment was a foundation for public devotion to the NHS. Though betrayed long ago by successive governments, most people still cling to a hope that it somehow still exists. In 1990, a 55 year-old man was admitted to a Leeds hospital with a stroke that left him incontinent of urine and faeces, and unable to walk, talk, or feed himself. Pressed by government, Leeds Health Authority had closed all its beds for chronic illness. It claimed his care was no longer an NHS responsibility, so his

family must pay for his care in a nursing home. The NHS ombudsman ruled this was illegal, so a Conservative majority parliament changed the law.[45] In 1995, giving evidence to the House of Commons all-party Health Committee, Conservative junior health minister John Bowis refused to commit the NHS to national responsibility for the hypothetical case of a patient on a drip, doubly incontinent, and confined to bed 24 hours a day.[46] Critical in opposition, Labour governments became equally evasive in office.[47]

One way or another, that simple commitment to comprehensive care for all who need it must be restored, and developed fully to embrace all the new kinds of care which advancing science makes possible. Public funding ultimately depends on public understanding. As people personally experience the random nature of misfortune, and the immense value and greater cost-effectiveness of social solidarity to pool risk compared with market and/or insurance systems abroad, they do understand. But we have to keep it simple. Somehow or other, progressive government must find ways to reach its public over the heads of powerful and ruthless interests who think news media exist to entertain and advertise, rather than help people to think and widen their minds. A Wales NHS documentary film unit could be one way to do this, perhaps combined with our Department of Education as a Wales Public Services Film Unit. This might market its products through BBC Wales and S4C. These broadcasters are unlikely to survive the next few years without subsidies from the Assembly, which might help them to recognise that the lives of ordinary people are usually more interesting than those of celebrities.

His final compromise was to leave out democracy, except for whatever grievances might reach parliament through MPs. He left autocratic power in the hands of doctors, with little or no accountability either in hospital or primary care. As in other nationalised industries, despotic power remained in the hands of appointed management.[48] Sixty years later the NHS still has no democratic structure. Shopping around by consumers is no substitute for active participation by citizens in a service owned by all. Bureaucratic accountability and fear of litigation has grown monstrously since 1983, but opportunities for simple exchange of information and ideas between staff and users have been left to survive however they can through increasingly bureaucratised processes of work and legalised processes of complaint. To be affordable and sustainable over the next twenty years, participative democratisation will be the most urgent of all projects for Wales NHS, if only to get and retain enough electoral support to make continued progressive change possible.

Democracy is said to have been invented in Athens, in times when roughly half its population was enslaved. Talk about democracy is meaningless when people have no control over their lives. As rule by, for and of the people, democracy is measurable by the extent to which decisions affecting society are taken by people who will themselves suffer their consequences. This means it is not just a matter of whether people have votes, but how everyone can take part in building the society in which they live, and do so for everyone, not just for themselves.

We already have the beginnings of democracy in Wales NHS, not only because elected Assembly Members have overall control, but because the NHS includes everyone who needs it, and increasingly respects the voices of patients as co-producers with staff. Not the shrill voices of demanding consumers, but the quiet voices of thoughtful people, with time to explain their troubles, the circumstances in which their problems must be resolved, and their own experience of universal fallibility.

In Glyncorrwg we tried to develop more formal democratic structures. The first representative patients' committee in Welsh primary care was set up by Dr Alastair Wilson in Aberdare in 1980. At a public meeting the following year, the first Glyncorrwg patients' committee was elected. It still functions more than 30 years later. It campaigned successfully to get overnight facilities for parents of children admitted to our local hospital, and served as an initial (and more intelligent) ethical committee than the official body to which we submitted our research proposals. However, it never became the democratic breakthrough we need. Much the same people get elected to all the many committees generated by small communities, typical of Wales outside our few cities. They get re-elected again and again. A better path might have been encouragement of self-governing user groups for specific health problems, so far as possible including all the people mainly affected, perhaps including one for people with complex combinations of problems, where the most immediately important questions about Wales NHS structure need to be addressed. We need groups where people can discuss their own experiences, constrained only by their own local customs of confidentiality, with a responsibility to present constructive conclusions to local health authorities, and wise enough to avoid sponsorship by commercial interests.[49]

We need to make Wales NHS into the property of the people, personally and collectively – a national institution shared and owned by everyone. This is the only way to ensure it will never be taken away, and that Wales NHS can resume development as a potential birthplace for democratic socialism, not in heroic words but in the hard work of fallible practice.

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