come to lack impartiality. The consequences of a miscarriage of justice are particularly serious where children and family life are involved.

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Health care: international comparisons

A conference held at the College in July 1994 examined the wide range of health care systems employed around the world and their varying responses to the combined pressures of demographic change and increasing patient expectations in the face of anticipated unsustainable increases in financial demand. The meeting, which was planned by Professor Roger Williams, was jointly sponsored by the College, the NHS Management Executive, Glaxo Holdings plc, the Nuffield Provincial Hospitals Trust and the Kohn Foundation.

The conference was opened by Professor Sir Leslie Turnberg (PRCP) who pointed to the rapidly and disproportionately rising costs of health care in all countries and the tendency towards overt or covert rationing in its delivery to patients. The purpose of the meeting was to examine the different ways in which the medical, ethical and financial challenges are being tackled, and to learn from the positive and negative experiences of others.

Professor C Ham (Director, Health Services Management Centre, University of Birmingham) contrasted the traditions of managed control of health care in the UK and Scandinavia with the free market approach of the USA, but pointed to the very public 'needs' for reform exemplified by the 1986 Dekker report in the Netherlands, through the UK reforms introduced since 1989, to the current Clinton proposals in North America. A common theme has been a move towards 'managed competition', with considerable differences in the meaning of this term according to the previously prevailing system. The changes in the UK appear among the most radical, but in no case yet have changes been adequately evaluated to judge their success or failure. The provider/purchaser split, with increasing influence vested in the latter, has been accomplished, possibly at the cost of equity. The transition itself has borne considerable financial and personal costs, and as yet funds are not always seen to 'follow the patient'.

Dr P D Martin (Vice President, Royal Australasian College of Physicians) reviewed the changes enacted in New Zealand since 1991 in response to increasing surgical waiting lists, increasing costs and patient dissatisfaction, in a managed service with many parallels to the British NHS. Discussion illustrated that, although in several countries the waiting list issue is

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not negligible, it is really only of clinical or political importance in New Zealand and the UK. As in the UK, a tier of administration (the area health board) was abolished, direct costs of care to the patient were increased (prescription charges) and there was a move towards contracting for health care purchase. The reforms have been costly in time and money, and contracts have so far had little bite. There is satisfaction with progress towards core service provision, but health care planning has not been aided.

Ms D Ariotti (Principal Adviser, Commonwealth Department of Human Services and Health, Canberra) recognised that the Australian changes had been less radical than those in the UK or New Zealand. The 8.4% of GNP currently expended on health care was not likely to increase despite a system where the majority of doctors work in the private sector. Reforms proposed and being introduced are wide-ranging and emphasise quality based on national targets for clinical outcomes, integration of and access to health care, with better responsiveness to patients and greater overall accountability of the system. Here too there is a purchaser/provider split. More rigorous accreditation of GP training coupled with a form of GP fundholding, improved audit of and response to case-mix, deregulation of the private insurance industry to increase competition, and a system of financial bonuses and penalties are intended to improve cost-effectiveness in conjunction with further contraction of the public sector. Discussion of accreditation/re-accreditation/recertification illustrated its international topicality. There was a view that strong leads taken by the Royal Colleges and their equivalents are the optimal route to appropriate continuing medical education with the necessary clout to satisfy purchasers.

Dr R Pagtakhan (Canadian MP and a paediatrician) considered health care reform in Canada: 'the issue from hell', in which a balance is sought between the increasing needs of an ageing and more demanding population and the decreasing purchasing power of the health dollar, in a setting where already 9.5% of GNP goes on health care. Most doctors are at present self-employed independent practitioners, and 90% of hospitals are private with funding predominantly from federal or local government (21% of the population has private insurance). Reforms emphasised increases in efficiency/cost-effectiveness. The need to define 'medically necessary care' more precisely and the difficulties in deciding who should draw the boundaries were considered. Canada too has shifted the proportion of health care expenditure from the tax-payer to the user, and has already recognised a consequent trend (as in the USA) to higher and less controlled costs. In a tax-based system the rich and healthy pressure pay a higher percentage of health care costs than in a user fee-based system where the sick and the poor (who tend to be the same population) pay relatively more. This leads to a worsening of the gap between the health care available to rich and poor, without any move towards a reduction in 'less necessary' care. For true equity there must be no user fees. This point was reiterated when comparing the situation in Kerala (southern India) where an emphasis on education and full employment has been widely considered to have improved morbidity and mortality both cheaply and with equity. Canada is moving towards greater control of the number of doctors and of the pharmaceutical near-monopolies, with funds related to patients' needs rather than the providers' levels of activity (again a purchaser/provider split) and targeted on a capitation basis in accordance with predetermined federal standards. The importance accorded to these principles is vested in the National Forum of Health headed by the Canadian prime minister. A concept of 'shared vision' has many of the features of the UK reforms and charters, with greater involvement of the citizen consumer, and (encouragingly) is to be 'research supported'. Performance-related pay was considered during the discussion of this talk, and there was some consensus that this was implicit in contracts for levels of service, but that it was highly undesirable in respect of the individual doctor because of the (insuperable) problems of definition and comparison between specialists.

The observation that, in New Zealand, an orthopaedic surgeon is 'financially equivalent' to 1.5 physicians pointed this up nicely.

Professor R I Kitney (Imperial College, London) introduced the American scene and reflected that the 13.2% of GNP currently utilised on health care includes much research and development work of international relevance, and also that the US constitutes 50% of the entire world market for health care products.

Dr R D Lasker (US Department of Health and Human Services, Washington, and an endocrinologist) also recognised an international convergence towards managed competition, the particular need in the US being to introduce order (and control) or to apply 'physics to physic', with emphasis on changing the balance towards promotion of health and away from the current illness-based practice, as well as the moves towards universal coverage. Most US citizens belong to one of over a thousand insurance schemes, with tax shielding through their employment. Medicare and Medicaid cater for some needs of the elderly, disabled and poor, from federal and state funds. The present 14% of the population without insurance conceals 25% who are without insurance at some time, and is anyway a rising proportion. Such individuals receive poor and delayed care. Doctors are mainly in single-handed practice funded on a fee-for-service basis, and the seven thousand hospitals operate autonomously. Little funding is available for preventive work, but duplication of administrative effort, poor bargaining power of the purchaser and the heavily procedure-dominated charging structure lead to an increasing proportion of GNP being spent on health care which
would reach an insupportable 16% by the year 2000 if current trends were to continue. Recent changes have preceded legislation and are increasing the role of the generalist as ‘gatekeeper’ and introducing an element of audit. Unified systems such as the Health Maintenance Organisations (HMO) allow relatively comprehensive care for a fixed premium by limiting care to a defined single centre, and are increasingly popular with employer and employee, subject to ‘performance monitoring’. Reduction in freedom of referral may, however, be combined with lack of continuity, as contracts are often only for one year, and teaching and research inevitably suffer. President Clinton’s reforms are intended to provide universal coverage, limit health care spending, improve preventive and epidemiological services with a new infrastructure for public health, based at least in part on a capitation system of funding, with continuing audit. Objections from the many with vested interests indicate that change will be evolutionary and incremental, probably via some degree of compulsory insurance or ‘employer mandate’.

Professor C R Cleaveland (President, American College of Physicians) developed this theme, emphasising the anxieties of those who may lose their jobs and therefore their insurance, and noted that doctors in the US have widely divergent views depending mainly on their own financial positions. Doctors in HMOs, GPs and most inner-city physicians (average annual income $100,000) favour the reforms but many proceduralists (income > $190,000) and those with their own small staff (mostly without health insurance currently provided by the doctor) are vigorously opposed to them. The number of doctors per 100,000 population, which has risen from around 150 in 1950 to over 230 in 1990, is directly relevant to total health care costs, doctors in the US as elsewhere being responsible for initiating around 80% of all expenditure. Only in the past year has the trend to an ever increasing proportion of specialisation begun to be reversed (around two-three times now compared with one-third in the 1940s). It was felt that malpractice issues do indeed affect medical and financial aspects and promote (expensive) defensive practices. The American College of Physicians (but not the American Medical Association) stands for universal coverage with standard benefits, a mixture of private and public funding with an ‘employer mandate’, with administrative streamlining, and support for public health, research and medical education from all-paying sources. Incremental introduction of policies directed towards these aims was felt to be reasonable, practicable, and potentially achievable by 2000.

The audience supported the world-wide swing towards a greater emphasis on prevention and health promotion but recognised that, however successfully implemented, this rarely releases any anticipated funds. Consumers can unbalance such ambitions as a result of media-stimulated (and media-supported) increasing expectations. This is particularly irksome when resources are apparently squandered on new but unproven high technology pursuits, and researchers themselves, in promoting their findings, may contribute to this difficulty. Education of the citizen towards reasoned and reasonable expectations was felt to be widely neglected. Involving the consumer in ‘rationing’ has not yet been properly assessed, since even the most managed systems involve the ordinary citizen only at the time of national and local elections (when many other issues are also at stake).

Professor M Moran (Department of Government, Manchester University) considered the German health care system to be the biggest, richest and also the most successful in Europe. Nevertheless cost-containment reforms are proposed every few years. The system is based on a virtually compulsory payroll tax and yields nearly free care at the point of delivery (more comprehensively and cheaply to the patient than is currently offered by the NHS). The patient, who has a very high degree of choice, may choose multiple opinions for the same condition. As in the US, there are over a thousand insurance funds which may be geographically or professionally oriented; they are a source of inequality since higher paid professionals will often find a scheme at a contribution as low as 8% while poorer workers may be required to find 16% (national average about 12%). There is statutory and almost complete segregation of inpatient and outpatient care, with status for doctors (who operate as if from lawyers’ chambers) vested in the latter. Financial negotiation is decentralised between single or small groups of doctors and the many funds; accordingly the system tends to be medically dominated. The principal exception to this fragmented system is the polyclinic of the old eastern provinces, and these are gradually being closed down. High medical unemployment(> 15,000) conceals patchy availability of care in industrial and rural areas. Doctors are very well paid and, although health care costs are high, the growing share of the German GNP was thought sustainable until recently.

Dr L Zylberberg (Counsellor for Social Affairs, French Embassy, London) summarised the key features of the French system. As in Germany, there is a free choice for the patient who will often seek multiple concurrent opinions from office-based specialists. Between two-thirds and three-quarters of all doctors work in the private sector, with funding from a virtually compulsory means-tested sickness insurance system. The patient is usually reimbursed in full, upwards of 75% of funding being ultimately tax-derived, although successive governments are deliberately reducing this figure. Public health and preventive medicine is centrally and local authority funded. Pressure from patients, and almost unlimited prescribing rights of doctors, lead to high spending on drugs, so a typical GP receives £45,000 in annual salary and is responsible for a drug bill of around £100,000 (compared with the specialist who receives an £80,000
CONFERENCE REPORTS

salary bill but may be responsible for only £40,000 spent on drugs). France is the third highest spender on drugs in the world. That there could be problems with the French system has evidently come as something of a surprise to the public and politicians alike, but the doubling of health care expenditure in the past 23 years, a high and increasing consultation rate, together with the demographic changes common to all of Europe, have demanded attention. There seems little prospect for a greater share of the GNP or increased public funding, and major reductions in reimbursement are not felt to be acceptable. Optimism remains that stability and continued equitable care can be provided through overt rationing, by restricting freedom in prescribing, with fiercer limits on the prices charged by the pharmaceutical industry, and with other moves to encourage medical controls on spending.

Dr K G H Okma (Ministry of Welfare, Health and Cultural Affairs, The Hague) described the effects of the Dekker report which introduced the formal concept of managed competition. Care in the Netherlands is currently funded from mandatory insurance with a social security component (about 60%) and privately (about 40%). There are some similarities to the German system but key differences stem from the substantial reliance on GPs as gatekeepers and a fixed national contribution rate for the various sickness funds. The Dutch have the lowest drug consumption in the West (but a high drugs bill). In contrast to Germany, there is a growing move towards the polyclinic philosophy. The continual needs for cost containment have led to chronic disagreement between doctors and the service managers. Market forces have indeed led to the closure last year of a bankrupt hospital. As in Germany, the strict split between inpatient and outpatient activities pertains, but this is being eroded by hospital-at-home activities despite the nominal illegality of such schemes.

In the subsequent discussion the question arose of how to assess quality within and between different systems (perhaps one of the sticking points of the day). It was agreed that these issues depend on detailed high quality audit at a clinical level as well as in simpler financial terms. The potential reduction of patient choice implicit in some obvious reforms of the French and German systems could be considered to be desirable in British and Dutch eyes, but this would be unlikely to win political favour locally. Increases in choice are not therefore necessarily a desirable aim of reform.

Professor J Calltorp (Nordic School of Public Health, Gothenburg) reviewed the pressures for change in Sweden, traditionally the home of one of the most managed health care systems. Since 1970 all doctors have been salaried in a system where 90% of all costs is met from taxes (albeit two-thirds set by local councils). The system offers a high degree of equity and clinical freedom, and good audit data allow activities to be priced quite accurately. Despite the legal obligation of heads of departments to carry medical and economic responsibility, the medical profession has little involvement in management. The 9% of GNP expended on health in Sweden is no longer an increasing proportion. This is believed to represent the success of reforms enacted over the past few years which have actively promoted a system of primary care with a registered GP and capitation-based payments, but this is not popular with doctors or consumers, the former in response to wage freezes, the latter because of (apparent) reduction in choice. A similar arrangement that in the UK for the purchaser/provider split is being introduced, but on a regional rather than a national basis, and does not yet include primary or long-term/continuing care. Early responses of doctors reveal disappointment, mainly with perceived inadequate global funding, but clinical decisions are newly recognised to take some account of financial considerations (more so in investigation than in therapy). It is not yet possible to ascertain whether these changes are for good or ill. There is concern that short-term political strategy has disproportionate influence and that long-term planning and preventive care are being penalised.

The current position and future intentions in the UK were considered, from their various perspectives, by four of the speakers. Mr A Langlands (Chief Executive, NHS Management Executive) briefly reviewed the changes affecting the NHS since 1974, concentrating on the evolution to a structure in which eight regional offices will act as the intermediaries between Trusts and family health service authorities (FHSA) on the one hand and the Department of Health and its ministers on the other. He praised NHS staff for nearly having completed the transition away from a more hierarchical system whilst continuing to work effectively during a time of great turmoil. He recognised the pressures facing the British and other health care systems posed by the demographic shift, the consumers’ rising expectations, and expensive technological advances, in a financial setting that is unable to keep pace. He was optimistic that greater cooperation between traditional providers of care, industry and the general population could promote cost-effective progress; the aim is to achieve a more patient-oriented style of delivery linked with a high quality, innovative, research-led and accountable service. His view that the reforms already in place have been sufficiently radical to set this in motion was received with some relief by those present. The present 7% of GNP available for the NHS was evidently not subject to upwards negotiation! The RCP President expressed the conference’s concern that equity was placed in jeopardy by some aspects of the reforms, not least the potential for two-tier care in response to pressure from fundholding GPs to the detriment of patients of other nearby practices. Unfortunately Dr D Colin-Thomé (a fundholding GP, Runcorn) dodged this aspect of his
remitt, while providing a daunting account of exactly what can now be accomplished in a high-achieving practice. The observation that the fundholding GP is in certain respects both purchaser and provider was also a relatively neglected issue, given the otherwise virtually global moves towards separation of these roles. The conference clearly felt happy to support calls for closer links between GPs and hospital teams to maximise cost-effective, patient-friendly care, and simultaneously to prevent overdelegation which might lead to patients being denied appropriate specialist care. Professor J R Bennett (Medical Director, Royal Hull Hospitals Trust) developed this theme (noting a 20% reduction in inpatient beds in the UK in the past four years) and emphasised the importance of hospitals concentrating on their traditional strengths. He was pleased to see competition encouraging initiative and cost-effectiveness, but less happy to see the skewing effects arising from unplannable emergency work, the losses of choices when hospitals close, and the potential for diminished professional collaboration between institutions. Like other speakers, he doubted that UK purchasers were adequately funded, and was concerned at the present ability of purchasers (and particularly fundholding GPs) to switch contracts on a year-by-year basis, thereby making even medium-term planning something of a lottery. Many believed that there was no adequate provision for education, training and research, since purchasers with short-term budgetary requirements inevitably accord these low priority. Careful audit, both internal and external, is probably the providers’ (and ultimately the population’s) best protection in this regard, but there is not enough time (and effort) to secure this audit. Several speakers from the floor emphasised the importance of increasing and improving the interface between primary and secondary care, but in the context of a flexible medical workforce attuned to future change. The Rt Hon Dr B Mawhinney (Minister of State for Health) felt that the conference had followed his own ‘marching orders’, considering problems as opportunities, arguing always for more resources (though expecting not to receive), and aiming to increase quality (and to a lesser extent quantity), at greater convenience to the patient. Improved medical efficiency must be demanded, recognising that the most expensive person in the health service is the doctor who ‘drives’ it. That improvement is still possible was, he suggested, indicated by the higher rates for day-case surgery in the US than in the UK, despite the latter’s generally recognised better infrastructure of primary care support. His aim remained a health care system increasingly driven by the purchaser on behalf of the patient. An analysis of the NHS should accordingly be based on the output of patient care rather than on the input of buildings, beds and staff. Efficiency alone is not enough. In parallel with the closer collaborations between different groups of doctors and other health care workers, there should also be closer collaboration, with an increasingly shared agenda between doctors and government. Common sense indicates that this should be achieved, but current international public debate confirms that it has not yet been achieved anywhere.

In summary, all nations are considering reforms and in most cases are already enacting them. There is a general convergence towards a system of managed competition with virtually all countries separating purchaser from provider if this was not previously the case. Central protection for public health, preventive medicine, teaching and research is widely considered necessary, but a partial reliance on private insurance schemes and direct contributions from patients is common to most. Concerns about reduced equity of care delivery in countries moving towards competition contrast with perhaps more selfish motives revealed by objections to limitation of currently generous choice for patients and autonomy for doctors in those systems moving in the opposite direction. Careful audit is needed to ensure not only that changes have their desired effects but also that these effects are of overall benefit to their recipient populations.

The full text of the papers presented at this conference and edited by Professor R Williams will be available from the Publications Department early in 1995.