

What does a National Health Service mean in the 21st century?

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Mary Wollstonecraft, born in 1759, was the first English writer to set out a coherent doctrine of “*native* unalienable rights”.¹ “It is necessary emphatically to repeat”, she wrote, “that there are rights which men inherit at their birth, as rational creatures, who were raised above the brute creation of their improvable faculties”. For two and a half centuries, people have argued about the nature of these rights. That clash of claims is relevant to the way we think about the National Health Service (NHS) in Britain today—not only because the NHS is enjoying its 60th anniversary, but also because 2008 is the 60th anniversary of two additional and equally epoch-making ideas.

The first is the Universal Declaration of Human Rights,² which asserts “the right to life”; “a standard of living adequate for...health and well-being”; “including...medical care”; and “the right to security in the event of...sickness”. The second is the World Health Organization’s (WHO’s) constitution,³ which states even more clearly that:

“The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic, or social condition.”

All three anniversaries—NHS, Universal Declaration of Human Rights, and WHO—are a departure point for a single proposition: that amid our sometimes furious debates about health services in the UK, we have a hidden weakness in what are now our four health systems—a weakness that threatens to jeopardise the principle that citizens value most of all about the NHS. That weakness is the slow erosion of the right to health as a core value of our civic culture. This erosion has proceeded to a point where the covenant created by the NHS—between the citizen, State, and profession—may soon fracture, perhaps irreparably.

I need to be modest about what I mean by the right to health. I do not mean the right to absolute freedom from disease or absolute freedom from any influence that harms wellbeing. I do not mean that individual rights should be able to trump any other societal claim, such as a reciprocal responsibility on people to reduce their risk of ill-health. I do not mean a right to health as a meaningless aspiration. I do mean a right to health as an idea that matters to us, as individuals, parents, children, colleagues, and companions in communities. I mean a right not only to the progressive creation of a society that places health at the forefront of its political, economic, and social concerns, but also to the creation of a well-governed, financially secure, responsive, and

innovative health system that delivers personal health services freely according to need. In Britain, a respect for rights goes a long way back—at least to Magna Carta and habeas corpus. In 2008, the UK High Court cited a serious breach of human rights when ruling that an antiterror law was “absurd” and “unfair”.⁴ Britain has long cared deeply about the rights of its peoples.

But politics is not easy. Trade-offs have to be made. Among the many pressing concerns facing a nation-state, where should health rank? In *Just Health*,⁵ Norman Daniels argues that health has a special moral importance in our societies. Ill-health restricts the opportunities open to all of us. Health expands those opportunities. Health is essential to the flourishing of our individual lives and to society overall. If Daniels is correct, there follows an obligation on us all to make sure that health is accorded special moral importance in public policy and political decision-making. That special moral importance would be most efficiently expressed as a right to health. And the fulfilment of that right might be a useful barometer to measure the progress of and pressures currently being exerted on the NHS.

The language of health

Doctors need to revise their vision of the NHS. Why? The answer lies in the way the profession chooses to discuss the health service. Take, for example, the British Medical Association (BMA), an organisation that can legitimately claim to represent the majority of doctors in the UK today. The BMA’s current mission statement is “Caring for the NHS at 60”.⁶ When one examines the issues of most concern to the most representative professional body in Britain, one sees a surprising pre-occupation with issues of self: pay, contracts, terms and conditions of employment, opening hours, and pensions.

These issues are not unimportant. But they do betray a professional self-absorption that is disheartening when one confronts the scale of the challenge facing the UK health system. To be fair, responsibility for the NHS goes well beyond doctors and the BMA. The reports by John Tooke and the Health Select Committee on the disaster of Modernising Medical Careers⁷ both concluded that the Department of Health let patients down badly. The Audit Commission reported in 2007 that a third of NHS Trusts failed to provide value for money.⁸ The National Audit Office has declared that the government’s flagship private finance initiative programme allowed commercial contractors to leach money from the NHS.⁹ Research from the London School of Hygiene and Tropical Medicine suggests that the UK has one of the least effective health systems in the rich world.¹⁰

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Meanwhile, the NHS is continuing to undergo fundamental structural reforms.¹¹ Doctors should be, but are largely not, shaping these reforms. Although doctors appear to know what they are against, they do not seem to be clear about what they are for. Doctors need to behave differently. And how they need to behave might begin with the principle on which the NHS was founded—the principle of equity. Equity, by which I mean simply fairness, is the central practical realisation of the right to the highest attainable standard of health. Perfect health equity means the creation of a health system that is free of bias—bias against those who are disadvantaged, socially, economically, culturally, geographically, or in myriad other ways. Equity remains an inspiring principle for creating a fair and prosperous society in Britain.

To argue for a right to health will not solve all the ills of the NHS. But thinking about health as the right of every citizen does provide a framework for protecting and advancing the outcomes that the NHS seeks to achieve. These philosophical goals for the NHS matter because the full enjoyment of health still remains a distant notion for many living in Britain today. For those with a chronic illness, for older people living alone, or for anyone enduring a life-threatening condition, the right to health does not mean a right to be fully healthy. It does mean a right to enjoy a system of health protection; to have greater control over one's health; to expect a progressive tendency towards an equal chance of realising the highest attainable standard of health; and to expect a national health policy that sets out a programme to achieve that standard for all.

The right to health is not in Magna Carta. It is not, and never has been, a universal right. Rights have histories.¹² They are established slowly, and usually after some great schism. (The French Revolution, in Mary Wollstonecraft's case. World War II in the case of the NHS, the Universal Declaration, and WHO.) Rights are created and agreed when their existence is politically essential and technically possible.

Doctors have a special role in arguing for a right to health. In 2000, on May 11, the UN adopted a statement called General Comment 14 (a comment on article 12 of the International Covenant of Economic, Social, and Cultural Rights).¹³ For human rights and health, General Comment 14 is as revolutionary as the American Declaration of Independence: it explains what a right to health means in practical terms. According to General Comment 14, the right to health means the availability, accessibility, acceptability, and quality of health care services. General Comment 14 enables observers of the NHS to devise a positive manifesto for its future.

Availability

An effective health system must have sufficient services and people to deliver care to those for whom it is responsible. Our preventive and curative health services should match our national burden of disease. Do we systematically neglect any aspect of these priorities?

WHO's global burden of disease study in the 1990s made one astonishing claim: the neglect of mental health.¹⁴ Unipolar major depression beat heart disease and stroke as a cause of disability. And in a report that *The Lancet* commissioned in 2007, the creators of a new global movement for mental health argued that one cannot truly claim to have achieved health unless mental health is included within that definition.¹⁵

If one takes just one dimension of mental health in the UK, one can see the size of the predicament.¹⁶ Of 175 million working days lost each year at a cost of £100 billion, a large proportion is due to mental ill-health. "An urgent...shift in public attitudes" is needed to destigmatise mental ill-health. A particular responsibility rests with the profession—as well as on business and the trades unions—to lead this shift. Doctors downplay their prevention role, and they often lack the necessary information to understand the importance of mental health.

Mental health problems frequently begin in adolescence. In a separate report *The Lancet* has commissioned, we tried to draw attention to neglected issues of adolescent health—including adolescent mental ill-health.¹⁷ At least one of every four or five young people will have one mental health disorder in any one year. The risk factors for adolescent mental ill-health lie within the family, the school, and the community. Yet at the most vulnerable time for developing mental ill-health in a young person's life, our health system is at its weakest. Based on the principle of the right to the highest attainable standard of health, there needs to be a wholesale change in our clinical and public-health culture, recognising the importance of mental health, revitalising the discipline of occupational health, and being open to radically different ways of delivering services that de-stigmatise mental ill-health. These issues were highlighted again in a report published by the Children's Society.¹⁸ As one young person struggling with depression put it, "None of the doctors took me seriously". It is time we did. This test of availability can be applied rationally across all evolving national patterns of illness and disease.

Accessibility

A national health service governed by the principle of equity should be exquisitely sensitive to discrimination. But here we enter the realm of one highly inflammatory political issue: immigration. The controversy around immigration and health was brutally crystallised by the case of Ama Sumani, a terminally ill 39-year-old Ghanaian mother of two with multiple myeloma. She had come to Britain to study banking. Until January, 2008, she received dialysis at University Hospital of Wales in Cardiff. Her student visa expired and the UK Home Office had two options—to extend her stay on compassionate grounds (given that she would not be able to receive the necessary medical care if she returned to

Ghana) or to remove her from the country. The UK's Labour government chose to deport her, despite appeals by Ghana's High Commissioner. Ama Sumani died in March, 2008, in Korle-Bu Hospital, Accra. Her friends reported that she hoped throughout her final illness that the British Government would reverse its decision. It did not.

The UK's political execution of Ama Sumani was an "atrocious barbarism"¹⁹—for this is what it was: her death following deportation was a forgone conclusion. The issue of access to health services for migrants goes much further than this single, albeit cruel, case.^{20,21} There are 60 million migrants in Europe, 8 million of whom are undocumented—that is, they have no legal status to live in their destination country. Undocumented migrants are one of the most vulnerable populations of all. They frequently have poor health.²² And although they may live and work in countries for long periods, their right to access health care is severely restricted.

Indeed, European governments seem to be using restrictions on access to health care as a weapon in immigration control. Should the NHS comply with this trend? Should the NHS be an instrument of the State's regressive immigration policy? Should doctors?

Unfortunately, some health professionals are unwittingly denying migrants' access to care. Project London is an initiative to improve access to care for migrants in the capital. Last year it found that pregnant migrant women could not access GP or hospital antenatal services because of the high fees that doctors and their hospitals were charging.²⁰ The government argues that public services operate on the basis of an exchange.²³ If you pay in, you are entitled to get something out. But some migrants do not pay in, and so they should be excluded from the NHS, says Britain's Labour government. This classification of who counts in our society and who does not is a politics that risks pandering to the most racist elements in Britain. It is the antithesis of the meaning of professionalism in medicine.

The NHS should be available and accessible to all those living at the margins of our communities. Services should not be denied to those living within the UK's shores if they have no other means of achieving the standard of care available in Britain. The UK government should be designing health policies that seek to eliminate, not encourage, health-related discrimination. Professionally, this is what it means to strengthen the moral contract between doctors and society: to increase the sum, not only of compassion, but also of justice—a word that doctors and the public sometimes seem too embarrassed to use.

Acceptability

The right to the highest attainable standard of health also means that the NHS should seek to understand the lives of those it serves; this is what patient choice should be about. Appealing to evidence and rational argument

alone is not enough to secure the democratic agreement of a people. An argument has to be made, backed by data. But any proposition also has to be debated as part of a democratic process aiming for broad public assent. A fair and inclusive process is crucial. Certainly, public views should not overrule medical knowledge. But policy makers and the health professions must work harder to achieve the social acceptance of policies that are informed by evidence. From the reconfiguration of NHS services to their commercialisation, an immense benefit would accrue from greater public participation in these often highly conflicted policy discussions.

Why? Present debates about the future of the NHS are usually deeply polarised. One political party will say that it wants to accelerate public-service reforms. Another predicts upheaval and apocalypse should any reform proceed at all. This way of debating public policy is neither serious nor sensible. A recent report suggests an alternative way of designing policies and changing behaviours: conversation.²⁴

Stilgoe and Farook²⁴ argue that powerful public engagement will only be achieved by "a genuine exchange of values, interests, and knowledge...conversations need to be broad and ambitious, not just in the doctor's surgery, but in the way policies and services are designed." The departure point for this new vision for policy making is the changing nature of expertise and the transformation in public access to information. Knowledge is now not only in the hands of professionals. Previously hidden information is now in the hands of everyone. That information needs to be personalised and interpreted, and these demands will mean a different and increasingly important role for the doctor.

Trust will be the critical governing principle in an information-driven NHS. "Experimental conversational systems" at all levels of the NHS will be a major force determining its future. Stilgoe and Farook argue that the existing frameworks within the NHS—biomedical, behavioural, and structural—are "throttling" health conversations. As chronic illnesses, such as diabetes and mental ill-health, become more prevalent and recognised, care will move out of hospitals and into homes. But this vision for self-care and patient empowerment will mean little if we do not find better ways to arrange our deliberations about health. One key element in thinking about the NHS of the future will be "the re-imagining of what a good doctor should look like." The profession has hardly yet begun to reimagine its role.²⁵

Yet a new culture of public and professional dialogue in health offers the prospect of erasing unhelpful barriers between groups—general practitioners versus specialists, public health versus clinical medicine—in ways that could release a new wave of productive creativity in NHS reform. There are obstacles. Professional groups will resist change that is perceived to threaten their power and status. Policy makers will

resist devolving control of strategy to local decision makers. Scientists will resist redefining what is seen as legitimate science to include more qualitative and interpretive disciplines. And all groups may resist opening up their world view to consider more existential aspects of health—the emotional, spiritual, and even religious dimensions of our lives and how they relate to our beliefs about disease and medicine. What is at stake here is our conception of a modern, advanced democracy. How does our society make choices? What is the role of the citizen in those decisions? And how should knowledge (and what kinds of knowledge?) inform those decisions?^{26–29}

Quality

A high-quality health system depends on creating a medical and public-health research culture that is scientific, highly skilled, and sustainable. The next decade should be a golden era to create a vigorous culture for a research-intensive NHS. The UK is investing the necessary money for science. There is the political will to support science. And the UK has strong scientific leaders who have articulated the case for research eloquently and successfully. But many observers of the medical community in Britain remain anxious. The culture for medical science is still wrong, they say. The UK is too bureaucratic in the way that it organises research. It is too expensive. The NHS does not value research. Those who regulate UK medicine do not care enough about fostering research in the NHS. Incentives are perverse. Health administrators focus too much on process, and not enough on outcomes. At a moment of particular opportunity, the UK risks throwing that opportunity away. The National Programme for Information Technology in the NHS—an ambitious scheme to connect doctors to an electronic patient record and online resources in health—is just one example of how expectations have been harmed by poor project management, overambition, and weak leadership.³⁰

And yet the UK is in a superb position to deliver on all four of these objectives—the availability, accessibility, acceptability, and quality of health services.³¹ Our system of medical training at universities and in postgraduate years, despite the horrors of Modernising Medical Careers,⁷ still ranks high. The UK has world-class research funding organisations: the Medical Research Council and Wellcome Trust. It has widely admired mechanisms for generating reliable and trusted clinical knowledge: the Health Technology Assessment programme and National Institute for Health and Clinical Excellence. A family of Royal Colleges, specialist professional faculties, and scientific and clinical academies set high standards of care, promote life-long learning, and influence national health policies.

But are these enormous comparative advantages being best used to strengthen the UK's health system and to

improve patient care? The short answer is no. Health professionals are sometimes reluctant to enter a debate about the social as well as the clinical goals of medicine. This diffidence is a strategic error.³² Doctors have an important story to tell and a compelling case to make for the right to the highest attainable standard of health. They need to start making that case.

Delivering the right to health

Three institutional modifications are necessary if the UK is going to guarantee sixty more years of an NHS committed to equity. First, the NHS does not need an independent management board governing its future.³³ It does need a Technical Advisory Group, akin to the UK's Committee on Climate Change, to make recommendations based on the best available clinical and health systems science about the priorities, policies, and strategies for the NHS. This group would be where controversial new policy ideas, such as funding and topping up NHS treatment with private care, would first be discussed and reflected upon—in a relatively calm environment where arguments and evidence would be finely appraised and judged. This Technical Advisory Group would report to Parliament, publish its advice, and be free to consider any issue it wished.

Second, the NHS needs a General Health Council, where technical advice can be weighed in a more democratic forum—including patient and civil society groups, professional organisations, regulators, trades unions, and the private sector. Several countries have established and described such a forum, with great success.³⁴

Third, the NHS needs to undertake an independent annual assessment of the UK health system's performance, especially from the perspective of a human right to health. There are ready examples of this kind of analysis.³⁵ For example, the UN's Special Rapporteur on the right of everyone to the highest attainable standard of physical and mental health reported on Sweden's progress in reforming its health system. He identified many strengths, but also several crucial deficiencies. Specific aspects of the right to health, such as quality,³⁶ can also be monitored and would be even more valuable if they were brought within a human rights framework.

There is an additional global dimension to revising the vision for the NHS. As professionals with a strong and respected code of values, doctors should not be concerned only with issues of equity at home. Doctors should also be concerned about the gross inequities that exist for those who live in low-income and middle-income countries. Doctors have a professional obligation to work to secure, progressively, the right to the highest attainable standard of health in these nations. The NHS—its staff and resources—has a vital part to play in this project. The Department of Health recognises this responsibility and is committed to devising and implementing a global health strategy for the NHS.³⁷

Revising the future

The birth of the NHS 60 years ago came at a historical moment that coincided (not accidentally) with the affirmation of the right to health. This principle, embodied in the idea of equity, was enshrined in William Beveridge's conception of an NHS available to all. In Beveridge's words: "The setting up of a comprehensive medical service for every citizen".³⁸ In more modern times, society increasingly recognises health to have a special moral importance. But the way doctors debate health—often fostering conflict and friction^{39,40}—reflects on erosion of this larger vision. Narrow and sometimes deeply self-interested skirmishes distract doctors from what should be their more urgent mission: describing and reversing health inequities in the UK. These distractions sap doctors' morale and enthusiasm for medicine. The current conditions prevailing in the NHS are creating a cadre of doctors who feel undervalued and alienated.⁴¹

The concept of a right to health is neither a fad nor a fashion—it is deeply ingrained in our moral culture.⁴² The UK has tremendous comparative advantages for rapidly improving the availability, accessibility, acceptability, and quality of healthcare, nationally and globally. Modest changes to the governance of the NHS could protect and advance these founding principles.

What can the individual doctor do immediately to implement a human rights approach to health? First, modern notions of professionalism emphasise the "moral contract between the medical profession and society".²⁵ But what is the underlying moral basis for that contract? This question can be answered in many ways—utilitarianism, for example. A right to the highest attainable standard of health is a powerful moral force to bind together a doctor's professionalism with society. So the first act of a doctor could be to embrace a right to health as the central tenet of his or her professionalism. Evidence indicates that doctors are highly committed to the just distribution of finite health resources, improved access to care, and higher quality of care.⁴³ The right of every citizen to health seems an instinctive desire among most doctors.

A second role for the doctor is advocacy and education. Whether through teaching or as part of the daily work of their health team—or in wider community roles locally, nationally, or even internationally—doctors can diffuse the idea of a right to the highest attainable standard of health among their colleagues. The doctor as social activist may not sit comfortably with every practitioner. But a quiet yet firm and persistent commitment to the right to health could build new and broad support among the wider health workforce. This kind of clinical leadership is sorely needed in medicine today.²⁵

Third, doctors can implement a right to the highest attainable standard of health by incorporating issues of availability, accessibility, acceptability, and quality of care,

adapted to local circumstances, into their practice. This approach might mean seeking out especially marginalised or disadvantaged groups within the communities they serve, identifying neglected dimensions of illness in their patients (such as mental health⁴⁴), or working with others to develop new services to meet local needs.

2009 will be Mary Wollstonecraft's 250th birthday. She went into labour with her second child at 5 am on Aug 30, 1797.⁴⁵ 18 h later she delivered a baby girl. But the placenta did not follow. Over the next 10 days she was attended by four doctors, all to no avail. By day five, she was septicaemic. The doctors squabbled over what to do next. But one, Dr Anthony Carlisle, showed what Wollstonecraft's husband, the writer William Godwin, called "kindness and affectionate attention...his conduct was uniformly tender and anxious, ever upon the watch, observing every symptom, and eager to improve every favourable appearance". Despite professional rivalries between physicians, obstetricians, surgeons, and midwives, one doctor understood what he needed to do. It was too late.

On Sept 10, 1797, Wollstonecraft died. Her writing had launched a new age where it was agreed that enhancing the rights of men and women could sustain society's progress towards "true dignity and human happiness... strength both of mind and body"—not a bad vision for the NHS at 60, and beyond.

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