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Books Reconsidered

Effectiveness and Efficiency

A. L. Cochrane

Before Archie Cochrane set down his thoughts on the effectiveness of health services, the pairing of "health" and "efficiency" was familiar only from the illustrated magazine of that name which introduced generations of adolescent boys to the parts other journals did not reach.

Like most really good ideas, his basic thesis was simple: treatments should be subject to scientific evaluation, preferably by means of randomised controlled trial, and the National Health Service should offer only those treatments which have been shown to be effective. This now seems entirely unexceptional, although we still have a considerable backlog of established therapies awaiting evaluation. Dr Cochrane's 'Good Idea' made healthy scepticism respectable and paved the way for the later development of health economics, clinical audit, clinical guidelines, needs-assessment and rationing. The fact that we now take for granted a legitimate place for so many of these activities is a reflection of the extent to which Archie Cochrane's proposals have become part of the contemporary NHS.

His fresh perspective sprang from a firm commitment to the ideals of the NHS, coupled with an ability to bring to bear upon its activities the then unusual standpoint of the researcher. His life experiences had equipped him unusually well to do this. He could recall attending a rally in the 1930s in favour of a national health service, carrying a banner with the cautiously inspiring slogan: "All effective treatment must be free". He was called a Trotskyist for his pains. He fought against Franco in the Spanish Civil War just before Julian Bell joined the cause (Virginia Woolf quite unreasonably blamed Archie for Julian's decision to go to Spain and his subsequent death there). By 1939, Archie had qualified as a doctor and was sent to Crete (Evelyn Waugh was the brigade intelligence officer) where he was captured by the Germans and spent most of the war years as a prisoner. As a prison camp doctor, he had ample opportunity to be impressed by the relative unimportance of therapy compared with the natural recuperative powers of the human body. The experience left him with an affinity for the null hypothesis which underlies all controlled trials and which he expressed with characteristic vividness: "we should be delightfully surprised when any treatment at all is effective and always assume that a treatment is ineffective unless there is evidence to the contrary". His deep affection for the NHS did not blind him to the shortcomings of an organisation which he described as "a favourite child who is now showing delinquent tendencies". Nor did he share the view that more is always better where health services are concerned. He was disarmingly ready to enumerate his shortcomings as a commentator; having devoted most of his professional life to field epidemiology and research, his time as a clinician had been limited to his relatively brief and atypical experience in the prison camp. He had little opportunity for what he calls medical administration or what we would call health services management.

Those of us too young to have personal experience of pre-1948 medical practice can still recognise the legacy of an attitude which he characterises as the belief that pure research is "U" while applied research is "non-U". He recalls himself being advised by distinguished colleagues that the best research should be utterly useless. This attitude was reflected in the founding principles of the Medical Research Council and its subsequent preference that it should be "unhampered by pressures to give precedence to those problems which appeared at the moment to be of the most pressing practical importance". Unsurprisingly, there was little academic interest in health services research which was certainly applied and therefore tainted.

If we sometimes worry nowadays that the emphasis on cost–benefit assessment of health services may lead us to ignore important but intangible

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human values, it is salutory to be reminded just how unsatisfactory was the process of resource allocation in the earlier years of the NHS. Archie succinctly identifies the guiding principle in those days as being "the same as last year plus or minus 5% for pressure groups". Those who feel nostalgic for those simpler, less contentious times must recall that it was this reliance on historical precedent which perpetuated the dominance of the acute specialities, and cast psychiatry in the role of Cinderella. His subsequent outline of a more rational approach to what current jargon would classify as 'rationing' or 'prioritisation' prefigures both the invention of the Quality Adjusted Life Year (QALY) as a common currency for comparing treatment outcome, and the current requirement that NHS purchasing authorities should base their decisions on the systematic assessment of the health needs of their populations.

There is so much to applaud that it comes as something of a relief to the critical reader to discover an area where some disagreement appears justified. There is more than just a hint that he had little time for those who emphasised the importance of social inequalities in determining health and health service usage. He is uncharacteristically tetchy when, after grudgingly acknowledging the research evidence of a social gradient in use of health services, he dismisses the information as useless since nothing can be done about it. It is hard in 1994 to be as confident as he was in 1972 that "the NHS has gone a long way towards reducing social class inequality" when we have seen a progressive widening of the health divide over the past 15 years. His firmly-stated opinion that 4% of the Gross National Product is quite enough to spend on a health service will seem startling to an audience aware that most Western countries now allocate to health a considerably higher proportion than this.

Archie's enthusiastic insistence that effectiveness should in future be the basis for allocating resources between health services, opened the door for unglamorous specialities like psychiatry to compete on an equal footing with the historical heavyweights of acute medicine and surgery. His clear statement that cure is rare while the necessity for care is widespread will encourage psychiatrists that his heart was in the right place. Research and social psychiatrists will approve of his collaboration with Aubrey Lewis in the 1950s in establishing a community survey of psychiatric disorder in South Wales, while psychotherapists will note that he was fascinated by the ideas of psychoanalysis, attended Freud's seminars in Vienna in the '30s ("dogmatic and disappointing") and spent over two years in personal analysis with Theodore Reik, following him from Berlin through Vienna to Holland. This may permit us to concede some justification for his judgement that psychiatry in the 1970s could rightly be criticised for using a large number of therapies of unproven effectiveness. We cannot but endorse the correctness of his call to ban the prescription of amphetamines, but we might be tempted to ask him to justify his claim that psychiatry is "basically inefficient". He obviously recognised the limited impact of randomised controlled trial (RCT) methodology in psychiatry and one longs to know what adaptation of the method he might have proposed to accommodate those areas such as psychotherapy which do not readily fit the classical design.

He toyed with the idea of publishing a league table of medical specialities, ranking them by the extent to which they had conducted and acted on the results of RCTs. With a characteristic mixture of humour and serious intent he invented instead two types of award: a commendation for the speciality he identified as having behaved most creditably in this respect (named a "Bradford" after that doyen of medical statisticians, Sir Austin Bradford Hill) and a 'wooden spoon' for the speciality which had most signally failed to evaluate practice. He had no hesitation in awarding the palm to the TB chest physicians. It is a tribute to the persuasiveness of his thesis that Archie Cochrane lived long enough to see the speciality which had been the first recipient of his "wooden spoon" (obstetrics and gynaecology) become the first to publish a comprehensive and regularly-updated review of evidence from RCTs of treatments, which now serves as a model for other specialities to follow (Chalmers *et al*, 1989). Perhaps if mental health research had received a more decisive raspberry, we might by now have had a similarly comprehensive database of psychiatric trials to guide our practice. He would surely have appreciated the intention behind the establishment in 1992 of the eponymous Cochrane Centre in Oxford (Chalmers *et al*, 1992; *Lancet*, 1992) dedicated to collating, analysing and disseminating the results of controlled trials of treatments, although he might well have protested that Bradford Hill, as the originator of the RCT, was a more worthy name than his. He would certainly have expected that the activities of the centre should themselves be subject to evaluation against its stated goals.

What further action would Archie have been urging on us now? We can be fairly certain he would have pulled no punches over the persisting long time-lag before changes in clinical practice

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reflect the findings which are available from the controlled trials he commended. The main components of an effective package of treatment of schizophrenia, for example, have been evident for a decade or more, but in how many services are all these components now routinely provided? Even where up-to-date reviews of the evidence from trials are conveniently supplied, they seem to be of less interest to clinicians than to managers and policymakers. How well does the growing enthusiasm among GPs (and psychiatrists) for selective serotonin reuptake inhibitors as a first-line treatment correspond to the extensive analysis of evidence from trials? We can anticipate that Archie would have supported the principles of clinical audit and the development of explicit guidelines on clinical practice while deprecating the extent to which these worthy activities sometimes fall short of the scientific standards which apply to good research. Never one to shirk the awkward implication of a rational principle, he would have encouraged us to face up to the difficult decisions which arise from prioritising and rationing health care on the basis of effectiveness, while reminding us of the fundamental principles of equity of care upon which the NHS was founded.

Archie Cochrane was a rational revolutionary, a prisoner, a poet, a meticulous scientist who rejected scientific English as unreadable, a pure academic who became the stoutest defender of applied research, a relentless gadfly of the medical establishment who delivered his criticism with a wry smile. He was an epidemiologist who read Freud, and it was from Freud's *Zukunft einer Illusion* that he drew hope for the gentle voice of intelligence to produce order out of chaos. When we look forward from the future which he so eagerly anticipated in 1972 we might be forgiven for imagining that if intelligence had a voice, it would sound like Archie Cochrane.

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