Editorial

The weaver's tale

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My great-great-grandfather, Robert Dykes, lived in Galston in Scotland in the 19th century. Through old parish records and birth and death certificates I have been able to trace a bare skeleton of a life on which I impose my impressions of what his times were like.

His father and grandfather were handloom weavers, and as he and his brothers and sisters grew up, their prospects looked good for a comfortable future. The handlooms on the ground floor of the house were the geese that had laid some relatively golden eggs for 150 years before.

The cloth that they produced was of the best quality and the price people were prepared to pay was good. They must have felt good as they maintained their professional standards and sent off their annual subscription to the Royal College of Handloom Weavers.

Then rapidly the world changed around them. Nothing changed about the techniques or the quality – we would all be grateful if our cloth was still made by them – but the world around them moved on and they were left behind. No doubt they were resistant to change, but soon the old handlooms were abandoned and the brothers and sisters found poorly paid jobs in the new factories, mines and engineering shops.

Robert Dykes was still working at the factory when he died in 1887, aged 80, of 'scirrous carcinoma of the stomach'.

He was a man who had outlived his vocation and he suffered for it. According to Smout[1] there were 84 560 handloom weavers in Scotland in 1840 and only 4 000 by 1880. The handlooms were no more and 120 years later Robert's successors are based in Fiji and Indonesia, and the only people who still make cloth like he did are hippies. Even the mining and heavy industrial occupation they moved to are no more.

Over the past four weeks I have attended three gatherings of GPs and there is no doubt that the prevalent feeling is one of deep pessimism. It seems that in government and in our own profession there are those who believe that General Practice is about to go the way of handloom weaving.

The delivery of excellent, clinically-based primary, personal and continuing care to individual members of our population seems now to be considered as a luxury item by our political parties and they would prefer to deal in the mass production methods of implementing screening programmes, reducing waiting lists or correcting the deficiencies of delivery to certain groups.

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It seems that the impossible game of health politics can now only be played by slick and thick-skinned managers who find easy gains in the shape of the erring doctor, the unfortunate patient or the deficient system, but difficult times in showing any profit from their enterprise. Fortunately they are not paid by results; that is the fate of the general practitioners.

In the past financial year, as a rural general practitioner, the profit from my small business fell by a disturbing 13%, and the 'goodwill' I paid for the privilege of succeeding to the partnership seems like a sick joke. I suspect it is that kind of statistic being repeated all over the country which is producing the gloom and doom. No other group in health care has taken such a recent reduction in income, and there should be no puzzle over the cause of the loss of morale.

In 1982 my first contribution to this journal was entitled *A time to be mature*, and if there ever was such a time it is now. There is no doubt about the beauty and quality of much of the product which is currently being woven in General Practice in this country. The question is whether values and passion are going to be enough to ensure the better health of New Zealand. Money will not be eulogised, but money is the problem.

The underlying issues are that people cannot afford health care without considerable subsidy, that governments cannot afford to subsidise all health care, and that health professionals cannot work without reasonable rewards.

So rationing of health care is inevitable and the planners struggle with what Weale[2] has described as an

inconsistent triad which is *a collection of propositions, any two of which are compatible with each other but which, when viewed together in a threesome, form a contradiction*. In the case of health care, Weale argues, the propositions are (1) a comprehensive service, which is (2) of high quality and (3) free of charge at point of need.

So you can have a comprehensive service of high quality but it can't be free; or you can have a free, high quality service but it can't be comprehensive; or you can have a free, comprehensive service but you can't have quality. Weale argues that the UK National Health Service (comprehensive and free but lacking quality) is at least better than the US system (comprehensive and high quality but not free.)

He advocates a third way which is high quality, free but not comprehensive, but this depends on decisions on core services which are impossible to reach. He also quotes Sir Isaiah Berlin: *We live in a world of conflicting values where clearcut solutions cannot in principle be found. To suppose that we can escape this conflict of values by retreating to an ideologically and organisationally simpler world casts a veil of deceit over the choices that must be made*.

Nothing could better describe the crisis facing New Zealand primary health care at the present time. For 10 years or more our hospital and accident services have been 'reformed' by reductionists who have attended only to what can be counted and what can be proved to be effective. Even measured by their only outcome factor – cost – they have failed to demonstrate success.

However, undaunted, these same ideological and organisational simpletons have turned their attention to primary health care and have produced reports which fail even to mention the overwhelming role of the general practitioner in our present system.

They describe a simple world where prevention and health promotion will replace diagnosis and prescription. Willing and happy professionals will go among the population filling in forms and completing surveys and the typical New Zealand general practitioner will be as redundant as the handloom weaver.

We have to beware the equal and opposite reaction by wishing to return to an ideology which states that General Practice is an effective way of delivering primary health care in every setting and with all cultures. Why don't both sides move on from our desire for simplicity and solutions and weave a more enduring product which people are prepared to pay for, thus ensuring not only our survival, but the renaissance of our health system.

This argument is not about the future of General Practice, it is about the future of our health system. We must all work together to improve the product remembering a few simple principles. The first is that good primary health care involving communities and individuals and delivering curative and preventive services is essential for all New Zealanders. The nature of our country's terrain and our bicultural heritage makes that task difficult enough without trying to start at the beginning by abolishing General Practice.

GPs, by their investment in premises and equipment and their employment of staff, *are* primary health care in this country. The current workforce needs to be affirmed and more appropriately rewarded.

The second is that dealing with people is difficult, if not impossible. The human tendency to selfishness and self-centredness affects the whole process in patients, populations, practitioners and politicians.

The final issue is that health services will always cost more than the state can afford. Most of the problems facing us all could be eased by extra funding, but rationing will always be necessary and targetting of health services to those who need them most is often difficult because there are those who cannot pay and those who will not pay if they can avoid it.

Unlike the handloom weavers, General Practice will survive the competition, but only by moving with the times, retaining our relationship with the people, and pricing ourselves in the right place in the market. In Robert Dykes' day the slick and thick-skinned managers seemed to win the day by taking advantage of market slumps and new technology, thus mass-producing his skills and reducing him and his family to poverty. In doing so they ruined the country and produced 'a nation epidemical' whose families have scattered over the world.

We need to find a new way to deliver not only health care but the services which make for a healthy community and emphasise individuality and the dignity of the person.

General Prac-tice is here to stay in New Zealand and this journal will attempt to provide a vehicle for scientific en-quiry, radical thought and ex-ploration of possibilities for the future.

As your new Editor I am fortunate to have known and respected all four of my predecessors: the late David Cook, Ian St George, Rae West and Tessa Turnbull.

I look forward to the challenge and hope that you will read what we produce and write in reply.

References

1. Smout TC. A century of the Scottish people. Collins. London 1986.
2. Weale A. Rationing health care. BMJ 1998; 316:410-411.