The future of General Practice

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It is a great honour for me to have been invited to give this presentation at your conference, and a great pleasure to accept. The future of General Practice requires urgent debate. There is a mounting sense of crisis. In the United Kingdom the majority of general practitioners have returned a postal ballot and have declared that they will resign next April if their terms and conditions of service are not improved. In an unprecedented three-day strike in the Netherlands, general practitioners protested against a lack of resources and increasing administrative burdens. I read recently that the best advice for a young general practitioner in New Zealand is to go to work in Australia. Later in this conference we will be examining further critical issues in General Practice, including the problems of demoralisation and burnout and the challenges of continuing professional development and education. In this presentation I would like to consider how effective General Practice-based primary care fits into a health care system and to offer some thoughts on how it could and should develop in the future.

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You will be pleased to know that I have not brought any slides of my practice, my consulting room or the English rugby team. I have, however, come with a story which was told recently in the course of a lecture on the need to rebuild trust between patients, medical professionals and politicians, of which I will say more later.

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A man was drifting across the countryside in a hot air balloon when he realised he was lost. He descended towards the ground and when he was within earshot, called out to a man working in a field below to ask him where he was. The man replied that he was standing in a hot air balloon and was 30 feet above the ground. The balloonist said, "You must be a scientist."

"How do you know that?" asked the man.

"Because the information that you have given me is completely accurate and also completely useless," replied the balloonist.

"Well you must be a health policy maker."

"How do you know that?"

"Well, you don't know where you are, you have no idea where you are going and you are blaming somebody else."

In this opening presentation I will try to describe where we are in General Practice, where we might be going and who might help us to get there.

General Practice or primary care?

This is not a merely semantic question, but part of an important discussion about the groups and structures that constitute primary care and how they relate to each other. For the purposes of this presentation I am going to use the terms interchangeably, in the sense that they both refer to General Practise-based primary care, and although I include other members of the primary health care team who themselves may be professionals of first contact, I regard the co-ordination of patient care in this setting as the responsibility of general medical practitioners.

Defining primary care

Where are we at the beginning of this new millennium? John Fry, almost a quarter of a century ago, enunciated the key features of primary care, and these have changed little over that time. However, in the intervening period the pattern of provision of health care has changed enormously in response to scientific, medical, political, financial and social pressures. Indeed, John Fry's narrative description of the role of the primary care physician of the 1970s seems now almost to reflect another era.

More recently Barbara Starfield,[1] in a important Lancet paper entitled *Is primary care essential?* (to which the answer was a resounding yes), redefined the characteristics of primary care as the provision of first contact, comprehensive, continuing and co-ordinated care. The location of a primary care system within the social and medical fabric of a community or a nation was described in

the Alma Ata declaration of 1978 and this extract provides important guidance. Beyond its structures, these are some of the key functions of General Practice, which include the appropriate use of resources, helping to understand and educate patients, to serve a gate-keeping role between primary and secondary care and to influence the appropriate provision of secondary and tertiary services.

Some of the problems we now face in primary care include those of recruitment, retention, burnout, poor rewards, falling professional esteem and loss of professional identity, and questions about the quality of care provided. It is, of course, important to recognise that these are not only problems of primary care but also of secondary and tertiary care medicine, and also of other professions in the western world.

The crisis in General Practice

The crisis developing in General Practice and primary care can be linked to a series of tensions between certain core aspirations and values of General Practice and primary care, and the changing medical, scientific, social and financial environment. I would like to discuss these in turn, and for each to offer a possible means of resolution.

First, there is a tension between the provision of personal medicine and the exercise of a public health role. Few would disagree that health promotion and disease prevention are key roles of General Practice, but to undertake health needs assessment and to modify service provision entails the collection and analysis of complex demographic, clinical and other data, often beyond the ability of individual general practitioners or small groups. Collaborative, interprofessional working and support from disciplines such as public health medicine, epidemiology and health services research is likely to be crucial in ensuring that we can meet this important obligation.

The tension between advocacy and resource constraints affects us all. Crucially, primary care remains under-valued and under-funded, although there is substantial evidence that clinically effective primary care is likely also to be cost-effective. There is confusion about the role of federal insurance, co-payment, private insurance and other ways of financing primary care. In many countries substantial sections of the population remain uninsured. We must continue to demonstrate the cost effectiveness and clinical effectiveness of primary care to ensure that appropriate investment is made at national and regional level. Politicians need to understand that high quality primary care is not a cheap option, but is a good investment.

One of the characteristics of General Practice in the past was its flexibility and ability to move quickly to respond to individual needs. Increasing bureaucracy, and the imperatives of accountability and clinical governance threaten this manoeuvrability, but with appropriate use of information technology, and well-supported administrative and management systems, it should be possible for clinicians to ensure that their desks and their minds are kept clear enough to practise medicine.

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There is potential for the personal role of the general practitioner to be both enhanced and threatened by team care and the need to delegate. Multiple professionals threaten to de-skill each other, and multiple contacts threaten to depersonalise medicine itself. Deconstructing General Practice has substantial professional and financial implications, so that participation rather than confrontation with other professionals and care providers is likely to be crucial. Health policy makers need to be warned of the dangers of asset-stripping primary care. Personal medicine is also threatened by increasing consumer choice and, in the absence of a unified medical record, disruption of personal and organisational continuity is threatened, duplication of resources is likely and communication between professionals will undoubtedly suffer. One, but of course not the only, approach to dealing with this problem is a registration and capitation system for patients with comprehensive primary care services, sufficiently well-resourced to meet patients' needs without the necessity of seeking alternative care providers. The gate-keeper role, essential clinically and financially, is likely to come under further pressure because of patients' expectations. Politicians and the media increase the hype about the miracles of medicine, and fuel patients' expectations of immediate access and 24-hour availability. Conversely patients themselves have increasing expectations of, and indeed increasing needs for, the pastoral role of primary care, when they are confronted by crushing medical and personal problems. We need to be realistic about the powers of medicine and our abilities to cure illness. This requires a much greater degree of honesty from ourselves, from the media and from our politicians.

Financial constraints

The provision of high-quality care at a time of shrinking financial resources affects us all. We are all constrained in our use of investigations, referrals and prescribing; managed care and corporatisation have been introduced in an attempt to deal with high spending in primary care. At the same time secondary and tertiary care budgets are also out of control. We must continue to develop and disseminate the cost-effectiveness arguments of high quality primary care and determine how best to provide cost-effective configurations of pri-

mary care services which are appropriate to local needs.

We are all familiar with the concept of the therapeutic illusion. The doctor/patient relationship remains central, yet the increasing pressure to practise evidence-based medicine and to abandon practices that have no evidence base is becoming irresistible. We must continue to press for more research funding and more research activity into the core activities of primary care and link this to relevant and effective continuing medical education programmes.

Political pressure

Many of these tensions have contributed to what amounts to a breakdown in trust between patients and their doctors. The second half of the twentieth century has been marked by the exercise of political power and of terror by successive leaders of nation states, and it is hardly surprising that concepts such as duty, community professionalism and societal values have been called into question. The professions themselves have been undermined by governments on both sides of the Atlantic and this bizarre process continues today in the United Kingdom with continuing adverse effects on relationships between patients and their doctors. Good communication has never been more important, and communication failure is almost always at the heart of medical complaints and negligence actions. Misunderstandings are more likely to occur between strangers than between acquaintances, and the preservation of personal medicine characterised by the development of mutual trust and understanding and a shared agreement about expectations is crucial.

The future of General Practice

This conference is entitled *Hot Stuff*, so my story about the hot air balloon is not entirely inappropriate. If we allow our balloon to rise a little higher, where might we see General Practice developing in the future?

First of all we must not allow General Practice to be dismantled and deconstructed. General Practice-based primary care is much more than the sum of its component parts and these cannot be hived off to corporate or entrepreneurial interests. We must win the cost-effectiveness argument, and demonstrate that putting appropriate resources into primary care really will lead to more effective use of resources in other sectors of the health care system. We have a prime responsibility to nourish and sustain a healthy primary care workforce capable of having healthy relationships not only with their patients but also with their own families. In creating comprehensive primary care we must work collaboratively with other professionals, but not necessarily with corporations. Some of the core values of General Practice are not always compatible with shareholders' interests.

We need to think imaginatively about ways to encourage and reward a varied and changing professional life. There is no reason why the brightest and most committed medical students should not once again view General Practice as *the* career choice, and we need to think of ways of ensuring that they do so. Linked to this we need to continue to build on our educational and academic foundations. General Practice provides a superb setting for undergraduate education, with role modelling that can have a profound effect not only on the future of our students but on the future of General Practice itself. We must continue to press forward with a properly-funded programme of research in primary care so that key issues in clinical medicine and in the configuration of primary care services are properly researched and form the basis both for our work and our continuing professional development.

Finally we must keep our patients at the centre of things, and not forget that they are the reason for all of this and in the end may well turn out to be our most important allies.

Reference

1. Starfield B. Is primary care essential? Lancet 1994; 344:1129-33.