Millennium 2000 questions for all

Eric Elder Address at the Asia/Pacific WONCA Conference, June 2000

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It is a privilege to be asked to give a keynote address at an international meeting in one's own discipline, particularly when it is at the furthest point it is possible to be from your usual place of work. However my Asia/Pacific credentials are strong: this is my third working visit to New Zealand, and I have had five previous experiences of visiting both Thailand and Australia since I attended my first WONCA meeting in Singapore in 1983. These visits and the passing years have taught me that General Practice looks more the same than it is different wherever in the world we travel. It is reasonable to hypothesise that the challenges of responding to change in the world of the new millennium will in principal, even if not necessarily in detail, be the same worldwide too.

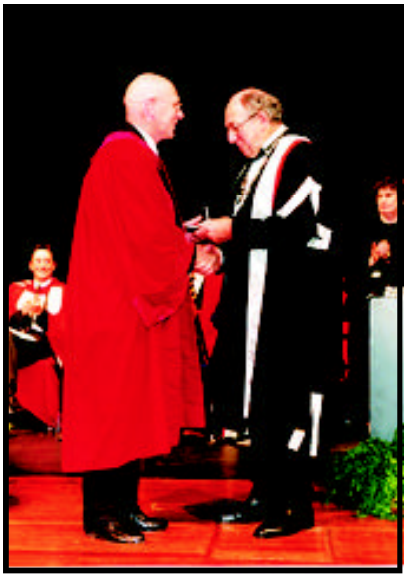
During my first visit to New Zealand in 1986 I met Eric Elder at a meeting we were both contributing to in Invercargill. We had both arrived early and we conversed easily, although neither of us knew anything of the other. I was completely taken over by his warmth and modesty, his obvious wisdom and his interest in others and their worlds. Eric Elder graduated in Otago in 1937, the year I was born, and of course, like my father, he was born in Aberdeen. He went on to complete 49 years as the doctor in Tuatapere – the perfect role model, and the epitomy of what this paper seeks to make sense of. It is a real honour for me to receive the Eric Elder medal of The Royal New Zealand College of General Practitioners at this time of my last major engagement at the end of my 30 years in university General Practice.

Innovation

The theme for Asia/Pacific WONCA 2000 is *Innovation in teaching, clinical practice and the delivery of care.* This paper takes a view from several backgrounds; these include research and philosophy, and the politics of health service structure and management. But, throughout, the issues of health care as they affect patients run close to the surface, and the whole is meant to resonate clearly with the world of contemporary physicians practising their trade. Wherever we are, the key questions are: when we are ill, can we see a doctor? Will the doctor be expert, or at least competent and safe, and will the care be effective? These questions point directly to the four issues I will explore in this paper. Are we talking about General Practice or primary care? How do we provide care? How do we define goodness at consultations? What are the roles of governments, colleges and universities in assuring that patients receive the best deal possible in the years ahead.

What is our discipline?

In the 1960s McWhinney defined the criteria of a discipline as having an independent body of knowledge, having specific skills, and being able to support its own research agenda and postgraduate training.[1] Richardson used similar criteria but did not include postgraduate training. Instead



Professor John Howie (left) with RNZCGP President Dr Graham Woods at the 2000 Conference.

he included the need for a discipline to have its own philosophy.[2] Philosophy is most simply defined as the system of beliefs and values which underpin an activity, and the several definitions of good General Practice which have informed the evolution of our subject all refer to the importance of matching knowledge and skills to attitudes.[3,4] What are the core values that this implies? The first is almost certainly holism. Integrating the physical, social and psychological dimensions of health into care is taught throughout medicine, but most clearly seen in action in General Practice where clear-cut diseases are a smaller part of daily practice than they are in hospital. We have taught and practised the importance

of using 'the potential of each consultation' to explore continuing health problems which may co-exist with acute problems presented, and are encouraged to take opportunities to offer preventative and health education procedures when appropriate.[5]

The second core value is the involvement of patients in the process of defining and managing their health and ill-health. As with holism, this is taught throughout medicine, but it is in General Practice that it is most easily seen in practice and where most systematic attempts to research and reward its practice have been located.

Again its tradition extends far back. In the 'modern' era, Balint was its most identified early proponent, but more recently Moira Stewart's team have done most to try to tease out how the behaviours and skills of consulters can be analysed and their relation to outcome assessed. Despite major investments in research, patient-centredness remains a difficult concept to tie to convincing evidence of patient benefit. Almost certainly this means not that the concept is wrong, but that we have not yet effectively 'operationalised' it.[6-12]

Patient-centredness remains a difficult concept to tie to convincing evidence of patient benefit

Wensing has reviewed the literature on what patients want from consultations with general practitioners, and amongst the responses they give are that they want good access to care, time to be listened to, the chance to see a regular doctor, involvement in decisions about their own care and explanations that they can understand.[13] Perhaps a new starting point for research into, and thinking about, patient-centredness needs to start from this point.

The first issue I want to raise in this paper is whether our discipline is General Practice or primary care. We are often tempted to use the terms as if they are interchangeable, and to an extent they are. For me the key difference is that General Practice is a service which is built around its core values of holism and patient-centredness; primary care on the other hand is simply a system for ensuring access to essential health care, and can be provided on a purely 'medical model' basis. In countries where a strongly developed General Practice system is used to deliver primary care, issues like continuity of care (either at practice or individual doctor level) and about the availability of adequate time to develop a properly holistic approach are higher up the agenda than they are in countries where resources are stretched more thinly and the mere availability of any primary care is an end in itself. The 'market-forces' vision of health service provision in the last decade has raised new questions about the advantages of the choice between General Practice and primary care as the way for the future, partly because primary care may on the surface appear a cheaper system to deliver, and partly because it allows patients the freedom to 'shop around' – which on the surface sounds an integral correlate with empowerment and patient-centredness, even if it may perversely promote the delivery of what patients want rather than what they need.

In the rest of this paper I work from my own belief that when General Practice is good, it is the best way to deliver primary care.

How do we deliver it?

To help link the philosophy of the first issue with the politics of what will be the last issue, I want to reflect on how we deliver care and assess its quality. For the first part of that task I want to present three necessarily brief case studies of how primary care/General Practice is delivered worldwide. The three I have chosen are the UK (because it is where I work and know the system best), Australia and Thailand (whose health services I have had enough involvement with to have a working feel for a number of issues which contrast between them and between them and the UK). The structure of UK General Practice has been reflected in many parts of the world and is, I believe, a fundamentally good system to use as a comparator. But in the modern era of increasingly rapid change, even it forces pressures to change which are not clearly for the good of patients or professionals.

The UK

The UK primary care centres around registration of virtually all citizens with a named general practitioner who usually works in a group practice with around four other doctors. Practices are well supported by nurses, and in the larger ones other professions (for example pharmacy, physiotherapy, counselling, social work and chiropody) are also attached or employed. Clinical and IT support are generally good. The services are largely 'free', being supported mainly through the state taxation system. Virtually all primary and secondary care is accessed through the practice with which the patient is registered, although a number of new initiatives giving access (for example to a nurse-manned help-line service) are presently being piloted.

The workforce is well trained and certificated; incentives to 'good' practice reflect varying central priorities generally relating to preventative medicine and biomedicine rather than to the promotion of holism or patient-centredness. The status of the discipline within both the Health Service and in the university sector is strong and improving, but like any professional activity never wholly safe from threat as beliefs and values in society shift.

The 'average' general practitioner looks after 1 800 patients and the average practice size is around 8 000 patients. Rurality is an issue of importance even if on a different scale from that in Australia and Thailand. It has however been comfortably addressed with a modest use of incentives.

The UK has around 30 medical schools, the uncertainty reflecting current processes of merging some and creating others. There are presently eight graduates annually for every 100 000 population, a figure which will probably rise a little by the end of the decade.

Australia

At first sight, the greatest difference between UK and Australian General Practice is that Australian patients do not register with a General Practice provider. Although many do attend one practice consistently (either from choice or through necessity) patients can attend several doctors either for one illness or for different illnesses, and both continuity and the usefulness of clinical records are threatened by this. Generally, patients pay a part of their consultation costs and have insurance cover. As in the UK, the workforce is well trained and RACGP Fellowship is a prerequisite for recognition as a principal. The incentive system is, however, less favourable to doctors in Australia, and average list sizes of 1 000 or below (in particular in the cities where the population is concentrated) threatens the viability of General Practice as a career.

> In General Practice the key issues are seen as access and effectiveness

Australian medical schools produce 6.4 graduates per 100 000 population per year. It is probably fair to say that both in the medical schools and in professional circles generally, Australian General Practice still struggles for parity of esteem compared with specialist medicine.

Thailand

Thailand is more different from both Australia and the UK. There is almost no parallel to the practice-centred provision of primary care. Instead patients choose between attending private clinics mainly staffed by specialists at the end of their day's work in hospital practice, or going to hospital out-patient clinics where most doctors are recently qualified graduates undertaking compulsory hospital-based service in the primary care arena. These doctors have little if any training in the particular challenges of primary care. Inevitably patients have long waits to be seen, have short consultations and virtually no continuity of care. In remote areas first contact primary care is provided by nurses and sanatoriums.

Currently Thailand's medical schools graduate just over two graduates per 100 000 patients per year, and there are in effect 10 000 patients for each medically qualified primary care provider. In recent years, there have been significant and visionary efforts by a small but committed cadre of government officials, a growing number of academic staff in Thailand's heavily stretched medical schools, and a still small number of Thai doctors committed to introducing a General Practice-based primary care model in local communities. But strong vested interests guard the autonomy of specialist and private medicine, and the incentives to attract and retain doctors in state-based primary care are conspicuously insufficient. Until these are improved dramatically, the status of the discipline is destined to struggle.

Examples

These case-studies are examples rather than representative of the huge variety of the contexts within which primary care is provided worldwide. How credible is it to comment on and to compare process and outcomes of care across such diverse settings? Partly these comparisons need to cover the total provision of services to patients, and at the level of comparing indicators of 'the public health'. Most difficult, and I believe equally as important, is to attempt to look at what happens at individual consultations which is where the 'core values' we have identified are expressed or not expressed. And then to explore the relationship between consultation 'quality' and the settings and systems which promote or inhibit its delivery.

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Quality of care at consultations

Interest in how to measure quality of care in medicine is now worldwide. In General Practice the key issues are seen as access and effectiveness. Adherence to guidelines attracts many, and the use of routine statistics on prescribing, referring, and achievement of public health targets has clear appeal to managers. The central component of General Practice is, of course, the consultation. Defining and measuring 'goodness' at consultations is a challenge still to be met on the scale necessary to be widely applicable on an everyday basis.

Over the last two decades we have been attempting to do this in a way which will capture the core values of the discipline. Our starting point was an attempt to link perceived stress on doctors to length of consultations and to decisions taken at them. Longer as against shorter consultations (in the UK context meaning 'ten minutes plus' as against 'five minutes or less') were related to more holistic consultations.[14] They were also related to a variety of desirable patient outcomes related to, but not quite the same as, satisfaction. These included feeling more able to cope with illness and health and life problems (measured immediately after consultations), and having a better understanding of what was happening – all matters patients have said are important to them. We have called this cluster of outcomes 'enablement', and feel it is a measure which may have a contribution to make to under-

standing what quality is and how it can be delivered most effectively.[15]

More recently our team has used the question *How well do you know the doctor you are seeing today?* as a proxy for continuity of care, giving us a second measure which is dependent on patients' responses.

In a recent study of 220 doctors in 56 practices in four culturally contrasting parts of the UK, we have created a 'Consultation Quality Index' (CQI) using data on consultation length, continuity and enablement as its three components. The CQI appears independent of the deprivation status of where the doctor works, independent of case-mix, and fair to younger as well as older doctors. It requires minimal input from the doctor, and should be capable of being analysed easily on a large scale.

The early results of our studies suggest considerable face validity (we have picked up one significantly depressed doctor and several doctors and practices with other important and hopefully remediable problems) and we have encouraging evidence that our scores may be repeatable over time. The doctors who scored best worked in smaller practices (total lists up to about 8 000 patients); the doctors scoring least well generally worked in larger practices (total lists typically over 10 000 patients).[16,17]

Somewhat by good fortune we have found another issue of importance. We asked both patients and doctors what languages they spoke at home and whether their consultations would be conducted in English or in another language.

'Other language' consultations were consistently shorter and more enabling, one apparent exception being when patients' problems were classed by us as psychological, when the brevity of consultation appeared a disadvantage. It is clear that work of the kind we have piloted in our 'home' setting needs to be repeated in diverse cultural settings, and that decisions on the 'right' health advice structure for one country against another should be based on a research base particular to that country.

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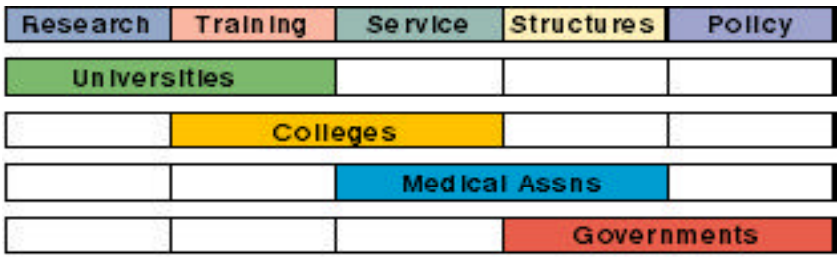
Finally, we tried to compare doctors' and practices' performance on our 'core-values' measure, with performance on a second measure we created based on routine-data indicators on prescribing and the meeting of public health targets. This was technically difficult as our CQI is doctor-based, and the routine-data indicators are practice-based, and there were almost no links between the two.

However, better prescribing does seem to be weakly linked with doctors whose consultations are longer; but, interestingly, inversely it is linked to greater continuity of care!

Figure 1



Governments, colleges and universities

This paper has ranged widely over a range of themes including service delivery and the structures and policy issues which underpin it, and research and training which in turn interdigitate with service delivery as well. Governments and professional organisations are likely to agree in principal about the importance of access to care, and the need for care to be effective, but achieving agreement on priority and detail within these broad domains is another matter altogether. Sadly it is also true that the different professional organisations (colleges, medical associations and universities) seem to perform no better than governments do when it comes to working together instead of seeming to be primarily interested in defending vested interests.

It is helpful to portray the domains and the institutions in the form of a map or grid (Figure 1). The way I have done this allocates two activities to each institutional group to indicate what most would probably agree to be their lead responsibilities. By showing overlap, I am trying to promote recognition of the reality that no group has sole ownership of any activity, and indeed all groups have definite competencies across all five domains.

The particular point that I want to make in this paper is that governments have traditionally worked with colleges and medical associations (the name 'WONCA' and the activities WONCA is particularly identified with indeed reflect this) and the contribution that universities can and should make has been under-valued and under-utilised by the artificial distance that seems to exist between academic (meaning 'university') medicine and the setting and implementation of health policy. It is easy to see why this happens. Governments deal in broad-brush initiatives and work to short time scales, constrained by electoral considerations and fluctuating financial realities and public percep-

tions and demands. Universities on the other hand value rigour and detail – particularly in research – and time scales are much longer, often to the point of losing their competitiveness in the world of applied policies.

In the current arena of health service development worldwide, the keywords have become evidence, accountability, access, effectiveness, efficiency and equity. This paper has touched on them all. We could add change and rate of change to the agenda. Worldwide people are either fatigued by the pace of change or frustrated by the absence of change. Could we all learn to work together in an environment of openness and trust, instead of working apart in an atmosphere of suspicion and defensiveness? The second choice seems to have so much to offer.

We could start the process by presenting Figure 1 as a circular continuum instead of as a two-dimension model whose ends are apart from each other. That would at least be a beginning!

This paper started with questions and issues, and must end with concepts. Two seem to capture the argument I have been developing. The first is philosophy and the second is theory. The philosophy I have centred on is reflected in the core values of holism and patient-centredness, and issues that patients themselves see as important (time, continuity, empowerment/enablement) have been presented as proxies for this philosophy.

The theory of primary care/General Practice that I use to help develop my practice, teaching and research says simply that the way content of care is provided (whether it will reflect core values, for example) is a function or reflection of how the values of the carer are expressed, and that this in turn is constrained or enhanced by the context in which the carer is working. In particular, context is a function of the availability of adequate staffing levels and of the incentives and rewards which attract (or fail to attract) doctors and nurses and mould the way they deliver their care. Visually this can be represented by the Stott & Davis square, inside the Balint 'doctor/patient/illness' triangle, with an enveloping circle (representing 'content') on the outside.[18] The theory postulates that the way this system works, predicts outcome. It is likely that this will be able to be demonstrated in relation to better patient education and prescribing, for example. Whether it will predict patterns of morbidity and mortality is, of course, an altogether different challenge, but given the importance of the decisions patients can themselves take to influence their own health, it is not improbable that the theory will apply at this level too.

For philosophy and theory to come together needs commitment and collaboration from professions and government, and sensitivity to the cultures and aspirations of communities. In the new millennium, the role of primary care is set to grow and we need to lead innovation by example. Above all, we need to be more proactive and less reactive than we have often been.

And we must base more of our effort on a thoughtful and purposeful integration of theory with philosophy than was generally the case in the millennium just ended.

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