Editorial

Still a time to be mature?

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This will be my last editorial for the *New Zealand Family Physician*. Only a year after taking over the position I have moved to the west of the West Island to take up the challenge of heading up the Rural Clinical School of the University of Western Australia and so I reluctantly put down my pen and cease to be your editor. I am delighted that Tony Townsend has been appointed as my successor and I am sure that in his hands the journal will continue to prosper.

By some coincidence the first editorial I wrote for this journal was twenty years ago in 1982, just before I took up my appointment as Elaine Gurr Professor of General Practice at the University of Otago in Dunedin.[1] It was a well reasoned homily written by someone who had no idea about general practice in New Zealand and no idea what interesting experiences he was to have both in the nine years in Dunedin and in the later three years in Winton. In that paper I wrote these prophetic words:

We have been rediscovered, we have entered centre stage, one can almost hear the compere reading the Alma Ata declaration. What we need now is a script and a performance which will have them on their feet to a man (forgive the sexism – it was 1982) *when it is finished. But we haven't started yet, the cynics are beginning to wonder whether anything is going to come, and I reckon that we have till about the end of the century before the general hail of rotten tomatoes begins to hit us*.

In fact this was written from a British perspective, because general practice has never really been discovered in New Zealand, at least not by politicians and health planners. Still I am sure everyone working in the discipline has the distinct impression of being booed off the stage, and there is genuine puzzlement about why that should be.

So where did it all go wrong and what do we do to restore the position of general practice?

The death of general practice

In his Presidential Report in 2001,[2] Niall Holland made the point that while the theme of current Government policy is to expand primary health care, the hidden message is that this can only be done by the death of general practice as we know it. The throwaway medical press which I get from New Zealand is full of this very point, with politicians denying that they have any such intention and general practitioners being starved of government funding to do anything while they see DHBs and PHOs being given pots of money to do what we've all been doing for years.

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I think I can write with some authority because I spent the last three years in rural general practice watching the last vestiges of a perfectly good system evaporating in the heat.

I joined Winton Medical Practice because it was the best and left it as the last full-time doctor out, and in the hands of a part-time colleague and brilliant practice nurses and staff. Thanks to them and their persistence it is still there, but like the New Zealand Health System, it won't survive without vocationally trained general practitioners. Winton Medical Centre is like a jet in the RNZAF: fast, functional, but dispensible in a policy which declares that the war against disease is over, and that lawyers, accountants and policy analysts are the essential workers in the creation of a new age for health. It was a vehicle piloted by doctors, navigated by nurses and maintained by clerical staff, but it is now redundant, replaced by the PHO 2002, whatever that will turn out to be when the wraps are removed.

The disaster is obvious for all to see if you live in Tuatapere, Winton, Oxford, Gore, Palmerston – where once there were excellent medical practices with 24-hour cover, GP obstetrics and the comfort of knowing that when you got sick, the doctor would be the person you saw the last time. This gangrene in the country is spreading to the towns and I do not know what we can do to stop it.

The case for general practice

It is ironic that general practice is in terminal decline in New Zealand just at the time when it is being increasingly recognised worldwide that the discipline of general practice/family medicine has much to offer the community. The underlying philosophy of individual patients, families and community groups having access to

a generalist physician who has known them over time, has access to their records and who can refer them to other medical services if it is thought to be appropriate, is being adopted in the former Soviet Block after years of decline due to the population-based model which is being forced upon us.

One of the problems we have faced in New Zealand is that the general practitioner is seen as an old fashioned concept. We are still saddled with the myth of Dr Cameron,[3] the elderly male doctor about whom hangs *'the odour of drugs, carbolic and strong tobacco'*.

The abstraction held by the *'bright young things'* who write our health policy is that we are male, individualistic, paternalistic, elitist and resistant to change. Much better to have a multidisciplinary team where the day can be spent in the collection of data and the discussion of evidence – admittedly an equal and opposite abstraction. The reality is that most general practitioners in New Zealand are intelligent, hard-working and clinically competent.

We are the most commonly consulted health professional, even by 18-year-olds.[4] Another problem that we have is that we have not had the time to describe what we do, or turn our work into randomised controlled trials. However, it is now acknowledged that general practitioner-led primary care is good for individuals and good for health systems. A review of the New Zealand primary care system noted that the only good thing about it was *'the use of generalists as the predominant type of practitioner and the low proportion of active physicians who were specialists'*.[5]

This same comment was applied to the use of the general practitioner in the UK[6] with the comment that *'a relationship based on personal doctoring has multiple functions: it serves as the first filter for identifying new health problems, it serves as a place where advice on health issues can be given, it provides an opportunity for comprehensive management, it contributes to the cost effective use of resources, and it provides support and advocacy for the patient.'* We could add the rejoinder of the title of that paper – *'Fix what's wrong, not right with general practice in New Zealand'*.

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Fix nothing. Throw it out.

The anguish of GPs and their patients has been obvious in all parts of this country, but what we failed to understand was the determination of the Ministry of Health to fix general practice one last time.

The focus for the reform has been the National Health Committee which consists of 12 people, only four of whom are medically qualified. Of the latter, two are academics and none are general practitioners.

The reformers want to emphasise population-based rather than person-centred primary health care and, with this in mind, they commissioned six papers on the topic. Although the NHC emphasised that these were independent opinions, they are, with one exception, hostile to the concept of general practice outlined above. The general theme is that GPs are biomedical interventionists who are too expensive for primary care. Examples are:

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...that GPs need retraining but nurses do not

'The literature notes the need for extensive retraining of medical practitioners to accommodate to primary health care. From a nursing perspective we argue that such immersion would not be needed for nurses who, as a result of nursing's theoretical orientation towards health and towards partnership, would embrace a community empowerment model without retraining.'[7]

...that primary health care based on general practice would be a big mistake

'As nurses we would argue that there might be high levels of over-servicing which arise from the medicalisation of health care and which generate considerable cost. Examples include ultrasound scans for normal pregnancy which have become routine in many instances, the cascade of interventions which characterise medical management of birth, and the excessive prescription of antibiotics which are not clinically indicated.'[7]

...that GPs are self-serving

'In response to the health reforms, GPs have formed groups called Independent Practice Associations (IPAs) primarily to protect their political and clinical freedom and resist government intervention.'[8]

The only rejoinder from the representatives of general practice was the statement that 'A Primary Care Organisation (PCO) model is suggested as the most promising population-based strategy to improve the delivery of primary care, and improve health outcomes. It is a capitation model with patient enrolment, of no specific size, but perhaps around 100 000 patients. PCOs would receive needs-adjusted funds for the delivery of a schedule of primary care services. Provided they can meet the performance criteria there are no restrictions on the way they choose to use resources to deliver services.'[9]

So where do you go from here?

It is quite clear to me that the Primary Health Care Strategy has as its main focus two issues, the promotion and protection of the health of certain identified groups, and the reduction in health inequalities between these groups. These are entirely laudable goals but there is a flaw in making it the main vehicle of funding primary health care.

As far as anyone can tell, it is proposed that these groups (PHOs) be funded in such a way that the enrolled pay nothing for their health care and they will have teams of primary health care workers working amongst them in order to achieve these goals. It is obvious that this cannot be afforded for all New Zealanders, so perhaps the basic assumption is that because the majority of New Zealanders have achieved maximum health status they do not need health care, or at least they can do without it until the others catch up. It is a concept that could only come from an academic wonderland but it has now reached the status of government policy and I guess all of you have got to live with the consequences.

There are obviously going to be two types of primary health care in the future, unless the IPAs can somehow miraculously transform themselves into 'third sector' organisations by becoming PHOs. The second type will be the primary health care obtained by those who are unfortunate enough not to be enrolled and funded through PHOs, a fully private general practice. In the PHOs, if the spirit of the reforms is heeded, episodic health care will be discouraged and much more effort will be put into preventive programmes.

We already know what happens with preventive programmes; half the people don't turn up and those who are identified as being at risk don't want to act on the findings. The professionals working in such schemes will be salaried but will be funded by the government for retraining in how to sit in meetings discussing things and how to cope with having paid holidays. Since no one has ever tried to mount such a strategy on such a grand scale, it is difficult to predict what will happen, but I suspect there will be massive public discontent and that the whole scheme will become a political liability.

The healing touch for our discipline will lie in solidarity within general practice

The difficult problem for those general practitioners who are left out of the process will be how to survive without subsidies, but I suspect it will be possible by raising fees to $60 to $70 per consultation and directing those who cannot afford this to the third sector. Given the present level of GP incomes, that course would probably be of net benefit and at least doctors would be saved the indignity of never being consulted about anything. The difficulty is that systems theory predicts that this will increase pressure on the third sector, thus denying them the time to devote to prevention which was the point of the whole exercise in the first place. Within three years there will be so much public discontent that the government will change and we will be back where we started.

General practice will survive

The Public Health lobby have won a strategic victory in imposing population-based primary health care on New Zealand, but there will be no death of general practice unless we decide we do not want to live. As I wrote in 1982, the healing touch for our discipline will lie in solidarity within general practice, and agreement on what we do and how dependent the people of New Zealand are on our efforts. The tragedy is that objectives of the strategy could have been achieved with our enthusiastic participation, if only we had been consulted and had been given the added funding to achieve these laudable aims.

The people need person-centred and not population-centred health care. A recent study showed that patient-centered communication influenced patients' health through perceptions that their visit was patient centered, and especially through perceptions that common ground was achieved with the physician. Patient-centered practice improved health status and increased the efficiency of care by reducing diagnostic tests and referrals.[10] You are living in interesting times and I wish you all the best.

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