2001–2002

New Zealand Family Physician – What's in a name?

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We have pronounced the last rites for the *NZFP* and I am honoured to give one of the eulogies at her funeral service. My first reaction was that the old lady must have reached over 200 editions and so it was probably time for her to give up the ghost. At least she was healthy right to the end and everyone enjoyed reading her and being stimulated by her content. However I am surprised that the Coroner has not been asked to investigate the circumstances of her death. Whenever I attend a sudden death, I make sure someone turns the body over to make sure there are no stab wounds in the back, and this death was very sudden. There she was, one minute, apparently going from strength to strength and now, all of a sudden, gone with no apparent debate as to whether her demise was really necessary. Sounds fishy to me! What's more her bed, still warm, is already occupied by a new journal – the *Journal of Primary Health Care* – which, according to the College website, has already achieved worldwide recognition.

The old journal, it seems, has the same problem as its namesake, the Family Physician, thought to have been buried without trace by academics, politicians and bureaucrats and replaced by Primary Health Care (PHC). There are some who say they are keeping the GPs quiet while they age and that this burial of the *New Zealand Family Physician* is only the first of many such ceremonies. Could this be a premature eulogy to the New Zealand GP?

There are three important questions which I wish to ask as we attend the wake of the *New Zealand Family Physician*.

1. Can we afford primary health care?

Since Alma Ata in 1977, we have been struggling to define what primary health care really means. The most recent document to come out of the Health Reform process in Australia says:

'Primary health care services respond to the individual preferences and circumstances of patients, their families, and carers, and actively support them in achieving best possible health outcomes.'[1]

The problem with that statement is essentially the problem of the definition of PHC – it can mean anything anyone wants it to mean. History teaches us that this promise to respond is an unrealisable dream because health care, like everything else, costs dollars. Health ownership, like home ownership, is a middle class goal, and the promotion of both has done drastic things to the world economy. Offering home ownership to those who could not afford it has very nearly destroyed our pension funds; health ownership has the capacity to do the same thing, only more slowly. The result is that we have to have health rationing which is theoretically possible in secondary care. Governments around the world have struggled with how to ration, the most enlightened example being the Oregon Health Plan, which has recently gone belly up. As a recent critique put it: *'the intentions behind the plan were good and noble but the notion that healthcare costs can be controlled line by line was foolish.'*[2] In primary care, the lines are more confused but responsibility for the process has taken an interesting turn.

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I will not bore you again by explaining Weale's inconsistent triad as I did explain it six years ago when I was *NZFP* editor.[3] Weale[4] believes that this conflict of rationing can never be resolved and concludes: *'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.'*

In New Zealand the escape has been via the Primary Health Care Strategy. The fact is that in New Zealand the majority of the population has already achieved health for all, in comparison to Afghanistan or even the United States. The problem is that certain groups, such as Maori and Pacific Island people and the poor and disabled have not. Why should this be when we are all living in the same environment? One of the answers is poverty and another is a lack of social support networks. Broadhead[5] demonstrated some time ago that age-adjusted relative risks of mortality for people with low social support networks

ranged from 1.5 for healthy people to 3.4 in the elderly and 3.5 in those who were disabled. It's a very specific problem and provides us with a huge problem but New Zealand has proposed a solution which constitutes a retreat to an ideologically and organisationally simpler world. The recommendations in a paper by Gribben and Coster[6] seem to have been adopted almost totally in the Strategy. What they wrote there was: *'There is increasing concern that deprived populations are not accessing appropriate health care. This article describes the models of primary care that have evolved in the new environment and suggests that these new structures, given appropriate support, are ideally placed to increase the focus of primary care on population health. A capitation funding model with patient enrolment and low fee-for-service barriers is proposed as the most promising model for delivering improved health outcomes.'*

The clear and laudable aim of this policy, honestly called 'an experiment' by Hefford et al.,[7] was to reduce health disparities. However the route by which that was to be achieved was interesting – community engagement and universal low cost or affordable primary health care – in effect by turning every family physician into a 'third sector' physician, i.e. an employee in the non-government, non-profit sector. Now the logic of that always escaped me. I could understand proposing a system that had evolved in 3% of practices and extending that to, say, 10–15%, but spending $818.8 million per year on subsidising primary care for those who can well afford it seems a bit peculiar. If the problem was lack of money and lack of social support, which some have in abundance and others lack, why waste money in moving to a universal system of low cost health care. The answer is that the changes were more about breaking the perceived power of the family physician than with providing better primary health care.

The philosophy behind the move was blatantly evangelical. The old fashioned Gospel Message was that there was an old way, mono-cultural, focussing on individuals and providers who worked alone, which had an emphasis on treatment, where doctors were the principal providers, where there was fee-for-service. The solution involved changing to a new way where we looked instead at the health of the whole population, we would become community and people-focused, and education and prevention were important. We also had to have teamwork – doctors had no right to be dominant and nursing and community outreach were to be crucial. Attention would be paid to cultural competence and we would have connection to other health and non-health agencies.

The saintly 3% minority who took a salary from community groups were canonised and the bad old general practitioner (GP) was scurrilously ridiculed by the arguments. We had enslaved the nurses and made them work in our practices, we had extorted money from our patients, our children were unimmunised, our old people unscreened and neglected: *'Traditionally GPs in New Zealand have adopted a self-employed, for-profit small business model'*; *'New Zealand's traditional pattern of primary care staffing is likely to inhibit the implementation of population-based primary care'*; *'GPs form the principal provider group of interest from the point of view of primary care policy for the historical reason that state funding has focused on the activities of GPs.'*[8] In contrast, we were told: *'the community-governed non-profit practices, which employ about 3% of the country's GPs have staffing arrangements and forms of practice better suited to the diverse demands of population-based primary care.'*[9]

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Three per cent is not enough for a political party to have support under MMP, but it is enough for wholesale adoption as a primary health care model. The retreat to an ideological and organisational world was complete. If this is Primary Health Care we cannot afford to have it.

2. Is primary health care (PHC) any substitute for general practice?

In 1983, in my first paper in this distinguished journal,[10] I wrote: *'The Declaration of Alma Ata is not talking about general practice but about primary health care; nor is it talking about our present system of free choice but about a bureaucratic primary care structure in which control will be exercised from above and in which patients will have no choice.'*

I never thought then that I was a prophet, but I do now. When I arrived as the first New Zealand Professor of General Practice, I was mightily impressed by New Zealand general practice and I have never lost sight of the evidence of its clinical effectiveness. This was confirmed by my three-year stint as a full-time rural New Zealand doctor. Here in general practice, patients and doctors have always looked after each other, and I suspect that the toothless horse bringing free consultations combined with higher GP incomes was too much of a gift to be rejected. In Winton[11] in 1999–2000 our subsidy from the New Zealand Government was $55.28 per patient. Now the mean capitation rate for non card holders is $155.71. A 300% increase in funding would perhaps have been enough to keep our business viable in Winton, but we were not offered the choice. Where you can still get doctors, nurses and midwives it would appear that things generally have

changed very little. New Zealand GPs and the vast majority of Kiwi patients are wise enough to know that properly qualified clinicians are essential to their well-being.

But dare we ask why it was done? What do the poor and vulnerable populations in New Zealand have to show for this investment in medical bureaucracy? Even the protagonists admit that tension between the twin policy goals of low cost access for all and very low cost access for the most vulnerable populations is a continuing and unresolved policy issue.[9] Meanwhile the problems remain, the main one being the conclusion from all these manoeuvrings that GPs and their patients are not to be trusted to manage their own affairs and that resources should only be given wrapped up in wasteful bureaucratic arrangements.

By all means have your salaried and socialised primary care for the 3%, even 10%, who need it, but if the 90% can be delivered by a self-employed, for-profit, small business model why would you want to change it? Dairy farmers in New Zealand work according to this model and are the pride and joy of even the loony left – why not take the money from the rich and use it to give free care to the poor? A strong and sustainable private sector is now the norm in all civilised countries, why not in New Zealand general practice?

Within such a structure the GP could continue to be a clinician, physician, surgeon, obstetrician and paediatrician – in short have a real medical role, not just to be some overqualified clerk who can eventually be superseded by cheaper nurses. In 2008 Jane Gunn and her colleagues[12] made the point that *'The essential role and inclusion of primary medical care in the conceptualisation of primary health care was poorly articulated. Perhaps the desire to reject medical dominance, combined with a poor understanding of primary care, explains why there was no definition of what a "suitably trained physician" would need to be like to deliver the ambitious goals. Even though there was increasing focus on the need for a team of professionals to provide primary health care, there was little systematic gathering of evidence to inform the roles and values of various team members.'* A return to this primarily clinical base would also help to solve our recruitment problem and students and prevocational doctors would once more be inspired to become GPs.

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Primary health care is not general practice. Just as we need both journals, we need both systems. The problem is that the zealots who run health policy need dictatorship to have their way. We know that having 'your own doctor' comes at a price that every society can afford and what Maori people need is self determination, an appropriate role in their own land, and their own doctor.

3. So enough talk of funerals, how do we promote health in the discipline of family medicine?

While I was in the Gulf States I founded a journal called *Al Hakeem*. This is the Arab name for a doctor. *Al-Hakeem* is one with wisdom, excellent knowledge, and excellent status. Flattery gets you everywhere, they say, and we have been very slow to blow our own trumpets, so to speak. It's been a hard road and in that 1983 article I wrote that the task of promoting general practice required *'The wisdom of Solomon, the skin of an armadillo and the charm of a belly dancer.'*

Actually general practice in New Zealand has done rather well in the matter of teaching, research and publication. In 1983 there were no Departments of General Practice and no professors in our discipline. Now there are four departments and we have exported (deported?) at least three professors elsewhere. We have senior academics in our discipline who are not GPs and we have many PhDs, masters and diploma students. Much has been made of the need to have our journal cited in the international literature, but the fact is that even without that facility, New Zealand general practice in 2003 led the world in publication output with 20 publications per million inhabitants, as opposed to 18 from the UK and 16 from Australia. When the number of primary care publications was set in relation to the total number of publications in human medicine, New Zealand again topped the table with 4.6% as opposed to 3.8% for Australia and 3.5% for the UK.[13]

There has been much fine research published in the *NZFP* and the papers of Ian Squires[14] and Bertram Young,[15] and the published thoughts and philosophies of Eric Elder, John Richards, Pat Farry and Rae West are in my files. It was fun to read – and will a deadly serious tome like the *Journal of Primary Health Care* continue 'Swamp Rat'? It was also informative and I have copies of Carl Jacobsen,[16] far ahead of his time on Maori health, and Jim Reid[17] – now proved right on doctor numbers (they thought we had to be culled.)

Like these predictions, the reports of the death of the New Zealand family physician have always been greatly exaggerated. In a debate on the new Medical School in Dunedin in 1894, one of the debaters referred to a statement by Dr Hocken that *'the principal fault in Dunedin was that the gentlemen who taught the students were busy men in general practice, and therefore not able to do full justice to the teaching.'* Another moved that the authorities of the Medical School *'should use every endeavour to in-*

duce all the lecturers to abandon general practice and devote their whole attention to the study of their several specialties.'[18] Then it was Medicine, Surgery, Midwifery, Gynaecology and Ophthalmology, now it is Population Health, Statistics, Public Health and Primary Health Care. What will be next?

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ARBs for lowering blood pressure

'Angiotensin receptor blockers (ARBs) are widely prescribed for hypertension so it is essential to determine and compare their effects on blood pressure (BP), heart rate and withdrawals due to adverse effects (WDAE)...The evidence from this review suggests that there are no clinically meaningful BP lowering differences between available ARBs. The BP lowering effect of ARBs is modest and similar to ACE inhibitors as a class; the magnitude of average trough BP lowering for ARBs at maximum recommended doses and above is -8/-5 mmHg. Furthermore, 60 to 70% of this trough BP lowering effect occurs with recommended starting doses.'

Heran BS, Wong MM, Heran IK, Wright JM. Blood pressure lowering efficacy of angiotensin receptor blockers for primary hypertension. Cochrane Database Syst Rev 2008; (4):CD003822.

The problem with health research...

'There has been some progress: more resources are going into research (eg, the Wellcome Trust); the research portfolio is more balanced, with clinical research getting more attention (eg, UK MRC); and research has incrementally more influence – we hear policy makers and practitioners increasingly talking about evidence-based policy and practice. This increased attention is welcome. However, there have been failures: resources are too few; basic science still dominates the research agenda at the expense not only of clinical science, but also at the expense of health system and policy research.

There are three key gaps that hinder further progress. First is the evaluation of health programmes...Second is the need for implementation science. ...The third gap is the absence of a political and social science dimension to understand why certain health programmes and policies work or fail.'

Editorial. The state of health research worldwide. Lancet 2008; (372): 1519.

Names

'We all took turns introducing ourselves on the bus we were to be sharing on a two week trip around New Zealand. Scots, English, Irish, Canadians, Americans, and a smattering of confused looking Germans. An American with the usual unabashed confidence stood up. "Now, I know all you Brits will laugh, but my name is Randy." A brief pause – then those British eyes met. A giggle escaped, then weeping, choking, gasping, excoriating, contorted spasms of spontaneous and uncontrollable laughter rocked the bus. Names are funny.'

Spence D. From the Frontline: You can call me Des. BMJ 2008; 337:a2328