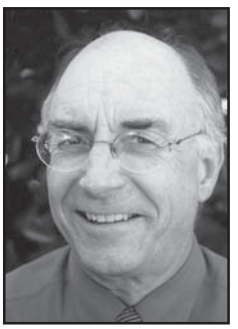
Editorial



Tony Townsend has been a general practitioner for 30 years. Although he has dabbled in medical politics, medical ethics, community-based teaching, university-based teaching, quality improvement and assessment, his passion remains clinical general practice. He is currently a full-time general practitioner in Whangamata.

Personal need and the public good

The College Conference in September last year helped to focus my thoughts about what had happened to New Zealand general practice in the last 10 years. I was working overseas from 1994 until 2001 and although I was able to observe what was going on I was not a participant in the changes to health care provision. My perspective is somewhat analogous to being an observer of a dysfunctional family rather than being a member.

In particular, the papers by Bruce Slane, David Russell, Ron Paterson and Marie van Wyk that are reproduced in this issue highlight some of the tensions that have developed between the competing interests of what is perceived to be the public good and the personal needs of the patients that we see in practice.

When I started in general practice close to 30 years ago there was no doubt that our role was to help individual patients who chose to consult us to access what was required to improve their health. We were aware that each person had issues which were unique and that these were influenced by biological, psychological, social and spiritual factors which later became more clearly articulated by general practice academics who helped us to frame our patients' health care issues using systems theory.[1] The influence of family, heritage, gender, ethnicity and socioeconomic factors were acknowledged, but our focus was clearly on that person who chose to come to us as a patient. Over the years our discipline developed and the core values of our profession became more clearly defined. When we were challenged to describe our role we spoke of providing generalist care that was accessible, comprehensive, continuous and coordinated.[2] Most of us embraced the concept of patient-centredness.[3] Of course, when we thought about it, it was what we had always been doing. We were always driven by the needs of the person; our patient. We were their advocate.

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In 1991 the Minister of Health, Simon Upton, published the Green and White paper, which was more correctly titled *Your Health and the Public Health*.[4] Despite a number of previous reports on the health care system, very little had changed. For better or for worse, *Your Health and the Public Health* signalled the beginning of the 'health reforms'. We have all been affected by what has happened since.

The government is responsible for putting in place structures and strategies to advance the health care of the people; they are concerned with public good. As a consequence of this the health reforms have a strong focus on population care. They are driven by demographics and moulded by political correctness. Because government spends public money and because they have a responsibility to the public, there is a strong focus on accountability. The current reforms are directed by *The New Zealand Health Strategy*, which claims that *'...it is an important document because it explains what sorts of health services are most important to New Zealanders'*.[5] When the government writes more specifically about our discipline, their vision is that *'primary care services will focus on better health for a population, and actively work to reduce health inequalities between different groups'*.[6] That our College is committed to these changes is apparent by reading *Aiming for Excellence*[7] in which the main emphasis is on strat-

egies designed to improve the care of our practice population. We have developed practice profiles, management systems and audit cycles. Many of us have become capitated, which emphasises that the government contribution to our services is dependent on the nature of the population that we serve rather than the individuals for whom we care.

These are important changes, but they come with a cost. Our core values, while continuing to be upheld in principle, are being eroded in practice. Access to secondary care services has not improved. We are daily frustrated by concerns from our patients who have to wait for long periods before they can be seen; six to eight weeks for an oncology appointment for metastatic cancer may not make much difference to mortality statistics but it seems a lifetime for a patient who is desperate for a lifeline. Dying while waiting for cardiac surgery does affect mortality statistics but may save money. Access to primary care services is easy for some and difficult for others. The proposal to preferentially fund some practices that agree to fix low co-payments in return for increased capitation funding has important implications for access and also has the potential to disrupt continuity of care. Fragmentation and changes to the delivery of primary health care services threaten comprehensive care; deregulation and the drive for efficiency[2] threaten continuity of care; competition threatens coordinated care. An interesting commentary on the impact of the health reforms, in particular management restructuring and deregulation, on professional autonomy and coordination of care, has been published by three geographers.[8] They conclude *'...the health reforms enacted since 1991 can be said to be reconstituting the welfare state through the formation of new organizational structures and institutional arrangements that have not only fragmented the health care system but have also, to some extent, dissipated the power of medicine'.* Quality requirements, information technology (including the use of computers as a consultation tool), data collection, protocols and best-practice guidelines all impact on the provision of personal medicine. The consequences of not practising personal medicine include increasing alienation, adversariness, complaints and litigation.[9] Gayle Stephens believes that *'personal medicine is the guiding light or red thread that illuminates and identifies our path amidst the many vocational diversions that allure and tantalize us...Personal medicine facilitates the practice of scientific medicine, but more than that, it goes where science cannot go. It is not heretical to recognize and criticize the limitations of science or to appropriate in modern form what physicians have always done for their patients while waiting for science to catch up'.*[9]

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Our challenge is this: How do we retain the core values that define our discipline in a professional environment which is constantly changing and threatening these values? The government is responsible for the public good; we respond to the patient's personal health needs. Both of these perspectives of health care are valid and both are important. One is not incompatible with the other but their meeting is uncomfortable.

The guru of quality in medical practice, Donald Berwick, reflecting on the death of his father, provides us with some pertinent suggestions:[10]

'Without a clear focus on the needs and experiences of individual patients, much of the financial and structural reorganization now rampant in health care will be unlikely to yield improvements that matter to the patients we serve. As we change the system of care, five principles can help guide our investment of energy: (1) Focus on integrating experiences, not just structures; (2) learn to use measurement for improvement, not measurement for judgement; (3) develop better ways to learn from each other, not just to discover 'best practices'; (4) reduce total costs, not just local costs; and (5) compete against disease, not against each other.'

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