General practice and the quest for unity

Jill McIlraith MBBCh(Witwatersrand) Cert FPRH FRNZCGP

Jill McIlraith has been a general practitioner in New Zealand for 13 years. She is a teacher for the College's Intensive Clinical Training Programme (having done her registrar time when it was called the FMTP) as well as teaching undergraduates and trainee interns in Dunedin. She has a particular interest in sexual health, being vocationally registered in general practice and in family planning and reproductive health. Before starting medicine in her late twenties, she did a degree in political science and trained and worked as a journalist in South Africa during a time of enormous political upheaval. She has long had an interest in the politics of health, particularly as they clash with economic realities and society's unrealistic expectations.

To think about Unity is to be swamped with clichés, all attesting to its desirability.

Such a Holy Grail has it become, that to dispute its worth or question its veracity as a core goal of primary health care in 21st Century New Zealand, is to risk the wrath of one's colleagues and to be labelled a destructive cynic.

Yet healthy scepticism should be part of the debate. If we apply evidence-based medicine to our daily clinical practice, should we not be applying the same standards to such a key goal and to the structures that are being promoted as tools for achieving this?

The 2003 RNZCGP Conference theme of *'Towards Unity'* will provide a forum to explore these issues.

Why do we want to work together? Is it for the good of our patients who accord us the ongoing privilege of being let into the most vulnerable part of their lives? Or is it for our good as health providers so that we can keep doing what we do well and attract heirs to our profession?

Or is it to satisfy a government agenda for uniformity that will make it easier to control primary health care in order to translate that power into votes?

Unity implies a formalising of what we already do. It takes what most doctors, nurses and support staff do on a daily basis and fits it into an overt structure. The rationale for doing so would be that such structures could be funded uniformly, be replicatable and allow for measurements of key outcomes linked to improved health for the communities we serve. We should be able to objectively judge whether such structures are delivering the goods.

If unity does not achieve this, there is surely no point in changing what we already do. If the aim of unity is to create a large, homogenous primary health care system there is a danger that the diversity and multiple models of general practice that now exist will be made extinct. The ability to respond to different communities' needs may be lost at the same time as we pay lip service to the politically correct idea of including such people in the decision making.

Unity implies a formalising of what we already do

Setting aside a disquiet about the national adherence to such an uncritically accepted goal, if we accept at face value that unity is a desirable goal, it is hoped that the 2003 Conference will answer the other fundamental question: How do we do so?

If all arms of the Medusa that is the health system (including the funders and the recipients of primary care) accept that Unity in Medicine is a Good Goal To Have (it somehow demands to be in capitals), the practicalities of how we are to achieve this have not been critically examined.

How do you organise such a diverse group of small businesses as general practices into one model and, along the way, declare that lots of other groups, from pharmacists to podiatrists, will eventually be included in this unified concept of primary health care? The solution so far is by imposing it from above by those who hold the purse strings, trading off the acceptance that working well together is what everyone in primary health care should be desiring and doing.

The questions as to how we actually achieve this are numerous. For example, what business and practice structures encourage working well together? Is a hierarchical management better than a consensus decision-making process? How do we meaningfully include patients as community representatives without being highjacked by particular lobby groups? How do we find and include representatives to speak for the most marginalised of patients such as the poorest, immigrant and refugee communities, inarticulate mental health patients or needy but distrustful adolescents?

How do we identify and nurture the leaders and the managers needed to help us work well for the betterment of ourselves and our patients? And how do we develop enduring structures that are flexible enough to acknowledge conflicting individual patient demands while apportioning health dollars in a fair and consistent manner? Do we have the courage now to tackle the toughest questions such as what core services we can, and cannot, afford as a country and to tell the individuals concerned that they won't get that particular treatment?

As I write this (in May 2003), one thing is evident: that general practice in New Zealand is going to have a structure imposed on it that will satisfy at least the government's concept of Unity. It has so far had little room for nurturing of grassroots participation and acceptance. The community seems as befuddled as doctors and nurses are as to how they are to participate in deciding on health goals and spending if the Ministry of Health-organised meeting on PHOs in Dunedin a few months ago was any barometer.

As present, government pronouncements about PHOs seem to be interpreted by the populace as being focused primarily on providing cheaper doctor visits and medicines to the individual. Yet very little evidence (can you recall any?) has been presented to show that the large increases in primary health funding are affordable in the longer term. Realistically it would seem likely that a large chunk of the allocated money will be soaked up by the extra layers of bureaucracy that PHOs are creating. And dare we ask: Does anyone out there really have vision of where PHOs will lead us in five or 10 years time?

Certainly no evidence on the viability and long-term value of PHOs has filtered down to those who will deliver the services. The doctors and nurses, supported by practice managers and receptionists who together make up the little cogs in the big PHOs' wheels, go about their daily business trusting that somehow this growing edifice will be sustainable and amount to something more than rhetoric to the monument of a unified and uniform primary health care service.

Underlying it is the assumption, albeit not the evidence, that the PHO as an imposed form of unity, will deliver what is promised: better primary health care for patients (as opposed to merely cheaper).

So far, the politicians and their worker bees at the Ministry of Health have done little to sell the PHO concept or back it up with research data. (But I do spare some pity for the poor health bureaucrats, who like us doctors and nurses, have seen several health reforms come and go in the past 15 years. Each time they have been required to sell the new concept as the best thing since hot chocolate and to promote the current favoured idea as the great solution to the insoluble. Most such ideas have met a whimpering death with even the political opposition not making too much of a fuss at the demise of another great idea.)

Unity implies that everyone involved places a similar value on key concepts and that there is agreement on core health needs

At the Dunedin PHO meeting, when the Ministry of Health representatives were asked at the end of the presentation (which was heavy on political jargon and woefully short on real vision or practical detail) what about PHOs would make it possible to attract and keep young doctors in general practice, the answer was a tangential but blunt one: Accept the vision of PHOs on faith, or get out.

The 'like it, or lump it' approach gives little ammunition to persuade young graduates that there is a future in general practice. As a teacher of general practice registrars, it is embarrassing to tell them to stick around on the basis of such a vague concept or on the promise that job satisfaction alone will sustain them when they are well aware that this is currency that does not pay student loans or let them live at a standard comparable to their surgical colleagues.

Certainly they will work hard to meet increasing community expectations of what sort of care can be delivered at what cost, as they are increasingly restricted in the drugs they can prescribe and by the twelve different agencies looking over their shoulders.

And every time the government promises cheaper doctor visits as the rationale of PHOs, the subtle and unspoken message is enforced – that you really shouldn't have to pay very much to see your general practitioner. It is hard to enthuse young colleagues to meet the hugely challenging work that is general practice when both government and patients think it could, or should, be done for less.

Unity implies that everyone involved places a similar value on key concepts and that there is agreement on core health needs. It implies that such a multi-disciplinary and integrated approach will deliver what it promises: benefits all round. To the patient it promises the immediacy of medical care at a lower personal cost. For the government, it provides a framework to impose its view of what primary care should be delivered at what cost as a way of containing burgeoning health spending.

But for those at the coal face providing that care, and working in teams as we already do, the challenge remains: how do we provide good individual patient care plus promote preventive health care when the ground is shifting under our feet? How do we make sure that all our team members are valued, supported and nurtured and attract young blood to make sure that in twenty years time, when I am old and frail, I have a good GP to go to?

As we work towards unity in the largely unknown framework of PHOs, I hope that we do not lose all those good parts of the present system. We need to incorporate the goodwill, the commitment and the resilience that it takes to do primary health care well, into this new framework. Unity may be desirable but it will only survive if it delivers on its promises. To all of us.