Whither the Kiwi GP?

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ABSTRACT

Family doctors are changing. Increasingly female, older, part-time, and aggregated into larger groups, today's general practitioner seeks a better balance between professional and personal time. Family doctoring is changing as well. Shifting from an acute care model best suited to infectious illness or injury, more time is now given to managing care teams responsible for prevention and for the care of chronic conditions. This essay explores the changing dynamic of primary care practice in New Zealand and across the world. It begins with a review of the value of primary care to the health of populations and to the effectiveness of health systems. Demographic, economic, and practice trends are discussed. Current initiatives to redesign primary care practice are described. The paper concludes that the essence of general practice continues to be the patient-doctor relationship and that a changing society and technology create challenges, and opportunities, for that relationship.

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Introduction

The changes underway in general practice are not unique to New Zealand. As I observe and speak with family doctors around the world, I see comparable changes and hear similar concerns, although viewed through the unique lens and distorted by the ambient noise of each health care system. I spoke recently on these issues at the 2008 Annual Conference of the Royal New Zealand College of General Practitioners (RNZCGP). I was asked to share my thoughts with a wider audience by reducing them to writing. Throughout this essay, I will interchangeably use the terms general practitioner, GP, family doctor/physician, and primary care physician. While there are substantial differences in training and practice around the world (e.g. primary care physicians in the US also include general paediatricians and general internists), the similarities among primary care physicians are more important than the differences.

At the outset, I must also confess that it seems a bit presumptuous for me, as an American, to offer a description of, much less a prescription for, general practice in New Zealand. Who am I – a Yank family doctor – to opine on the status and future of the Kiwi GP? Propriety would dictate that I should leave such pronouncements to leaders of the RNZCGP, but since you asked...

Primary care is valuable

The evidence is clear and compelling: people do better with primary care.[1] More precisely, those who live in countries with more robust primary care systems have better health outcomes than those who do not.[2] After income, having a primary care doctor is the most powerful predictor of a longer life.[3] Rates of all cause mortality; infant mortality; low birth weight; death from cancer, heart disease, or stroke; and self-reported health are better in US states with greater proportions of primary care physicians.[4]

During the 1990s, a natural experiment played out in Indonesia, when significant investments were made in primary care during the first half of the decade.[5] From 1996 to 2000, total Indonesian spending for health care declined by 10% because of a severe economic downturn. The distribution of health care spending changed even more dramatically over that time period, with 20% less spent on primary care and 25% more spent on hospital and specialty care. Thus, the proportion spent on primary care went from 2.5 times that of hospital and specialty care from 1990 to 1995, to 1.6 times from 1996 to 2000. The shift in spending was associated with a reversal in improving health outcomes. Infant mortality, which dropped 70% across all provinces from 1990 to 1995, rose 14% in 22 of the 28 provinces from 1996 to 2000.

Spain passed legislation in the 1980s that codified national policy to promote primary care. Ten years later, death rates related to stroke, hypertension, and lung cancer were lower in those areas that first adopted the primary care reforms, compared to those areas that were slower to strengthen primary care.[6] In both the UK and US, increasing the number of primary care doctors by 1 per 10 000 population decreases the mortality rate by 5–9%,[7] while increasing the number of specialists by the same proportion increases the death rate by 2%.[8]

Outcomes less dramatic than death are also improved by increasing the numbers of primary care physicians. The federal Medicare programme,

which provides health care coverage to older and disabled Americans, annually ranks states by their aggregate performance on 24 indicators of quality (blood pressure control, glycosylated hemoglobin levels, etc.). For every additional primary care physician per 10 000 people, a state's quality ranking goes up 10 states and costs go down US$684 per Medicare beneficiary.[9] Conversely, for every additional specialist physician per 10 000 people, a state's quality ranking goes down nine states and costs go up US$526 per Medicare beneficiary.

Why specialists do worse

It seems almost counter-intuitive to some that health care outcomes should be superior when provided by a generalist, versus specialist, physician. When a patient has chest pain, how can it not be better to see a cardiologist? If the chest pain is due to myocardial infarction with cardiogenic shock, then it may be better to start with a cardiologist. The patient's dilemma however, is that chest pain is rarely due to myocardial infarct and shock. More likely is that the pain is due to chest wall syndrome, reflux esophagitis, anxiety disorder, or angina that is not life threatening. The challenge as a patient is to accurately determine the cause of an undifferentiated complaint ('chest pain') and to know that a physiatrist *[physiotherapist]* should be selected for chest muscle spasm, a gastroenterologist for reflux, a psychiatrist for anxiety, or a cardiologist for cardiac pain. The challenge for the specialists that attend the patient is to resist the temptation to pile on unnecessary tests and treatments and to accurately diagnose and manage conditions that may be outside their specialty (e.g. the psychiatrist managing a patient who has chest pain due to anxiety and who develops a myocardial infarction).

There is evidence that specialists outside their area of expertise do worse than generalist physicians when managing a number of conditions, including community acquired pneumonia, acute myocardial infarction, congestive heart failure, and upper GI bleed.[10] Communities with higher proportions of specialists have later stage diagnosis of breast[11] and colorectal[12] cancer. Areas with more specialists have higher utilisation of unnecessary health care services.[13] Finally, as more professionals are required in a specialist-centric health care system, there is a greater risk for handoff or communication errors between professionals.[14] Thus, when deciding on a personal physician, the choice becomes clear: costs are about one-third less and death risk is nearly 20% less when a primary care physician is chosen over a specialist physician.[15] The reasons for the superior performance of the primary care physician are felt to include the focus on the prevention and earlier detection of various conditions, a holistic approach to a person's health, and the strength of the continuity relationship.[16]

Changing times

Having made the case for the value of a primary care doctor as one's personal physician, there are a number of demographic, economic, and practice changes underway that raise questions about the sustainability of the traditional model of general practice. The traditional vision of general practice is the bucolic image of a GP working in a single-handed practice, curing acute illnesses, making leisurely home visits, luxuriating in uninterrupted reflection on the case at hand, receiving handsome compensation in addition to chickens and homegrown produce, and enjoying the unquestioning compliance of devoted patients. How close the traditional image reflected the reality can be debated. What is clear today is that the tradition of general practice has given way to care systems that are increasingly complex and chaotic, patients that are more diverse and demanding, and practice realities that are more challenging.

With few exceptions, the median age of nations is increasing. As populations age and sanitation and vaccines improve, chronic disease has supplanted acute illness and injury as the most common source of morbidity and mortality, even in developing countries.[17] People are in flux, with nearly one in seven Americans moving each year to a new locale that is 50 or more kilometers from their previous home.[18] The growing expectation is that services of every sort are convenient, quick, and accessible 24 hours per day. The economics of medical practice are also changing. In any system where a third party pays directly for the physician's services with little or no contribution from the patient at the time of service, patients may have little incentive to make judicious use of the health care system or may devalue the doctor's time. In a free and increasingly diverse society, where people make their own choices about when and how to use the health care system, it becomes ever more difficult to assure the equitable and appropriate use of the system.

Paying doctors

There are several methods commonly used to pay doctors: salary, capitation, fee-for-service, and payment for performance. Each model has its strengths and weaknesses, for both patient and doctor. When salaried or paid a set amount per patient per year, the doctor does not have to worry as much about predicting income or covering practice costs. Often times however, the preset amount may not keep pace with inflation or with the doctor's income expectations. When paid in advance or at a fixed amount regardless of the quality or effort put into the service, the physician has little incentive beyond professional pride to go the extra distance for the patient.

When paid a fee for each service, doctors tend to provide more services. This can be beneficial for patients when those services are necessary, or detrimental when they are excessive or dangerous. When the fee that is paid

stays constant or declines, the physician must make up the difference by providing more services (i.e. seeing more patients or providing more services per patient). In primary care, where time is needed to develop and nurture trusted relationships, relying exclusively on fee-for-service payments will eventually become counter-productive. The limits of time create relationship problems as visit length shrinks in the face of pressures to increase visit volume and unnecessary or excessive services. Moreover, recording and billing a fee for each service – every telephone call, completed form, etc. – becomes burdensome in a busy primary care practice.

Paying for performance has the advantage of tracking the outcomes of care against specified goals, thereby assuring the payer of care that the money invested in health care is well spent. Pay for performance has several major limitations. Doctors often have very different mixes of patients for reasons that are beyond their control – those with disproportionate numbers of chronically ill, impoverished, or non-adherent patients are less likely to achieve the performance targets. In addition, the performance targets are typically set by experts and managers and rarely reflect what patients want or expect of their health care. In the United Kingdom, an ambitious effort known as the Quality Outcomes Framework was instituted in 2004.[19] National Health Services authorities badly underestimated the number of targets that they expected British GPs to achieve, nearly bankrupting the bursary and proving that few groups are as adept at making the grade as are doctors.

Balanced against the payments made to doctors is the growing expense of operating the practice, as personnel and equipment costs continue to rise. In an effort to share practice expense and improve lifestyle by sharing coverage burden, doctors are collecting themselves into larger groups. Yet larger groups require more time for making group decisions and more sophisticated and expensive management. Over time, the managers of large groups become separated from the physicians providing patient services, creating potential problems with trust and a sense of ownership.

The experience in New Zealand is consistent with these global trends.[20] The composition of the New Zealand GP workforce consists primarily of full-timers (46%) who work an average of 57 hours per week, part-timers (25%) who average 36 hours per week, and locums (13.5%) who average 37 hours per week. About 13.5% of GPs do not work as general practitioners. Overall, New Zealand's GPs work an average of 48 hours per week. There are significant differences among Kiwi GPs however, with rural GPs averaging 60-hour work weeks, mostly due to more on-call hours compared to their urban counterparts (16 versus six hours).

My fear is that as GPs shrink their scope of services and reduce their accessibility to patients, we will wither into irrelevance as overpaid, and unsatisfied, triage officers

The 2007 CORNERSTONE study[21] showed that about half of the respondent practices' funding was through capitation (49%), compared to 4% in 1998. About 23% of funds came through the General Medical Services (Section 51) and 22% through Maternity Section 51/88, although maternity care services for GPs increasingly represent first trimester care only. The average CORNERSTONE practice had four GPs (two partner GPs, one employed GP, and one locum); three practice nurses; and 3.5 other staff. The ownership structure for the CORNERSTONE practices included joint (40%), private (39%), community trust (7%), or private company ownership (5%).

Renewing yesterday's values for tomorrow's patients

Adapting to the changing needs and expectations of patients will require new models of care. A number of these ideas were explored at an international colloquium of six countries, including New Zealand, which was convened in Toronto in September 2006.[22] Key attributes of the new model of care include advanced or open access scheduling (patients are seen the day they desire), online appointments, electronic health records, group visits, electronic (e.g. email) consultations, chronic disease management including registries for specific conditions, web-based information, a team approach to care, clinical practice guideline software that prompts clinicians as patient data are entered, outcomes analysis to track clinical performance, and alternative payment models that blend capitation or case management fees with fee-for-service payments and pay for performance bonuses. In the United States, these elements of the new model are encompassed in the concept of the patient-centered medical home, where care is initiated, coordinated, delivered, and held accountable.[23]

Historically, the GP served as the point of entry to the health care system for most patients and provided care that was convenient, compassionate, comprehensive, capable, and cost-effective. A key ingredient that enabled the GP to do all these things was a trusted and healing relationship. The increasing mobility of the population, the growing demand for 24-hour convenience, and the rising expectation on the part of doctors for protected time free from patients have chipped away at the continuity relationship. Yet, without the special knowledge of the whole patient and the entire family fostered by the relationship, the GP who performs a well child examination, or any other service, risks being viewed as an incompletely trained paediatrician or as an overly expensive nurse. My fear is that as GPs shrink their scope of services and reduce their accessi-

bility to patients, we will wither into irrelevance as overpaid, and unsatisfied, triage officers.

So, how do we bridge this gap between rising patient expectations for convenient and yet expert care; between doctor expectations of protected personal time and professional satisfaction? I believe that the answer can be found by going back to the future – by returning to a mutual commitment, by the doctor and patient, to the continuity relationship. Some patients will need proof of the value of the continuity relationship and the expertise of their family doctor. We can share the data on the demonstrated superior value of primary care. We can give them a chance to sample the greater convenience and safety of being cared for by someone they know and trust. We can put the power of the Internet and other decision support and treatment tools into the GP's hands at the point of care.

Some doctors will need proof that they can open themselves up and be more readily available to patients without having their personal lives overwhelmed. We can show them new technologies like web-based resources when patients just want information, asynchronous communication such as email or text message when patients desire only an eventual response, or inexpensive systems such as web cams or video-capable mobile phones that allow for telemedicine consultation when distance separates doctor and patient. Also, doctors will always need some redundancy built into their patient coverage, so that they can be confident that there will be someone to assist their patients during the times that they require immediate assistance and their doctor cannot be available.

Finally, I believe that we can get to a more robust therapeutic relationship, with all of its benefits, by recognising that healthy relationships are bilateral. In other words, just as the patient must trust the doctor, the doctor must trust that the patient will not abuse the relationship. Coaching patients on how to use the system and what is reasonable to expect can go a long way toward correcting inappropriate utilisation and reducing calls at inconvenient or inappropriate times. The successful and satisfied GP of the future will figure out how to build bridges to promote more and easier connections with patients, not more walls to block out or ward off patients.

The Kiwi GP has shown a remarkable ability to adapt to a changing health care system.[24] By focusing on the changing needs of patients, by striving to provide more comprehensive services to patients, and by committing to connect more with patients, I see a bright future for New Zealand general practice.

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