

THE FUTURE OF PRIMARY CARE

Papers from a Symposium
held on 13th September 1995

Edited by Jane Griffin



Office of Health Economics
12 Whitehall London SW1A 2DY

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ISBN 0 901387 99 1

Printed by White Crescent Press Limited, Luton

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Foreword

Jane Griffin

The chapters in this book are based on the contributions to a conference organised by the Office of Health Economics and held at the Zoological Society of London on 13 September 1995. The various contributions, from many distinguished authors from the United Kingdom, continental Europe and the United States highlight many aspects of the international debate about the future of primary care.

In the United Kingdom the government has adopted an objective of a 'Primary care led NHS' and as part of this process, the Secretary of State for Health, Stephen Dorrell, announced in October 1995 a debate on the future of primary care in the UK, in which the Minister for Health, Gerald Malone would tour the country listening to the opinions of people involved in the delivery of primary care. In June 1996, the government's consultation document 'Primary Care: the future' was published. In it the Secretary of State underlines the government's commitment to a 'Primary care led NHS'.

The government's document sets out five key objectives for primary care: that it should provide continuity; be comprehensive; be properly co-ordinated so that professionals work together to meet a patient's needs; be the gatekeeper to secondary care; and address the needs of local communities as well as of individuals. The ministerial roadshow also identified five principles for the planning and delivery of primary care services: quality; fairness; accessibility; responsiveness and efficiency. Finally it identified seven areas for action: resources; partnerships in care; developing professional knowledge; information, involvement and choice for patients and carers; securing the necessary workforce and premises; better organisation, including information technology and management support; and local flexibility.

It will not surprise readers that the issues emphasised in the government's paper are similar to those discussed in the following eight chapters. For example, in the chapter by Professor Starfield the characteristics of a strong primary care system are discussed. These characteristics she argues are: accessibility; continuity or longitudinality of care; comprehensiveness; and co-ordination, both through better relationships between professionals and through improved use of information technology. Professor Starfield goes on to consider the impact of the GP as gatekeeper on health outcomes and finds, using international comparative data, that not only is a strong primary health care system associated with better health outcomes for its population but is also associated with lower costs. It is therefore concluded that strong primary care is an efficient use of health care resources.

We need to put the UK primary care system into an international

Foreword

context. In this book there are chapters looking at three very different models of primary care, in Finland, the Netherlands and the United States, by Dr Mäkelä, and Professors van der Zee and Light respectively. Other important issues addressed in these papers are the future of fundholding by Professor Ham, and the causes of and solutions to low GP morale, by Professor Mant and Mr Towse. In the final chapter, Professor Roland sets out his vision as to how the dangers of fragmentation and the challenges to define and assure quality of care can be met.

This book is a contribution to the continuing debate on the future of primary care and I hope readers will find many of the ideas and concepts discussed thought provoking and stimulating.

The future of general practice: an overview

Professor David Mant and Adrian Towse

Introduction

The UK model of general practice has stood the test of time. It is a much loved feature of the NHS, which has been copied by other countries. It offers all citizens 24 hour free access to medical care whilst also being a successful and acceptable mechanism for rationing scarce medical resources. The best loved general practitioners (GPs) are those who have won the hearts of their local community by offering continuity of care, characterised by a strong personal commitment to the well-being of their patients. It would be senseless to forget or to undervalue this tradition.

However, general practice is changing:

- the government is experimenting with GP purchasing of secondary health care and trying to influence the primary care provided by GPs through contractual requirements and financial incentives;
- health professionals are responding to changes in cultural values and social circumstances by limiting their accessibility to patients, particularly out of normal working hours;
- more patients are getting older, others live in less cohesive social groups, and many are becoming more aware of the fallibility of doctors, and of the existence of new diagnostic technology in hospitals which is not available to GPs;
- professional autonomy is being eroded by demands for professional accountability for the quality of care both from the state and from consumers of health care.

We are about to witness a watershed in the history of primary health care in the UK. The pressures on a tax funded health care system from consumer expectation and public spending constraints are not reversible. There is no way back to the country practice of Dr Finlay. General practice has been elevated to centre stage to deal with these pressures, and if it is to survive, it must move forward and seize its opportunity.

The UK government has committed itself to 'a primary care based NHS'. It has given GPs budgets to purchase hospital care as well as contracting them to provide both clinical and preventive primary care for their registered patients. It has allowed them to keep savings made from economies in prescribing. It has shifted NHS resources from secondary to primary care. It has promoted the use of information technology (IT) so that health care computing is more advanced in general practice than in hospital medicine. And it has achieved a subtle but undeniable increase in the influence of GPs over their hospital colleagues.

2 *The future of general practice: an overview*

In the light of this support for UK general practice, general practice training schemes should be overwhelmed with applications and GPs should be bullish in their enthusiasm for an increasingly worthwhile vocation. Sadly, quite the reverse is true. GPs in the UK are increasingly unhappy with their lot. Training schemes cannot recruit. Experienced practitioners are seeking to leave the speciality. The medical journals document low morale and growing disillusionment.

The structure of this overview

This book reports a series of papers presented at a conference in September 1995 on the future of general practice. The contributors to the conference were from overseas as well as from the UK. They presented an impressive array of information on the organisation and funding of primary care systems in Europe and North America. They dealt with an range of issues from comparison of the effect of primary care on the performance of national health care systems to the importance of continuity of care to the individual patient.

During the conference it became clear that in looking to the future of general practice we were addressing two distinct issues — its organisational role within the health care system, and its clinical role as a provider of medical care. The purpose of this overview is to review the key organisational and clinical issues raised by the contributors and to try to summarise the vision for the future of general practice which emerged. We conclude with some reflections on what the conference papers and debate told us about the causes and possible remedies for low morale amongst UK general practitioners.

The organisational future of general practice

How important is general practice to an effective health care system?

The architecture of the average NHS hospital is a testimony to piecemeal fixing — small bits have been added on or removed to deal with 40 years of changing circumstance. However, at some point it is important to examine the whole structure to decide whether it is still serviceable and cost effective. To a great extent this is what Barbara Starfield's presentation did for primary care (pages 18 to 29). She defined primary care as having four attributes — longitudinality (person-focused care over time), comprehensiveness, co-ordination of care for patients requiring specialist services, and accessibility for first contact care. She then referred to her earlier work (Starfield, 1994) in which she had assessed the health systems of 11 countries according to their possession of these attributes, and ranked them accordingly. She had also ranked each country for health system outcome, based on expressed population satisfaction, per capita expenditure on health and medication, and 14

different health indicators. Her findings indicated a strong positive correlation between the strength of primary care in each country and outcome.

GPs would obviously like to infer causality from this relationship. In the panel discussion (pages 73 to 78) Robinson urged caution — he argued that the evidence for the cost-containment in a primary care based system was much firmer than the evidence for cost-effectiveness. He also pointed out that high variation in referral rates between practices suggests considerable inefficiency in the system. However, the onus must also be on those who challenge causality to provide alternative evidence to support a health care system without a strong primary care component. The data Starfield refers to in her paper are certainly compatible with her conclusion that a strong primary care infrastructure is more equitable, efficient and effective than a speciality based infrastructure.

There is one more point to consider, however. Arnold points out (page 78) that in Germany, although the government is keen to encourage use of primary care physicians, patients prefer, when given the choice, to go directly to a specialist. This is in apparent contrast to the point that Light makes (pages 61 to 72) that medical specialisation in the USA and Germany reflects a triumph of the medical profession over the public. It calls into question Starfield's claim that primary care is positively linked to patient satisfaction. There is a possible explanation. Starfield notes that the specialist is less able to distinguish a potentially self limiting condition from a more serious one, and therefore will often subject a patient to unnecessary, expensive, and sometimes life threatening, tests and treatments. On the other hand, the patient may be more concerned about the risk of a failure to diagnose the serious condition and may judge this less likely to occur with a specialist. Given a tendency to overtreat, the system will not only be more costly but, by producing poorer health outcomes for the patient, will generate less satisfaction with the system.

Has the UK the right amount of general practice, too little or too much?

The analysis referred to by Starfield (Starfield, 1994) has two outliers — the UK and Finland. They are first and second equal respectively in the primary care score rankings, but have poorer satisfaction ratings than a number of other countries. There is grave danger of inferring too much from limited data. Mäkelä points out (page 43), the strong primary care system in Finland does not act as an effective gatekeeper — less than 50 per cent of referrals to hospital are made by the general practitioner.

The countries which ranked second equal (with Finland) on the analysis in primary care score were Denmark and the Netherlands. Both rated better than the UK on outcome although the organisation, extent

and culture of primary care in the three countries is very similar. Explanations can be sought in the data presented by van der Zee (pages 46 to 60). It may be that the most important statistic is the proportion of GDP spent on health care, (which is shown in Figure 4 on page 52). Although the gap has narrowed since 1990, in the 1980s the UK spent approximately 6 per cent of its GDP on health care compared with 7 per cent in Denmark and 8 per cent in Netherlands. We should recall Robinson's point that primary care may be organised to be cost containing rather than cost effective.

Van der Zee argues that we should seek to explain differences in health outcome not in terms of primary care alone but also in the context of its relationship with secondary care. In this respect — and in contrast with Belgium, France and Germany — the UK, Denmark and Netherlands are very similar in that consultants are tied to hospitals. However, there are differences, — in the UK and Denmark hospital consultants are salaried whereas in the Netherlands they are independent contractors paid on a fee for service basis. In the UK and Netherlands consultants run an out-patient service whereas in Denmark (where consultant numbers are highest) the alternative to general practice care is hospital admission. Van der Zee is clearly right to stress that the primary care system should not be seen in isolation.

How should general practitioners be paid?

Almost every contributor alluded to the issue of optimal method of payment. The question was raised as to whether the independent contractor status of UK general practitioners had outlived its value and discussion from the floor raised the difficulties of professional mobility and unfavourable career structure from which a self employed contractor system inevitably suffers. From the point of view of morale and recruitment, this issue needs to be widely debated in the UK context. However, from an international perspective, whether general practice is a salaried or franchised service is perhaps less important (and was certainly less discussed) than the various financial incentive systems which can be applied by health care managers in both situations.

Ham, although talking mainly about budget holding (pages 30 to 36), stressed that one of the most interesting aspects of the NHS reforms had been the effect of financial incentives on the provision of care by general practitioners — particularly prescribing habits and preventive care. In discussion it was pointed out that there was little evidence that the changes in prescribing had improved cost effectiveness (rather than simply reduced cost). However, there can be little argument that GPs have striven to achieve set targets for preventive care irrespective of the limited scientific evidence of effectiveness. The immediate future undoubtedly holds more management defined targets linked to

remuneration — although evidence that this will improve the quality and outcome of care remains elusive.

The only paper which discussed a general practice payment system in detail was given by Mäkelä from Finland. As with most organised primary health care payment systems, it has three components — basic salary, capitation and fee for service. The basic salary payment is weighted for age, experience and area of practice. The capitation payment is made only for patients who make more than 3 visits in a year. Fee for service payments are made for selected procedures and visits by other patients — creating an incentive for seeing all patients. Again, it was reported that this payment system was effective in achieving key objectives (recruitment to rural areas; increasing opportunities for anticipatory care) but it emphasises the difficulty of making any general statement about the optimal system of payment.

Has general practitioner purchasing improved care?

Ham's brief was to review the UK experience of general practice fundholding. He emphasised that general practice purchasing was promoted to solve the problems of secondary, rather than primary, care and that its future depended on the extent to which it was successful in achieving this objective. His paper indicated that:

- the financial incentives involved have changed professional behaviour in primary and secondary care
- the process of care at the primary-secondary care interface (e.g. shorter appointment waiting times and better discharge information) has improved
- cost savings in primary care are being deployed creatively
- the expected adverse effect of risk selection has not materialised
- the transaction costs have been high

He added that the lack of evidence of risk selection (i.e. non-acceptance of high cost patients by fund holders) probably reflects the high, and historically based, levels of funding. As fundholding becomes more widespread and the financial incentives diminish, risk selection may still become apparent.

In the panel discussion, Robinson reminded the audience that there is no evidence that fundholding is better than alternative models of purchasing secondary care, particularly non-fundholding primary care consortia, or that it has improved the health outcomes of secondary care. It had speeded up the process of care for some while reducing equality of access. He recalled that the evaluation of fundholding has been restricted to partial or non-comparative evaluation — or, to use an acronym, 'PONCE'-ing around¹. Nevertheless, Ham suggests that it is

1 His comments pre-date the publication of the Audit Commission's study of fundholding.

likely that GPs have a unique awareness of many aspects of the quality of health care and can purchase 'patient-focused' aspects of care effectively. At the same time, Ham questions their ability to adopt a population perspective and suggests that health authorities may be in a much better position to assess health needs and to take strategic decisions, particularly in relation to other community agencies.

This view was strongly supported by Roland who argued that the individual patient and the public health perspectives are potentially conflicting, and that GPs should restrict their involvement in planning and commissioning health care to patient related issues.

Will budget holding damage the GP role of patient advocate and implicate GPs in rationing?

The tension between patient centred and population based purchasing raises the question as to whether the role of the GP is to ration NHS resources as effectively as possible or to obtain the best deal for their patient out of the system. No doubt one incentive to enter fundholding has been the prospect of getting more resources for the GP practice and getting better hospital care for patients. However, the converse is to require the GP to ration aspects of secondary care. Starfield argues for the gatekeeping role to be empowering rather than punitive. It can make care more effective, less dangerous and less costly, if patients are spared referrals for self limiting conditions. Likewise primary care practitioners should be encouraged to make necessary referrals, to ensure patients receive timely and high quality secondary care. Ham refers to the improvements in communication between specialists and GPs that fundholding has led to, exactly the kinds of experimentation with different modes of consultation that Starfield wishes to see between primary care practitioners and specialists. Inevitably greater GP purchasing responsibility, including budget holding for prescribing, brings GPs more directly into priority setting or rationing. It also seems able to produce new approaches to providing care that are better for the patient.

Will fundholders make health authorities redundant?

Ham's key message is that general practice fundholding and health authority commissioning should not be seen as competing models. He suggests that 'synchronised purchasing' may be the way forward. Perhaps the most convincing argument in favour of joint purchasing is its inevitability, although Ham's vision of purchasing arrangements in 1997, illustrated in Figure 2 on page 35, suggests that the bulk of purchasing responsibility will still fall to health authorities for the foreseeable future — even with 10-15 per cent of the population being covered by total fundholding, (in which general practitioners are responsible for all prescribing and secondary care costs for their patients).

This is because the secondary care purchasing covered by existing fundholding arrangements (provided to 40-50 per cent of the population) is limited and Ham's view was that the uptake of fundholding is likely to be limited to a maximum of about 60 per cent of practices because the generous reimbursement of administrative costs, and other windfall profits from fundholding, will inevitably fall over time. And of course general practitioners remain accountable to health authorities for the provision of primary care under the terms of their own contracts.

What will the impact of GPs competing for patients be?

Starfield notes that we do not have good research findings on the impact of free choice of physician, although countries with highly developed primary care systems do not restrict choice of doctor. In the UK the trend has been to make it easier for patients to switch GP practice. The threat of patient 'exit' should encourage GP fundholders to use their budgets to deliver better care to patients. Light notes that the emphasis in the UK reforms on developing consumerism, patient rights, and better handling of complaints, all leading to increased demand, is in sharp contrast to the US 'payers revolt' where the objective is to reduce patient choice in order to keep down costs. In our view aggressive competition between fundholders for patients would tend to produce the same effect as Ham predicts from a move to capitation based funding formulas — ie an emphasis on weeding out patients who consume more resources in money and time than they bring in under the funding formula, to ensure the better funded patients get good service and stay. Light notes that managed care competition in the US is leading to better care for 90 per cent of the enrollees, but worse care for the sickest, most expensive, 10 per cent. However brought about, high patient turnover rates threaten continuity of care, which is one of the key strengths of primary care.

The question arises as to how well placed the patient is to judge the performance of the GP? Will a greater willingness on the part of the GP to respond to patient preferences enhance or compromise their professional skills? We note that Rolands argues that quality control must come from within the profession or from the purchaser. However he places great importance on time with the patient, as does Murfin (page 74). Rolands cites evidence that the quality patients most valued was 'a doctor who listens'. There may, therefore, be less conflict between the profession and patients on which factors determine the quality of general practice. Competition for resources will, however, remain a potentially divisive issue threatening equity of, access to, and continuity of care.

Is general practice politically sustainable?

Robinson reminded the conference that decisions made about the structure of primary care reflect political reality rather than issues of ethics or evidence. Light reminded us that 'managed care' was not simply a mechanism for achieving coherence in the fragmented US health care system but also a mechanism for exerting political control. In other words, to understand managed care we have to ask two questions — managed by whom, for what? He suggested that the future role of primary care depended on the balance achieved between three countervailing powers in any health care system: the community, the medical profession and the sponsor (either state or private enterprise). The implicit objectives of each group are characterised in Figures 1-3 on pages 62 to 64. His analysis suggests the following:

- Despite the size of the speciality, general practice is likely to enjoy low status within medicine if it does little to advance its professional objectives
- General practice is likely to be favoured by sponsors as it minimises costs
- Support of general practice may also be favoured by sponsors if it is seen as a means of limiting the power of hospital consultants

Community organisations have an inherent interest in the benefits of general practice but will resist changes which limit consumer access to what is perceived as best quality care.

Light suggests that the difference between managed care in the USA and the management of care in the NHS reflects the nature of the sponsor. In the UK the state has been fostering consumerism, both as a political philosophy of the governing party and as a mechanism for controlling the medical profession. In the USA, state and corporate health care organisations are determined to reduce consumerism, which is seen as an expression of professional manipulation of demand. Light also perceives very different attitudes to primary care. In the USA the primary care physician is a professional foot soldier who can be recruited to keep the gate but who needs to be as strictly controlled by the health care manager as their hospital colleagues. In the UK, the political pre-eminence and freedom accorded to the general practitioner is, by implication, attributed to their willingness to accept the role of state franchised mercenary who can act as both the advocate of the consumer and a professional quisling.

Although this analysis is compelling, we should not forget the most important function of the general practitioner is providing clinical care. The gate keeping and purchasing role of general practice probably occupies less than 10 per cent of overall time and resources. It would be a poor political strategy for survival to convince politicians and health care managers that the main value of general practice lay in this

administrative activity, rather than the 90 per cent of time spent on clinical care.

The clinical future of general practice

Should general practice become more specialised?

Roland points out (page 87) that there already exists considerable specialisation within primary care. Figure 1 on page 88 shows the range of health professionals involved and emphasises the role of the general practitioner as a co-ordinator of community based care. He reminds us of the evidence that specialist nurses in general practice can provide effective care of chronic diseases (such as asthma, diabetes, hypertension and schizophrenia) and effective preventive care. One option, which the Finns have already adopted, is to extend the scope of activity of the primary care team to incorporate all specialised community care and social services under one umbrella. Whether or not the administration and financial purchasing of these services would be best managed by the GP is a matter for debate. Roland suggests that primary care team size should not exceed twelve people.

Roland also notes, on page 87, that there is considerable scope for developing specialist clinical skill within general practice (such as in slit lamp use, minor surgery, use of non invasive modern technologies such as echocardiography, and increased use of near patient testing technologies) aided by the availability of expert advice using information technology. Indeed many general practitioners already possess specialist clinical skills because of their previous careers or hospital practitioner appointments.

A number of experiments with internal referral within general practice have been described and, given the financial incentive to fund holders, this practice may become more common. However, Roland argues convincingly that the advancement of medical technology increases rather than lessens the need for the generalist physician. The best protection a general practitioner has from the encroachment of specialists is to provide better diagnostic skills for undifferentiated problems, better management skills for non life threatening conditions and better preventive care. Providing long term continuity of care is very important, although the continuity of out-of-hours care is less important.

How much difference will be made by information technology?

Information technology is better established, and used more widely in clinical care, in general practice than in hospital medicine. The IT revolution has already happened in general practice. The fact that many GPs use computers in the consultation means that there is an

unparalleled opportunity to provide expert IT support at the point of clinical decision making. Recent advances in fibre optic and computer chip technology mean that the time interval to accessing support is now decreasing to the point that it becomes feasible within a consultation. Roland picks out two specific areas (page 91):

- Telemedicine: there is great scope for reducing the need for out-patient appointments and reducing unacceptably long waiting times by organising brief specialist consultations at a distance
- Decision support: there is a particular opportunity to guide decisions about prescribing, diagnostic test ordering and hospital referrals at the time of clinical decision making during the consultation

However, information technology will not only increase the general practice knowledge base — it will also help health care managers to monitor performance and to impose policy decisions on prescribing and use of resources. A great deal of prescribing is already done by computer — it is not difficult with existing technology for the computer to recommend the BNF generic drug of choice taking into account the patients age and personal medical history². It is equally possible for practices with a computerised hospital link to order tests and make appointments, constrained by local policy guidelines. Whether such technological advance improves clinical care will depend to a large extent on whether the guidelines are based on sound empirical evidence from clinical research in a primary care setting.

Could the point of first contact be a nurse?

The most frequently cited reason for low morale in UK general practice is the growth in consumer demand, particularly during evenings and week-ends. The NHS is also struggling to meet the financial cost of this increased activity. One solution for both parties is to substitute a (less expensive) nurse for the general practitioner as the point of first contact. There is some evidence to support the feasibility of this approach. Roland quotes an upper estimate of 85 per cent for the proportion of general practice tasks which fall within the clinical competence of a trained nurse. In Finland, Mäkelä reports a ratio of about 5:1 for nursing to medical staff within primary care teams. In the UK, a great deal of chronic and preventive care is already undertaken by practice nurses and resuscitation of patients with acute illness is now routinely performed by trained para-medical staff before arrival in hospital. A formal assessment of the clinical outcome of employing a nurse as the health professional of first contact within the primary care team is needed.

It is possible that attempts in the UK to substitute a nurse for a doctor

2 The NHSE is piloting one such prescribing decision support tool — PRODIGY. It takes account of diagnosis but not other patient characteristics.

as point of first contact will be rejected. Indeed it may lead to a rejection of the paternalism of the gatekeeper role altogether. If GPs withdraw services in the face of consumer demand, and sponsors seek to substitute less expensive labour to reduce costs, a consumer revolt may have to be faced.

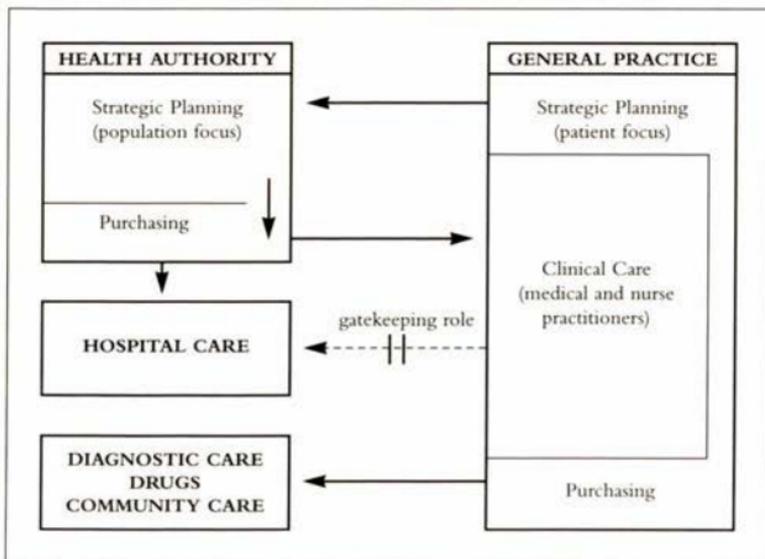
On what criteria should the quality of general practice care be assessed?

A recurrent theme raised by all contributors was the need for explicit criteria by which the quality of general practice can be judged. This issue was addressed in principle by Starfield, Roland and Mäkelä. It was also raised by a number of discussants. Rolands' formulation of the dimensions upon which the quality of care should be assessed were as follows:

- Ease of access to care
- Equity of provision of care
- Quality of clinical care
- Range of services
- Quality of anticipatory care
- Degree of continuity of care

He also added that good clinical care cannot be delivered in 5 minutes a patient. One simple and easily measured care target might therefore be a minimum consulting interval.

FIGURE 1 The organisational future of primary care?



Will care become protocol driven at the expense of professional autonomy?

Rolands argues that the profession must drive clinical audit, and by implication must be involved in establishing evidence-based protocols in primary care. With good use of IT within the practice as a decision support tool, protocols will support professional autonomy rather than undermine it by enabling the clinical experience of the primary care physician to be combined with up to date external evidence in a professional judgement about the appropriate treatment for a particular patient. As Light and Starfield both note, the conflict with professional judgement occurs where protocols are not driven by clinical evidence but imposed by purchasers and payers seeking to use the physician as a cost containing gatekeeper.

A vision for the future

It is difficult to develop a vision of the future of primary care in the UK which does justice to the depth of the discussion and to its international perspective. We attempt to do so within our distinction between organisational and clinical issues, linked to the need for a resolution of low professional morale.

The future organisation of care

Figure 1 characterises the organisational future for general practice. The major role of general practice continues to be the provision of primary care and gatekeeping for secondary care. However, it retains a purchasing role. Fundholders continue to purchase drugs and diagnostic services, and all GPs enjoy an extended role in the purchasing of other community services (including community and nursing services). However, its purchasing role in relation to secondary care is restricted to providing a patient focus to guide the strategic, evidence based, purchasing of health authorities.

FIGURE 2 The clinical future of general practice: the spectrum of first contact care?

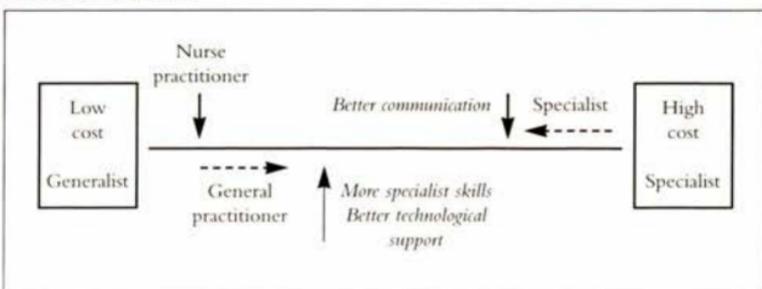


Figure 2 characterises the clinical future. The problems of falling GP morale and increased consumer demand for both primary care and access to specialist services is met by three changes:

- the GP moves nearer to the specialist by developing more specialist skills (perhaps by increasing specialisation within practice) and by making greater use of modern non-invasive technology for diagnosis and clinical management;
- some first contact care is provided by nurse practitioners;
- specialist knowledge is brought nearer to the GP by use of information technology and telemedicine.

The resolution of low professional morale

We summarise in Figure 3 below the main causes and possible solutions we have extracted from the conference papers and discussion.

The figure identifies three main external drivers — the actions and expectations of patients, NHS policy, and clinical advance — and we discuss these in turn.

The impact of changing patient expectations

Patients are now more likely to question the judgement of their GP. There is a danger that patient ability to switch GP practice will lead to GPs feeling under even more pressure to move from doing what is right to what may impress the patient. However, as we noted earlier, patients may well value the same qualities of primary care as GPs, notably the length of the consultation, and the ability of the GP to listen and communicate. If GPs feel they can manage the consultation length (even if this involves some delegation — see below) and have appropriate communications skills, then professional morale may improve. Significant patient turnover will, however, damage continuity of care. Our view is that patient inertia will limit the degree of switching. If it does not, then financial incentives may lead to risk selection on the part of GPs, reducing professional morale and the cost effectiveness of the NHS.

Patient demand is threatening continuity of care. The growth in night calls is already leading to a de facto separation of the night time contract. Rolands suggests that continuity of care is not a real barrier to the hiving off of this element of GP services — as indeed has happened in Holland. We see this as inevitable and a boost to GP morale. The use of a nurse practitioner as first point of contact is a more difficult issue. Could the first point of contact be a nurse? It is important to distinguish between referral and first point of contact. The latter most sharply focuses on what is the 'skill' of the generalist as perceived by both the GP and the patient?

FIGURE 3 **Causes and proposed solutions to GP low morale**

	CAUSES	SOLUTIONS
Changing patient expectations	<ul style="list-style-type: none"> ● more questioning and challenging of judgement ● shopping around ● more night calls ● more demand for acute and chronic care during daytime 	<ul style="list-style-type: none"> ● longer consultation time ● strong communications skills ● not needed — not happening in practice ● separate night service ● nurse, rather than GP, as alternative point of primary contact
Impact of NHS policy	<ul style="list-style-type: none"> ● incentive payments undermine professional judgement ● fundholding professionally divisive ● budget holding forces explicit responsibility for rationing ● NHS 'under resourcing' limits ability to deliver good patient care ● NHS 'business values' erode professional service values ● erosion of autonomy by imposed protocols ● performance monitoring 	<ul style="list-style-type: none"> ● professional consensus on criteria for incentives ● salaried status ● all GPs to have some purchasing role ● future funding of NHS to be explicitly addressed ● professional lead in development of protocols and quality criteria
Impact of change	<ul style="list-style-type: none"> ● complexity/pace of innovation ● poor access to secondary care advice and facilities 	<ul style="list-style-type: none"> ● degree of specialisation ● use of IT for decision support ● enhanced 'consultant' role

The impact of NHS policy

A number of changes brought about by the GP contract and the internal market reforms have reduced GP morale. The introduction of incentive schemes relating to targeted interventions, some of which were not supported by obvious evidence of effectiveness has both eroded professional and financial autonomy. An obvious partial resolution is for

financial incentives to be clearly linked to cost effective interventions which are accepted by GPs as professionally appropriate. Alternatives including salaried status need to be considered. However, most GPs would be reluctant to accept that salaried status could either enhance their professional independence or their economic bargaining power.

Fundholding has reduced morale because it has divided GPs, and has pitted GPs against each other in the belief that they were playing a 'zero sum game' for resources both for practice support and access to secondary care (in practice it has not been a simple 'zero sum' exercise as we discuss above). However, fundholding has arguably reinforced the professional and financial autonomy of the GPs who are in fundholding practices. Indeed non fundholders have complained that fundholders are able to increase the value of their practice premises and business, at a time when property values had been falling, or were at best static. In part GP morale will be raised by clarity on the future of fundholding whichever policy direction is taken. We have put forward a model in which GPs are active purchasers of other primary care or community based care, but (generally) have only an advisory input into the planning of secondary care purchasing, which is undertaken by the health commissions. This brings purchasing responsibility in line with primary care professional skills.

Many GPs believe that fundholding and 'target budget' and incentive schemes for non fund holders are drawing GPs into explicit rationing. Of course GPs have always been resource constrained in the time and support they have available in the practice, and have always taken account of pressures in the hospital sector in their 'gate keeping' role. However, these changes are taking place at a time when many GPs believe under resourcing of the NHS is affecting the care their patients receive, and a policy ethos of looking to manage the NHS as a multi billion pound business is encouraging managers to try and erode professional autonomy and clinical freedom. The impact of these pressures on GP morale will only be resolved by the re-establishment of a political consensus on the ability (or otherwise) of the NHS to provide comprehensive care.

Protocols, some capable of delivery into the consultation through the practice IT system, together with pressure for external scrutiny of GP conduct, are hitting GP morale by threatening to turn the profession into technicians with a 'cook book'. As Rolands pointed out, these developments are inevitable and indeed desirable. If they are driven by the profession will they enhance, rather than diminish, the status of the GP.

The impact of clinical change

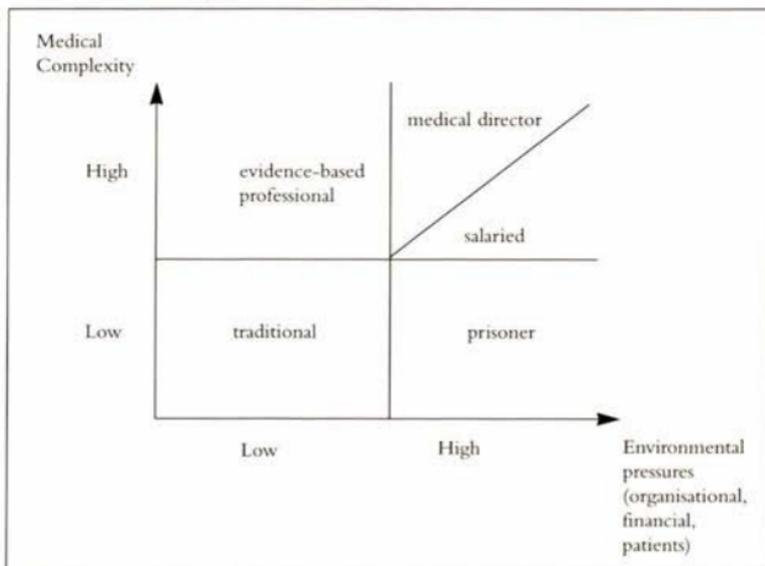
The main challenge is the rate of growth of medical knowledge in

relation both to new treatments and the effectiveness of existing ones. A degree of specialisation in general practice will be important in helping GPs combine good quality care with professional interest, as will professional involvement in the generation of protocols and use of IT as a decision support. Technological developments making some diagnoses and treatments easier to perform will enable some 'secondary care' activities to be performed in a primary care setting by GPs. Consultants are currently moving closer to GPs by performing some clinics at primary care centres. In the future 'telemedicine' may enable the consultant to consult with the GP and the patient, empowering the GP.

Medical complexity and environmental pressure

The themes from the conference suggest that whilst primary care is seen as effective and cost effective, with the USA and Germany both seeking to promote it within their specialist based health care systems, primary care in the UK faces many challenges, not least of which is low GP morale. Workload and financial reward are components of this, but the conference papers and discussion suggest to us that the perception of the erosion of professional autonomy and status is key, and in our discussion above we have pulled out the factors that are seen to threaten the

FIGURE 4 Future professional roles



medical professionalism of the GP. We can divide these into two sets of themes — those relating to the complexity of medical knowledge and practice, and those relating to the environment, namely organisational complexity, financial pressure and patient demand.

In Figure 4 we have two dimensions — medical complexity and environmental pressure. We end up with several stylised outcomes for the professional role and standing of the GP. These are as follows:

- with relatively low levels of complexity of medical knowledge and of environmental pressures we have the 'traditional' GP, offering continuity to patients;
- as medical complexity increases, the GP specialises, but with environmental pressures low, is able to maintain a strong patient focus and to combine external evidence on clinical effectiveness with good personal clinical experience. We have the 'evidence-based professional' GP;
- at relatively low levels of medical complexity but relatively high levels of environmental pressure we have the GP as 'prisoner', being pushed into becoming a manager/co-ordinator with rationing responsibility, whilst being subject to professional downgrading, with, for example, the use of nurse practitioners, to reduce costs;
- at high levels of medical complexity and environmental pressures, there are two possible outcomes. GPs may become 'medical directors' running primary care businesses with their fellow GP directors, with clinical specialisms and distinct management responsibilities. Continuity is provided by the practice, not by the individual GP. Alternatively, the GP may become a 'salaried' (although in principle they could remain self employed) professional, within an organisation managed by a full time chief executive (single handed or smaller practices will be de facto managed by the health authority) with a strong patient focus, but subject to practice driven care protocols and budgets.

Our categorisation is simplistic, but in our view a helpful way of identifying the key issues and tensions. Fundholding, for example, has the ability to turn GPs into 'prisoners', 'medical directors' or even 'salaried' professionals depending on how the purchasing and management activities are handled, and on the rate of growth of relevant medical knowledge. We hope that our analysis has highlighted the challenges facing primary care, and provided a constructive framework for the reader to enjoy the excellent papers that follow.

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Is strong primary care good for health outcomes?

Professor Barbara Starfield

Introduction

Health planners in most countries recognise the need for an infrastructure of primary care services within their health services systems. Despite this, countries vary markedly in the strength of this infrastructure. Policy-making pursuant to primary care planning is hampered in the absence of information about the relationships among systems structures concerning financing and organisation of services, the processes of delivering high quality care and the health outcomes that can be expected and achieved. That is, building of a strong infrastructure for primary care requires not only a political commitment but also knowledge about the relative importance of various structural and procedural elements of health systems that facilitate primary care.

In some cases there are no tools to acquire data to inform decisions. In others, the instruments to acquire information may exist but may not have been applied. Where they have been applied to obtain data, these data may not have been organised into information. In other instances, information may be available but not widely appreciated. Each of these alternatives may lead to a situation in which monitoring of system performance and re-calibration to correct inadequacies is not carried out. The process of planning for information, the development of instruments to obtain data, and the organisation of data into information all require a conceptual basis for the policy question, which in this case is the organisation of a health system into defined levels, with primary care as its base.

The aim of this paper is to provide an operational definition of primary care, to review the differences in the achievement of the primary care infrastructure in eleven Western industrialised nations, summarise available information about the impact of certain structures and processes, identify areas where additional information is needed, and suggest ways that the attainment of primary care may be evaluated and made amenable to alteration by those responsible for making health policy.

Defining primary care

Primary care is a level of the health system that provides the means of achieving optimal equity, effectiveness and efficiency of health services. It does this by performing four functions which, in concert, define primary care uniquely. These four functions are: the point of first

contact for all new needs; person-focused rather than disease-focused care over time; providing care for all needs that are common in the population, and co-ordinating care for both those needs and for needs that are sufficiently uncommon to require special services. Each of these features can be assessed and measured, first by specifying certain structural features of the health system that provide the potential for achieving them, and then by examining those behaviours of providers and patients that signify accomplishment of them.

- Thus, first contact care requires that primary care services be accessible and available in space, time and socio-cultural characteristics. The extent to which this accessibility reaches its potential is assessed by determining whether the population actually uses the primary care services each time a new need surfaces. You therefore have a structural feature of accessibility and a process feature of use by people for each new problem.
- Person-focused rather than disease-focused care over time, sometimes known as longitudinality (Alpert and Charney, 1974), requires that both providers and population agree on their mutual relationships. That is, a population must be defined by the health services provider, and that population must characterise that provider as its primary care source. The 'behaviour' representing longitudinality consists of the population's use of that facility for all common needs rather than the un-referred seeking of care elsewhere for certain types of needs. I should say at this juncture that some of these things are taken for granted in the UK, but this is not the case in the United States.
- Comprehensiveness requires, as its structural component, that the primary care service have, on hand, the full range of services for dealing with common health problems in the population. Its behavioural counterpart is the actual provision of services for all common needs.
- Co-ordination comes into play whenever people require referral to services for uncommon needs. In order to achieve co-ordination, providers must have available a mechanism of information transfer, usually including the recollections of the providers themselves and medical records of computerised encounter information, but sometimes supplemented by innovations such as patient-held records.

Primary care, health outcomes, and health expenditures

Research conducted in the most recent five years provides the evidence to support the value of primary care. International comparisons show graphically that a primary care orientation rather than a specialty orientation produces better outcomes, whether measured by available health indicators, total health care expenditures, medication use per capita, or satisfaction of the population with its health system. It is clear

that better rankings for the combined outcomes are associated with better rankings for primary care; better rankings for primary care are also associated with lower costs (Starfield, 1994).

Confirmation of the benefits of a strong primary care infrastructure comes from studies conducted within countries as well. For example, areas with greater primary care physician and lower specialist to population ratios have both lower costs (Welch et al, 1993) and better health, even after controlling for other determinants of health outcomes (Shi, 1994; Farmer, 1991). Such areas also have lower hospitalisation rates for people with conditions that should not occur in the presence of adequate primary care services (Parchman et al, 1994).

Functions of primary care

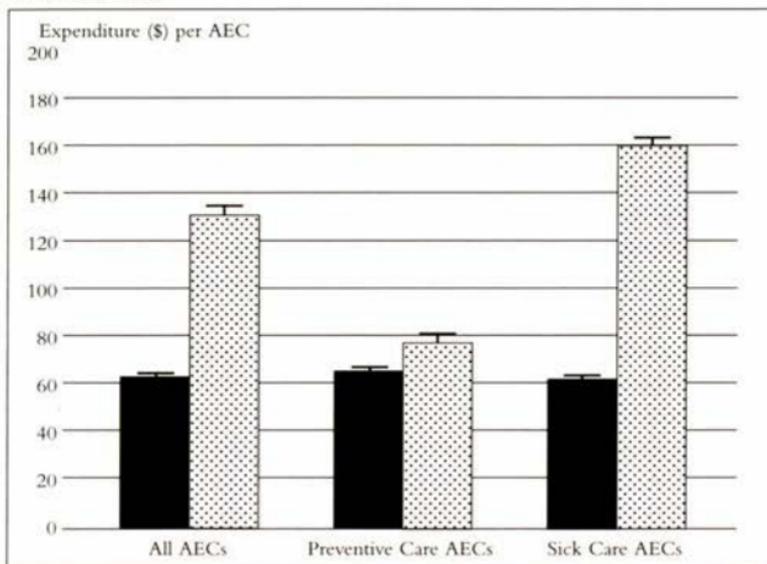
In countries in which a tradition of primary care is not strong and in which health policy has been dominated by specialists, specific tasks or approaches rather than system functions are often invoked as the defining characteristics of primary care. Thus, we see that primary care in the United States is often characterised as accessible care, humane care, preventive care or health promotion care. These are all tasks rather than functions. Since these tasks are also appropriate for most types of specialty care, and, at least to some degree, are provided by many specialists, defining primary care in this way allows vested specialty interests to lay claim to being 'primary care providers' when it is advantageous, politically and financially, to do so. Since there is then no distinction between primary care providers and specialists, confusing specific tasks with an approach to organising services is not helpful in specifying the respective roles of primary care and specialty care. Therefore an ability to assess and evaluate the adequacy of attainment of the four unique functions of primary care (these are not tasks, but functions) will go a long way towards furthering policy development, including manpower planning, that is directed at strengthening it.

First contact care

First contact with primary care services produces more appropriate and less expensive care (Moore, 1979; Roos, 1979). When people go to their primary care source for the first visit in a new episode of illness the costs of that entire episode are more than halved, as compared with the situation where they go elsewhere.

Using data collected nationally in the United States, the Figure shows the episodes of care, preventive episodes of care and sick care episodes of care plotted against the expenditures of care for the entire episode. The figure demonstrates that when people go to their primary care provider for the first visit, in either a preventive care episode or a sick care episode, or when you combine the total, the costs of the entire

FIGURE First contact care and expenditures per ambulatory episode of care (AEC)



Mean expenditures for an episode were compared by presence (■) and absence (▨) of first contact care for all AECs, preventive care AECs, and sick care AECs. The crossbars represent standard errors of the means.

Source: Forrest, 1995

episode are more than halved.

This is the case for a wide variety of reasons for visits, such as minor injuries, common acute illnesses, common symptoms, viral exanthems and general medical examinations and it remains the case even when visits to emergency services occurring as the first visit in the episode are excluded from the analysis (Forrest, 1995).

Longitudinality

The benefits of longitudinality, that is a relationship between a practitioner and a patient (or between a facility and a population), have also been well-documented. These include better recognition of patients' problems, more consistent preventive care, better compliance with physicians' recommendations, less inappropriate use and less hospitalisation, and more satisfied patients (Starfield, 1992).

Comprehensiveness

The benefits of comprehensiveness, that is delegating care for all common conditions to primary care practitioners rather than to

specialists, accrue from its greater efficiency and effectiveness. Specialists, encountering a common problem, often regard it as potentially more serious than it is likely to be, and therefore mount a more extensive work-up and interventions. The prior probability of a serious illness given any set of presenting symptoms and signs is greater in a specialist's practice than in primary care practice. That is, patients presenting to specialists have a higher likelihood of serious illness than those presenting in primary care, even when their clinical presentation is identical (Sox et al, 1990).

As a result, the training and experience of specialists makes them much more prone to misjudge the likelihood of serious illness in a primary care patient than is the case for primary care physicians. This phenomenon is likely to be a substantial part of the reason for higher costs in health systems with poorer development of primary care resources. Until research provides more firm conclusions, a rule of thumb based on theoretical calculations suggests that no more than 20 per cent of an average population should need to be seen by a specialist in a year. If health utilisation data indicate a more frequent use of specialists, there is likely to be inadequate provision of primary care services. Moreover, under-recognition of common problems in primary care practice also suggests inadequate comprehensiveness. For example, fewer than 15 per cent of the population in a practice with a diagnosis of a psychosocial problem in a year suggests inadequate comprehensiveness, since surveys have shown at least this proportion of the population has a diagnosable mental health problem of one type or another.

Co-ordination

Co-ordination is assessed by determining whether the primary care practitioner is aware of specialty visits that are made, assists in making them, provides information that facilitates diagnosis and management by the specialist, and receives and recognises information about the patient from that specialist after the referral is completed. The benefits of co-ordination include greater efficiency of care and less likelihood of adverse effects resulting from incompatible recommendations and treatments.

Cost-sharing

Dedicated health policies can either facilitate or hamper the development of a strong primary care infrastructure. There is no evidence that putting barriers in the way of people seeking services saves money. Information on hospitalisation from a comparative study of 11 western industrialised nations shows that available beds per 1000 population, admissions as a percentage of the population, and an average length of stay have no relationship with costliness of the system.

Countries with the highest costs, for example the United States, have a very low number of hospital beds (Starfield, 1993).

The same is the case for a number of physicians. The United States has a physician population ratio that is just at the mean for OECD countries and rather lower than many of them. The actual contact per capita in the United States is 5.3, which is considerably lower than the 8.4 in Australia, the 7.5 in Belgium and the 11.5 in West Germany. It is even lower than in the case of Canada, which is 6.6. Thus the high cost of the US health system is not a result of its population overseeking services.

Countries with strong primary care do not use cost-sharing for primary care services to any significant degree. Cost-sharing decreases the use of health services by people, but it does so indiscriminately, reducing both necessary as well as unnecessary care (Lohr et al, 1986; Siu et al, 1986). It also reduces the likelihood of receipt of indicated preventive care (Lurie, 1987; Blustein, 1995). Cost-sharing compromises the likelihood of good outcomes, particularly for those unable to afford it or those in poorest health (Brook et al, 1983; Shapiro et al, 1986).

It is what is done to people when they do seek services that is costly. This relates directly to whether patients are seen by primary care clinicians or by specialists. That is why the United States is so expensive. It is not because people over-seek services. It is because of what specialists do in response to the seeking of services.

The primary care physician as gatekeeper

Policy directed at gatekeeping also will facilitate a strong primary care system, particularly if gatekeeping is viewed as an empowering strategy rather than as a punitive one. That is, support provided to the primary care physician for appropriate decisions about referral will strengthen the role of the primary care physician relative to specialists. In Canada, for example, gatekeeping is encouraged by paying specialists less if patients are not referred by a primary care practitioner.

Gatekeeping is a means of making care more effective, less dangerous and less costly (Franks et al, 1992). Patients are often spared unnecessary, sometimes life-threatening, and costly diagnostic and therapeutic interventions because a primary care practitioner is better able to distinguish a potentially self-limiting condition from a more serious one. On the other hand, specific efforts to encourage necessary referrals by primary care practitioners would help to improve the timeliness and quality of care when patients need specialty services. Experimentation with different modes of consultation between primary care practitioners and specialists wherein both types of physicians gain more experience in the appropriateness of referrals will help to provide information to improve the process of gatekeeping, to reduce unwarranted referrals and

to facilitate warranted ones. Analysis of experiences with budget-holding by primary care physicians in the United Kingdom should provide other countries with information on the usefulness of this financial inducement to encouraging first contact care (Light, 1994).

Characteristics of a strong primary care infrastructure

So far, this paper has summarised what is known, although not necessarily widely recognised, about health policies that facilitate primary care and about the advantages of a strong primary care infrastructure. There are, however, many system characteristics whose effect on primary care provision is unknown. Since many of these are readily amenable to policy interventions, their recognition should help to focus research attention on them.

Physician Reimbursement

The first of these is the method of reimbursing physicians. The conventional mode of payment of practitioners in countries with a strong primary care infrastructure is salary or capitation for primary care practitioners and salary for specialists. Fee-for-service reimbursement is most often associated with an absence of gatekeepers and is generally associated with more physician contacts per person per year, lower referral rates, longer consultations and a greater proportion of patients per 100 encounters receiving laboratory tests or procedures, more home visiting and a greater use of computers for billing purposes only (Gervas et al, 1994). Some countries, for example Denmark and the UK, use mixed systems of reimbursing primary care practitioners, with fee-for-service inducements to encourage certain desirable practice patterns (such as for indicated preventive procedures) and capitation otherwise. In the United States some managed care organisations are considering paying primary care physicians by fee-for-service with specialists paid a capitation. We will learn a great deal if these policy decisions are regarded as an opportunity for natural experimentation, with evaluation of their implementation and impacts.

Referral and referral practices

Little is known about the way in which decisions should be made concerning appropriateness of referrals. Patients should be referred to a specialist for one of two reasons: a diagnostic or therapeutic conundrum for which the primary care practitioner needs short-term advice only, or because the patient has a long-term problem that is sufficiently unusual that primary care practitioners could not be expected to maintain sufficient competence in managing them alone. Theoretically it should be possible to determine, through epidemiological analysis, the distribution of problems in the population so that informed decisions

could be made about the proportion of patients who will need referrals of each type in a given time period, and thus calculate the appropriate number of specialists that are required for referrals. At present there are no such data. Data from the US National Medical Care Expenditure Survey indicate that at least 35 per cent of the US population are seen by a specialist in a year, suggesting a rate of use of specialists that is considerably greater than necessary (furthermore, the 65 per cent of people who are seen only by primary care physicians includes those seen by specialoids — physicians who often function as specialists) (Fry & Horder, 1994).

Some countries, for example the UK, are creating new types of arrangements for primary care/specialist interactions. Encouraged by contracting which involves accountability for expenditures for referrals, primary care physicians are arranging with specialists to provide consultative services within the primary care setting. Such practices are advantageous for the patient, for whom the services are more convenient; for the primary care physician, who derives the benefit of education directly from the specialist; and the specialist, who is in a better position to assess the patient's natural surroundings and their impact on treatment decisions. Systematic efforts to evaluate the extent of these benefits, as well as any disadvantages, would be useful worldwide.

The European referral study demonstrated that countries with strong specialty systems relative to their primary care systems have high re-referral rates, that is, a referral for which the patient had been referred at least once in the previous three years, and a short waiting time to see specialists, both of which lead to over-use of specialty services. In the absence of information about the appropriateness of referrals, or, alternatively, health policies that provide disincentives for over-referral, specialists will continue to control demand for their services (Fleming, 1992).

Patient choice of physician

Free choice of physician is something we do not know much about. In fact, the issue of free choice of physician has little relationship to the issue of primary care. Countries with highly developed primary care systems do not restrict choice of physicians. Even in Sweden and Finland, where primary care services had been provided by health centres rather than individual physicians, recent reorganisations of primary care services are linking individuals in the population with particular physicians. In these countries as well as in other industrialised nations individuals choose a primary care physician but typically are permitted to change their affiliation at any time. Ironically, it is in the United States, where 'managed care' systems are in the ascendancy, that

free choice is most limited. Managed care systems, while widely considered synonymous with primary care are, in reality, poor approximations of it. Managed care, with its emphasis on reducing utilisation, often imposes barriers to the seeking of physician services, even primary care services. Moreover, there is little emphasis on development of long-term relationships with a particular provider, which often are compromised by policies that sever relationships with providers because of negotiations that change people's insurance plans or fail to renew contracts with physicians or physician groups. Choice of provider is often limited by the offering of only a few options in health benefit plans; typically, large employers offer a choice of only one HMO and one indemnity plan. Moreover, even when choice is not constricted by this mechanism, individuals are generally permitted to change their affiliation with a plan only once a year, at most. In contrast, highly developed primary care systems allow people to change at any time.

Thus, the issue of free choice in primary care in the United States concerns only the matter of choice of site of care at each point of service, not the choice of primary care physician. Point-of-service plans, the most rapidly growing form of health insurance in the United States, are an attempt to introduce this option into the US managed care scene. However, even those enrolled in this form of plan appear to use it uncommonly, because of its high out-of-pocket expense. Free choice, in the sense of choice of primary care physicians, remains more constrained in the new US health care marketplace than elsewhere in the industrialised world.

Free choice of specialists, although not integral to primary care, is a related issue. In managed care settings, free choice is limited because of contractual relationships between health plans and specialists (and, in the British scene, by contracts between groups of GPs and hospital specialists). In western industrialised nations with highly developed primary care systems, free choice is constrained more by the way in which resources are distributed than by specified contractual arrangements. That is, in countries where resources are distributed according to population needs, there is likely to be limitation of choice as a result of the availability of only a limited number of specialists within a reasonable geographic radius.

Areas of high priority for research are the extent to which free choice, as it operates in systems with a highly developed primary care infrastructure, produces different effects on costs and quality than either the more limited free choice in managed care systems or the theoretical free choice in conventional indemnity insurance. Also of high priority is the extent to which free choice of specialist is associated with different types of outcomes in the different systems.

Teamwork

In many countries, teamwork is the norm in primary care practice. Most often, these teams consist of a physician and a nurse. In large practices, in group practices, or in 'integrated' health systems, teams may be more diverse. Little is known about the number and types of such teams, how they operate, or the extent of their impact on medical care processes. In theory, health professionals working in tandem with physicians could fulfil one or more of three types of functions: a substitutive function; a supplementary function, or a complementary function.

In the substitutive mode, the individual takes over the functions of the primary care physician. Many nurse practitioners in the United States function in this manner, especially in some managed care organisations. Patients see nurse practitioners, who perform all of the four functions of primary care: first contact; longitudinality; comprehensiveness; and co-ordination. Primary care physicians in these organisations apparently function primarily as secondary care physicians, for the purpose of consultation and guidance, although the literature contains little if any description of the nature or extent of these roles. In a country such as the US, where the tradition of primary care physician education is not strong, it is possible that primary care will become over time a function performed largely by nurse practitioners.

Health professionals functioning in the supplementary mode carry out tasks that are delegated by physicians for purposes of efficiency. For example, certain aspects of the physical examination, or counselling in well-child care conventionally are physicians tasks that may be assigned to other personnel trained specifically for these tasks.

In the complementary mode, non-physician health professionals add breadth to primary care services by providing services not usually provided by physicians. Social work services and community health services are examples of such functions.

No good description or analyses of teamwork are available to help guide policy decisions. In the face of a universal need to achieve both better effectiveness and better efficiency of health care services, better information is clearly of high priority.

Community orientation

Although no Western industrialised nation has achieved community orientation of its primary care infrastructure, there are good theoretical reasons for interest in it (IOM, 1984). Better awareness of health needs as they exist in communities can only improve the appropriateness of health services. Little is known about the relationships between primary care and public health in these countries. There is undoubtedly considerable variation in what is considered a public health problem and

what is considered a primary care problem, and considerable disagreement as to what clinical preventive services should be provided to entire populations through a public health approach or only to high risk populations, usually through primary care mechanisms (Starfield & Vivier, 1993).

It would be very helpful to examine the approaches used by different countries in order to inform health policy makers about the alternatives.

Hospital-based and community-based specialists

In countries with a highly developed primary care infrastructure, specialists generally practise in hospital settings. The opposite is the case in countries with relatively strong specialty systems. However, there are important exceptions to the rule. For example, Spain, with its strong base of primary care, has community-based specialists. Better delineation of the roles of primary care and specialty physicians, and particularly new ways by which they interrelate in the care of patients, should focus a reconsideration of the appropriate locus of practice of specialists. Better information concerning the relative need for secondary care (short term consultation) and tertiary care (long term management for uncommon problems) may help in consideration of the policy alternatives.

Conclusion

There are many things known about primary care and many more to learn. We know that:

- Primary care can be defined;
- Primary care can be measured;
- A strong primary care infrastructure is more effective, more efficient and more equitable than a specialty-oriented system.

Policy decisions concerning ways of reimbursing primary care physicians and specialists, the appropriateness of various types of referrals, the importance of free choice of primary care physicians and/or specialists, the role of teamwork and the locus of practice of specialists await the findings of more extensive health services research.

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Primary care led purchasing in the NHS: Fundholding and other models

Professor Chris Ham

Introduction

In recent years there has been a shift of power within the Health Service. We have seen purchasers refocusing their activities, from the management of health care institutions and hospitals to thinking about the population, its health needs and how best they can use their resources to respond to those needs. In addition, dialogue has opened between health authorities and general practitioners, combining a public health agenda with an interest in primary care. A consequence of this shift in the balance of power has been to put specialists and secondary care providers in a more accountable position, and to give purchasers, including GP fundholders, a greater capacity to exert leverage over how services are delivered. This policy has been reinforced with recent measures to develop a primary care-led NHS.

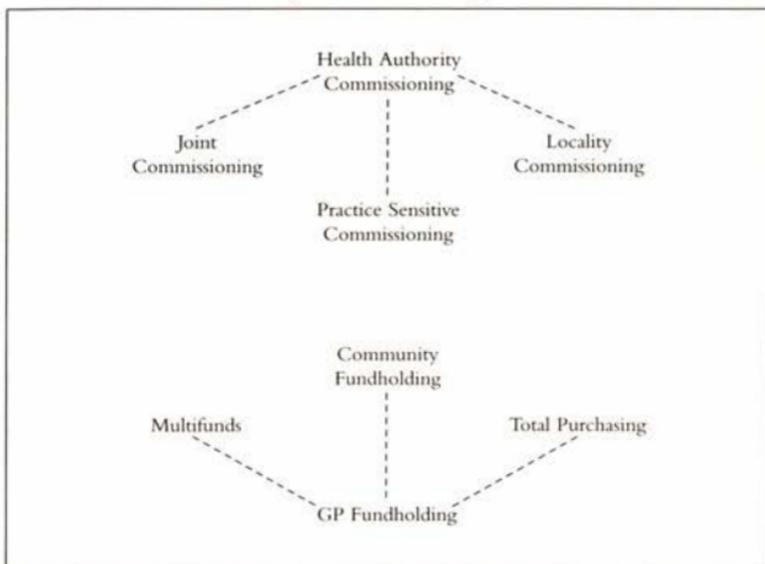
There are two key components in this policy. One is the extension of fundholding, with three new options on the table, including 'total purchasing' for a number of practices. The second is the move to integrate district health authorities and family health services authorities in England and Wales from April 1996, bringing these two countries into line with Scotland and Northern Ireland where integration has existed for some time. These integrated authorities will be expected to give priority to primary care, strengthening primary care provision and ensuring that all GPs, not just fundholders, have influence over planning, purchasing and the commissioning of health care.

Starting with the two original models of purchasing: the population-centred approach, focused on the work of health authorities, and the more patient-oriented fundholding, what we have seen in practice is the rapid development of a range of mixed or hybrid models as shown in Figure 1.

Fundholding has gone off into different directions with community fundholding, total purchasing, and the spontaneous emergence of multi-funds, with a new association which has been set up to bring together the work of those multi-funds.

At the top of Figure 1, starting from the population-centred model, we see health authorities developing a range of locality-based approaches to commissioning, trying to devolve and de-centralise their decision-making. We see interest in practice-sensitive purchasing as health authorities try to get alongside individual practices, often

FIGURE 1 Health authority commissioning



developing notional budgets in the process. More strategically, we see the development of joint commissioning between health authorities and their local authority partners. This innovation and experimentation has not been driven from the centre but has evolved from the bottom up. Managers, doctors and others have taken the opportunity to see how far they can test out these different approaches.

What does the evidence, such as it is, tell us about the likely effectiveness of these alternative purchasing models?

The impact of fundholding

Fundholding has had a number of effects. The UK experience certainly suggests that if you change the incentive structure facing primary care physicians they will change their clinical practices, not on the basis of good research evidence but because the way in which they are paid has changed. This is an important conclusion to draw, not just from fundholding but also from the 1990 GP contract and the impact that this had on health promotion, prevention work and other aspects of GPs' clinical activity.

What fundholding has done in particular is:

- (1) Change prescribing behaviour, producing more cost-effective prescribing, and increasing the use of generic drugs. GPs in

fundholding practices have consequently often made savings in their drugs budgets.

- (2) Reduce waiting times for hospital appointments, both outpatient and inpatient, for the patients registered with fundholding practices. There has also been improved communication between general practitioners and their specialist colleagues: for example, getting discharge information back more quickly to GPs — a common complaint over many years.
- (3) Increase the range of services being delivered within primary care. Often the savings GPs have made, in prescribing budgets, for example, are redeployed to pay counsellors, physiotherapists, and dieticians to deliver care in the practice rather than referring patients to hospital to receive those services.

Equally important, it should be acknowledged that the adverse effects of fundholding that I and many other people predicted do not seem to have materialised so far.

- (1) The main danger anticipated was that fundholding would create an incentive for GPs to select patients. This does not appear to have happened, although the absence of research does not help us make that judgement. The reason that risk selection has not materialised is that despite the intention in *Working for Patients* to establish budgets on a capitation basis, they have been set on an historical basis, looking at what GPs have done in the past and therefore they have been relatively generous without creating a strong incentive to introduce risk selection.
- (2) The literature indicates that management and transaction costs appear to be relatively high in relation to fundholding, as compared with other models of purchasing. This is not just because of the management allowances paid to fundholders, but more especially because of the additional workload for the NHS trusts in having to negotiate tailor-made contracts with a large number of small purchasers.
- (3) The survey evidence appears to suggest that one of the main complaints GPs have about fundholding is the workload. This is unsurprising, given that taking on a budget will involve additional responsibilities. How long that can be sustained is an important question which needs to be addressed.

The achievements of fundholders which I have mentioned have been thrown into sharper relief by the fact that on the whole health authorities, following the population-centred purchasing model, were much slower to develop their role as purchasers. One reason for that is they were not encouraged to be very entrepreneurial in the early days. The emphasis was on steady state; the political line was to progress rather slowly.

Over time their impact has increased. They are now working with GPs in localities and through all sorts of other mechanisms. In the process, they are re-focusing their attention away from simply the management of health care services to the public health agenda set out in *The Health of the Nation*. The emphasis is now on evidence-based medicine, ensuring cost-effectiveness in the use of resources, and also the policy of a primary care-led NHS.

The innovation we have seen in primary care has not been confined to GP fundholding. We are also seeing some very important developments in primary care provision and commissioning in non-fundholding practices. For example, the Lyme Community Care Unit in Dorset is achieving many of the same benefits that fundholding has done without actually going down that route.

Assessing models of purchasing

What sense can we make of all of this, given incomplete evidence, a rapidly moving picture, and differential development of the alternative models? We need to find a way of combining population centred and patient-focused purchasing. The simple question — who is the better purchaser, the health authority or the fundholder — is the wrong question to ask. The evidence suggests that health authorities are better at some aspects of purchasing, assessing community health care needs and working strategically with their partners in local authorities and in the voluntary sector. Equally, GPs in fundholding and, to some extent, in non-fundholding practices are better at other aspects of purchasing. They are much closer to their patients. They have more direct experience of the quality of care. They can respond to demands in a way which it will always be difficult to do for those who staff health authorities. The challenge is to combine the leverage of health authorities and the bite of fundholders to see if we can get the best of both of these different models of purchasing.

Having made this point, it should be emphasized that there is no guarantee that the sum of multiple purchasing decisions will add up to an appropriate pattern of service provision for people who are living in a given health district. Indeed, putting it more forcibly and more bluntly, if we do not co-ordinate and synchronise purchasing decisions by health authorities on the one hand and fundholders on the other there is a real risk of instability and fragmentation. The ability to ensure good local access to comprehensive services will no longer be there because there is not the capacity in the service to plan and co-ordinate in the way we have become accustomed to over the last 45 to 50 years. So there needs to be 'synchronised purchasing' in the new NHS. How that is to be achieved has never really been specified.

Turning to the future, fundholding is now seen as the preferred

option for GPs but not the only option. There has been a shift in policy. It is quite likely that fundholding will expand to cover perhaps 60 per cent of the population in England by next year. It will be difficult to get beyond the 60 per cent figure because some GPs remain opposed to fundholding. Other options will therefore be needed, including locality commissioning and GP commissioning groups.

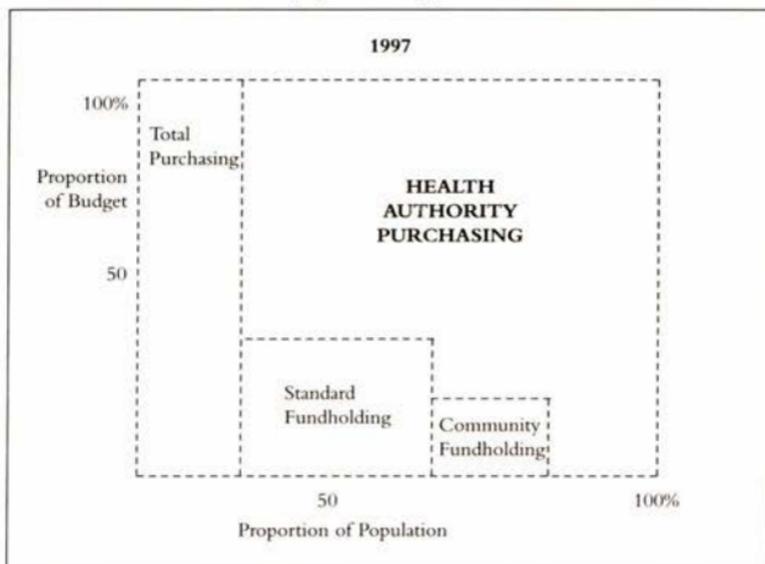
Let us also recognise that, as the financial constraints in the health service tighten, we may find not only further practices going into the scheme, but also some exits from fundholding. If the Government is serious about moving away from the current budget-setting method towards the capitation approach to fundholding, then over time that could mean some significant shifts for individual practices — both up and down. Under that system, the financial attractions to the losers of remaining as fundholders will diminish. It would not be at all surprising if some practices felt that they had achieved what they wanted in two or three years of fundholding and decided to leave the scheme after that; especially if health authorities become better purchasers and they become more sensitive to GPs. The relative advantage of the different models may then change.

Despite the support and the momentum behind fundholding, health authorities will continue to have an important role themselves as the direct purchasers. Whilst they will also take on the more strategic, enabling role that has been prescribed for them, we are a long way from the position where health authorities will give up holding a budget. At the present time, the proportion of the hospital and community health services' budget controlled by fundholders is relatively small compared with the vast amount of resources still under the control of health authorities. The question is how will that change and how rapidly?

Speculating about two years down the track it might look something like Figure 2. Total purchasers are in the left-hand column, GPs buying all services for their patients, covering perhaps 10 to 15 per cent of the population in England. Standard fundholding will expand because of the extensions to the services that GPs are purchasing, and we know that more practices will come in. Then we have the community fund holding option right at the end. This is not a precise prediction. However, it does suggest that there will still be a considerable amount of resources under the control of health authorities as direct purchasers. So for some time to come there will continue to be a role for health authorities, even with the current emphasis placed on the expansion and the development of GP fundholding.

What about a change of Government? Let me be bold here and suggest that it may not make that much difference. First of all, I do not think fundholding will be abolished overnight. If you are a future Labour Secretary of State, it is unlikely that you would wish to

FIGURE 2 Health authority purchasing



antagonise a large number of GPs with a unilateral decision to get rid of fundholding. It is more likely that the policy will be geared towards encouraging GPs to leave fundholding of their own freewill and to participate in alternative GP commissioning models.

There would seem to be increasing convergence between the political parties. Labour's GP-commissioning model does not appear to be that different from the current policy, of a primary care-led NHS. GPs who are already commissioning, under the umbrella of an integrated health authority, seem to be operating in a way which would be rather similar to how they would function if there was a change of Government in the next year. The Labour Party has shifted its thinking and it is prepared to be discriminating in its response to present policies.

Conclusion

To summarise and conclude, what I am suggesting is that a convergence is taking place. There are some outstanding differences but if you cut behind the smoke-screen of the political debate you discover quite a lot of common ground now emerging, as both political parties begin to move towards a new consensus. There are some key challenges, however, which emerge whatever the political future may hold.

(1) There is a need to strengthen management capacity still further in

primary care. If we are expecting even more to happen in a primary care-led NHS, not only commissioning but also service delivery and service provision, this will require a further investment in the management skills of all primary care staff, not just GPs. We will have to find the resources to make that happen.

- (2) There is a serious problem of morale and motivation amongst GPs. We need to recognise this and find some ingenious ways of addressing this issue.
- (3) There is a challenge for the new health authorities. The history and tradition of district health authorities has, until very recently, been in relation to secondary care and specialist services. There is a risk that the family health services authority contribution will be swamped as the new appointments are made and as the new health authorities are established. We must avoid that and we must ensure that there is a genuine primary care focus, not only in what health authorities say and in the plans they produce but in how they allocate resources.

If we can meet these challenges then the idea of a primary care-led NHS will become a reality. If we cannot, then it is simply another of those nice phrases which we should dispose of in the dustbin of political rhetoric.

The organisation of primary care in Finland

Dr Marjukka Mäkelä

Introduction

It is always a challenge to describe and to understand different models of health care because of the differences in the historical backgrounds and because of the abundance of interactive details which exist in every health care system.

This paper will look at the organisation of primary care in Finland under the following headings:

- the principles and structure of health care;
- the public and private providers of services;
- the community and primary care teams;
- the old and new methods of payment; which we have for health care;
- health care funding and general practitioner remuneration, and
- future challenges.

The principles and structure of health care

The principles in the Finnish health care system are very similar to those of many other European countries. We have tried to achieve equality of access, to provide preventive services free of charge, and to arrange mainly public funding for the services. These have been the mainstay of our health care system since the 1950s. In the 1970s we changed from a system that was similar to the British system of general practitioners to multi-professionality and to community health centres. This was done to achieve better accessibility and regional equality.

The problem of accessibility continued until, at the end of the 1980s, we realised that something had to be done about it. In the late 1980s and early 1990s the solutions have been wider multi-professional teamwork and a multi-sectoral approach. At present we are trying to combine primary health care and social welfare at the community level. This is a really exciting development.

Finland has a population of 5 million, with a population density of only 17 inhabitants per square kilometre. Some people have very long distances to reach their health centres. The country is divided into 450 municipalities, which means that the majority of the local authorities deal with fewer than 15,000 people.

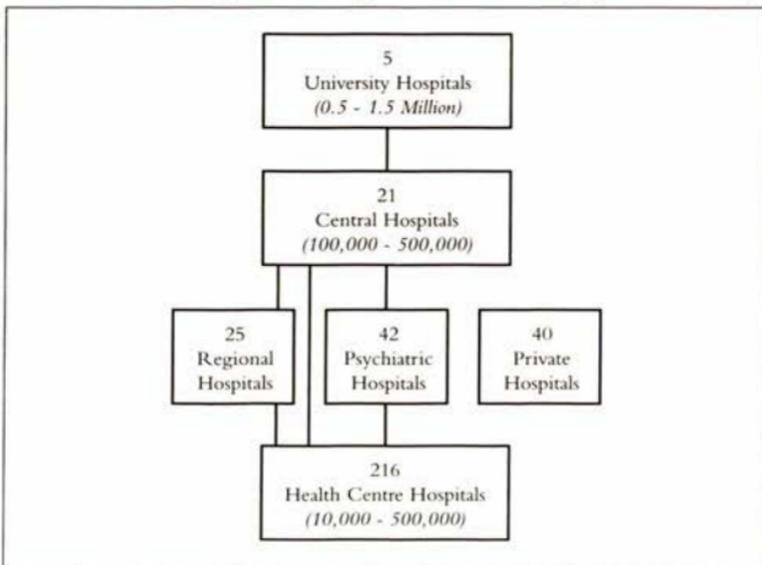
The local authorities/municipalities are responsible for providing both primary and secondary health care. The health centre is the organisation rather than the building where the services are provided. It also covers dental care, environmental health and many other services in

addition to GP services. Secondary care is mainly provided regionally. Private services are to be found mainly in the large cities where they substitute for some primary care and offer a range of specialist services.

In order to understand the Finnish system it is also useful to know that the health services are constructed on a regional basis. The central hospitals were built mostly after the Second World War. They were evenly spread throughout the country, equal access could be provided. Regional hospitals provide additional services in the main specialties. The psychiatric hospitals are still managed within a separate organisation, but one of the next moves under discussion is the merging of psychiatric hospitals with regional hospitals. There are a number of private hospitals, mostly catering for specific needs, such as rheumatoid surgery. Finally, there are over 200 health centre hospitals, and almost all have their own bed wards (see Figure 1).

The Ministry of Social Affairs and Health has also decided that certain procedures, such as organ transplants and some forms of cancer treatment, can only be undertaken in appointed centres of excellence, listed by the ministry. We are now discussing where fertility procedures are best provided. At present both private and public organisations offer these services with a wide variation in outcome.

FIGURE 1 **Secondary and tertiary care in Finland (population bases)**



Public and private providers of primary health care services

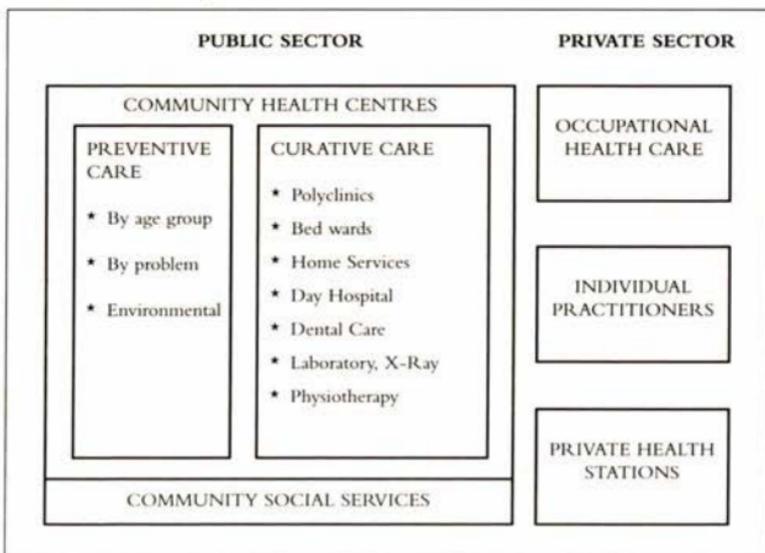
The municipalities are responsible for both primary and secondary care. They can provide these services themselves, form unions to provide services together, or buy services from outside. The community health centres offer both preventive and curative care. Preventive care is dealt with by age group, and to some extent by problem.

Consultations are mainly with general practitioners. Some consultations for minor problems and part of the follow-up for common problems are provided by nurse practitioners. Increasingly, hospital consultants visit the health centres in their region either to see patients directly or to consult the GPs about their problem cases.

GP consultations used to be arranged in a polyclinic fashion: consultations were booked with any health centre physician that was available. This resulted in poor continuity of care, and most health centres now list patients with a personal physician; this is described in more detail in the context of primary care teams.

Health centres (HCs) also operate bed wards, home services, ambulance services, and day hospitals. Dental care for children and other specified groups is also part of primary care. All HCs have laboratory and X-ray facilities and physiotherapy departments; some have their own speech therapists, psychologists, etc. (see Figure 2). We are now also combining the community social services with the primary care services.

FIGURE 2 Primary health care in Finland



Health centre hospitals mostly take care of chronically ill patients, but some HC wards are very active. A few communities even take care of their own minor surgery and deliveries. This is most common in locations which are at a long distance from the secondary hospitals.

Preventive care is by age group. Much of this care is provided by the general practitioner, who now also treats the same population when they are ill. Maternity services are generally provided by nurse practitioners who have special training in this area, although about a fifth of the maternity consultations will be with the general practitioner. The well baby clinics are similarly arranged. The GP sees the baby three times during its first year, then yearly up to the age of four, and then every two years. The nurse practitioner meets the children more often and consults the GP if there is uncertainty about the findings during these consultations. Preventive care is continued in the school and student health services, often provided by the same nurses that run the well-baby clinics for these children.

Some preventive care is arranged by health problem, such as dental services, occupational health services, the prevention of infectious diseases at both the individual and environmental level, and screening for certain health problems such as mammographies.

The community and primary care teams

Figure 3 indicates the personnel involved in the running of a typical health centre covering a population of 25,000. Some of the personnel work only in open care, some on bed wards, and some, for example the physicians, on both sides. There are some 70 nurses in the health centre; more than 50 people from other nursing professions (physiotherapists etcetera), 15 GPs, and about 90 other workers, such as the managerial team, technicians, cleaners and cooks. This large institution employs some 4 per cent of the working population of the community.

FIGURE 3 Personnel in primary care per 25,000 population

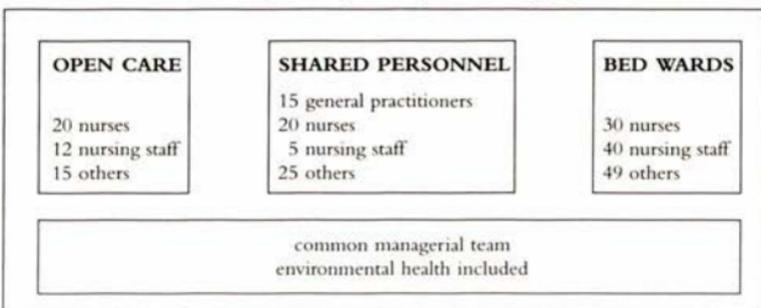
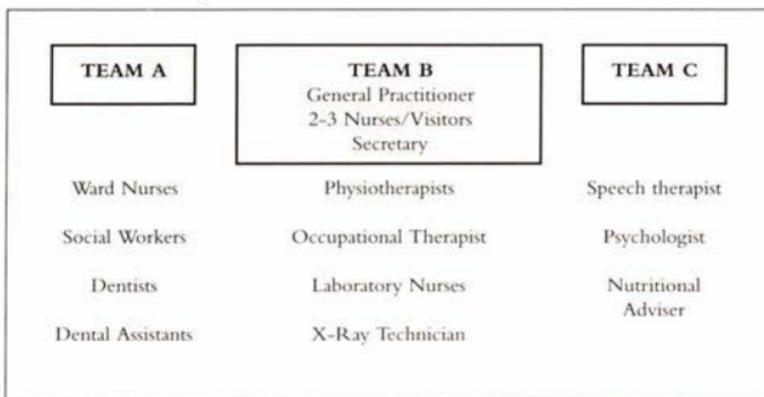


FIGURE 4 Primary care team



The primary care team is arranged so that there are about seven teams in a health centre of this size. They are responsible for the population in a given geographically defined area. The core team comprises the general practitioner, two or three nurses or health visitors and a secretary (see Figure 4). Whatever the health problem of a patient living in the area, their initial point of contact will always be a member of the team, often the secretary who knows the team's commitments. If the secretary cannot make the decision, it is passed on to the general practitioner who then decides whether or not the patient needs to be seen right away or within a few days; the general practitioner can consult other specialists in the health centre, which may include psychologists, speech therapists, social workers, nutritional advisers — depending upon the population structure of the community.

Each member of the population is listed with the team physician. This was a major change made in the early 1990s. Instead of having 15 physicians and the patient being able to consult any one of them, the patient is now registered with a named physician and knows that this person should be their first point of contact when they have a health problem.

Health care funding and general practitioners remuneration

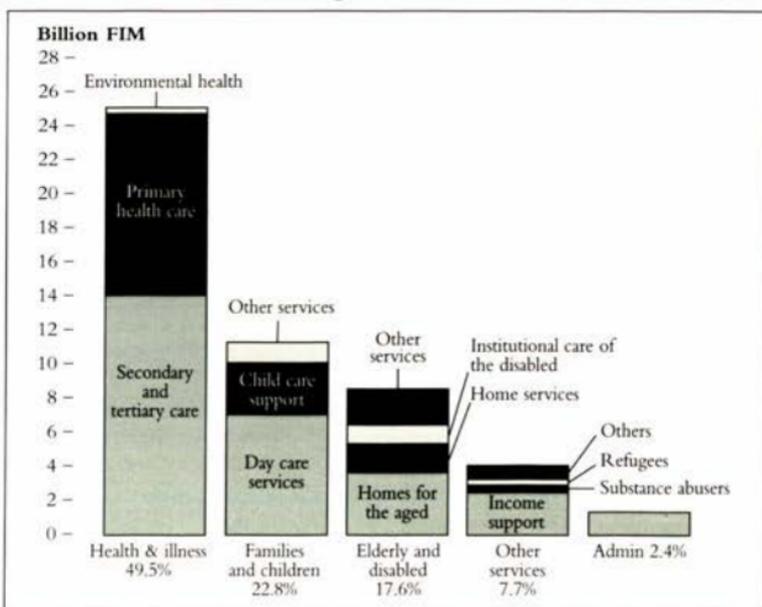
The funding of municipal services is arranged so that about half of it comes from the municipal budget. The local authorities have the power of taxation. The balance is provided by State support, depending on the wealth of the community. The municipalities therefore receive from the state between 30 per cent and 60-65 per cent of the total cost of their health care, both primary and secondary. About 10 per cent comes from

user charges, some of which are means tested. Those exempted from such charges include children under 15 and war veterans.

Figure 5 shows the costs of such a health and welfare system. The first column gives details of primary, secondary and tertiary health care showing that together they represent about half of the cost of all social welfare and health services in the community. The total for all health services is approximately 50 billion Finnish marks, which is about £800 per person per year: about £400 for the primary health care services and a little over £400 for secondary care. It is interesting to note that the administrative costs of the system are very small, just over 2 per cent of the total.

Services that are funded mainly through user fees include private practice and dental care for adults (children and young adults are covered by the community dental care system). Compulsory state health insurance pays between 20 and 70 per cent of the use of private health services and is collected through taxation. Thus, Finns are paying through taxes both for the municipal health services and the private health care system. This is now being strongly challenged in policy discussion.

FIGURE 5 The cost of municipal health and welfare services in 1993



Forty-five to 90 per cent of drug costs are covered by the state health insurance, which also provides the main funding for student health services. Occupational health services are funded through a separate budget with the main contribution from the employers. Optional private health insurance can be taken out, but this is very uncommon. The state subsidises some of the organisations which provide certain health care services, for example services for the handicapped.

Large employers often provide the occupational health services in their own primary care units. However, these usually offer no other forms of preventive care, for example maternity care, or emergency services. Neither do they cover for secondary care services other than for those procedures connected with occupational diseases. Much of the expensive care for the population falls on the municipal health centre.

Because the preventive services are nurse-based, it could be argued that nurses function as gatekeepers to the general practitioner. Nurses also give a notable amount of curative care, such as systematic follow-up of chronic diseases, advice in mild acute problems, and working with chronic patients especially during home visits.

In theory, there is compulsory referral for secondary care, but this is not strictly enforced. Because the municipality stands for the costs in secondary care, patient referrals are supposed to be accepted by municipal health centres. Over 50 per cent of the treatment episodes are initiated by the hospitals: they want to follow their own patients or consult other specialties within the hospital. Additionally, private practitioners remit their patients, and in many acute cases patients use self-referral. The health centres have little possibility for true gatekeeping in this situation.

Municipal health boards decide what secondary care is purchased. But since the hospitals are municipally funded, there is a strong motivation to use your own hospital, instead of shopping for better quality, shorter queues, or lower prices. The left hand gives money to the right hand, and other providers are not considered.

Our health services market has also been very closed, but it is now slowly opening. Municipalities are increasingly purchasing services from a variety of sources, particularly for procedures where waiting lists are long. The excess capacity in our hospitals makes this easy; we have twice the number of beds per inhabitant as is available in England. All this combined with long travelling distances and ample state funding for health services, results in vacillating price levels and difficulties in achieving a true market. In the new situation, general practitioners must deal with a larger number of hospitals. Patients also have mixed feelings about increasing travelling distances.

There are basically three payment methods that can be used for general practitioners. In Figure 6 these are combined with the types of

FIGURE 6 **Payment methods and incentives**

PAYMENT METHOD	PAYMENT RESPONDS TO
Input-based (salary)	Levels of input delivered (time)
Throughput-based (fee for service)	Number of services delivered (procedures)
Population-based (capitation)	Number of persons covered (demand)

Source: Birch et al, 1994.

incentives that each method offers (Birch et al, 1994). First, there is the input based method of payment or salary, where physicians are paid for the time they spend working. In the throughput based method, payment relates to the amount of services delivered. This can be counted as the number of consultations, interventions, or other procedures and is generally known as the fee-for-service model. The third option, capitation, is based on the size of the population that uses the services regardless of how much services are provided or how much time is spent doing this.

Finland is implementing an interesting mixture of the three payment methods for GPs in health centres. The basic salary is based on age and experience. Patients who consult three or more times per year are defined as the core population, and for each of them the GP receives a small monthly fee regardless of whether they consult. This means there is an incentive to see these patients only when necessary. The size of the core population varies from 15 to 20 per cent of the patients on the GP's list. For other consultations there is a fee-for-service payment. Clearly there is an incentive to see each year most of the population at least once, while limiting the number of visits per individual to less than three.

It has been shown in well-designed studies that the coverage of the population increases when the physician is transferred to this system from the salaried system. It makes perfect sense. The cost of this system is a 10 to 20 per cent increase in the physician's income, while the access problems disappear and consultations increase by six to 20 per cent.

Future challenges

The future challenges we face are, first, the quality of care. There are small area variations in treatment practices which are quite difficult to explain in terms of the health of the population. There is good data for secondary care and primary care data is increasingly available.

Second, accessibility continues to be a problem in those areas where the physicians have not gone over to the personal list system.

Third, the collaboration between primary care and the social services is a very important development. Many of the services are not very easily distinguishable in terms of health care or welfare services. One explanation for our high number of beds is that we also include some old people's homes as hospital beds. Teamwork development and the care of the elderly are real challenges where this collaboration is helpful.

With personal lists based on patients' addresses, there arises the question of how the patient can choose his/her physician. Our experience in changing to the list system is that only a very small percentage of patients wanted to stay with their old physician or wanted another physician than that allocated to them in the geographical arrangement. The figure was between one and three per cent. This is manageable, even within the geographical divisions.

In conclusion, what we find useful for primary health care is the population approach. We are trying to offer full-scale primary health care services, from the preventive to the rehabilitative, with a multi-professional team combining health and social services and collaborating closely with secondary care. We are also trying to use a payment system which supports the aims of our health care ethos.

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The case of the Netherlands

Dr Jouke van der Zee and Jack B F Hutten

Introduction

In the summer of 1995 I spent my holidays in the Baltic states — in Estonia. Driven by some incurable professional curiosity, I interrogated people there with questions like 'What do you do when you, your children or your parents become ill?' From this heavily biased, low-number survey I received some straight forward answers. They said 'When you know what is wrong with you, you go to a pharmacy — and, actually, you do the same when you don't know what is wrong with you! Unless you just drop down or start bleeding heavily — then you call an ambulance. Before the revolution, we would have two weeks in a spa, paid for by the employers. But that is now over'. When I mentioned that I had heard rumours about general practitioners and primary health care being introduced, they said 'Yes, perhaps 30 or 40 miles away there might be a centre like that', but people were not able to report any concrete experience.

This experience from Estonia adds a third type of health care system, the pharmacy-based one, to those of hospital based and general practice. It is important to recognise that the typical GP-based system is not the only solution to primary health care, and that other solutions are possible and perhaps even feasible.

In the Netherlands, as well as in Denmark, the United Kingdom and members of the British Commonwealth like Canada, Australia and New Zealand, general practitioners form the core of primary health care. They act as gatekeepers, for outpatient and inpatient specialist care, for the utilisation of allied health care services, ambulatory mental health care (in the Netherlands) and a good deal of prescribed medicines.

GPs provide general medical care to a relatively stable¹ list of patients united in households, composed of both sexes, and all age categories². It is care for all members of the household, young and old. The family, or, more generally, the household is the doctor's frame of reference and also his entry to his medical records.

In the Netherlands, the UK and Denmark general practitioners form a self-conscious, well-organised and professionalised group of doctors, scientifically backed by productive university departments of general and family medicine.

1 The stability of a GP's list depends largely on the general stability of the local population; in inner city areas there is more mobility than in typical residential areas.

2 Here we deviate from Starfield's description in the paper this conference was based upon: 'Primary care is first contact, continuous, comprehensive and co-ordinated care provided to populations undifferentiated by gender, disease or organ system' Starfield Barbara, Is primary care essential, *The Lancet*, vol 344, 1994, 1129-1133.

By combining successful strategic skills, like the foundation of a college³, the creation of a research journal, and by wriggling themselves into the medical faculties, in general fostered by Ministries of Health, who supported home care ideology and relatively cheap health care, general practitioners succeeded in breaking the vicious circle of low popular and academic esteem, low pay and low medical prestige that is typical of the position of GP's in many other countries.

Developments continue: in the UK the GP-fundholding scheme is an expression of a genuine 'primary care led NHS' while the Dutch GP's adopted a system of guidelines⁴ for the detection and treatment of diseases that comes as close to 'evidence based medicine' as is compatible with day to day clinical practice⁵. This process took more than three decades from the start in the 1950s to the consolidated position nowadays. It would therefore be naive to expect that the example could be copied with immediate success and without considerable effort. But, the good news is that the vicious circle can be broken.

This paper consists of three parts:

- General introduction regarding health, health care, finance and especially insurance.
- The position of GP's.
- The relationship with secondary care.

The information sources are as follows:

- the OECD health care database. It is a well-known treasury of health care data but also a source of inevitable errors and misunderstandings (OECD, 1993);
- a study by the Birmingham GP Douglas Fleming, head of the Birmingham Research Unit of the Royal College of General Practitioners, who compared consultations and referrals between GP's and countries in a European comparative study (Fleming, 1992; 1993);

3 The British College of General Practitioners stems from 1952 and became 'Royal' in April 1967, the Dutch College ('Nederlands Huisartsen Genootschap') was founded in 1956 and the Danish College ('Dansk Selskab for Almen Medicin') in 1974. The Colleges' journal stem respectively from 1950 (UK) and 1957 (NL). The Danes never had a typical Research Journal; they founded in 1980 the Scandinavian Journal of Primary Health Care. The first chairs in General or Family Medicine were at the universities of Edinburgh (Richard Scott, 1964), Utrecht (Jan van ES, 1966) and Copenhagen (Paul Backer, 1974).

4 Rutten G.H.M.M. and S Thomas (eds) *De NHG standaarden voor de huisarts, Wetenschappelijke Uitgeverij Bunge, Utrecht, 1993*. The Dutch guidelines do not cover the complete range of possible treatment; they are '(single) illness-oriented' and do not pay much attention (yet) to comorbidity or general behavioural aspects in diagnosis and treatment. However the carefulness by which the standards are produced; their subtle but clear combination of evidence based intervention and common practice makes them in general acceptable for the odd 7000 GP's in the Netherlands. Increasingly, the guidelines are used in legal and correctional procedures and, even with regular intervals they are summarised in the *Journal of the Dutch Consumers Association (Consumentengids, July 1992, January 1994)*.

5 In Denmark no such major development seems to take place; but, why change a winning team.

- an overview of 'Health Care and General Practice across Europe' carried out at NIVEL by Wienke Boerma (1993);
- a European comparative study (in the BIOMED programme and the European Commission) about 'practice profiles' of general practitioners in Europe also conducted by Wienke Boerma⁶;
- several smaller studies like the thesis on GP remuneration and revenues by Diana Delnoij (1994), a comparative study by the Belgian Institute of Hygiene and Epidemiology of some European networks of GP-Sentinel stations (van Casteren, 1991) and an Anglo-Dutch study on prescription behaviour by the British GP Robin Hull (Hull et al, 1992), who worked on both sides of the North Sea.

A general introduction to the health systems of the Netherlands, Denmark and the United Kingdom

Health

In this paper 'health status' is used as a starting point for comparison rather than the outcome. If the three countries differ considerably regarding their populations' health status further comparison should take this into account. Two general indicators for the population's health status are used:

- Life expectancy at birth for male and females (Figure 1)
- Potential years of life lost (Figure 2)

The first indicator is well known and generally accepted; the second concerns deaths under 65 years due to causes that are in one way or another preventable or amenable to (medical) interventions such as deaths from traffic accidents, liver cirrhosis, lung cancer, ischaemic heart diseases (OECD, 1993)⁷. The data on the 'gender gap' in life expectancy and the development of this indicator over the period 1960-1990 show a certain increase in life expectancy — especially in Britain — and a striking stagnation in the life expectancy of the Danish males.

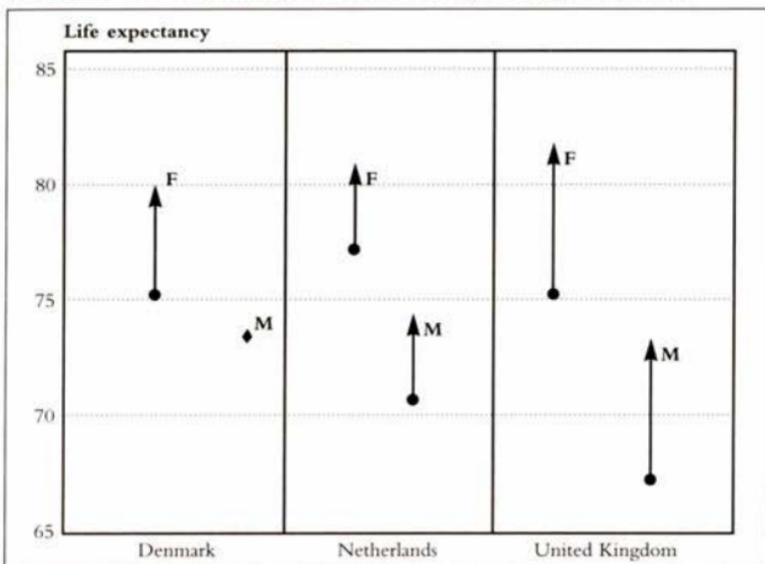
The development in life years lost shows some gain in Britain, some in the Netherlands (who had the best position in the sixties) and the least in Denmark. In 1960 the position of the British males was by far the worst, now they are better of than the Danes.

By and large and certainly in 1990 the differences between the three countries are within the same range; we do not have to adapt our conclusions to substantial differences in health status. It is the development *over time* that shows stagnation in life expectancy for the Danish males and a considerable increase for the British males.

6. Articles submitted.

7. OECD, Health systems, facts and trends 1960-91, Paris, tables 3.1.1. and 3.1.2. (life expectancy) and 3.2.1. and 3.2.2. (life years lost).

FIGURE 1 Life expectancy at birth. The gender gap 1960-1990



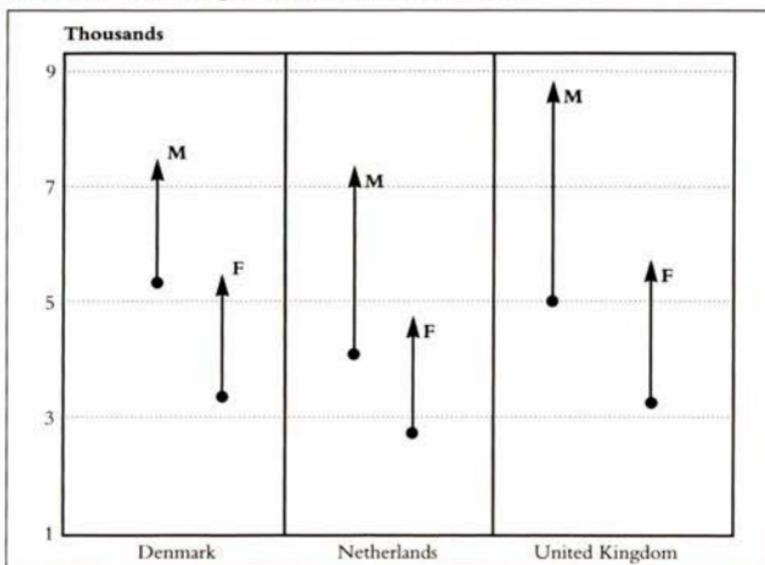
Source: OECD health data (1993)

Health care financing

The next subject is the general structure of the health care system: the Dutch system differs from the other two, that are funded by general taxation. In the Netherlands funding is by social security, earmarked premiums in a mix of public and private responsibility that essentially, was imposed during the German occupation in 1941. The fact that the basic principles are still valid shows the tenacity and social acceptability of the original Bismarckian principles (responsibility shared by employers and employees, no forced participation for the well to do, little state interference in general and in particular not with the provision of care)⁸.

The Dutch health care financing system can be characterised by the following image: a public roof (the Catastrophic Illness Legislation [literally: the General Exceptional Medical Expenses Act, AWBZ]) supported by two unequal pillars: the public and private scheme for

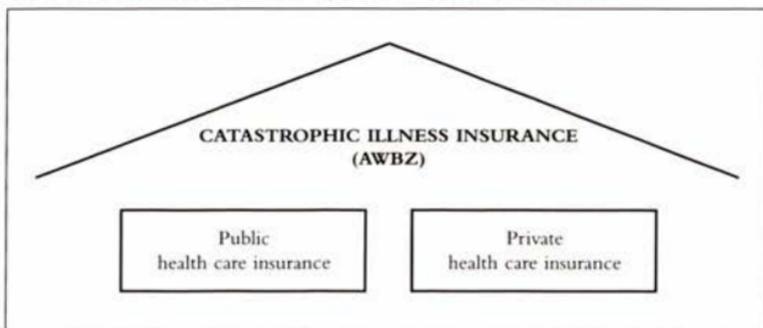
8 De Swaan characterises the Bismarck social security principles in his major study on the origins of the modern welfare state as follows; 'a system that survived two world wars, national socialism and a foreign occupation' A. de Swaan, *In care of the state*, Cambridge, Polity Press, 1988. An illustrative anecdote in this respect is, that, when Alsace-Lorraine returned to France after the First World War, they insisted (and succeeded) in keeping the German social security legislation instead of adopting the French rules.

FIGURE 2 **Years of potential life lost 1960-1989**

Source: OECD health data (1993)

health care insurance; respectively covering 62 and 38 per cent of the population (Figure 3).

In previous decades the roof tended to expand; beside catastrophic illness (mental retardation, nursing home condition, illnesses that require hospital treatment of more than one year) it gradually came to include home care (home nursing 1980, home help 1989), ambulatory mental

FIGURE 3 **Health insurance system in the Netherlands**

health care (1982), all mental health care (1989) and finally all prescribed medicines and rehabilitation services (1992). The costs covered under this catastrophic illness scheme increased from 12.5 billion guilders (5 billion pounds) in 1989 to 22.8 (9 billion pounds) in 1994 while the expenditures in the public health scheme hardly decreased in real terms (14.8 billion guilders (6 billion pounds) in 1989 versus 16.4 (6.5 billion pounds) in 1994) general inflation not exceeding 15 per cent in these five years (Central Bureau of Statistics, 1994).

Now, in 1995, the process of shrinking the pillars in favour of the roof has stopped. The new Minister of Health announced that prescribed medicines will be retransferred from the catastrophic illness scheme to the public and private health scheme hoping, wrongly, that this shift in financing will be budgetary neutral.

Another process (also part of the Dutch health care reforms) of harmonising the public and private schemes by introducing nominal fees in the public scheme and increasing solidarity in the private scheme has been delayed.

The central element in the Dutch 'Dekker' reforms, that is, introducing competition between insurers (public and private) by collecting all proportional premiums in a central fund while returning age/sex/region adjusted standard allowances and using the nominal part of the premium as an element of competition, has only caused a prophylactic merging of health insurers in order to diminish competition and create sufficiently large risk pools (Groenewegen, 1994)⁹.

Even for insiders, it is unclear what is really happening in the Dutch health reforms and it looks suspiciously like the previous decade of health reforms (1975-1985) when, on paper¹⁰, the Dutch health care system was organised along Brezhnev type planning procedures (that is to say that framework legislation was passed in parliament) while the only concrete legal measure taken consisted of a tiny bit of regulation regarding the establishment of general practitioners.

The most probable outcome of this typical Dutch continuing debate (presumably impossible to understand for citizens of a two-party democracy, where the party in power introduces major reforms like the GP-budget holding principle practically without parliamentary or public debate) is that in November 2001 we will celebrate (discreetly,

9 The number of 'Sick Funds' decreased from 53 in 1986 to 26 in 1994, while at the same time the public sick funds also merged with private health insurers.

10 In a WHO-publication by A Meyer-Lie: 'Health planning: a comparative study' (Finland, Hungary, Italy, the Netherlands, Sweden) the Dutch health care was described as if the planning laws were already executed (Geneva, 1988). William Glaser misunderstood the Dutch skills in talking instead of doing when he described the market elements in the reformed Dutch health care (W A Glaser, *Health Insurance in practice*, San Francisco, Jossey Bass, 1991).

FIGURE 4 **Total expenditure on health. Percentage of GDP**

Source: OECD health data (1993)

like we did in 1991) the 60th anniversary of our German based health care and social security system.

Health care expenditures

The health care expenditures, expressed as percentage of the Gross Domestic Product have developed in different ways for the three countries (Figure 4).

Initially, in the 1960's they were all around 4 per cent GDP, but have increased at different rate. The Netherlands had a huge increase in health care costs (and in all public expenditures) between 1965 and 1975 when all towns and villages started to build a hospital, the number of consultants exceeded the number of GP's and there were no legal or other 'instruments' to curb costs.

After 1975 expenditures more or less stabilised, or, rather, kept in step with the general economic development, recently they have started to rise again due to the chaotic situation that Dutch health care is in present. Rigorous budgeting of hospitals and other institutions (since 1981/83) has helped to prevent further increase of the expenditures.

The Dutch are by far the highest spenders of the three countries mostly due to expenditures for institutional care; not only acute hospital

care, but also long term care in nursing homes¹¹.

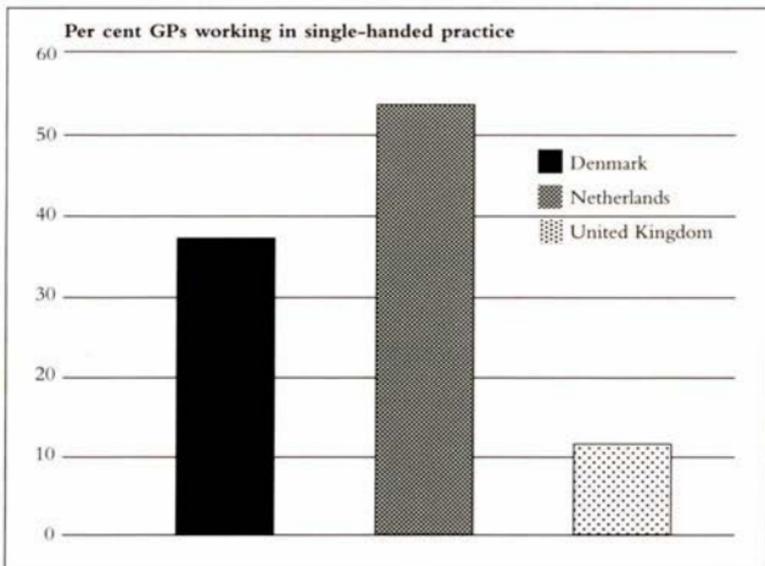
The Danes saw their health care costs rising in the seventies, but spending has stagnated at a lower level. In the UK the increase in expenditures came later, in the mid-seventies and eighties, but, the ceiling was reached earlier than in the Netherlands.

Place and position of the general practitioner in the Netherlands, Denmark and the United Kingdom

The practice setting of GP's in the three countries is different. In the Netherlands half of them still practise single handedly; in the UK this is rare (10 per cent) while Denmark is somewhere between the two (Figure 5).

The Dutch GP's have the highest average list size (2300 inhabitants per GP); the Danish the lowest (1500 inhabitants per GP), but compared to the Belgians (500 inhabitants per GP), the Italians (750 inhabitants per GP) and the French (1000 inhabitants per GP) the doctors' density can be much higher.

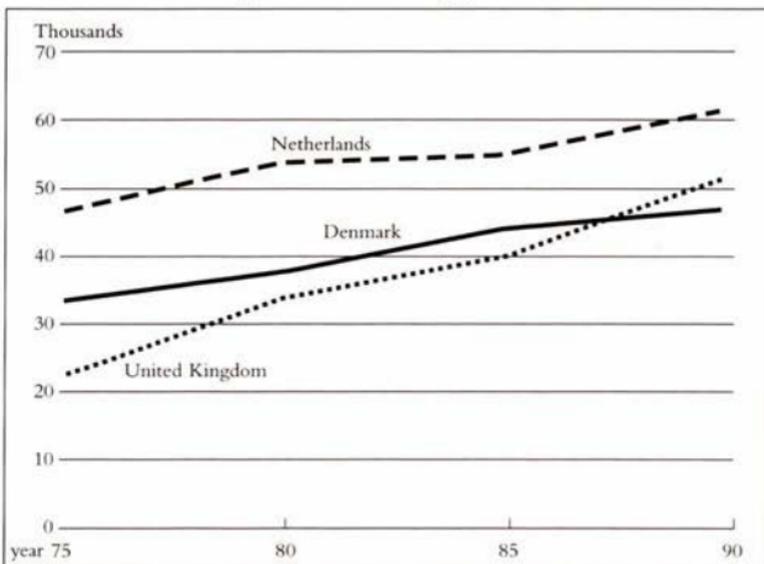
FIGURE 5 Practice setting in 1990



Source: Boerma et al. (1993)

11 This statement is supported by the OECD "Health systems, facts and trends 1960-1991" study. From chart three (page 19) can be derived that both general spending levels and inpatient expenditures are high in the Netherlands and that in Denmark inpatient care expenditures are relatively high, but general spending level is low. In the UK both levels are low.

FIGURE 6 GPs' average net revenue in ppp\$



Source: Delnoij (1994)

Remuneration of GP's is not similar. The Danes have a mix of capitation (flat fee for those over 16) and fees for (specific) services; the Dutch have a flat fee for their publicly insured patients and send bills for consultations and visits to their private patients (rural doctors generate extra income by dispensing drugs and performing home deliveries). The British GP's have the most complicated remuneration; a mixture of allowances, an age differentiated capitation fee and fees for specific services such as preventive activities. Figure 6 shows the average net revenues, all expressed in purchasing power parity adjusted \$US, for GPs in the three countries.

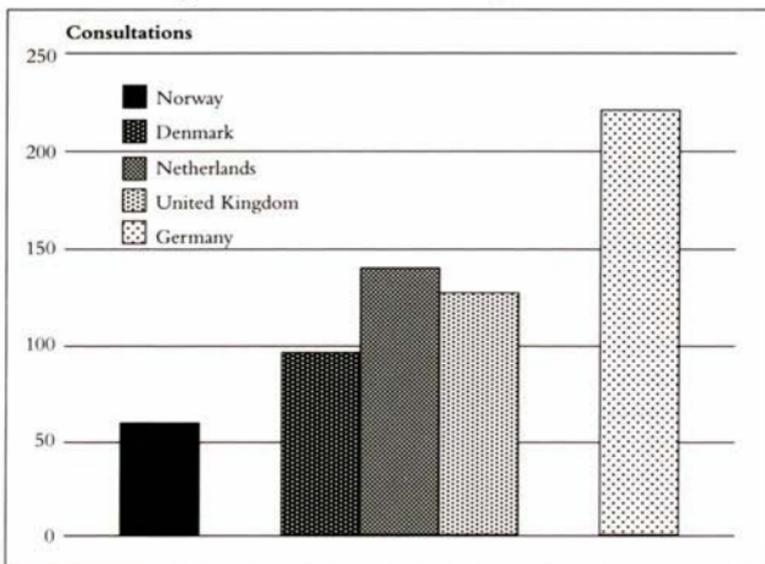
GP interventions, activities and incomes

We find differences and similarities in interventions and activities between the countries.

The differences in consultations per week reflect the different list sizes; In Fleming's study Denmark has approximately 100, the UK 130 and the Netherlands 140, while list sizes were respectively 1500, 2000 and 2300 (1 : 1.3 and 1.5) (Figure 7).

Home visits, as a percentage of consultations, are lowest in Denmark, 10 per cent, the UK, 16 per cent, and highest in the Netherlands, 20 per cent. World champion is Belgium with almost 50 per cent of

FIGURE 7 Average number of consultations per week



Source: Fleming (1993)

consultations being home visits; the result of a combination of fierce competition and a cash fee for service payment. When you accompany a Belgian doctor on his home visits, the last two or three minutes are always concerned with the exchange of money and writing the receipt.

The number of diagnoses with a prescription is similar in Denmark and the Netherlands (55 and 56 per cent) and higher in the UK according to several sources. Compared to doctors in other countries, the Dutch, Danish and British GP's are reluctant prescribers.

In the European 'Practice Profile Study' we found that preventive activities are less common in Dutch and Danish general practices than in British practices (see Figure 8); Dutch GP's do not like to act like health police officers. This information stems from questionnaires but is corroborated by data from the Dutch national survey of morbidity and intervention in general practice (van der Zee and Verhaak, 1990).

In a European comparative study on the use of laboratory facilities, in which British and GP-sentinel networks participated, little difference was found between the British and the Dutch group (and the Irish doctors), but there was a marked difference between the North Western European doctors and Swiss or Southern Europe, where tests were ordered in a much higher frequency.

So what can we conclude from the first part of our comparison:

- In the figures shown the most marked difference between the Dutch, Danish and British doctors is in the domain of prevention, where the Dutch and Danes do less. In prescribing medicines the British doctors are more proactive than their Danish and Dutch colleagues, but compared to GP's from Central and Southern Europe, the GP's from the North West have more in common (specially in their reluctance) than they differ.

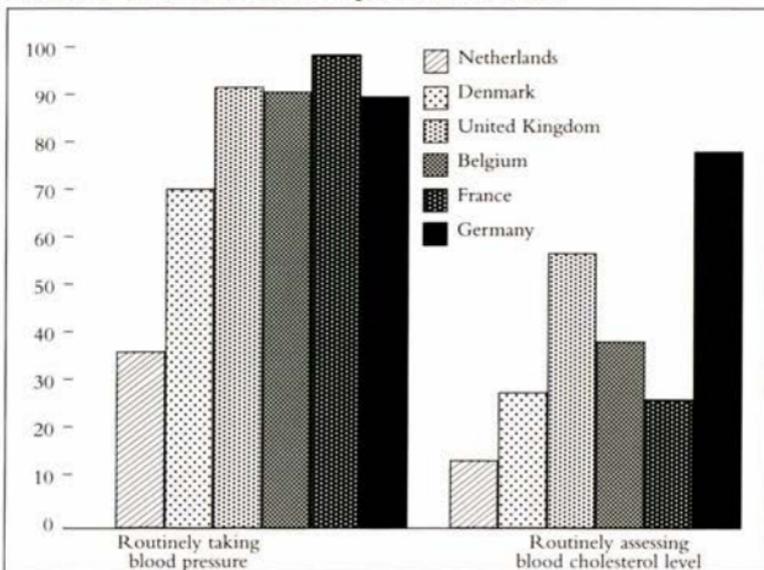
These differences and similarities cannot be easily connected to differences in position, although the smaller list size of the Danish GP is reflected in lower consultation rates and the extra payment for preventive activities for British GP's seems to be effective.

The position of GPs versus consultants and hospitals

With regard to the relationship between GPs and consultants the differences are more marked between the three countries.

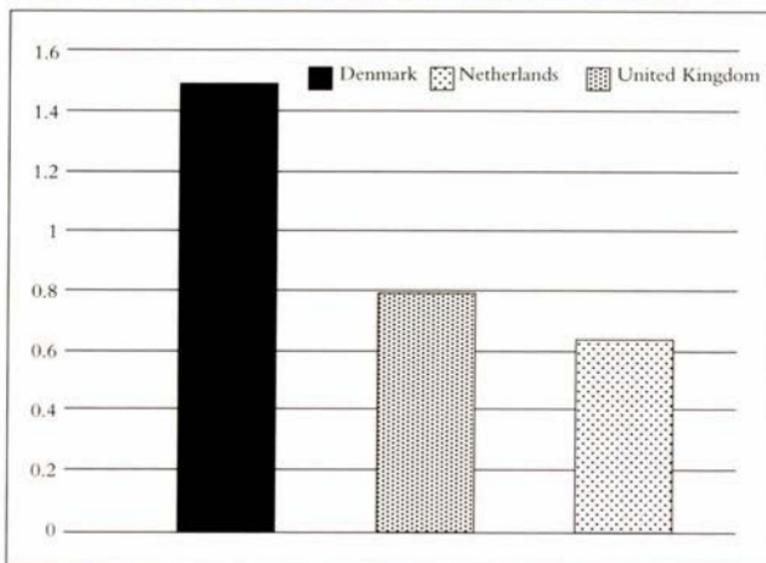
In all three countries consultants are tied to hospitals; there are, unlike in Belgian, Germany and France, no independently established ambulatory consultants. In Britain and Denmark however, consultants are salaried employees (in Denmark, the exceptions are ENT doctors and ophthalmologists); in the Netherlands they are independent

FIGURE 8 GPs' involvement in preventive activitie



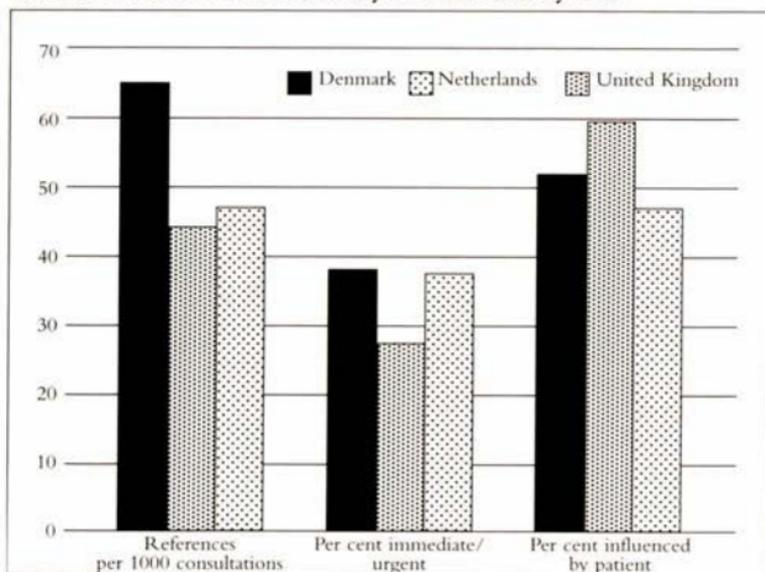
Source: NIVEL (1995)

FIGURE 9 Medical consultants per 1,000 inhabitants in 1990



Source: NIVEL (1995)

FIGURE 10 Referrals to secondary medical care by GPs



Source: Fleming (1993)

contractors, commonly organised in partnerships, remunerated on a fee for service base. Part of the remuneration of the Dutch consultant derives from the referral card (valid for a brief period of 6 weeks, 3 months or for a year) issued by the GP for his publicly insured patients.

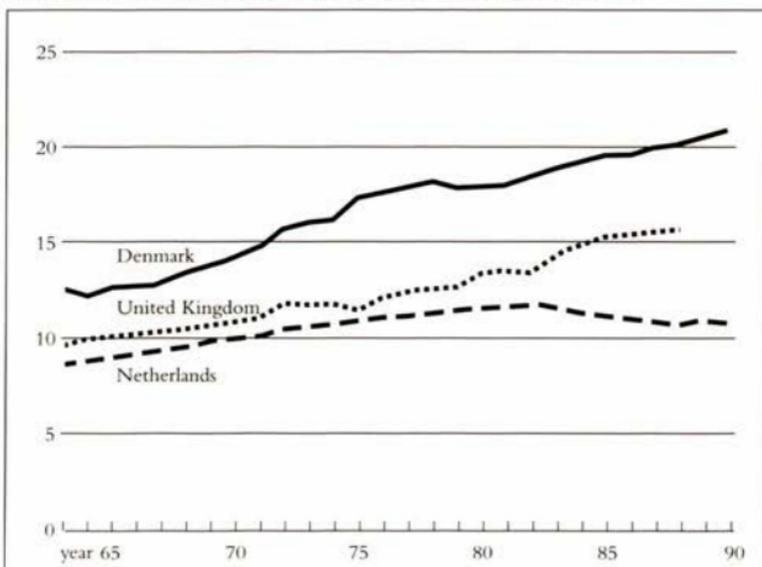
In the Netherlands and Britain consultants can be found both in inpatient and outpatient departments; in Denmark the outpatient department is weakly developed. There a patient is either under the treatment of a GP or is admitted in a hospital. There is a considerable difference in the number of consultants per 1000 inhabitants with Denmark being extremely high (see Figure 9).

Referrals

Fleming's study on referrals shows that, in absolute numbers, Danish, Dutch and British GP's do not differ much, but related to the number of consultations the Danes have higher referral rates than the other two countries (Figure 10).

There are some differences in the degree of urgency and the Dutch doctors assign more referrals at the request of their patients. In Fleming's study the Dutch doctors are the 'softest' or the most 'patient friendly' and the Southern European doctors the most tough. It is apparently uncommon to admit that a decision was taken under patient pressure.

FIGURE 11 **Admissions per 100 population. Inpatient care**



Source: OECD health data (1993)

Admission rates are markedly higher in Denmark than in other countries (Figure 11). In Denmark, a patient is twice as likely to end up in a hospital bed than in the Netherlands. Here the lack of outpatient departments can be observed. However, it is found that the more admissions there are the lower the average length of stay. It should also be noted that the salaried doctors in the UK and Denmark have longer waiting lists than the fee for service entrepreneurs in the Netherlands.

This all leads Fleming (1993) to the thesis that optimal health care delivery is associated with:

- Controlled physician density
- Capitation payment for general practitioners
- Restricted access to secondary care via general practice
- Fee for service payment for specialists

Conclusions

- (1) The first conclusion is that it is useless to consider primary care without taking into account hospital and specialist care. The differences in the organisation of secondary care seem to have more marked effects than the PHC parameters we used.
- (2) Do we need outpatient specialists, either independent ambulatory specialists or tied to hospitals as salaried employees? The example of Denmark shows that even well equipped GP's cannot fill the gap between hospital and home.
- (3) Paying specialists by fee for service creates an incentive to treat patients quickly; does this obvious advantage outweigh other effects such as the possibility of overtreatment?
- (4) The Dutch spend quite a lot on health care — not solely on acute hospitals (40 per cent) but also on nursing homes — which are in some countries outside the health sector.
Even independent gate keeping by GP's cannot prevent this.
- (5) Danish and Dutch GP's are reluctant prescribers. British GP are not, that is, compared to the other two (not to France, Belgium or Southern Europe). Dutch and Danish GP's are reluctant in prevention. Fortunately children's immunisation is not the task of the Dutch GPs, so the Dutch have good immunisation rates. Many years of life are lost as a result of preventable diseases, but do we want GPs to interfere with our bad human habits?

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Primary care meets managed care

Professor Donald Light

Introduction

The character of primary care is best understood not as what providers with certain kinds of training do, nor as a practice that includes a specific list of services, but as a distinct approach to health care from which the other two derive. This means that primary care is an important form of managed care: the clinical management of whole persons, families, and perhaps communities, in health and in various forms of symptomatic condition, in illness and in chronicity, in growing and ageing, in birthing and in dying. Primary care providers, not just doctors, manage more illnesses and disorders, in more states of being, than any other clinicians. The range of GP-managed care is so great that doctors in the US need four specialities to get the same job done that GPs do, one for babies and kids, one for women, one for old people, and one for all the other adults left over! The range of clinical management in primary care forms an important foundation for considering what primary care means in an emerging era of managed care, for the term 'managed care' must and does refer to something else: to care managed by payers, or by purchasers, or by their agents such as managed care corporations.

A model of countervailing powers

Thus the heart of all questions about primary care and managed care are questions of power and organisation. Managed by whom? For whom? This is why I have developed a model of countervailing powers as the best framework for analysing the shifting balances of powers and relationships over time in health care systems (Light, 1995a). Each party has its own priorities and values which imply different ways of organising and managing health care (Light, 1994a). Each has its own strengths and weaknesses or blind spots. Any modern system contains elements of each: sometimes dominant, sometimes secondary, sometimes suppressed. Primary care operates within the resulting system, which means that the future of primary care can best be understood within this larger framework of countervailing powers.

One model of a health care system is community-based or consumer-oriented (Figure 1). These are value-driven models. My argument about economics is that the economics of health care follow values in the society. Economics does not so much lead as reflect societal values. Here the key value is to develop with others priorities and programmes to minimise disease, to minimise death and suffering, to promote ties and

FIGURE 1 Ideal type of a community-based health care system

<p>Key values and goals To develop with others priorities and programs that minimise disease disability, death and suffering. To promote ties and mutual support among members. To minimise the financial impact of illness.</p>	<p>Organisation A loose federation of member groups. Administratively collegial. Organised around work or communities. Emphasis on low-tech, primary care and prevention. Strong ties to other community programmes (educational, occupational; social service).</p>
<p>Image of the individual An active, self-responsible, informed member of the community.</p>	<p>Division of labour Egalitarian. Participatory. More health care teams. More delegation, substitution. Strong primary care base.</p>
<p>Power Local control. Mutual decision making. State and profession relatively weak.</p>	<p>Finance and costs Taxes, premiums, or mix. Community based budget which contracts with doctors and facilities for service. All care free or nearly free at point of service. Costs low compared to the Professional model.</p>
<p>Key Institutions Community boards. Mutual benefit associations.</p>	

mutual support amongst members, to minimise the financial impact of illness. This set of values and goals was much more common before the turn of the century, but I suspect that we will come back to it again. The image of the individual is as an active, self-responsible, informed member of the community. Power is local and mutual. It is a fairly democratic idea that is nicely developed in a book called *The Ends of Human Life* by Ezekiel Emanuel, a physician/philosopher at Harvard (Emanuel, 1992). The institutions are community boards or mutual benefit associations. Organisation tends to be loose, administratively collegial, inclusive of primary and prevention.

Another model of what health services should be like reflects the values and orientations of the organised professions (Figure 2). It seems to me that the medical profession, but also the nursing and other professions, are striving to have a system that will first provide 'the best clinical care to every sick patient'. In the US one might add, to every sick patient who can pay and who lives near to the doctor's practice. We

FIGURE 2 **Ideal type of a profession-based health care system**

<p>Key values and goals To provide the best clinical care to every sick patient (who can pay and who lives near to a doctors practice). To develop scientific medicine to its highest level. To protect the autonomy of physicians and services To increase the power and wealth of the profession To increase the prestige of the profession.</p> <p>Image of the individual A private person who chooses how to live and when to use the medical system.</p> <p>Power Centres on the medical profession, and uses state powers to enhance its own.</p> <p>Key Institutions Professional associations. Autonomous physicians and hospitals.</p>	<p>Organisation Centred on doctors' preferences of speciality, location, and clinical cases. Emphasises acute hi-tech interventions. A loose federation of private practices and hospitals. Weak ties with other social institutions as peripheral to medicine.</p> <p>Division of labour Hierarchical, doctor controlled. Specialty oriented.</p> <p>Finance and costs Private fees paid by individual doctors when feasible. Private, voluntary insurance as passive vehicle to pay bills. Highly inflationary.</p>
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do not have any distribution requirements in the US. The next priority of the professional model is to develop scientific medicine to its highest level and to protect the autonomy of physicians and services. The image of the individual in this model is a private person who chooses how to live and when to use the medical system. Power centres on the medical profession and tries as much as it can to use state powers to enhance its own. Institutions are professional associations, autonomous physicians and hospitals. Organisations tend to be centred around doctors' preferences of speciality, location and the clinical cases. There is an emphasis on acute, hi-tech intervention.

A third model is based on the values of the state or sponsor, like IBM or Xerox in the US when they oversee and purchase all care for their employees (Figure 3). The goal here is to strengthen the state or the corporation (or whatever the sponsor is) by fostering a healthy, vigorous

FIGURE 3 **Ideal type of a state-or sponsor-based health care system**

<p>Key values and goals To strengthen the state and sponsor via a healthy, vigorous population. To minimise illness and maximise self-care. To minimise the cost of medical services to the state. To provide good, accessible care to all sectors of the population. To instil loyalty, gratitude.</p> <p>Image of the individual A member, and thus the responsibility of the sponsor.</p> <p>Power Either democratic or autocratic or a cross-mixture. Secondary power to medical associations.</p> <p>Key Institutions The ministry or department of health and its delegated system of authorities.</p>	<p>Organisation An integrated system, administratively centralised, or decentralised. Organised around the epidemiological patterns of illness. Organised around primary care. Relatively egalitarian services and recruitment patterns. Strong ties with health programmes in other social institutions.</p> <p>Division of labour Bureaucratic, physician controlled. More health care terms. More delegation, substitution. Strong primary care base.</p> <p>Finance and costs Taxes, premiums or mix. Community based budget which contracts with doctors and facilities for service. All carefree or nearly free at point of service. Costs low compared to the Professional model.</p>
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population, to minimise illness and maximise self-care, to minimise the cost of medical services to the state or sponsor, to provide good, accessible care to all sectors of the population, and to instill loyalty and gratitude. That, by the way, is one of the main reasons why the Clinton reforms failed. The Fortune-500 wanted to continue to control health care as a corporate benefit which could give them some control over employees and keep unions weak. The image of the individual here is as a member and thus the responsibility of the sponsor.

It seems to me that this model splits into an autocratic model that is very top-down, or a decentralised model which is more elaborate and delegates power. Thus, the institutions in this model can either be top-down or delegate authority. Of course the British are so clever that they do it both ways! They have an ideology of delegated power, while what is affectionately called 'the Kremlin' keeps issuing orders! The 'Kremlin', which is what some NHS managers called it, is a conflation of the

Secretary of State for Health, the junior ministers, and the NHS Executive. The state model tends to be an integrated system administratively, centralised or de-centralised as the case may be, and organised around epidemiological patterns of illness and around primary care.

The professionalisation of primary care

The history of 20th century organised primary care concerns the movement from consumer-based and member-based care to professional and state-based care. It is widely believed that doctors practised pretty much on their own in the latter part of the 19th century, particularly in the United States, and that forms of managed care did not occur until the current era. Looking closely at the United States, it can be seen that reports by physicians and others paint a somewhat different picture.

They describe, in places as widespread as California, New York City, Buffalo, and Louisiana, pervasive and rapidly growing prepaid, capitated health care plans by hundreds of local fraternities in the last quarter of the 19th century. Friendly societies proliferated throughout Europe, consisting of workers who organised health care, educational programmes and other services for their members. America's fraternal societies and 'lodges' arose among the millions of immigrants who streamed into the United States. They chiefly brought people together and promoted fellowship. Providing benefits arose out of this impulse. Their larger importance was more clearly seen in some other countries such as Germany, where friendly societies or workers' groups of one kind or another were more centrally focused on mutual aid and health care (Light et al, 1986). Needs were defined by members, services organised to meet them, and providers were hired or retained to deliver them. They were non-profit, non-hierarchical, more flexible than a national health service, oriented towards prevention and maintaining health, and run by the members who paid for the services.

In the current era of so-called 'consumer-oriented health care', which is very fashionable and politically correct in the US and in the UK, it is ironic to note how few health plans are owned and run by those who pay the premiums and receive the services. Investor groups run them, government agencies run them, doctors run them, hospital administrators run them — almost anybody runs them, except consumers.

Consumer-based primary care proliferated. By 1916 a medical society report stated that:

'Buffalo, New York, can boast of 240,000 people out of half a million who can or do have the services of a lodge physician for the munificent sum of 50¢ to \$1 per head per year and, as near as can be ascertained, this percentage of over 50 is not especially different from that found in other cities

of the same size and of similar manufacturing facilities throughout the eastern portion of this country. The number of people being treated in this manner has, at a conservative estimate, been multiplied about 50 times during the last 20 years.' (in Light, 1991).

To the extent that lodge practice, or contract medicine, provided care for poor labourers, the medical profession felt ambivalent. On the one hand, contracts by lodges, county health programmes and the like guaranteed that doctors would be paid for treating patients who would otherwise have been treated for nothing. They were estimated to be about a quarter of the population. On the other hand, the low capitation rate implied that professional services were not all that valuable, especially when the rate was set by competitive bids, rather than by the profession. The doctors did not set a low rate as their decision of what was fair to charge poor patients. Rather, the low, winning bids threw into question the value of full-charge services, unless one could argue that inferior medicine was being delivered to those patients and better medicine to patients paying fees. But if one made that argument, how could one explain that doctors were upholding the high standards of professionalism?

The organised profession began to respond and by 1912 the American Medical Association (AMA) Principles of Ethics attacked this kind of consumer-based, wholesale health care organisation by saying:

'It is unprofessional for a physician to dispose of his services under conditions that make it impossible to render adequate services to his patient or which interfere with the reasonable competition among the physicians of a community. To do this is detrimental to the public and to the individual physician, and lowers the dignity of the profession.'

'Reasonable competition' means non-economic, professional competition. Thus, in the name of competition, the AMA ethics opposed organised markets.

It appears that state medical societies moved from reports and complaints to action after 1910. A number of them began to expel or threaten to expel members who engaged in these competitive, discount plans known as contract practice. An important leverage came from getting hospitals to agree that only physicians who were members in good standing with their county or state society would be given hospital privileges. Other techniques used included publishing an honour roll of physicians who refused to accept contract practices, publicising abuses of unfair contracts and educating physicians about the evils of wholesale, competitive contract medicine. One county medical society wrote:

'This evil has been growing insidiously in all its various forms for some time... Your Committee shall not spare its efforts until every man is located who has the audacity to stand for such a system... While almost two-thirds of the members are pledged to this movement, there yet remain about 200

who have not stated their position, and the Committee shall continue its investigations until every member has taken a definite stand.'

From the perspective of a guild or a professional monopoly, medical societies were naturally alarmed by health care contracts of this kind, because competing doctors bid each other down to \$1 per member per year to win these contracts. The medical societies admitted that many doctors competed actively for these contracts but nevertheless accused the fraternities and consumer associations of exploiting doctors. These doctors, it was clear to committee members, needed to be saved from themselves. One notes, however, that none of the reports was made by members of the societies who did contract practice, even though they were acknowledged to be numerous.

Behind this effort to crush consumer-based primary care and professionalise it was an interesting notion of free choice. What the profession, at least in the US, meant by free choice or 'reasonable competition' was permitting patients to choose any doctor on an equal financial footing, that is, under uniform fees. This was distinct from 'ruinous competition', which meant competition on price. So 'free choice' meant that physicians were not organised into economically competing groups. Thus professional free choice eliminates market free choice.

Campaigns to suppress contract medicine between about 1903 and 1918-19 were successful so that by the 1920s, the organised profession had established its values and models for a health care system, one that maximised professional self-management and the development of the best clinical practice for every sick patient. The model in figure 1 had been replaced by the model in figure 2, where primary care plays a lesser role.

A similar kind of story could be told in Germany, where there was a very interesting development of worker-run local sickness funds that delivered primary care (Light and Schuller, 1986). When Bismarck passed national health insurance, the sickness funds were successful in gaining two-thirds of the seats by agreeing to pay two-thirds of the premiums. There arose a flourishing and growing array of sickness fund clinics and community-based centres run by the enrollees or patients. For example, one of the largest funds in Berlin before 1900 created an integrated system of health care for over 400,000 members. It included two hospitals, 38 clinics, x-ray institutes, dental clinics and health baths, all owned by the fund and managed by worker-members as a comprehensive, prepaid system.

An important part of that early history in Germany was the In-Kind Principle, which required that funds deliver services directly and not purchase them. While its purpose was to prevent funds from raising premiums without delivering commensurate services, it created in effect

a social economy of health services. The centres in the larger areas combined specialty services with rehabilitation programmes, pharmaceutical dispensaries, public lectures and courses in social hygiene, booklets on educating young mothers about raising babies, and so on. As these comprehensive primary care centres proliferated, they threatened the private practice physicians, who began to organise.

Matters took a more militant turn in 1900 when the *Leipziger Verband* was formed. Its full title read 'Union of German Physicians for the Defence of Their Economic Interests'. It organised over 200 strikes and boycotts per year between 1900 and 1911, winning about 90 per cent of them. Bit by bit it began to control the recruitment committees, the contract committees, and other important committees overseeing primary care services in the clinics.

Eventually this militant union came to represent all sick fund physicians. It greatly reduced competition by requiring that the local sickness funds negotiate with the entire pool of physicians in an area rather than having individual competition. It also got the In-Kind Principle removed, further decreasing consumer control and increasing professional control of primary care services. Even so, there was continuing hostility against these consumer worker-run clinics. When the National Socialist Party began to develop a campaign, it attracted many physicians who were against socialised medicine and who considered these local worker-run clinics as hotbeds of socialism and as being heavily populated by Jewish physicians who had played key roles in developing some of the most interesting developments in social medicine in the first two decades of the century.

By 1933, therefore, physicians had joined the National Socialist Party in larger proportions earlier than any other profession in Germany. They were rewarded in 1933 by two regulations. One was the *Berufsverbote*, which basically removed the license of any physician who was socialist or Jewish. 'Socialist' meant any physician who had a contract with these worker-based local clinics. With unfettered zeal, members of the organised profession began to turn in doctors working at the clinics.

By the late-1930s several things had been accomplished by the organised profession, with the help of the Third Reich. First, local and state physician associations had succeeded in destroying the member-run primary care centres as such. They were converted into part of the state system. Second, physicians were rewarded for their allegiance to the National Socialist Party by being granted the status of a profession in national law. Third, member-run sickness fund associations, which had been instrumental in developing public health policy, were taken over by the Party. When World War II ended, therefore, the Allied forces, in deciding to let Germans build their own democratic institutions, in effect were allowing the remaining physicians and their professional

associations to have a free hand in constructing a professionalised health care system that emphasised private practice and specialty care.

Ironies of success

What is interesting about the dominance of professionalism in so many systems is that, while it produced spectacular clinical and scientific successes, it also produced certain ironies of success. Sub-specialisation and the elaboration of clinical medicine led to spiralling costs, the development of hospitals and increasingly elaborate infrastructures. In the case of some countries like the United States, these produced a new class of professional managers. They became another source of power and were the early progenitors of the new corporate managed care managers in the US. On the clinical side, professionalisation produced an increasingly elaborate division of labour, which led to increasing turf battles (Light, 1988) and the issues of substitution and increasing governmental regulation.

The very success of the professional project spawned four sources of de-professionalisation. These were the development of professional managers, competing providers, government regulation and cost controls. Professional autonomy, which then leads to individual autonomy, was and is a major source of significant clinical variations in utilisation, and the significant use of unnecessary procedures, which then became centrepieces of criticism of the profession in the United Kingdom, the United States, and elsewhere. In these and other ways, professionalism has been its own worst enemy and has spurred other countervailing powers into action.

The buyers' revolt

The excesses of professionalism has led to what could be called a buyers' revolt in the late 1970s to mid-1980s, both in the UK, the US and other countries (Light 1995b). It seems to me that the buyers' revolt centres around the state or sponsors finding that a professionally dominated system is simply too distorted. It has too many specialists, and it is too far away from the epidemiological needs of the population. Providing the best clinical medicine for every sick patient means that primary care has low status, that public health and prevention are not very interesting, and that treating the chronically ill is boring. There are a lot of things which tend to be underplayed and ignored, while specialty medicine is strengthened. I want to point out, however, that when you have a purely state-run system it also has fundamental weaknesses, as did the early consumer-run groups. Each model has its strengths and weaknesses.

In the UK, the Thatcher reforms, which seem to me the UK's version of the buyers' revolt, emphasised supply-side competition of specialists in hospitals, with GP fund-holding being part of that. My sense is that

GP fund-holding was yet another way to 'get the consultants', like 'get the guest' in Albee's play *Who's Afraid of Virginia Wolf?* It was one way that Kenneth Clarke wanted to get a wedge in and divide the medical profession in half politically, splitting the BMA down the middle. It was mainly for these reasons that GP fund-holding began.

The British version of the buyers' revolt has much more emphasis on clinically managed care than the US version. The interesting thing is that in the UK primary care and clinically managed primary care are regarded as the answer to a newly reconstructed and cost-effective health care system (Fry et al, 1995). In the US, by contrast, the buyers' revolt was led by professional managers, and they seem to see primary care physicians as foot soldiers for corporate generals and as gatekeepers for investors' financial estates.

There is also an interesting contrast in the emphasis in the UK on developing consumerism, patients' rights, making complaints, and the better handling of complaints — all leading to increased demand. It is not clear if Mrs Thatcher understood, but her reforms were guaranteed to increase costs. In the US we had too much consumerism and the goal was to limit consumer choice, to stop having Americans running around seeing every physician they wanted to see whenever they wanted to see them, and to get them into managed care systems with a primary care gatekeeper. That has led to a very demeaning concept of primary care in the US as merely gatekeeping. That is unfortunate, because it is clear that a good primary care physician does much more than gate-keep. In fact, if anything, that is the least important thing they do.

In the United States having primary care within managed care has produced benefits and liabilities. The benefits are that we are moving hundreds of thousands of people per month into managed care systems with a strong primary care base, with a referral network system, with more-or-less co-ordinated care, and with integrated records for the first time, so that everybody knows what everyone is doing about a patient or a patient's family, and with a risk-adjusted capitated payment system which puts the incentives in the right direction. However, when this is being done by multi-billion dollar corporations for profit, it can lead to denied and restricted services. It leads to oligopolies and market control by a few corporations in all the most sophisticated markets in the United States.

One of the more pernicious things that has been highlighted for the first time is that primary care within managed care is leading to better services for 90 per cent of the people who are enrolled — which is why the satisfaction rates are so high — but it is leading surreptitiously to worse care for the sick 10 per cent. We now have two new surveys, one by the Robert Wood Johnson Foundation (1995) and one by the Commonwealth Fund, of sick patients who are sick enough to see

specialists (Davis, 1995). In both surveys the sick patients in managed care systems are two to four times more likely to say they did not get a full work-up; they did not know who the provider is; they had difficulty seeing their specialist; and that there were delays in their service. There are all kinds of subtle ways in which managed care corporations skimp in providing health care, like supply barriers. Investors can design a system with few cardiologists per 10,000, so cardiology services are not available as much as one would like. There are gatekeeper barriers, by having two or three call-in numbers with a nurse at the other end who does not know the patient and does not know you. Yet you have to explain who you are and what your patient's problem is. That will be written down and sent to an anonymous committee, which may be in Kansas City. They will review the case and decide what will be done about it. Meanwhile the clock ticks, the patient suffers, the doctor wastes time, all in the name of 'efficiency'.

Another surreptitious tactic is provider turnover, caused by managed care systems structuring the contracts so that the sub-specialists, particularly in the areas where people have chronic disorders, are terminated and turned over. This makes people with chronic disorders very unhappy so they leave the system, which is just what investors want them to do. The quickest way to make money is through biased selection or de-selection, as the case may be.

It is also important to note that most of the managed care contract physicians in the United States now have to sign a no-cause, non-renewal clause. That means that they can be fired for any reason, and they have agreed in advance that no one has to explain why. And there are gag clauses — meaning that doctors are prohibited from saying anything critical about anything going on in the organisation.

In these ways the buyers' revolt has radically shifted the balance among the countervailing powers in health care towards primary care, but as an object of exploitation. This contrasts with the empowerment of primary care in the UK to lead managed care (Light, 1995b).

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Panel discussion

Professor David Mant

The key issue for general practice is the paradox that exists between the rhetoric of a 'primary care led NHS' and the reality of decreasing recruitment and morale. This is a problem that must be dealt with, otherwise we will not have a generation of general practitioners to deliver the high quality care we have come to expect in the UK.

There is little firm evidence to explain this paradox, although two hypotheses have been widely discussed. Firstly, the administrative burden of the new internal market is falling mainly on general practitioners and leading to pressure of work and disaffection. Secondly, whilst GPs have increasing control as purchasers of health care, their control as producers of health care is falling. This is partly because of the growth in consumerism (ie. consumers are demanding more from general practitioners), but it is also because the government contract with general practitioners is becoming more prescriptive. In addition, the 1990 contract was not evidence-based and general practice morale is still suffering the consequences.

Personally, I think that there is a third reason, and that is that general practice is as much about reassurance, and avoidance of unnecessary investigation and treatment, as it is about early detection of disease. This task is extremely hard and it is getting harder. With increasing public recognition of the power of biological medicine, the GP is likely to find his position uncomfortable, particularly if there is confusion about the extent to which resource considerations have determined a recommendation of 'watchful waiting'.

Looking to the future, the organisational role of the general practitioner must change. The financial benefits of fundholding will decrease as there is more equitable distribution of funds. Although general practitioners are keen to fulfil an organisational and planning role in the NHS, enthusiasm and financial support for the role is likely to wane. Moreover, as general practitioners there are many things we do not know which are important in purchasing secondary health care. Although we do have unique knowledge of the NHS which should be tapped in planning service provision, we should admit that there are limits to this knowledge before we are justly accused of over reaching ourselves.

I have two solutions to try to resolve the primary care paradox. In the first place the position of general practice should be nearer to secondary care. There needs to be better integration and more expert knowledge among the general practitioners. Nurses should be used to fill the gap between the consumer and the general practitioner. Secondly, if general practitioners are to fill a management/public health function, then that role has to be better defined and training and resources allocated to it.

Dr David Murfin

General practice in the United Kingdom is unique and has developed and strengthened under a state controlled health care system. A registered list and gate keeper role are integral to the functions of the family doctor. The future role of the general practitioner in primary care will place an emphasis on management, purchasing, prevention, improved relationships with colleagues, concern over communication and an awareness of the expectations of society.

Looking first at management and purchasing, Traditionally, general practitioners have not been trained to cope with business and the management demands of practice. The challenge for all of us working in general practice is to engage in the process and to tackle future training and development needs for those who operate the system. Fundholding and purchasing should be seen as an opportunity. The hope of some GPs is that the whole thing is going to go away, and obviously it is not. It would be very wrong of me not to recognise, however, that there are people who have become demoralised and that we also have recruitment problems at present.

General practitioners have increasingly shown their ability to improve waiting times for secondary services and have been able to extend their own services in the community. My own vision is that general practitioners should control as much of their own resources as possible and this ultimately will make general practitioners more proactive in their work. The present system is also benefiting from a considerable managerial drive which is taking things along very rapidly.

In terms of purchasing commissions, the reforms have succeeded to some extent in developing a system which is slightly more responsive to patient needs. There have been positive gains in some aspects of the recent NHS reforms. The secondary sector has been made more responsive to patients. There have also been some very interesting innovations in terms of the employment of staff in fund-holding practices, by delivering care which is far more appropriate, as the GPs see it, in terms of their own community.

Prevention now plays a large part in general practice and family doctors have delivered on most parameters. In the UK, we are encouraging GPs to think more and more about this area, teaching our trainees (registrars) in general practice about prevention, while trying to focus their minds on the opportunities in every consultation.

Doctors will also need to think carefully about how they link with their colleagues in other health care professions. They must concentrate on improving team building as well as service quality improvement in their practice.

Good communication is vital in general practice and the future

development of training and assessment must give due concern to this issue. Communication is paramount to good general practice but it is often a major source of complaints. We should ensure that communication and consultation skills are part of general practice training. We should also strive to maintain performance through a professional lifetime. Because of professional isolation, doctors who come adrift often are poor communicators and do not mix well with their colleagues.

Access to general practitioners is not given as much priority as waiting times in hospitals, but it remains a great concern for patients. In the United Kingdom it is not unusual for a patient to wait two weeks to see a doctor particularly if electing to choose a specified doctor. We must work with our colleagues, including nurse practitioners, to solve this problem because patients are having difficulty getting into the service.

Whilst the system is ideal in many ways, personalised care, based in the community, general practitioners need to recognise that changes may imbalance the system. We must argue against the potential for a two tier system and argue against financial pressures to comply. We have to debate rationing. It may recently have been softened to 'discussion on priorities', but the clinician must be prepared to become involved.

I feel that within the NHS we have a wonderful system, delivered at a low percentage of gross domestic product. In recent years a slogan has developed, that general practice is 'the jewel in the crown of the NHS'. Who am I to argue against that? Despite all the problems we have in recruitment, the future of general practice in broad terms has never looked better.

Professor Ray Robinson

One of the issues which has come out in a variety of guises, both in the papers presented and in the subsequent discussion at this conference, is the interplay between ideology and empirical evidence in the formulation of primary health care policy. This is an area of great personal interest to me. In addition to being a researcher who tries to generate research-based evidence, I was until recently the vice-chairman of a health authority. Having sat on this health authority over the last five years, during the period when the NHS reforms were introduced and developed, I have to say, in all honesty, that most of the major decisions we made were not based on evidence. They were as a result of diktats that came down from the NHS Executive or Region, and were associated with things like organisational change, resource shortages, etc. It is fairly clear to me that ideology or political values have been an important determinant on the way policy has been developed, and this is particularly true in the primary care area.

Whilst it would be naive to think that this has not always been the case — it is self-evident that politics is governed more by values than facts — it is not unreasonable to argue that, at a time when we are all being urged to practise evidence-based medicine, we might just shift the balance a little towards more evidence-based policy-making. In that spirit I have picked four themes that have cropped up during this conference on which I would like to offer a few thoughts in terms of the R & D agenda if we are seeking to develop a more evidence-based system.

The first topic is gatekeeping. It is an important aspect of the UK system and it is one that is highly regarded in other systems around the world where direct access has led to a far higher level of expenditure on health care. However, on more than one occasion at this conference it has been claimed that this is of proven cost-effectiveness. I would like to suggest to you that we do not really know whether it is cost-effective or not. We know it contains costs, but to establish its cost-effectiveness we need measures of effectiveness associated with referral behaviour. Given we have such large variations in referrals around the country, I would suggest that there is a good deal of over- and under-referral. To be able to make the statement that 'GP gatekeeping is cost-effective' we need to know what the optimal level of referral is. I think we are some way from knowing that. There is a good deal of research that needs to be done in that area before we can make claims that we have a cost-effective system in place across the country.

The second area I would comment on briefly is primary care-led purchasing, which has been a central element of policy over the last three or four years, starting with GP fund-holding and moving to the

new primary care-led system. It has been pointed out that there is a lack of comparative evaluation of fund-holding. That comment is true of a good deal of health policy in recent years. Jack Dowie of the Open University refers to 'partial or non-comparative evaluation', which goes under the acronym of 'PONCE'! I think that there has been a good deal of 'PONCE'ing' taking place in recent times in the NHS! My Institute at Southampton, together with Martin Roland's at Manchester and others, are responsible for carrying out the evaluation of the total purchasing sites. We are endeavouring as far as possible to compare the performance of these sites with some 'controls'. This is not an easy task but it needs to be done if one is to isolate the factor of interest.

A lot has been said about primary care-led purchasing and purchasing behaviour, however, the bulk of primary care is to do with provision. Some of the major policy initiatives that are taking place at the moment are to do with shifting the balance, moving erstwhile secondary care services into primary care settings. This is a third area where policy is yet again taking place with very little evidence to support what is going on. At Southampton, we are working on a project which is designed to develop guidelines for carrying out economic evaluations of shifting care. Our preliminary literature search suggests that there is very little hard evidence on schemes such as outreach clinics, direct access by GPs, and even shared care. There are a couple of good studies on diabetes and asthma care, but not a great deal of research evidence. So once again I would suggest to you that a major policy thrust is taking place in the absence of hard evidence, we need more evidence to make sure it is done properly.

Finally, we should be talking about a research and development agenda. Most academics are concerned with the research side of the equation, the development side is of far less interest. However, this stage is crucial. If we want to put research into practice we need to develop methods by which best practice can be developed. To do that, the evidence we need relates to personal incentive structures, organisation incentive structures, and the behaviour that follows from them. It is not sufficient to use macro-level data, as produced by the OECD and others, to show that a particular payment system is in operation and therefore particular behaviours follow. One needs a far more micro approach to establish why decisions are made within primary care, if we are to succeed in getting research evidence into practice.

Professor Michael Arnold

Of the four speakers participating in this panel discussion I am the only one coming from a country which has no primary care system, that is Germany. This could make one wonder what I can contribute to a discussion on the future of primary care.

However, when one looks at the figures relating health outcomes and strength of primary care infrastructure it is clear that in fact Germany is doing a little better than the United Kingdom. This makes me very happy! Then I asked myself if it is primary care structure that is fundamental to health outcomes and the UK system is considered so superior to what we have in Germany, what is happening?

Given the freedom in our system for both patients and doctors, it would be very easy to establish something like a primary care system but, so far, this has not happened. Until recently we had a system of 'vouchers' whereby the patient could use these vouchers to go to the doctor. As a rule the patient had the choice to contact one doctor every three months. If there was a need for another doctor (ie another specialist) then he would be referred by this doctor. The system has now moved on and we now have 'chip cards', with which the patient can go to the doctor of his choice and contact another or even several within the 3 month period. One consequence is that patients are tending to consult specialists more and more and are moving away from general practitioners. This is contrary to what is wanted politically.

On the other hand, increasingly the notion of patient autonomy is being raised. It is recognised that patients should have a new role in the healthcare system and that there should be more individual responsibility for healthcare. What we are doing in Germany would seem to fit in with this ethos. Patients go to the specialist if they want to. Should we turn around and say 'No, you must go to the primary care doctor in the first place' and establish a new system which goes against our tradition?

There are many people in Germany in favour of a primary care system. Unfortunately, it is very difficult to convince the population as a whole that we should have such a system. It is a concept which not only goes against our tradition and against the German legal framework but more importantly, there is no clear evidence of the superiority of the primary care system. Looking at the relatively low health expenditure of the UK, it is difficult to determine to what this is attributable to. Is it the budgeting? Is it the primary care system? Or is it the behaviour of the patient and of the doctors both respecting the scarcity of resources?

Audience discussion

Dr Peter Barrett (Nottinghamshire Local Medical Committee): I have been very interested in the panel discussion and I welcome Professor Arnold's emphasis on the future of primary health care.

One of the things we have to address in the near future is the morale of general practitioners. In this country, since the Patients' Charter and subsequent media exposure, we have had an explosion of patient demand. This is putting enormous pressure on GPs as the gatekeepers to secondary health care. Part of the demoralisation is the fact that most GPs cannot cope with this pressure. It has led to an increase in complaints, because patients are not getting what they want.

The basic problem is that the cake is too small and we, like sparrows, are squabbling over the crumbs. We have to educate the public about what can be afforded with the current level of resourcing. As general practitioners, we need to resume some control over what we can offer, and to stop being regarded as a bottomless bucket into which anything that does not fit into defined secondary health care can be put. This would help GPs' morale considerably and should help persuade politicians to be much more open and honest about what the health care system in this country, and maybe in other countries, can afford.

Professor Arnold: With regard to increased demand we have a similar situation in Germany, although I suspect that it is even worse than in the UK. Because we have competition between doctors for services the patient is in a position to be able to blackmail the doctor to have the treatment they want. This is also cost-driving. I think that a well-organised primary care system would do better.

Dr Paddy Keavney (Nottinghamshire LMC): There has to be a recognition of the consumer, the consumer's changing demands and changing perceptions of illness. There also has to be a recognition that our young colleagues have a different perception of their careers. They are looking at us and saying 'We don't want to be like them — giving 110 per cent to our profession'. They are saying 'There is more to life', and they are probably right.

We are developing the old-fashioned 'boutique' type medicine into more of a 'supermarket' concept, where we have to accept that we will be working in teams; where there is a division of skill mix, and it is a matter of educating the public as to where in that system they have to direct themselves in order to get answers to their increasing problems.

That begs the question which I do not think has been addressed by health authorities: contract-setting in primary care. One of the difficulties of the past 20 years is that we have expanded general practice beyond all recognition from the time of our forefathers. I joined my

father in practice and, within two to three years, the concept of what I wanted to do and what he had been doing for 30 years were totally different. I and my colleagues have expanded the services, and no one comes to say 'Is that what we want? Can we afford that?' Because as we ourselves increase demand for the services we offer, so we increase the demand on the secondary care sector. Contract-setting in primary care is something which has not been examined.

There also has to be a value for what we provide. One of the great difficulties I have, working in the City of Nottingham, is that my patients really have no idea of the value of the services we provide. When a review body says that there is no relationship between remuneration and workload, one suddenly feels that the Government and the powers-that-be also have no idea of the value of what we offer in practice.

Finally, at some stage there has to be control. Control of demand, of what the patient wants; and control of what we can provide in primary and in secondary care. There needs to be more liaison between primary care physicians and secondary care physicians, because secondary care is often so sectionalised that it does not understand the whole person. Hopefully those of us in primary care are bringing that type of perception into health care management.

Ms Christine Funnell (Chairman, Long-Term Medical Conditions Alliance): Patients are people who use the health services. Calling us 'consumers' is somewhat unhelpful, because 'consumers' implies that we have power. In fact, we have very little power. When you are a patient you are using a service and you are in an inverse relationship to the delivery of the health services.

The health services are there for the people that use them. It is what keeps lots of people in work. We need our doctors, managers and everybody else, but they are there as servants of that service; the ownership belongs to the patients. If we turned it on its head and did not talk about managed care or medical models of care, et cetera, but talked about patient- or people-centred models of care, we may come up with answers or solutions to some of the very vexed issues we all have to face — rationing being one of them.

If we started from that premise, that people do not want to spend their lives as users of the service and we really involved patients as consumers in the whole decision-making process, we might come up with some sensible answers to some of these problems.

I issue a challenge to you, about how we can involve consumers in the decision-making processes you are all involved in, so that it is not about the health care professionals educating the public, but about the public educating the health care professionals; about our total health

needs. We are people who have parts of our body that are not working so we cannot function properly — not a disease that happens to have a body attached.

If we looked at it like that, we might come up with some solutions that are more helpful than some of these vast, complex processes that are currently in vogue.

Dr Anthony Snell (Barnet Health Agency): Earlier on we talked a little about evidence-based medicine and about protocols being made available to the public. I wondered what the views were on how we can take that forward, if we want to take it forward in this country. Should we make that evidence-based medicine available to the public? If so, in what way and in what format? If doctors and nurses are expected to deliver services on an evidence-based system, then should we publicise that? And what would be the consequences?

Professor Robinson: I see no alternative other than to inform patients about the best evidence available on diseases and treatments. We have already started at the King's Fund with videos on prostate disease that try to inform people about the options that face them and the outcomes, surgery and so on? I think they are a reasonably well-publicised example of that sort of approach.

I would like to link that point to the one about increases of demand and inappropriate demand. It seems to me that as we do provide more evidence to people, particularly in areas of health promotion, we will probably stimulate demand rather than actually reduce it. The question then becomes how do you cope with that.

We recently carried out a study at my own institute in the south-west region, where inappropriate patient demands were cited by GPs as one of the major sources of stress they face at the moment. The question then is what do we do about this? There have been suggestions that we educate patients, and evidence-based approaches may be a way, but may soak up the problem. There has been a counter-suggestion that the patient should educate the doctors. Being a fairly simple-minded economist, it seems to me that we have to talk about rationing instruments. At the moment we are using non-price rationing in the form of waiting times — having to wait two weeks to see a GP. My guess is that the patient education may very well come in a rather negative way: that people coming along to surgeries are made aware that some of their consultations are trivial, and that might be a good way of educating patients. Are there other instruments? Does the price mechanism any part to play in it?

Mr Geoffrey Hulme (CIPFA): It is easy to ask patients what they want. A bigger question is what they are prepared to pay for in their taxes and charges. In a sense that is the mechanism that has to be taken further

There is now a national problem, because people say in surveys that they want better services and are ready to pay for them, but when it comes to an election they appear not to be ready to vote for that extra money. We therefore have an Opposition which is not committing itself to spending more money on the health service, and will certainly find difficulty in doing so.

I wonder if the answer does not lie in more local decision-making. It might be possible for local government to have a budget which it could use for different services — education or health or whatever — that local people thought was the most important. The education and health professionals would try to get across the local problems: what are the problems at the margins; where could more money be spent, and what good would it do? If you could make it work, it might be possible to get a more meaningful dialogue at local level than you can at national level, where the talk is always about averages and where no one actually knows what the effect would be for themselves. There are obviously a lot of difficulties in this, but I wonder whether it is worth thinking about?

Professor George Freeman (Charing Cross & Westminster Medical School): Some very interesting things have come up. One of them was David Mant's suggestion that modern biomedicine is offering so much that we are now reluctant to counsel waiting. I do not agree with that. I think that we are being given better evidence of when to wait and when not to wait. We can get over this by communicating better with our patients. That is the way to achieve better satisfaction on both sides.

We have heard a lot about morale in the practice. We have to think about what people expect as a professional reward. One is money but, as we have heard from the recent debate on the out of hours issue, it is not just about money. What is clear to me, working as head of an academic department, together with health authorities, is the way practices are presently judged. They are judged on criteria which are different from those the practitioners themselves value. The bit that is left out is that which is difficult to measure: how to measure success in consulting. We need a good quality measure of our interaction with patients. When we can get that measured and rewarded, we will be valued properly and we will then be valued by society.

Dr David Black (Registrar, Public Health Medicine, Sheffield DHA): I would like to make some comments about morale in general practice,

having chosen not to continue a career in general practice.

The training needs to be different. All doctors should spend some time in general practice as part of their pre-registration time. What would improve morale in general practice would be to look at the experience of doctors working in secondary care: their working week has more variety; there is more time spent in a variety of different tasks, working in multi-disciplinary groups, which GPs do but often squeezed in during the surgery. It does not form a core part of the work.

I would prefer to see a prolonged training in general practice with the development of a special interest, which could be a GP in a surgery or a group of surgeries with a variety of special expertise. This would also improve morale in general practice.

I also think that external quality measures are important as a stimulus to improving the quality of what you do. Outside monitoring of what is happening, a different method of payment, possibly capitated payment — would all be moves forward.

Dr Carol Gibbs (GP, Cardiff): I have a lot of sympathy with what was said earlier on. Very few people know what goes on in general practice. When I started 25 years ago I did do a lot of medicine. Then I was de-skilled because a lot of the medicine went into secondary care. The expectation was that I was a father figure, the one people brought all their problems to.

All of a sudden, it is wonderful. We are fund-holding. From not being able to access any of my previous clinical skills because I was stopped direct access to any investigations, I am now able to access all the skills I lost over a period of 20 years. That is part of the challenge. But there is a dichotomy between what is expected by the patients and what I want to do as a doctor. I am a doctor. I am not a counsellor. I am not a physiotherapist. I am not a priest. I am not a pharmacist. I am a doctor and what I was trained to do was to give a clinical medical opinion. I feel that concept has been lost by patients.

Dr C Trower (Buckinghamshire Health Board): I would like to ask the Panel how they would advise a chief executive of a new integrated health authority who finds himself in the position of wanting to ensure a primary care focus and to put GPs on the executive, but equally finding the NHS Executive saying he has to meet targets on junior doctors' hours, and provide a renal service etcetera and the director of finance says 'You can forget about any developments in primary care if you want to do all that'.

Professor Robinson: In a sense that was one of the points I alluded to. You may well be committed in principle to a primary care-led NHS but

the practicalities of day-to-day work of a health authority means that there are a lot of objectives you need to respond to, some of which are more pressing than others because they are 'must-dos'. In some quarters there is a very real fear that they will be squeezed out.

Having said that, I am impressed by the work I have done around the country at the commitment of many officers to try to get this system in place by April 1996. Whether or not they succeed remains to be seen. I have in mind one chief executive who told me that when he hears about the primary care NHS he is put in mind of Gandhi's comment when asked what he thought about British civilisation — he said he 'thought it was a good idea'!

Lord Peston (The Chairman): What do you say to the lady who said she would like to be a doctor and practise medicine? She does not want to be a manager or a bureaucrat and all the other things she is now told she has to do. Is it the story of 'your day is over'?

Dr Murfin: Absolutely not. Clinical medicine is still central to general practice. Fundamentally we must try to be the best doctor we can be to our patients in the clinical domain. That is what it is all about. But unless you can take on all the other areas of managed care, with all the changes being accelerated through the NHS Executive, then you will not deliver the best service to your patients.

Ms Julia Dent (Ealing Hammersmith & Hounslow Health Agency): One of the challenges on the agenda facing primary care is that the three roles of general practice have to be clear to the new health authorities: the role of provider, the role of gatekeeper and the role of purchaser. The health authorities' challenge is to decide which role they are addressing and when. The problem with the primary care-led NHS is in the document which is about putting services close to the patient. The needs of the population have been translated into GP fund-holding and GP-led purchasing. It has neglected the provision role.

I suppose I see that the profession has to work with people like me, to actually describe what they do as providers. Unless we describe that in 'health servicespeak' it will not get on to the agenda. That is the real challenge: how to evaluate it and monitor it, and how to make it central to the health authority agenda.

Mr E G Dean (Basingstoke & Northants Community Health Council): The general practitioner's job is surely not to defend the system but to say 'We are overworked. We need manpower. We cannot provide the service that not only the patient expects from us and neither can we provide the service the Government have written into our

contract.' Let us have less of this setting up a system to suit the professional and have more setting up a system which your consumers require.

What does the consumer or patient want? I suggest to you that that is an efficient system which they can access fairly easily, and find the kind of results that they are looking for. If they need to see a consultant then they need to be referred as early as possible.

The future of primary care

Professor Martin Roland

Introduction

General practice is the dominant discipline within UK primary care. The majority of primary care is delivered by general practice-based teams. Indeed, the role of general practice as the core primary care discipline has been strengthened by the 1991 reforms, which have increasingly given purchasing power to GPs. In this article I comment on the future of general practice as the core primary care discipline, discussing two threats which are currently facing the generalist — from fragmentation within general practice itself and from the growing body of specialists working from within the community. I discuss the challenge to general practice to define and assure the quality of care offered, and finally set out a vision for the future of primary care in the UK.

Risk of fragmentation

The threat that primary care will become fragmented, making it more difficult to provide care of high quality relates to three current issues.

- (1) Defining a core of general practitioner services. The General Medical Services Committee of the BMA has this year produced a consultation document defining these. Although there may be a need to define the core of general practice, there is also a danger. We may lose sight of the fact that a large part of the case for the generalist is that the whole is greater than the sum of the parts. A definition of a core range of services may expose general practice to precisely the threats from which it is intended to protect it, and lead to Trusts progressively bidding to provide care which is currently provided within general practice.
- (2) How important is 24-hour responsibility to general practice? Those with a pessimistic view of the future regard a separate night-time contract as the start of an inexorable chipping away at general practice, which will leave it unrecognisable as a distinct discipline. I do not share these fears. The experience of one comparable health care system, Denmark, is that splitting the out-of-hours contract from the day-time contract has proved a success.

Personal continuity of the 5 per cent of care which occurs out of hours is not in my view necessary for a high-quality primary health care service.

- (3) There are pressures for purchasers to look at sections of general practice care and towards specific service contracts, i.e. contracting from general practice. These are clearly going to be a feature of primary care in the future.

These developments mark the end of an era where general practice is an amorphous blob of care in which quality can be neither assessed nor assured. Back in 1985, the RCGP policy statement on quality said that each general practitioner should be able to say what services his practice provides for his patients, and each general practitioner should 'define specific objectives for the care of his patients and should monitor the extent to which these objectives are met.' Such service standards are not easy to set or to meet. There is a real risk that primary care will become seriously fragmented if exposed to the full force of a health care market.

Risk of specialisation

A second possible threat to generalist care, is the risk of specialisation. I want to talk both about the risks of specialisation within general practice and the growth in community-based specialist care.

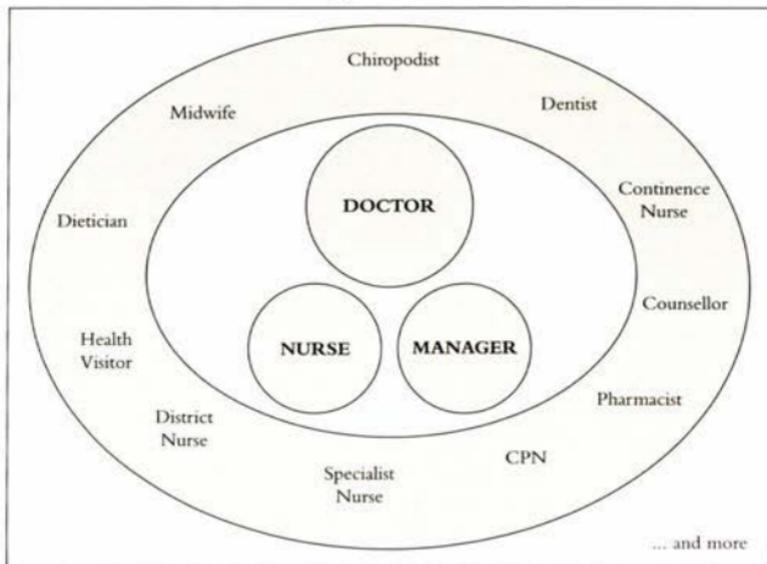
(1) Specialisation within general practice comes in two forms.

- a) The first is the employment of health professionals within the primary care team to carry out specific specialised tasks. The most obvious example here is the growth of the practice nurse. Much has been written about this, especially on the other side of the Atlantic. Estimates range from 4 per cent to 85 per cent as the proportion of the generalist's work which could be done by nurses. I do not wish to defend the methodology of these studies, but there is at least the basis for a debate.

Indeed, in the UK many of the achievements within general practice in the past 10 years have been related to developments in practice nursing.

The last two practices that I worked in, practice nurses trained as specialists in asthma and diabetes. I did not find my role as a general practitioner threatened. Indeed, I think that the greater threat to primary care comes from those who believe generalism means that the GP must be all things to all people.

- b) The second form of specialisation within general practice, is the extent to which GPs themselves should become specialised within practices. This is an area where there has been very little public or professional debate. The fear within general practice is that once GPs start to become specialised this will mean the start of an inexorable slide, where the benefits of generalist care may be lost. The most obvious and perhaps least threatening areas for specialisation are those where particular technical skills are required. So, for example, the capacity of a group practice to provide high-quality care may be enhanced if only one or two partners can use a slip lamp, insert an IUCD or carry out minor surgery. This is a crucial debate for the profession to have, and it will be particularly important to evaluate innovative models of practice.

FIGURE **Doctor/Nurse/Manager**

(2) I now want to discuss the possible threat from the growth in community-based specialist care.

A discussion paper from the Royal College of General Practitioners (RCGP 1996), describes a core general practice team of doctors, nurses and managers, sometimes including district nurses and health visitors (see Figure). But what is the role of the health professionals in the outer circle who are increasingly based in the community?

I believe the ever-increasing capacity for sub-specialist care to deliver effective interventions in community settings is one of the strongest reasons to protect the role of the generalist. Theodore Fox put it well over 30 years ago, saying:

'The more complex medicine becomes, the stronger the reasons why everyone should have a personal doctor who will take continuous responsibility for him, protecting him from the zealous specialist.'

The plethora of community-based specialists requires the coordinating function of a small core primary health care team. That, within the UK context, is the general practice-based team. What is unclear, however, is which of the other professional groups should provide direct access to patients. Few would argue that patients should not have direct access to dentists and pharmacists. However, it is right, within the UK context, that access to community-based medical

specialists continue to be by referral from GPs. Of course there are blurred edges. How should a specialist paediatric asthma clinic run by specialist asthma nurses interface with general practice? There are unresolved issues which need debate.

I now want to go on to discuss two challenges relating to the need to define and assure the quality of care offered.

The need to define quality

There are a wide range of dimensions of quality. In relation to 20th century primary health care I would like to suggest six.

- (1) Access. One of the major strengths of the UK health care system is the fact that almost the entire population is registered with a general practitioner. In the move towards market orientation in the health service, it is extremely important that we guard against erosion of this principle, ensuring for example that fund-holding arrangements do not impair access to care for difficult or expensive patients. A second element to access is ensuring you actually get to see the doctor; standards of access can be assessed, and it is important that they are maintained.
- (2) Equity. On the whole, the NHS does not have a bad record of at least trying to distribute resources to where they are needed. One of the least attractive aspects of fund-holding has been that it has led in some cases to a two-tier service. Sometimes this may result in an overall improvement in service, but we need to ensure that equity remains a fundamental principle in planning our health service.
- (3) Clinical care and performance. If there are threats to primary care disciplines from encroaching specialists, then primary care professionals need to be able to demonstrate that they have better diagnostic skills, especially for undifferentiated, ill-structured problems, better management skills, especially for minor and moderately serious conditions and those with important psychosocial components, and provide better preventive care. Much time is spent thinking about the interface between primary and secondary care and the role of GPs in purchasing secondary care. It is very important that we do not neglect the core aspects of clinical care within general practice itself.

In looking at the quality of clinical care, we must not neglect important dimensions of quality because they are hard to measure. Haigh-Smith and Armstrong (1989) carried out work on large groups of patients, trying to identify the elements of quality which patients felt to be important. Top of the list was 'a doctor who listens'. This ties in with concepts developed within general practice over the past 30 years that it is the quality of the individual consultation which is a key element of quality of care. An increasing

amount of work from groups at St Thomas's, from John Howie's group in Edinburgh, shows that time is an essential element to quality of care. Good clinical care cannot be delivered in five minutes per patient. We must not forget that the quality of the individual clinical encounter is at the heart of medicine, and that primary care must be structured to allow sufficient time for the consultation. General practice must not choose performance indicators which are easily measured but ignore those which are key to good medical practice.

- (4) The range of services provided. There is a generally shared view that it would be desirable for a wide range of services to be provided cost-effectively from a base which is fairly close to the patient's home.
- (5) Anticipatory care. This is a weak link in primary care at present. Stott and Davis (1979) identify continuing care as one of the potential parts of all primary care consultations. The service is very demand-led, however, and practices are often not all that good at planning long-term care of chronic disease. Diabetes is perhaps the example to show that it can be done. Tudor-Hart wrote in 1983 that '*Organised personal responsibility is the key to improved outcome*'. Long-term management of chronic disease is often poorly coordinated, with communication between specialists and GPs that has changed little in the last 40 years, despite huge changes in the way in which care is provided. New ways of organising care for chronic illness are needed for the changing needs of our patient population.
- (6) Continuity of care. One of the questions about primary care in the future is whether the loss of continuity which results from working in larger teams is outweighed by the benefits that result. I do not think that continuity of care is always essential. However, there are occasions when personal care from one's own doctor becomes extremely important. We need to be able to describe those situations where continuity of care makes a real difference to outcome. Some of the developments I have described make personal continuity of care look seriously endangered. My belief is that personal continuity is a feature of NHS care that is worth vigorously defending.

The need to assure quality

I move on from definitions of quality to assuring quality. As the emphasis on purchasing effective care in the NHS increases and as we start to experience health commissions purchasing care from the primary sector, quality assurance will become increasingly important. The message to the profession is clear: if they do not lead on this issue then they will be led, whether they like it or not. In the area where I work, a novel collaboration between the local medical committee and

the health authority has developed a range of quality standards towards which the majority of Manchester practices working. There is a real opportunity over the next few years for professionals to work with Government and health authorities to define the important elements of quality and to determine how they can be delivered and assured.

The primary/secondary interface

The primary/secondary interface is an area where the boundaries are shifting rapidly. Some of these changes have already been mentioned, particularly those which relate to specialist activity in community settings. However, if we look to future developments at the primary/secondary interface, there are a number of technological changes which are likely to make a dramatic difference in the next decade.

The first is the development of near-patient testing, that is, the availability of sophisticated diagnostic tests which can be provided in primary care settings. For many types of problem, diagnostic facilities would become available in GP surgeries. Second, as less invasive forms of investigation are developed in hospitals, an increasing range will be able to be accessed directly by GPs. Already the cost of a simple lumbar spine MRI scan is beginning to approach that of an x-ray of the lumbar spine — itself a notoriously unhelpful investigation.

Third, there will be a revolution in information available, either on CD-ROM databases or via the Internet. It is hard to predict whether this will have more effect on the behaviour of doctors or patients. Certainly clinical information systems will become available to GPs at the touch of a mouse button. GPs in Britain have been enthusiastic supporters of computers, and there is no reason to think they will not be keen to embrace the new opportunities which technology offers. However, this information will also be available to patients and it will be interesting to see how having access to sophisticated information equalises power in the relationship between doctors and patients.

Fourth is the advent of telemedicine. Here we really have no idea how relatively easy access to specialists could change the interface between generalist and specialist care. Pilot work which we have carried out in Manchester suggests that GPs' use of specialist consultation could increase significantly when there are opportunities for rapid access to brief specialist advice. What a change that could be from the 'big deal' hospital referral, for which our patients currently wait for weeks.

Public health and primary care

Moving on to discuss primary care as a base for planning the health of populations, I have already referred to the strength of the UK system in having virtually the whole population registered with a GP. But, what about the responsiveness of general practice to its communities? This is

an area where we can foresee changes, but it is very difficult to predict their effect. At an individual level there have been changes in the relationship between doctors and patients and a rise in consumerism, that is, the expectation of the patient to be treated as a customer. It makes it very difficult to provide good care, especially when the patient's and the doctor's assessment of need do not coincide.

At a population level, GPs do not have good mechanisms for responding to the needs of their communities, or even getting any sort of view from their patients at all. For many general practitioners patients' expectations are something to be feared. One of the features in the Labour Party's published document on health care is an increase in consumer responsiveness. It would need a radical change in the views of many GPs if this is to be seized as an opportunity rather than regarded as a threat.

Partly because there has been so little evaluation we are really in the dark about the competence of GPs to fulfil the role of planning the population's health. Whilst there can be little doubt that GPs can be very effective purchasers for individual services it is to be questioned whether GPs are able to plan for care of populations. One of the things at issue here is the potential conflict between the values of the doctor who regards himself as committed to individual patient and the doctor who takes a broader population perspective. The problem is that these two value systems are radically different and may at times conflict. Indeed, the sort of people who go into general practice may be precisely those who value personal responsibility over their wider responsibilities within the NHS. So perhaps the most radical and perverse of the recent changes in the NHS has been the introduction of a system which requires those doctors most committed to personal care to take on a population perspective. Clearly there have been those within the medical profession who have taken this on with enthusiasm, but there are others who do not want to or who have taken it on with reluctance.

There is a lot of rhetoric about the importance of links between primary care and public health. My observation is that few doctors are able to be equal champions for these two value systems, and the NHS needs to be very careful before it goes further down a road which downgrades the one-to-one relationship between doctors and patients that has been the essence of British primary health care over many years. The relationship is under threat from a number of issues which have been discussed during the course of today — from expanding teams, to new roles in commissioning, and the increasing market orientation of the NHS.

A vision for the future

I conclude with seven points which are my vision for a future which preserves the strengths of British primary care.

- (1) A model of primary care based around the general practice team has served Britain well. It is a model which other countries are now seeking to emulate. This basic feature of the NHS does not need fixing.
- (2) It is difficult to operate a well-functioning team where there are more than 12 or so doctors and nurses. If care continues, as I believe it should, to be centred around a core general practice team, the team needs to find new ways of interacting and communicating with the increasing number of other professionals who, quite appropriately, are providing care from a community base.
- (3) The relationship between the health professional and his or her patient is key to providing high-quality patient care. Personal continuity is not always important but it is sometimes very important. I am not suggesting that general practice should return to the days of Dr Finlay and Tannochbrae, but if we allow general practice to become like a department store then our patients will be the losers. We must remember this when developing quality indicators for general practice and, in particular, protect the time needed for the encounter between the doctor or nurse and his or her patient.
- (4) There are opportunities which are at present poorly realised for individual doctors or nurses within practices to develop specific skills. Specialisation within practices offers the opportunity to increase the range of services available. The amount of referral that occurs within practices could be increased. Fear that these developments will lead to a mini-specialoid service are probably overplayed.
- (5) The profession must seize the opportunity to define quality standards. There is a window of opportunity in the next few years that must be grasped.
- (6) Where expert advice is needed we need much better ways of communication. The growth in IT offers a great opportunity for desktop decision support for GPs, which may enable them with confidence to undertake the increasing amounts of care being asked of them. Telemedicine may offer opportunities for rapid access to brief specialist advice, which is notably lacking in the NHS at the moment.
- (7) Finally, however models of purchasing develop in the NHS, I am sure that GPs need an important voice in the services provided for their patients. I am less convinced that GPs, whose main interest is personal care, are the best people to plan the health care of populations. I do not agree with those who believe that the future of public health medicine is somehow to become hybridised with general practice. Both disciplines have distinct contributions to make.

The Government has correctly recognised the potential of a primary care-led NHS and the potential for general practice to take a leading role in that change. Yet as we have heard, perversely, at a time when general practice should be riding high, morale is lower than for many years. This is for many reasons, some of which we have heard, one of which is that a transfer of work to the primary sector has taken place without a comparable transfer of resources. Morale and resourcing need to be tackled. Adequately resourced, properly motivated, British primary care has the potential to become the envy of the world.

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