Medical reforms and the roles of GPs in the United Kingdom

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Two forces shape the evolution of institutions:

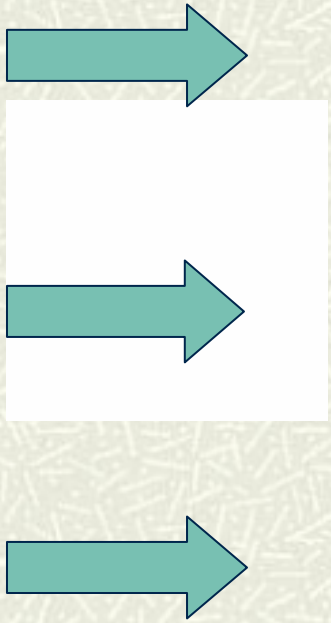
- History

and

- Human nature

Changing views of health care

- The privilege of a few
- Something to be bought
- A service to be made available



- The right of everybody
- Something provided free
- A commodity to be produced and marketed

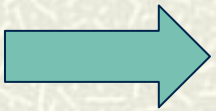
Changing status of patients

- **Passive beneficiaries**
  - who ought to be grateful,
  - and do what they are told by doctors

- **Consumers**
  - who have expectations,
  - and who vote for politicians in elections

Changing roles of doctors (?)

- **Professionals**
  - Altruistic
  - Independent
  - With a monopoly



- **Providers**
  - Entrepreneurs
  - State employees
  - Competing for contracts

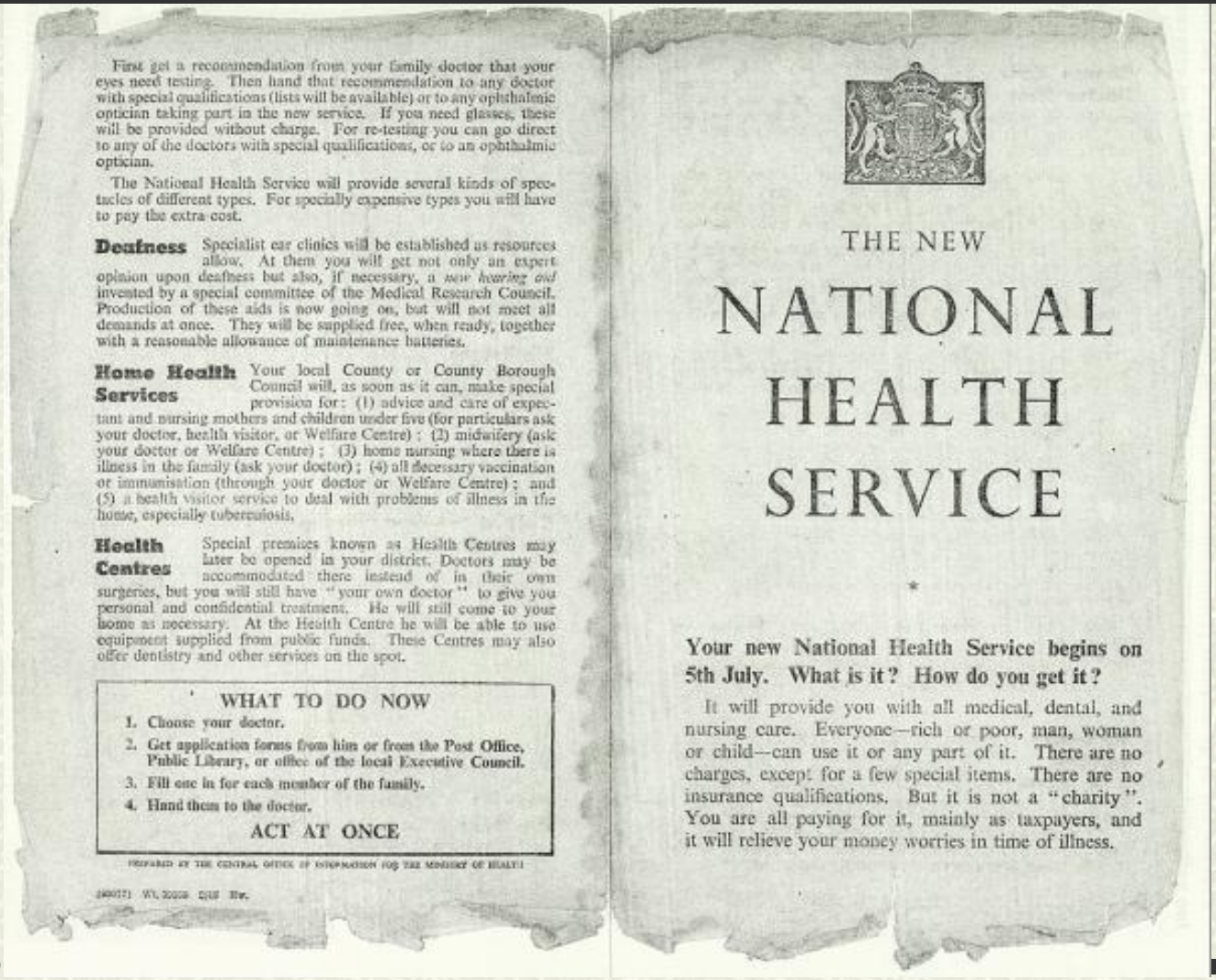
The changes facing doctors

- Technological advances
- Spiralling costs
- Rising public expectations
- ‘Demystification’ of professions
- Social & cultural contexts
- Political agendas
- Speed of change

Historical landmarks

- < 1911 – Healthcare provision mainly private & unregulated
- 1911 – (Lloyd George) Compulsory health insurance
- 1948 – National Health Service (NHS) established

Foundation of the British NHS, 5th July 1948



First get a recommendation from your family doctor that your eyes need testing. Then hand that recommendation to any doctor with special qualifications (lists will be available) or to any ophthalmic optician taking part in the new service. If you need glasses, these will be provided without charge. For re-testing you can go direct to any of the doctors with special qualifications, or to an ophthalmic optician.

The National Health Service will provide several kinds of spectacles of different types. For specially expensive types you will have to pay the extra cost.

Deafness Specialist ear clinics will be established as resources allow. At them you will get not only an expert opinion upon deafness but also, if necessary, a *new hearing aid* invented by a special committee of the Medical Research Council. Production of these aids is now going on, but will not meet all demands at once. They will be supplied free, when ready, together with a reasonable allowance of maintenance batteries.

Home Health Services Your local County or County Borough Council will, as soon as it can, make special provision for: (1) advice and care of expectant and nursing mothers and children under five (for particulars ask your doctor, health visitor, or Welfare Centre); (2) midwifery (ask your doctor or Welfare Centre); (3) home nursing where there is illness in the family (ask your doctor); (4) all necessary vaccination or immunisation (through your doctor or Welfare Centre); and (5) a health visitor service to deal with problems of illness in the home, especially tuberculosis.

Health Centres Special premises known as Health Centres may later be opened in your district. Doctors may be accommodated there instead of in their own surgeries, but you will still have "your own doctor" to give you personal and confidential treatment. He will still come to your home as necessary. At the Health Centre he will be able to use equipment supplied from public funds. These Centres may also offer dentistry and other services on the spot.

WHAT TO DO NOW

1. **Choose your doctor.**
2. **Get application forms from him or from the Post Office, Public Library, or office of the local Executive Council.**
3. **Fill one in for each member of the family.**
4. **Hand them to the doctor.**

ACT AT ONCE

PREPARED BY THE CENTRAL OFFICE OF INFORMATION FOR THE MINISTRY OF HEALTH

(46077) W.L. 20008 5/48 Hw.

THE NEW

NATIONAL HEALTH SERVICE

*

Your new National Health Service begins on 5th July. What is it? How do you get it?

It will provide you with all medical, dental, and nursing care. Everyone—rich or poor, man, woman or child—can use it or any part of it. There are no charges, except for a few special items. There are no insurance qualifications. But it is not a "charity". You are all paying for it, mainly as taxpayers, and it will relieve your money worries in time of illness.

Principles of the NHS

- Comprehensive health care for everyone
- Funded out of general taxation
- Free at the point of service
- Care ‘from cradle to grave’
- Every citizen registered with a GP

Political concessions

- **Consultants** allowed to continue private practice
  - Up to 2/11^{ths} of time
  - Remainder contracted to employing hospitals
- **GP**s retained ‘self-employed’ status
  - Tax & employment advantages
  - Free to provide care as they saw fit

The ‘Lord Beveridge fallacy’

- “The amount of disease in the population is finite.
- Therefore once it is treated, the demand for health care (and the cost of providing it) will remain constant.”

But in ***fact*** …

- Patients' perceived needs are open-ended and continually expanding.
- So demand for treatment can never be satisfied.
- Therefore, as treatments become more expensive, the potential cost of the NHS grows exponentially.

The problem for politicians

- How to satisfy the public's increasing expectations for health care,
- but keep costs within what can be afforded,
- and (at the same time) remain popular with the electorate!

Political solutions

1. ‘Purchaser – provider split’
2. New contracts for medical staff
3. New roles for non-medical staff
4. Guidelines,targets & incentives
5. Competition & ‘patient choice’

The ‘purchaser – provider split’

One sector of the NHS purchases medical services from another sector which provides them

For example

- ‘Fund-holding’ GPs commissioning out-patient services from a local hospital (1990)
- NHS buying-in private or overseas teams to perform cataract surgery
- Local NHS managers putting primary care out to competitive tender

New contracts for medical staff: (i) Hospital consultants, 2003

In exchange for higher pay and faster career progression:

- 10 (4-hour) sessions / week devoted to NHS (*7 clinical, 3 e.g. admin, teaching, research*)
- Job descriptions & timetables agreed with management
- Flexible emergency & on-call arrangements

New contracts for medical staff: (ii) GPs (2004)

- Patients registered with a practice, not a named GP
- Quality & Outcomes Framework (QOF)

  Pay linked to achieving targets in *e.g.*
  - chronic disease care
  - additional or enhanced services
  - organisation & practice management
  - accessibility, patient satisfaction
- Can opt out of out-of-hours responsibility

New roles for non-medical staff in primary care

- Specialist nurses, e.g. asthma, diabetes
- Nurse practitioners (with prescribing rights)
- Medical Care Practitioners
- Community pharmacists, opticians
- ‘NHS Direct’ – telephone advice and triage

Quality control: audit, guidelines & targets

- New official bodies:
  - Healthcare Commission auditing quality of care
  - NICE (National Institute for Clinical Excellence) advising on new treatments
  - National Patient Safety Agency advising on risk management
  - *Clinical Evidence* (published by BMA) – compendium of evidence-based guidelines
- Pay linked to indicators of good practice

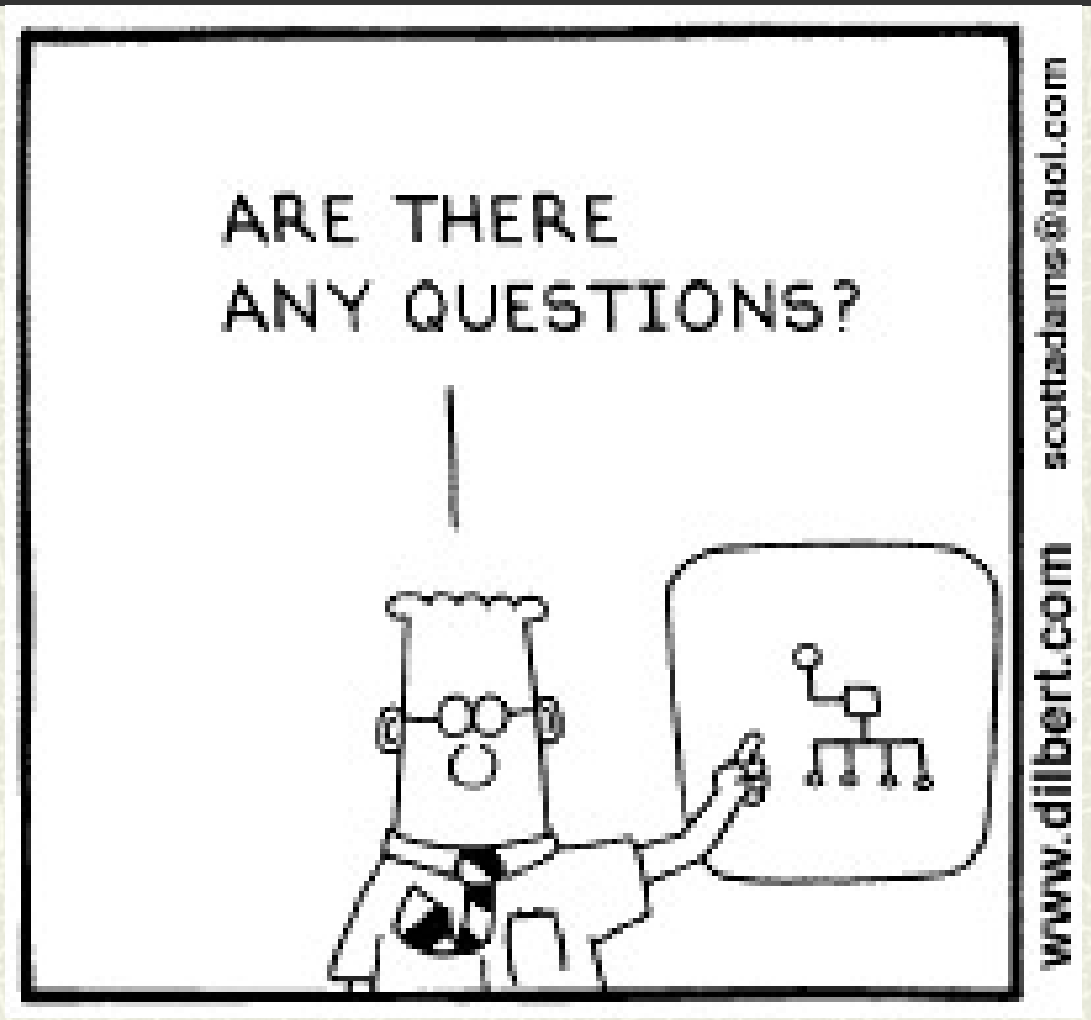
Competition & ‘patient choice’

- No more monopolies – private & independent providers can compete for NHS contracts
- Hospitals compete for GP referrals, e.g. by length of waiting list, facilities or expertise
- Published ‘league tables’
- ‘Choose and book’ for GP referrals
- ‘Walk-in centres’ for primary care
- ? Patients able to register with more than one practice

The story so far …

- The ideals of the National Health Service – to be comprehensive and free – are challenged by rising costs and expectations.
- Medical care is increasingly seen as a commodity within a regulated market economy
- The medical profession is coming more under state control

Before I continue …



The traditional view of the GP

- ‘Failed specialists’
- ‘Jack of all trades, master of none’
- Dealing with minor illness
- Referring (and deferring) to consultants
- Long-term personal care of individuals and families
- Domiciliary surgery, midwifery & terminal care
- Home visiting

Two emerging roles for the GP

- Clinical generalist
- Gatekeeper

The clinical generalist

- Focus on ‘the person who has the disease’ rather than on the disease itself
- Diagnosis in physical, psychological & social terms
- ‘Family’ and ‘narrative’ perspective
- Undifferentiated or atypical illness
- Managing complexity, co-morbidity, uncertainty and risk
- Concerned with doctor-patient relationship

The ‘gatekeeper’ role of the GP

- Clinical sign-posting, directing patient to appropriate care
- A brake on inappropriate use of expensive secondary care
- The patient’s guide & advocate
- A regulating influence on patient demand

Some current concerns

- Erosion of ‘generalism’ and ‘family medicine’ as a valued discipline
- Inequalities in GP performance
- Health inequalities
- Containing demand and costs
- ‘Commercialisation’ of health care
- ‘Change fatigue’
- Manpower, recruitment & retention

Erosion of ‘generalism’

- Expectation of ‘an answer to every problem’
- Worship of the high-tech specialist
- Reduced continuity of personal care
- Increasing litigation
- Over-reliance on measurable targets

Inequalities in GP performance

- Too wide a gap between the best and the worst
- Little control over poor performance (but revalidation to be introduced soon)
- Continuing education is optional (but appraisal system in operation, requiring Personal Development Plans)

Health inequalities

- Lower social classes suffer more cancers, heart disease, respiratory disease *et cetera*
- Poverty leads to poor housing, nutrition & environment, and higher use of tobacco & alcohol
- Tudor Hart's 'Inverse Care Law' (1971): *"Those in the greatest need receive the poorest health care"*

Containing demand & costs

- Ethical tensions between ‘doctor as patient’s advocate’ and ‘doctor as custodian of healthcare resources’
- Increasingly educated population, with access to information via Internet
- If there has to be rationing and prioritising, who should do it – doctors or Government?

Commercialisation of health care

- A question:

  “How far are the economic laws of the market appropriate to how society cares for its sick members?”

- Doctors, patients and policy makers will all give different answers

‘Change fatigue’

- Too much or too frequent change is unsettling,and allows insufficient time for full benefits to be obtained
- Health care should not be a political football
- 改善 (Kaizen) would be better!

Manpower & recruitment

- UK medical schools not producing enough young doctors
- Too reliant on overseas doctors
- Young doctors expect better ‘work / life balance’: part-time or portfolio careers, increased mobility
- >60% of entrants to GP training are female
- Many older GPs are retiring early

Lessons we are learning in the UK

(I) **Reassert core professional values**:

- ***Excellence*** – high clinical standards
- ***Compassion*** – care for the individual patient
- ***Trustworthiness*** & integrity
- ***Altruism*** – putting the patient first
- Continuous i***mprovement***
- ***Leadership*** & ***partnership***

Lessons we are learning in the UK

(2) **Doctors must work cooperatively with patients and with policy makers**

- **Explain** what we do and why we do it, clearly and insistently, using all available media
- **Listen** to what patients & policy makers want,and respond positively

Lessons we are learning in the UK

(3) Promote high quality care

Set high standards for

- entry into practice
- ongoing performance
- education & training

Lessons we are learning in the UK

(4) **Maintain a sound academic base** for the discipline of family medicine

- Royal Colleges and Academies
- Strong involvement in undergraduate medical curriculum
- Active university departments of general practice

My message …

General practice and family medicine is the best job in the world.

We must keep it worthy of the next generation of doctors, and

make sure, through education & training, that they are worthy to join the profession.

Finally …

'Thank you' from the

Royal College of General Practitioners

to the

Japanese Academy of Family Medicine

for your contribution and commitment to the discipline of general practice

Now I've finished

Thank you for your attention