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Interpersonal continuity:
old and new perspectives

There is a wide perception that British general practice is being compromised.[1] As it has been 'the envy of most of the western world',[2] this is of concern. The new General Medical Services (GMS) contract offers and emphasises supplemental reimbursements that are limited to the provision of measurable clinical services. Are NHS quality efforts aiming to improving care consistent with its commitment to a 'primary care centred' health service? To answer this question, we draw on evidence of the benefits of a primary care-led health system, explore aspects of primary care responsible for its benefits, and discuss how current efforts in the US and the UK threaten the achievements of primary care.

Lessons learned from failure of primary care in the US

We turn first to the experience in the US, where there are large variations in the provision of primary care and where there are large associated variations in mortality and in other measures of outcome. Mortality in the US is lowest in states where there is a greater proportion of primary care doctors[3] and for individuals reporting a generalist rather than a specialist as their personal doctor.[4]

Hospitalisation rates are inversely associated with access to primary care doctors and to their numbers.[5,6] Areas with better primary care resources have higher life expectancies and lower all-cause mortality and mortality from the major causes of death, even after controlling for income inequality and major sociodemographic characteristics associated with health. Areas with better primary care services also have fewer disparities in health between socially advantaged and socially disadvantaged population groups.[7] Among industrialised countries, the US has one of the most highly specialised health systems, with very poor and declining primary care infrastructure.[8,9]

Why primary care is effective, efficacious, and equitable

The benefits of primary care are attributable to several mechanisms:

- Availability of more primary care physicians (but not specialists) increases access to and equity of access to health services.[7,10]
- The technical quality of primary care, particularly as measured by generic indicators, is better than that provided by specialists.[7] Recent studies using better methods show higher quality even for care of major illnesses.[11,12] This is most likely due to a greater appreciation of the importance of multi-morbidity in the care of patients.[13]
- Both primary and secondary preventive activities are more adequately undertaken in primary care than in speciality care.[7]
- Seeking care first from primary care avoids unnecessary visits to specialists.[14,15] Where direct access to specialists is common (as in the US), a high supply of specialist services confers no benefit to the quality of care, despite higher costs of care.[16]
- Specific benefits derive from the individual key features of primary care.[7]

Primary care has four key functions which, in combination, define it. Each function consists of a structural aspect and a behavioural manifestation. Person-focused care (rather than disease-focused care) is one of the key features.[17] Sometimes referred to as 'longitudinality', person-

focused care involves the definition of a practice population and manifestations of interpersonal relationships that indicate a person focus.

The other three features are first-contact use, which involves accessibility and use by the population of services at the first realisation that care is needed; comprehensiveness, which requires the structural component of availability of resources to meet all common health-related needs of the population, and the provision of services to meet those needs without referral; and coordination, which requires a mechanism that facilitates information transfer about patients' health needs, and health care and recognition of that information in the care of the patient over time.

Threats to the benefits of primary care

The underlying rationale of interpersonal relationships is facilitation of information transfer. When people voluntarily associate with each other, communication is generally freer and more complete. 'Trust' that the physician will do the right thing is more appropriately conceived as the ability to question and clarify. This rationale for better interpersonal relationships in health services is supported by a wealth of evidence of benefits that stem from better communication. These benefits include better recognition of people's problems; more accurate diagnosis; better concordance with treatment advice; fewer drug prescriptions; better preventive behaviours; less emergency use, fewer hospitalisations (especially for ambulatory-care sensitive conditions); and lower overall costs.[7,17,18]

Some of these benefits, however, are now threatened by health system and health services changes, particularly in the US and the UK.

The challenge of adverse effects. Rates of adverse effects are rising, largely resulting from increasing rates of interventions (each with a finite chance of an adverse side effect) and increasing use of pharmaceuticals. In the US, rates of use of medications are increasing rapidly, with consequent increases in adverse effects.[19] The more doctors people see, without the coordination of care provided by a clinician with whom good interpersonal relationships have been established, the greater the likelihood of adverse effects.[20,21] Almost twice the proportion of people see four or more doctors in a 2-year period in the US than in the UK (49 versus 28%). With the increased availability of, and encouragement to seek care from, walk-in or on-call centres in the UK, this difference may narrow or evaporate.

The challenge of overuse and unnecessary use of tests and procedures. In the US, the only population comparable to the UK population in terms of assured financial access to services is the older population. In people aged 65 years and over in the US, the volume of laboratory services and procedures per Medicare beneficiary increased between the years 2000 and 2005, ranging from an increase of 34% for coronary angioplasty to an increase of 94% for MRIs and 530% for laboratory tests. No evidence of a relationship between use of such technology and improved health outcomes in the population or reductions in use of older technologies was identified.[22] A focus on process-oriented quality of care assessments, as with the majority of indicators in the Quality and Outcomes Framework, threatens to increase the volume of testing, without any evidence that this increase will improve population health. Although most of these indicators are based on some evidence that they should improve health, at best this evidence derives from studies of efficacy in selected populations rather than effectiveness in general primary care populations. Better interpersonal relationships allow patients to question the rationale for performing tests and procedures, instead of assuming the value of what is recommended.

The challenge of 'disease mongering'. In the last 20 years in the US, the prevalence of diagnosed disease has increased markedly, largely due to lowered thresholds for diagnosis of individual diseases or increasing inclusion of risk factors as synonymous with diagnosed disease.[23] In combination with increased survival from existing disease, the frequency of comorbidity (or, more accurately, multi-morbidity) in the population has increased, further reducing the utility of disease-oriented treatments. Furthermore, an increasing diagnosed disease burden places even greater focus on the inadequacy of disease-oriented approaches to health services and greater burden on coordination of care. The disease-orientation of the majority of quality indicators is increasingly dysfunctional as a measure of health improvement and as a basis of payment for performance. This focus on process monitoring need to be balanced with incentives to focus on improvement in patients' problems and meeting their health needs.

The increasing focus on 'prevention' rather than care as the main focus of health systems. While indicated interventions at the earliest possible time are always a priority, the current focus on intervention at the stage of risk factors does not necessarily lead to improved population health. Ten 'threats' to the primacy of preventive activities have been documented (J Gervas *et al*, unpublished data, 2007). Public health practitioners, policy makers, and clinicians need to be vigilant in setting priorities for prevention, including priorities in quality assessment frameworks, so as not to interfere with the caring function of health services.

The likelihood that payment for performance is antithetical to patient-centred care.[24] Payment for performance is based on professionally-defined indicators of performance. These indicators do not include measures of the extent to which patients' problems are recognised by practitioners, despite evidence that agreement between practitioners and patients on the nature of the patient's problem(s) is associated with a greater likelihood of improvement.[25–28] Established interpersonal relationships are essential in making appropriate decisions about the costs and benefits of various preventive strategies in individuals. Payment for performance is most appropriate when it is based on improvements in people's health and meeting their health needs.

Thus, despite the increasingly frequent and robust evidence of the benefits of primary care, certain features of health policy, particularly in the US and in the UK, are likely to compromise these benefits to health.

The resemblance of variations in primary care and resultant outcomes in the NHS to those in the US

Access to primary care in the US varies widely among states and hospital service areas.[3] In the UK, access to primary care is in principle (and largely in reality) available to everyone, but there are at least two similarities between problems of primary care in the NHS and in the US. First, there are wide variations in GPs' rates of referral to secondary and tertiary care, and in the rate of hospital admissions and emergency care.[29,30] Secondly, there is considerable geographic variation in the ratio of GPs to population size.[31] There are, in addition, wide geographic variations in the rates of secondary and tertiary care.[32]

That there are wide variations among practices in both countries reflects the uncertainty and ambiguity of many decisions in primary care as well as variations in practitioners' vulnerability to external pressure to practice in certain ways. Faced with a patient's presenting problem, a decision must be made whether or not to treat and whether or not to refer for consultant opinion or secondary care. As the doctor of first contact, the generalist in primary care has the most frequent and earliest opportunity to help patients express their preferences for accepting or rejecting therapeutic options.

When patients report that they share 'common ground' with their physicians, outcomes are better, including fewer post-visit concerns, lower referral rates, and fewer diagnostic tests.[33] In an era of greater consumer and patient input, the goal is to help balance the patient's values against the gains or potential losses of therapy at the margin where the risks and potential benefits of intervention may be evenly balanced and often defy measurement. This is when the patient's values must become a determining consideration and where interpersonal continuity is especially important.

To be effective, continuity must be 'relational' as well as 'informational'; the concept of relational continuity implies familiarity and mutual confidence that can and usually does arise from repeated contacts over time. Few, if any, of the above-mentioned threats can be dealt with using better transfer of information, by whatever means, from one practitioner to another. It is knowledge of the needs of patients and the extent of their comfort in divulging their problems that is the crucial aspect of continuity.

Continuity of personal relationships is one of the most important distinguishing characteristics of general practice. It is at the expense of general practice that the new GMS contract fragments primary care into reimbursable commodities, thereby providing incentives for disease orientation rather than person-focused relational continuity.[19] The price may well be an increase in costs, hospitalisations, and adverse events. It is to be hoped that those in the NHS responsible for the GMS contract are aware of the issue and make allowances for it in the future.

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