Population health

You GPs must be a frustrating bunch. If you look at us from the perspective of those wanting the health system to run like a finely honed machine, we're the expensive grit that gets trapped in the big cogs. You can feel the hand-wringing exasperation in all those articles that start 'GPs should …'. We should be screening for everything from anxiety to Zika. We should be following the guidelines for … well, anything really. Why won't we just implement 'The Evidence'?

There are studies that show our specialist colleagues do follow the guidelines on their patients more than we do. If only this happened for everyone, imagine how good population health would be!

Of course, we'd point to our increasing workload. More patients are seeing fewer of us with more problems. How can we be expected to add in those extra bits of screening and prevention?

The way we do population health is one person at a time. Our unit of action is the consultation, where we try to make progress on the problems people bring to us and work on prevention to avoid bigger problems in the future. Of course, everyone is an expert on what happens in a GP consultation, because everyone has been in one.

In Australia about 85% of the population see a GP at least once a year. All those responsible for developing health policy know what we do, and it often might look pretty easy to them. By definition, they are employed, usually with a computer on the desk, on a reasonable income, with control over much of their own lives. But that's not where the real gains are to be made.

Improving population health means improving health for those whose lives are harder for us to imagine. Where a lack of money means health comes second to housing, welfare, and legal matters. People face big, complex systems that appear designed to deny them. The only relief might come in the form of the instant hit of nicotine. For many GPs this is our bread and butter. The majority of our patients have more than one chronic disease, where simple guidelines don't apply. Many present with symptoms of distress that don't have a medical diagnosis, where the guidelines can't apply.

We need feel no shame about not following the guidelines for many (not all) of our patients, as all too often they are designed for ideal average patients, not the messy, complex real people that we see.

We can legitimately claim that our role in population health is to select the individual people who will benefit, and to protect those who won't. Our ally in this is the way we use time. Time to get to know our patients; time to develop trust so that eventually we are the ones who are asked to guide action and change. We know this isn't a one consultation thing. We know that once we're established in our practices we stop having 10- or 15-minute consultations with our patients. We start having consultations lasting 2 years, split up into 10-minute blocks.

It might well be that the so-called 'paradox of primary care' — that we follow guidelines less but get better results[1] — is achieved through our ability to frustrate those in health policy, and giving us more time to do so.

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REFERENCE

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