Two cheers for general practice

THIS issue of the *Journal* is special for two reasons; its appearance coincides with the 11th World Conference on Family Medicine organized by the World Organization of National Colleges, Academies, and Academic Institutions of General Practitioners/Family Physicans (WONCA) in London and with the meeting of the Council of the Royal College of General Practitioners to consider the Government's Green Paper on primary health care.[1] The Green Paper is one of a series of documents recently published which are of crucial importance for the future of general practice in the United Kingdom; these include the report of the Community Nursing Review[2] (the Cumberlege Report) and the Nuffield enquiry into pharmacy services.[3]

To mark the 1986 WONCA Conference, the *Journal* is publishing abstracts of the papers presented in the plenary sessions. In future issues of the *Journal* we anticipate publishing material from the poster sessions which have become a major feature of the Conference. Under the theme 'Towards 2000', the speakers at the Conference will consider the role of general practice in implementing the Declaration of Alma-Ata which seeks health for all by the year 2000 through improvements in primary health care. The problems facing workers in primary health care in developing countries can make the health problems of the relatively affluent countries seem feeble in comparison. However, malnutrition in parts of Africa and obesity in western Europe are both problems of nutrition that can lead to death and both require effective health education for large populations and provision of effective medical care to individuals. General practice and primary health care are not synonymous. Throughout the world, including the United Kingdom, general practitioners are increasingly being challenged to demonstrate their effectiveness in providing care which is acceptable and accessible to the communities they serve.

The 1986 World Conference takes place at a crucially important time in the development of general practice in the United Kingdom. The Government's Green Paper is claimed to be the first major reappraisal of primary health care since the introduction of the National Health Service in 1948. Like the Conference, the Green Paper looks forward to the year 2000 and beyond. It is tempting to give a personal reaction to the proposals contained in the Green Paper. The responsible approach is for all doctors to read the document in full and not to rely on the interpretations of others. The true voice of the public and of the profession must be heard if beneficial changes in primary health care are to be achieved. Many of the positive aspects of the National Health Service have been maintained by consensus within the country and the system has largely retained the goodwill of the public and of the health professions in spite of a long history of inadequate funding.

The content of the Green Paper has clearly been influenced by proposals put forward by the College's policy statement *Quality in general practice.*[4] For example, establishing a performance-related contract for general practitioners is seen as a method of improving the quality of family doctor services up to the level of the best. Even at a general level this proposal is controversial. The next difficult step for the College and for the Government will be to specify in precise terms the activities and performance indicators which can be used to evaluate the quality of service provided. It may prove to be the judgement of Solomon to select methods of payment which will both satisfy the majority of doctors and result in tangible benefits to patients. There are many views about the scope and nature of general practice and it would be unwise to neglect qualitative aspects of practice when seeking to evaluate performance.

Perhaps the one principle upon which all can agree is that general practitioners should be allowed to give detailed information about the services they provide. This information could be available to patients, potential patients and to family practitioner committees. This would enable intelligent debate to take place about the appropriateness of services to individuals, groups and communities. The provision of information rather than the execution of a particular activity may be the fairest and most productive approach to improving quality in general practice.

In the other editorials in this issue of the *Journal,* authors were invited to speculate on the nature of general practice in the United Kingdom in the year 2000. The articles were written before the Green Paper was published and are perhaps more valuable because of that fact. The ideas contained in them have not been conditioned by the specific proposals in the Green Paper and challenge some of the current orthodoxy.

The title of this editorial perhaps requires explanation. General practice in the United Kingdom has received muted praise in the Green Paper. Furthermore, the proposals for change are less radical than were envisaged. It will require drive and energy by the College membership to convert this slightly lacklustre discussion paper into a set of concrete and radical proposals for the changes in general practice which will create excellent primary health care in the twenty-first century.

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Towards 2000

TO be allowed to gaze into the crystal ball in public is both a privilege and a challenge. A privilege, because it might spark off new trains of thought in the reader, and a challenge because only time will tell whether you got it right.

There are certain things that we can be reasonably sure of. The population will get older, or rather the section of the population that is very old will get larger. The resources available for health care in the foreseeable future will not be enough to meet demand. New technology will continue to develop and produce significant effects on our professional activities and the private lives of our patients. Consumerism, including the wish of patients to know and to be involved more, will continue to increase.

How will these forces affect health care and more specifically general practice and primary health care?

Resources

The stresses and strains in the health care system over the last few years have been all too obvious, as cash limits have been applied rigidly and reports have emerged of shortages of nurses and hold-ups in cervical smear results. General practice has been largely protected from these pressures, although it has suffered sporadically from the withdrawal of certain diagnostic services and the reduction of community nurse staffing. There have also been instances of family practitioner committees becoming more rigid in their interpretation of regulations, such as those relating to practice staff reimbursement. Now that family practitioner services are clearly separated from hospital services we may expect to see further consideration of how far the hospital budget should be providing resources for the general practice budget.

These questions are inevitable. What is not inevitable is that they should be divorced from an overall strategy. If money and other resources are short there has to be a broad plan that allows planners to take resource decisions logically. This includes the recognition that the health of the population leaves much to be desired. The World Health Organization's publication *Targets for health for all* from the European Regional Office in Copenhagen[1] stresses the need for a fundamental change in health developments. Much higher priority must be given to health promotion and disease prevention, and to the involvement of individuals and community in health development. Primary health care is the key to those changes, because it is here that most prevention should be carried out. So we need a firm commitment from the government of this country to pursue these policies and to evaluate expensive technological diagnostic and treatment developments in terms of their cost-effectiveness and relevance to an overall strategy. Allocation of resources between the primary and secondary services must be decided as a result of an agreed logical policy.

Technology

Although the introduction of microcomputers into general practice is proceeding slowly it is nevertheless gaining momentum, and the benefits of new technology are becoming clearer.

The first returns are seen in the area of the office. The computer comes into its own in manipulating and sorting the thousands of patients registered with the practice. So it can make child's play of such things as identifying and sending for people for immunizations and blood pressure checks and for women for cervical smears. But the important point is not that the computer finds and sends for all these people — manual systems can do that, albeit more tediously — but that it can tell you immediately how well you are doing and provide data for the rest of the health district. So we can expect, and demand, a much greater flow of information about practice health outcomes, especially in prevention, from a computer-based system.

The other two main areas of current development are in repeat prescribing, thereby providing instant audit of all long-term medication and in the construction of individual computerized patient problem lists.

The movement of microcomputers into the clinical area of the practice is a little slower. This is much more expensive because of the large number of visual display units required, and doctors and nurses need to operate the equipment directly. Nevertheless, we can begin to see where these developments will take us. They will enable us to survey much more easily the relevant factors in the management of chronic disease and long-term problems and will allow doctors and nurses to be prompted and reminded of possible courses of action.

By the year 2000 we could expect to see the majority of practices with microcomputers providing a regular flow of information about prevention, chronic disease, prescribing and workload.

There is another side to technological innovation that is less well-developed, but could have far-reaching implications for primary health care. We have seen a slow introduction of diagnostic aids during the last decade with electrocardiographs, sonicaid foetal heart detectors and blood glucose monitoring machines. But it is likely that with miniaturization and more sophisticated technology, more biochemical and haematological investigations could be done rapidly and reliably at the bedside or in the treatment room. An instant read-out of biochemical data by the microcomputer could transform the management of some chronic diseases. Make sure you have enough electrical power points in your building!

Consumerism

In the United Kingdom and elsewhere the desire by consumers to know more and to be involved more is gaining momentum and nowhere more than in the field of health care. The number of articles on health matters in magazines and the number of radio and television programmes testify to that. What are the implications for general practitioners?

We have already detected moves to involve the patient more in decision making in the consultation. These moves will be accelerated as patients have access to more information through the media and through their own viewdata system.[2] These developments should be welcomed as liberating for the doctor and more relevant for the patient.

The greater involvement of the consumer will be felt in practice organization as well. Patient participation groups have developed to help inform doctors and nurses about the views of patients on the provision of care in the practice. At national level a report from the Royal College of General Practitioners' Patients' Liaison Group[3] has stimulated practices to provide more information for patients and intending patients, and has started a national debate about how far the provision of more information and even advertising should go. Coupled with that is the question of how patients can have more choice of doctor in the National Health Service and how changing doctors can be made easier. By the end of the decade it will be common for patients to ask for the details of what the practice has to offer before they register, and to consider changing practices if they believe the service is unsatisfactory.

Quality

The twin developments of consumer pressure and scarce resources has stimulated general practitioners to examine anew the quality of services they provide. The Royal College of General Practitioners' recent policy statement[4] has set out the developments we believe are necessary to see progress towards better quality of practice. They include the need for general practitioners to say what services they intend to provide for their patients, to set specific objectives for their care, and to measure how far they are achieving them.

The move towards higher quality will inevitably mean an adjustment of the existing contract for NHS general practitioners which in some ways discourages quality improvement. We shall need to devise ways of rewarding those doctors who can demonstrate moves towards patient care of a high order and consumers may wish to contribute to that debate.

Education

These changes towards higher quality general practice will have major implications for medical education. Undergraduate education is already out of step to some extent with the health needs of the population and has proved somewhat resistant to signifi-

cant change. More rapid change is to be expected in the field of postgraduate education. Vocational training in general practice has been available for nearly a decade and a half and is now compulsory, but the period spent in the practice is too short. The College's policy statement[4] has highlighted the need for a period of higher training during the first two or three years as a junior principal equivalent to the hospital senior registrar period. By the end of the century we shall see higher training available in half-day release courses throughout the country. These courses will include clinical and operational management and performance review: subjects that are more useful to the principal and that are less relevant to trainees at their stage of learning.

The emphasis in continuing education will move from the postgraduate centre into the practice itself and become directly related to measurable outcomes of patient care. Clinical meetings of the primary health care team, taking place during normal working hours, will involve setting objectives for care, sometimes in association with specialists, and reviewing progress with the aid of the microcomputer.

Management

The key to many of the improvements in primary care lies in effective management. While most doctors are clear that certain things need doing, experience tells us that ensuring they get done is much more difficult. Examples include being reasonably accessible to patients, ensuring high immunization and cervical cytology levels, and making sure hypertensive and diabetic patients are well-monitored and well-controlled. The great advantage of the NHS system is the registered list of patients and this is just starting to be fully exploited.

Conclusion

How then will our changing general practice look by the year 2000? Its team of doctors and nurses with their practice manager will be actively planning their patient care, for higher remuneration will depend on demonstrating good results. Nearly all their patients requiring continuing supervision will receive their care solely in the practice where the local specialists will visit from time to time. Evidence of good long-term care and prevention will be reviewed regularly and the information passed at regular intervals to the district health authority and in a modified version to the local consumer group. The nursing section of the team will have increased proportionately to provide care for a significant number of elderly patients in their own homes.

General practice, as a major component of primary health care, will become the central pivot around which health services revolve because of its major role in preventive and anticipatory care, its relevance to the needs of the local population, and its new developments in management and technology. Although this is the logical route for health service development to follow this depends on general practitioners recognizing three things. Consumers have a right to expect a high standard of care from all general practitioners. Our colleagues in nursing and other related professions have a right to expect to be able to work closely and effectively with us. The health authorities have a right to know what we are doing so that our activities can be seen as part of health services as a whole in a more informed way than they are at present. It should be an exciting time.

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Warm to general practice, cool to Alma-Ata

I HAVE been asked to consider, on a purely personal basis, 'ways in which general practice can help to meet the aims of the World Health Organization declaration of Alma-Ata'; with the rider that the occasion would be 'a good opportunity to speculate on the future of general practice in the United Kingdom'. You can imagine the general dilemma in which this places a retired consultant whose experience of general practice, other than as a patient, is limited to a number of locums done soon after qualifying — an experience which, incidentally, I would recommend to any aspiring consultant who will find himself in the position of discussing patients with their family doctor. But within that dilemma, I have a specific difficulty, which perhaps I can describe best by indulging myself in a flash of tactless honesty. On the one hand, I know little in detail of the present state of general practice in this country, yet I believe its future to be firmly assured; on the other hand, knowing something of the evolution of the Alma-Ata statement, 'health for all by the year 2000', I can only regard it as coming somewhere between a slogan and a noble ideal, and not as a realistic picture of the state of the world in 2000 or any other year. The remainder of this article gives the grounds for my firm belief in the future of general practice in the UK, irrespective of the particular directions which it may take; and also for my scepticism (not, let me underline it, pessimism) on the practicality of the course purporting to be set by Alma-Ata.

General practice

I believe that the aims, and to a large extend the methods, of medical practice are broadly similar, whether it is carried out in hospital or in the community; and indeed the hospital is part of the community, and not part of outer space. What may be different are the conditions in which practice is carried out; but I regard these as peripheral to the essence of good medical practice. These beliefs form one part of the grounds on which I view the future of general practice with optimism; for not only are we getting better entrants to our medical schools, but more of them are opting for a career in general practice.

My second reason for optimism is the recognition among doctors in this country that specialist doctors should see patients only on referral from a general practitioner. This excellent principle is sometimes adduced by critics of our profession as evidence of medical protectiveness; this is a travesty, for it primarily protects the patient from falling into the hands of an inappropriate specialist, a category which could include the specialist who is willing, other than in an emergency, to see the patient who rings his front-door bell.

A third ground for optimism is the development which has taken place in family practice towards team-work, secretarial help, postgraduate training and increased contact with colleagues both in general and in specialist practice. The single-handed