Editor's Briefing

Two major themes run through many of the articles in this month's Journal — the need to sustain a skilled primary care workforce and the financial problems facing western countries in sustaining the quality and provision of health and social care, with evident interactions between the two.

There are recruitment and retention problems in general practice in the UK, other European countries, and in north America, where readily-identifiable factors, such as remuneration, combine with more subtle pressures, such as professional prestige, to deter graduates from entering a career in primary medical care. The trouble starts well before medical school. The political and societal images of medicine are largely hospital-centric, reinforced by media stereotypes. Governments have traditionally proclaimed their commitment to investments in health care by telling the electorate how many new hospitals they plan to open, rather than how many new GPs they plan to recruit, despite the rhetoric about primary-care led services. On page 628 Blythe and Hancock call for a national undergraduate curriculum for general practice in the UK, something that many other specialties have already put forward. This seems a very good way of embedding the role of primary care more firmly in the minds of teachers, as well as students, at an early stage, as well as ensuring that some of the basic skills of primary care, such as early detection of serious disease and safe prescribing, are firmly on the agenda. Blythe and Hancock don't go into detail about the timing of teaching on primary care or about the minimum time that students should spend in general practice placements: all these ideas deserve serious consideration if the expectations currently placed on general practice are to be fulfilled.

David Bird takes up the theme in relation to early postgraduate training, the UK's Foundation Programme, and sets out a cogent argument for trying harder to ensure that the original target of over one-half of junior doctors having a general practice placement is met. He cites improving clinical decision-making, learning about team work, and enhancing communication skills as three key areas in which general practice placements provide particularly good opportunities. Having Foundation doctors in the practice is also a stimulating experience for established practitioners.

Stephen Gillam has been looking at the Dilnot report on funding social care in the future, and regards the main thrust of the report, that both individuals and the state will need to pay more in the future, but with some protection of personal assets, as an advance. Limiting an individual's contribution to their long-term care to somewhere between £25 and £50K, and raising the asset threshold above which no means-tested help would be given, will cost the government approaching £4 billion annually by 2025. Gillam is understandably uncertain about the likely impact of changes of this kind on GPs in their commissioning role, but can see how a more standardised and less uncertain mechanism to support social care in old age could improve planning for chronic disease management and end-of-life care.

In this challenging political and fiscal climate, it is important not to lose sight of the quality agenda. In contrast to the tone of the King's Fund report reviewed by Nigel Mathers and Helen Lester, general practice in the UK has taken a lead role in paying attention to quality. Variations in quality of care are found across the whole of medicine, and failures of care in hospital settings and the ubiquity of patient safety problems in in-patient care remain at least as problematic as variations in the quality of care among general practices. The King's Fund report is valuable in emphasising the importance of continuing to measure performance, to improve care standards, and to provide transparent reporting of process and outcome measures, principles that need to be embraced as central to the commissioning of all services in the future.

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DOI: 10.3399/bjgp11X601208

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PUBLISHED BY
The Royal College of General Practitioners,
1 Bow Churchyard, London, EC4M 9DQ.
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ISSN 0960-1643 (Print) ISSN 1478-5242 (Online)

PRINTED IN GREAT BRITAIN BY
HPM Limited, Prime House, Park 2000, Heighington Lane Business Park, Newton Aycliffe, Co. Durham DL5 6AR.

Printed on Carbon Balanced paper

WORLD LAND TRUST™
www.carbonbalancedpaper.com
CBP0004840504111835