Editorials

Time to put patients first by investing in general practice

General practice is the cornerstone of the NHS, dealing with 90% of all patient contacts in our health services and helping to ensure the delivery of safe, effective patient care.[1] Yet in recent years concerns have been mounting that a number of pressures facing GP surgeries are pushing UK general practice to breaking point.

GENERAL PRACTICE UNDER PRESSURE

A central part of the problem is that practice workloads have been rising relentlessly for some time. NHS England estimates that surgeries in England dealt with 340 million consultations in 2011 to 2012, up from around 300 million in 2008 (the last year for which the most robust data is available).[2] Anecdotal evidence, and the findings of a poll commissioned by the Royal College of General Practitioners (RCGP) in 2013, suggest that most GPs are now dealing with a workload of 40–60 patient contacts every day.[3]

Despite this growth in demand, general practice has suffered from a chronic lack of investment over the past decade, with its share of UK NHS spending now standing at a record low of 8.39%. In 2011 to 2012 around £8.7 billion was spent on general practice in Britain (including both local and national contracts, but excluding prescription costs): almost three-quarters of a billion pounds less, in real terms, than in 2005 to 2006. This represents an 8% drop at a time when the overall NHS budget in Britain has increased in real terms by 18%. General practice in Northern Ireland (for which comparable data is unavailable) has seen its funding share drop for 3 consecutive years down from 8.22% of Northern Ireland health spending in 2010 to 2011 to 7.96% in 2012 to 2013. In real terms, funding for general practice services across the UK has fallen for 3 consecutive years from 2011 to 2013.[4]

For some reason, when decisions are made about where investment in the NHS should be directed, general practice and the patients who rely on it are missing out.

Alongside this, serious questions have been raised about the current and future capacity of the general practice workforce. Worryingly, the headcount number of GPs (including registrars) in England actually fell in the year up to September 2013. Although the number of full-time equivalent (FTE) GPs has been slowly rising, rates of recruitment are lower compared to many other specialties. In the decade between 2003 and 2013, in FTE terms the number of GPs rose by 4451, but over the same period the number of hospital doctors increased by 12 673 (both excluding registrars).[5] Furthermore, the general practice workforce is unevenly spread across the country, with the fewest doctors in the most deprived areas, exacerbating health inequalities.[6]

> *"...general practice has suffered from a chronic lack of investment over the past decade, with its share of UK NHS spending now standing at a record low of 8.39%."*

CRISIS OR OPPORTUNITY?

If some of this makes for grim reading, it's worth reminding ourselves that this crisis comes at a time when the skills of the expert medical generalist are more important to the delivery of safe and effective care than ever before.

Demographic change has undoubtedly been a key factor in rising demand, and the two age groups that are expanding the fastest, that is children and the over 75s, are those that have the most to benefit from the continuity of care that we know a well-resourced general practice can provide.[7]

Closely linked to this is what is probably the single biggest challenge facing the NHS in the coming years: the dramatic increase in the number of people living with multiple morbidities. Those living with more than one long-term condition are expected to rise from 1.9 million in 2008 to 2.9 million by 2018.[8] A 2011 study indicates that these patients account for around 78% of consultations in general practice.[9] There is also evidence that around 65% of those aged >65 years are living with multiple morbidity, and that its prevalence increases with deprivation; with people in deprived areas having the same prevalence of multiple morbidity as more affluent patients who are 10–15 years older. In particular, physical and mental health comorbidity has been shown to be almost twice as common in the most deprived than in the most affluent areas.[10] What is clear is that for the NHS to have a realistic chance of tackling this challenge, a shift of focus will be needed, away from treating single diseases in isolation and towards the whole person care that GPs provide.

Alongside this, a consensus has been growing for some time that many patients can and should be much more effectively cared for in the community rather than in hospitals. This makes good sense not only from a clinical and practical point of view, but also in terms of the financial sustainability of the NHS as a whole, given that a single episode of care in hospital can potentially cost as much as a year of care in general practice.

ANOTHER WAY — INVESTING IN THE FUTURE OF PATIENT CARE

If given more time to plan care with patients, particularly the vulnerable older group, GPs could help refocus the NHS on providing more personalised care that takes into account the patients' family, work, and home life, achieving a shift towards preventing ill health in the community rather than treating it in hospital.

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"... the agenda could be about to swing towards promoting an old but still powerful concept: the GP– patient relationship."

Increased resources would give practices greater scope to provide more flexible opening hours for those patients who consider this a priority. The RCGP has raised concerns about the impact of poor access to general practice on patient safety, with data from the GP Patient Survey suggesting that people are having to wait more than a week for an appointment on as many as 27 million occasions every year.[11] Investing in new technologies would also help practices to pioneer greater patient access to health records, consultations, and treatments remotely.

Much of this is already happening and there is growing evidence that investing in general practice leads to improvements in patient care.[12]

Despite being under huge pressure in recent years GPs have still managed to lead the way in terms of developing new models of delivering primary care. Federations of practices, in particular, have been identified as a model that can drive the delivery of more joined-up primary care at scale.[13] GPs are also well positioned to lead the creation of multidisciplinary teams, working with colleagues across primary, secondary, mental, and social care. With more time and resources to dedicate to leadership and service development general practice could accelerate these initiatives.

SIGNS OF PROGRESS, BUT A LONG WAY TO GO

In England, the government's recent *Transforming Primary Care* initiative,[14] demonstrates that the agenda could be about to swing towards promoting an old but still powerful concept: the GP–patient relationship. The £250 million announced by NHS England to support the development of new personalised services for vulnerable older people as part of this is a starting point from which we can build.

However, much more will be needed. It has been estimated that if action isn't taken, general practice's share of the UK health spending will slump to 7.29% by 2017, and that to simply stand still funding will need to increase to at least 9% of current UK NHS spending.[15] However, to enable general practice to really transform patient care in the ways described above, the RCGP has estimated that an investment of 11% of the NHS budget across the UK will be needed by 2017, including a significant workforce boost.[6] The alternative, that is continued disinvestment in general practice, simply isn't an option if we want to put patients first.

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Provenance
Commissioned; not externally peer reviewed.

DOI: 10.3399/bjgp14X679921

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Editorials

The future of general practice in China:

from 'barefoot doctors' to GPs?

'BAREFOOT DOCTORS'

The concept of the 'barefoot doctor' was developed as part of China's infamous Cultural Revolution: an estimated 1 million agricultural workers were trained to meet rural health needs for sanitation, health education, first aid, and primary care.[1] They received little formal instruction and received mainly 'on the job' training. Similar programmes were established to create 'worker doctors' in factories and 'Red Guard doctors' who were housewives serving as physicians' assistants in urban health stations. The 'barefoot doctors' made significant contributions to infectious disease control as well as the expansion of primary care in rural China with infant mortality rates falling dramatically between 1950 and 1982.[2]

In 2009 China announced a comprehensive 3-year Health Care Reform programme with the primary aim of ensuring universal access to health care for the whole population of 1.3 billion.[3] There are a number of components to this programme, which include better primary care (especially in rural areas) and universal access to health insurance. The central government has invested part of the allocated 850 billion Yuan (approximately £85 billion) to fund the development of rural health care so that every village will have a clinic and thousands of community level clinics will be either built or upgraded in urban areas. This programme has been followed by a capacity-building plan to address the serious shortage of GPs available to deliver community based care: China intends to train an additional 300 000 GPs by 2020.[4]

NON-COMMUNICABLE DISEASES

'Barefoot doctors' were created to deal primarily with the challenge of infectious disease in rural areas; the new GPs, however, will need to address the growing problem of non-communicable diseases (NCDs) in both urban and rural areas and will require far more training than 'barefoot doctors'. The future role envisaged for community services in China is not dissimilar to that of general practice in the UK with community-based responsibility for prevention, primary (first contact) care, and health education.[5]

However, the current healthcare system is not organised to address the treatment and management of the main causes of chronic disease in China — cardiovascular disease, chronic obstructive pulmonary disease, diabetes mellitus, and lung cancer — despite the expectation that the frequency of these four conditions will 'double or even triple' over the next two decades in people >40 years of age if effective preventative measures are not taken.[6] For example, the current rate of smoking among Chinese men is approximately 54% and the average intake of salt is >12g per day (twice the current World Health Organization recommendation).

> *"Chinese people tend to seek high-level care even for minor self-limiting conditions."*

Around 90% of the Chinese population now have some form of medical insurance, mostly as part of the government supported New Cooperative Medical System that operates at a local (county) level. Premiums vary widely across the country depending on local mean income but they are generally fixed at an affordable level.[7]

Another problem is that Chinese people tend to seek high-level care even for minor, self-limiting conditions.[8] Since they do not currently need to get a referral from primary care, patients present at secondary and tertiary facilities with often unrealistic expectations and when treatment fails doctors are deemed responsible, leading increasingly to violent confrontation.[7]

GENERAL PRACTICE IN CHINA

The typical GP set-up in China is a community health centre with six or seven sub-clinics employing 50 GPs and 50 nurses. However, the precise role of the GP within the new system of health care remains to be defined and despite this enormous investment, serious problems remain in access to treatment, quality of care, and costs of health care to people in poorer areas.[9] Patients prefer to attend hospitals since primary care doctors are less qualified than their hospital colleagues. For example, in 2008, the number of outpatient visits per hospital bed was 1048 in China compared to 313 in England.[10]

A huge amount of progress has been made developing general practice in China and a number of successful diverse models of 'general practice' have been used to pilot current policy in different parts of the country. It is clear from the experience of 50 pilot sites that multidisciplinary teams delivering health care in the community are an essential component of all the models that have been developed. However, the attractiveness of general practice to doctors needs to be improved. At the moment the incentives to become a GP are poor and it is essential that new GPs can be offered:

- a guaranteed income (provided by the government or the market linked to the pricing of medical services); and
- improved career prospects and status with opportunities for promotion, continuing professional development, and for academic research and teaching.

GENERAL PRACTICE DEVELOPMENT

Policy guarantees need to be in place because they are not yet fixed and young doctors will be reluctant to commit themselves to a career if there is no guarantee that the policy of developing general practice will continue following the end of the current reforms.

There is also currently a huge lack of qualified trainers and it is essential to develop community-based clinical training

> *"Multidisciplinary teams ... are an essential component of all the models that have been developed."*

"It will probably take at least one generation for people ... to appreciate the importance of community care."

centres ('teaching practices') as well as university academic departments so that medical students can see general practice as an attractive high status career. In addition, the research that such departments should undertake should be initially focused on the development of Chinese Quality Indicators for General Practice and their implementation (namely, the QOF).

Finally, an 'attractive offer' has to be made to potential patients for them to register with an individual GP team and linked to this is the importance of high-quality medical records that could be kept by the patient and brought to each consultation (such as child health records in the UK). Linked to this is the importance of developing a single standard for IT systems.

It will probably take at least one generation for people in the community to appreciate the importance of community care, develop trust in a registered GP (in terms of treatment and referral), and to value the role of the 'expert generalist'.

In summary, a fundamental challenge for the China Health Care Reform is to increase the use of primary care, which is affordable and appropriate for most conditions. Early reports suggest a small shift in flows away from secondary and tertiary facilities,[11] but the solution may have to be more radical, with general practice being given a gatekeeping role:

'Who cares if a cat is black or white, as long as it catches mice!' (Deng Xiaoping, 1961).

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Provenance
Commissioned; not externally peer reviewed.

DOI: 10.3399/bjgp14X679933

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Editorials

Boost or burden?

Issues posed by short placements in resource-poor settings

BACKGROUND

An estimated 40% of medical students seek out experiences working in resource-poor settings during their training and significant numbers also contribute after graduation.[1] It is argued that this benefits their hosts and, some believe, the UK too.[2,3] In this issue Elnawawy *et al* report on the complex issues identified through qualitative study of one such voluntary primary care scheme in Nepal.[4] Despite a small number of respondents from a single non-governmental organisation in one country, these interviews highlight a number of important issues that chime strongly with our experiences, including the risk of significant unanticipated negative impacts. We argue that elective students, doctors seeking out-of-programme experiences, and experienced GPs should be encouraged to deeply consider what they are hoping to achieve, and how they can ensure their contributions are positive, both for themselves and their hosts. 'Donor' organisations facilitating placements (including medical schools and deaneries) should also plan, prepare volunteers, and carefully consider contextual issues as part of their responsibility.

Elnawawy *et al* offer few specific solutions, so in this editorial we seek to increase awareness among medics wanting to work in resource-poor settings and argue for more considered models. Collectively we have witnessed highly-effective, positive outcomes as well as poorly conceived and misguided visits. We discuss some of these and conclude that there should be more organised 'fair trade' type opportunities, perhaps including a 'kite-mark' system to improve standards or to be in line with the efforts of the Tropical Health and Education Trust (http://www.thet.org).

CLINICAL

Elective hosts report that even senior students can make a welcome contribution to clinical service delivery provided they stay for 6 weeks or more in one area, can be supervised adequately, and communicate without utilising key staff time. Postgraduate placements can more obviously contribute to service delivery, but still require effective engagement with service providers or risk negative consequences. For example, naïve or overly enthusiastic attempts to help can disrupt existing systems, waste scarce resources, and even compromise services. In particular, ill-conceived short-term surgical missions have been seen to exhaust sterile supplies and leave wards overflowing to such an extent that emergency capacity is depleted. However, other examples with close local collaboration have shown positive effects. In Sierra Leone there is no reconstructive surgery but huge post war demand. A UK charity, ReSurge Africa trains and educates Sierra Leonean staff aiming to develop a self-sustaining reconstructive service. The commitment involves surgical/training missions and overseas education. We are also aware that a number of doctors make annual visits of 4–6 weeks to Malawi. Knowing the host site, volunteers can settle swiftly and their contribution will typically be used to free up local staff to pursue other initiatives. Such arrangements require close collaboration plus intermittent local oversight, so continuity of care is maintained.

> *"Coping with uncertainty is core to the experience but sound preparation reaps rewards."*

EDUCATIONAL

Most returnees are clear that they have personally learned far more than they left behind, but appropriately delivered education or staff training has a potential impact beyond direct care and elective students can help here too. Unexpected learning in both directions is common and attitudinal or professional behaviour, the 'how' rather than the 'what is done', can be very powerful. For instance sharing differences in working practices, such as 'named clinician' boards, and students can be buddied with local clinical officers or nursing students, who translate and facilitate patient interactions while learning examination skills in exchange.

It is difficult to deliver training in a poorly-resourced environment and postgraduates will often find themselves teaching informally 'on the job'. Support for local tutors cannot be underestimated and adequate preparation in the challenges of education may be important too. For example PowerPoint® is obsolete without reliable power or a projector. Students have limited access to textbooks or other resources and learning is often very 'traditional'. College lecturers in Sierra Leone dictate while students copy and classes of over 100 bring challenges; creativity, flexibility, and passion are necessary attributes for a volunteer. Adapting teaching methods is a necessary skill but preparing and gathering resources in advance can help; role play or 'skit' can depict clinical scenarios very effectively.

In Malawi one unit holds weekly educational meetings for all clinical and nursing staff to which visiting doctors are invited to give short presentations, which can be very valuable. The sessions aim to improve knowledge and skills as well as sharing experiences and can help take some pressure off senior local staff. But it must be a relevant topic at a suitable level.

ETHICS

Ethical issues in resource-poor clinical settings can be very difficult and all volunteers can expect to meet considerable

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"'Donor' organisations facilitating placements (including medical schools and deaneries) should also plan, prepare volunteers, and carefully consider contextual issues as part of their responsibility."

challenges.[5] However, if cultural sensitivity has any credence it is surely that societies are entitled to create their own customs and practice. So expecting to work within local norms is essential. Challenges might include sex bias, and women can find it more difficult to contribute their views equally. Corruption can also be the norm; students might bribe lecturers, patients might expect to do the same as standard. This may drive the local health care economy and if, when, and how a visitor challenges these is a delicate matter. Leading by example with consistency and perseverance can be successful ways to improve practice but dealing with issues such as these practically and emotionally requires preparation and self-awareness. Coping with uncertainty is core to the experience but sound preparation reaps rewards. Appropriate clinical competences should be considered and in place.[6]

Resources are also a major problem for hospitals and will always be a potential ethical issue, 'transaction costs', using up the sterile gloves or even arriving bearing gifts can create issues. Communication between the volunteers (or organisers) and the host partner is vital; misinterpretations can leave lasting bad feeling affecting other volunteers and placements. Even donations of expired drugs or outdated medical books may be well intended but can be unhelpful, cause offense or even harm.[5,6]

CONCLUSION

Host units generally appreciate and value visits from western staff and students, otherwise they would not accept them. However they can clearly be a mixed blessing and factors such as associated funding, the hope that some will eventually return to work there in the future, or even an element of moral support for isolated ex-patriot staff may be at play. Sending organisations have a responsibility to formulate goals for both hosts and volunteers, aid preparation, provide support, and measure the outcomes, both good and bad.

So, if interested, how might you try to ensure that you support or choose more responsible placements? We suggest you:

- try to choose an organised placement through known frameworks rather than 'do-it-yourself' (see http://www.thet.org);
- the longer the placement the better;
- consider your objectives and motives thoroughly and prepare well (for example, take time to speak to previous volunteers and learn about the placement);
- remember the placement should not primarily be about you, show respect and cultural sensitivity by fitting in; and
- approach the placement with a sense of humility, you may discover better ways of doing things, even with limited resources.

Overall the majority of volunteer placements are highly positive for the individual concerned, and welcomed by host sites. The bottom line here is whether you become more of a boost or a burden ... and that is largely within your control.

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Provenance
Commissioned; not externally peer reviewed.

DOI: 10.3399/bjgp14X679945

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Editorials

RCCP Continuity of Care Toolkit:

promoting relational continuity

The Royal College of General Practitioners (RCGP) has recently released the Continuity of Care Toolkit[1] that gives practical advice about how to diagnose and protect the capacity of patients and practitioners to 'retain contact with each other' (a nice succinct definition of relational continuity). The toolkit recommends an initial diagnosis of the state of continuity of care in the practice as a trigger for conversations about what specific actions can be taken to safeguard continuity of care. Starting this conversation has just become easier with the availability of a Continuity Calculator,[2] which helps practitioners generate the needed continuity statistics for the practice.

The toolkit is a welcome response to more than a decade of policy initiatives focusing almost exclusively on improving dimensions of continuity of care that relate to coordinated and consistent management of diseases and facilitated information flow between providers. The need to organise and coordinate care in a way that preserves and promotes relational continuity has not been on the policy radar. From across the Atlantic, we applaud the College's publication of the toolkit and affirm that its relevance extends well beyond the College's UK membership.

RELATIONSHIP-CENTRED CARE

However, before applying the toolkit to facilitate continuity, it is helpful to remember that continuity is one path towards something more meaningful: relationship-centred care. Relationships are the antidote to an increasingly fragmented and depersonalised healthcare system.[3] It is easy to forget to value them in a healthcare environment that pays for performance in delivering commodities of care. That same healthcare environment assumes that primary care clinicians take long-term responsibility for patients, but may be subtly devaluing the relationship by focusing on disease care, convenience, and short-term cost reduction over long-term value. It is precisely in this context of a growing need for a relationship, that the RCGP toolkit emerges.

Ian McWhinney observed that:

'Continuity of care in family practice cannot be adequately described merely in terms of duration ... but involves the family physician's ongoing commitment to the patient and his family as persons.'[4]

> *"The need to organise and coordinate care in a way that preserves and promotes relational continuity has not been on the policy radar."*

VALUING THE RELATIONSHIP

One empirical study found that the degree to which patients value a continuity relationship with their family physician is indeed predicted by the duration of the relationship.[5] But as McWhinney intuited, longitudinality of contact is not the only path. This same study found that patients' commitment to the relationship also was strongly related to the degree to which they could endorse the statement *'this physician and I have been through a lot together.'*[5] Implied in this is the idea not only of being together for a long time, but being together during key life events: the kind of togetherness that helps to build shared understanding and meaning; that builds trust and a sense of being understood, even when words are not shared. Patients who both have been through a lot with their physician and who have been together for a long time are extraordinarily committed to the relationship.[5]

The RCGP Continuity of Care Toolkit begins by stating that the evidence shows the benefits of continuity for patients and for a high value healthcare system. More subtly stated, but equally important, is that continuity of care matters to the primary care physician. Continuity helps GPs to do their job better and be more confident in managing clinical uncertainty. Although relationships can be a source of consternation (for example, continuity with the heartsink patient),[6] the ability to be a part of people's lives over time also provides a great source of meaning for the GP and contributes to their professional satisfaction.[7]

INVESTING IN THE RELATIONSHIP

The toolkit recognises the challenge of retaining practitioner–patient contact in the context of limited practitioner availability or the imposed constraints of an advanced access system. It alludes to another, often neglected, part of relational continuity: the extension of relationships with trusted colleagues to patients. By defining smaller teams within large practices or having a buddy system with colleagues, physicians can still give patients the security of a relationship even with constrained availability. The toolkit could emphasise more, however, the importance of making this arrangement explicit, thus surrendering the buddy relationship visible to the patient[8] and to recognising that it can be more challenging to extend the therapeutic relationship to a professional in another discipline, who provides complementary care that is outside the purview of the GP. When patients are out of contact for extended periods, for whatever reason, practitioners can initiate a special visit to reconnect and renew continuity.

Continuity is an investment by both the GP and the patient. Investments in primary care relationships, just like investments in the bank, pay dividends over time. Investment in continuity provides a relationship bank account in which interest accrues from

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both large deposits and from many small deposits over time. And when the chips are down — when a new diagnosis, or a family crisis, or infirmity makes patients long to be known as a person — the relationship account yields great rewards during these times of greatest need. It is this relationship asset for which the RCGP Continuity of Care Toolkit provides the investment manual.

Setting up the opportunity for this dividend sometimes requires short-term sacrifices. In health care this often has involved the patient waiting for care or accepting a less than convenient appointment. The RCGP toolkit provides ways to diagnose these tradeoffs from both the patient and the practice point of view, and to prescribe treatment, sometimes using new communication technologies, sometimes organising systems differently.

Continuity provides a foundation for moving to higher levels of care:[9] for building on the provision of basic care of individual diseases, mental health, prevention, and family care, towards care that is integrated across multiple domains, and personalised and prioritised based on what Iona Heath calls *'balancing the biographical and the biotechnical'*,[9] and what Ian McWhinney calls *'an acquaintance with the particulars.'*[10] Investment in the continuity relationship over time and key events results in a relationship that is healing, but that also involves abiding — sticking it out together even when healing is not forthcoming — that is a source of meaning in the end.[11]

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Provenance
Commissioned; not externally peer reviewed.

DOI: 10.3399/bjgp14X679957

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