Editorials

What sort of practice in 2040?

It would be foolish to predict the shape of health care in 20 years' time, but a greater folly not to ask what sort of health system we would like to see, thereby shaping the future and facing up to some difficult questions along the way. We can no longer rely on short-term fixes and the tides of party politics. If major surgery is needed, cosmetic adjustments will not do. We need to envision a system of healthcare firmly founded on the values of equity, inclusion, social justice, and compassion. Graham Watt's powerful accompanying editorial on the shameful persistence of Julian Tudor Hart's inverse care law pulls no punches on this, and warns of a potential nightmare scenario — 'the social horror of market forces determining the future of the NHS'.

"Any new vision of health care must command the support of doctors, nurses and other health professionals, patients, politicians, and funding agencies, and describe a future in which the medical and clinical workforce has reclaimed its morale and professional pride."

THE NHS

The NHS is still capable of delivering superb care. There is excellent general practice and marvellous hospital care. Thousands of hard-working, resourceful, and committed people are still prepared to go the extra mile. However there are deep systemic problems. Quality is uneven, funding inadequate, recruitment and retention rates dangerously low, morale in some sectors is in tatters, and, on a number of metrics, patient outcomes and health indicators fall below those of our European neighbours. The status quo is not an option and there is danger in regarding recent funding commitments made by the Prime Minister as the solution to a problem which requires radical, structural reform. Any new vision of health care must command the support of doctors, nurses and other health professionals, patients, politicians, and funding agencies, and describe a future in which the medical and clinical workforce has reclaimed its morale and professional pride. It must be realistic and achievable, and will need to capture the imagination of medical professionals across the workforce and at all stages of their careers.

GENERAL PRACTICE

What does this mean for the future of general practice? General practice needs to begin with a reality check. Is a system of primary medical care essential in 21st century healthcare? Are last century's principles of general practice fit for this one? Which models of general practice are most likely to meet future needs, and which should be abandoned? Are the right people doing the right jobs, and is teaching and training capable of producing the workforce that will be needed in 20 years' time? Why have we been so slow to use the communication tools and technologies that are taken for granted in almost every other walk of life?

IS PRIMARY CARE ESSENTIAL?

This was the question that Barbara Starfield asked 30 years ago and her analysis of a limited number of countries with recognisable primary care systems produced a definite 'yes'.[1] The analysis would bear repetition. Some countries without effective gatekeeping systems and direct access to specialists have excellent health outcomes, and there have been concerns about delays in diagnosis and access to investigations in countries with strong gatekeeping. The picture is further complicated by variations in how long patients must wait to see a GP, and how long they then need to wait for attention in secondary care.

COMPREHENSIVE, CONTINUOUS, COORDINATING?

Is this mantra of general practice care the right basis for service redesign? Any system of first-contact (primary) care has to offer access for any health problem, but whether this requirement is best served by making an appointment and waiting to see a highly-trained GP in a possibly distant physical location is another matter. Continuity of care is highly appreciated and does appear to have significant health benefits for patients with chronic diseases,[2] but for others episodic care may be at least as appropriate, as long as there is informational continuity, including smooth data exchange across the primary–secondary care interface. As comorbidity and polypharmacy become the norm, coordination of care from multiple providers is of the highest importance in optimising outcomes and protecting patient safety.

THE PRACTICE

In planning the future of general practice it is critical that principles of equity, access, quality, and justice are embedded in the process, to defuse lingering controversies about practice size, and resolve the financial and structural debates relating to partnerships, estates and premises, indemnity, and funding. Patients must be assured of timely access to the services they need and if this is not possible at a particular location, informal collaboration, more formal networking or other arrangements must be in place across clinical and administrative domains of practice to achieve it. The review of the Quality and Outcomes Framework contains proposals that could incentivise cross-practice working for patient benefit.[3] The potential benefits in terms of staffing patterns, recruiting, rotas, providing teaching and training facilities, and shared infrastructure are self-evident.

THE EXPERT GENERALIST

Over 40 years ago John Fry wrote that a GP should '*recognise that he is but a member of a team within the community and must learn how best to work together with his generalist and specialist colleagues in the medical, nursing, social and other health fields*'.[4] Plus ça change ... yet everything has changed, and we are casting about for a role description that will make the job attractive and fulfilling again.

An attractive alternative model of primary care, the Roundhouse,[5] may contain some clues. In this concept GPs are consultant primary care physicians (CPCPs) — expert generalists — and support a team that includes physician associates and advanced clinical practitioners, (who could be the first ports of call for many consulting patients), working with community pharmacists, occupational therapists, physiotherapists, nurses, counsellors, paramedics, and social

"Politicians, the Royal Colleges, the universities, the BMA, and the NHS will need to put aside their concerns about control and territory, and recognise that they too need to work together to resuscitate the health system."

workers. The CPCPs would not be directly involved in routine clinical and administrative tasks, but would lead the complex team, taking overarching responsibility and supporting consultations taking place in the building, at home, and by telephone or email. They would be available to the resident pharmacists, nurses, and others, and have protected time to develop and disseminate clinical guidance and new ideas for the practice. Depending on location, practices like this could stand alone or be linked into networks or incorporated into superpractices. Add undergraduates, foundation doctors, trainees in medicine and other disciplines, and other primary care professionals to the mix, and it isn't difficult to see how a proper career structure for GPs could be developed.

Professional bodies can become locked into traditional thinking that gets in the way of innovation, and the very slow progress towards genuine interdisciplinary care is an example of this. I hope very much that we are seeing signs of change. The recent RCGP assessment of progress with the GP Forward View[6] is guarded in terms of achievement, but strong on some important recommendations for future work. Expanding the multidisciplinary primary care team and the development of new professional roles must, however, be seen as a means of providing better patient care through genuine collaboration, not merely 'freeing up GP time'.

TECHNOLOGY

Technology has the capacity to enhance clinical care, patient management, and practice administration now, and to transform practice in the future. Online, email, and telephone access, with a clear menu to enable patients to navigate the website/system easily, is provided by many practices. Decision aids, reminders, and diagnostic prompts derived from the data held in the electronic patient record, and artificial intelligence applications in clinical computer software can be used during and after the consultation. Systematic safety netting for low risk but not no risk cancer symptoms, for example, or 'assertive outreach' to track medication adherence. Machine learning techniques can be used to identify groups at risk by virtue of age, frailty, dementia, or multimorbidity. The management of chronic illness, with an emphasis on partnership with patients, offers huge opportunities for IT-supported monitoring and follow-up. Problems at the interface between medical and social care can potentially be ameliorated by smart sensors, wearables, telemedicine, and other monitoring technologies. Telemedicine can also greatly facilitate interprofessional communication. Recent commercial initiatives to provide almost instantaneous access to a real or robotic GP have stalled because of the implications for general practice funding. This is a controversial area, where it is important to distinguish an insistence on evaluative evidence from professional protectionism.

IN THE FUTURE ...

The NHS still exists and has absorbed examples of effective practice from home and abroad. Propelled by better funding from hypothecated taxation and increased contributions from affluent older citizens, practices have redesigned their clinical staffing structures and rethought their professional roles. They now have sophisticated clinical and administrative systems, and share with, learn from, and enjoy economies of scale and centralisation of back office functions with other networked practices. Hi-tech entrepreneurs have become the allies of, not competitors with, the NHS. Highly intelligent machines work in synchrony with medics, nurses, physician assistants, and therapists to ensure accurate diagnosis, appropriate and personalised treatments, reliable chronic disease management, and a high level of patient safety. Patients are much better informed of what practice teams provide and how to make the best use of virtual and real life contact with them. Medical, nursing and allied health professional students, coming into 'Roundhouse' style practices, see general practice as a fulfilling profession taking place in well-designed modern spaces with strong interprofessional support, and this influences their career choices. Many medical schools have shifted their focus from biomedical research to the training of a range of health professionals, for which they have been financially incentivised. GPs in training can see that they have a rewarding and structured career ahead of them on the journey to becoming expert generalists — consultants in primary care — and to lead increasingly large groupings of staff and practices.

Politicians, the Royal Colleges, the universities, the BMA, and the NHS will need to put aside their concerns about control and territory and recognise that they too need to work together to resuscitate the health system. The tragedy of Brexit has been a huge distraction and the new Health Secretary needs to ensure that a major review of the NHS, as well as technological fixes, is kept firmly on the agenda.

ADDRESS FOR CORRESPONDENCE

Roger Jones
Editor, *BJGP*, Royal College of Practitioners, 30 Euston Square, London NW1 2FB, UK.
Email: roger.jones@kcl.ac.uk

Roger Jones,
BJGP Editor, London.

Provenance
Commissioned; not externally peer reviewed.

Competing interests
The author has declared no competing interests.

DOI: https://doi.org/10.3399/bjgp18X699857

REFERENCES

1. Starfield, B. Is Primary-Care Essential? *Lancet* 1994; **344(8930):** 1129–1133.
2. Pereira Gray DJ, Sidaway-Lee K, White E, *et al.* Continuity of care with doctors—a matter of life and death? A systematic review of continuity of care and mortality. *BMJ Open* 2018; DOI:10.1136/ bmjopen-2017-021161.
3. Report of the Review of the Quality and Outcomes Framework in England https://www.england.nhs.uk/publication/report-of-the-review-of-the-quality-and-outcomes-framework-in-england/ (accessed 2 Nov 2018).
4. Fry J. (ed) *Trends in General Practice.* London: Royal College of General Practitioners, 1977.
5. Lewis DM, Naidoo C, Perry J, Watkins J. The Roundhouse: an alternative model for primary care. *Br J Gen Pract* 2016; DOI: https://doi.org/10.3399/bjgp16X685129.
6. Royal College of General Practitioners. General Practice Five Year Forward View Annual Assessment Year 2. 2018. http://www.rcgp.org.uk/policy/general-practice-forward-view.aspx (accessed 5 Nov 2018).