

A typical afternoon surgery. A middle-aged woman with chronic back pain who has seen numerous doctors already. A child with a lump in the neck, which might be insignificant but could be life changing. A man with multimorbidity for review after a hospital admission. He takes 15 regular medications, sees three different specialists, but no one is sure why he keeps collapsing.

These are not simple problems. Many patients bring a list of problems to the consultation¹ and many consultations involve multiple long-term conditions, or multimorbidity.² Half of the population aged over 65 have multimorbidity, with poor general health and quality of life, poor mental health, and reduced life expectancy.³ Over the next 20 years the number of people with four or more chronic conditions is going to more than double, and more than two-thirds of these patients will have dementia or mental health problems.⁴ People with multimorbidity have high health needs and should be the top priority for the health service.

WHAT KIND OF CARE DO PEOPLE WITH MULTIMORBIDITY NEED?

Like everyone else, they not only need treatment for simple illnesses, but also need well-organised chronic disease management. National Voices found that patients want the people caring for them to know them as a person, know about all of their relevant conditions, and have knowledge of local support services.⁵ They want a single trusted point of liaison for advice and to help them coordinate the help they need.

General practice is a system that, when it works well, can do all of these things because it is local and accessible, generalist, and comprehensive. If you have got multimorbidity, you do not have to go to a different clinic for each condition. General practice is person centred, not disease centred, and builds trust through repeated contacts over time. It is the route to almost all other services, which increases the efficiency of the whole system. GPs have a responsibility for a defined local population, including the housebound, people with learning difficulties, and people who don't look after themselves. Thanks to their registered list of patients, GPs can proactively arrange care for people who need it.

The GP Forward View captured the essence of general practice very succinctly:⁶

'The GP is an expert medical generalist and must be properly valued as the provider of holistic, person-centred care for undifferentiated illness, across time within a continuous relationship.'

Most GPs would agree with this definition, but the current reality does not support the rhetoric. Many GPs do not feel valued, and increasingly patients do not experience person-centred care within a continuous relationship with their GP. Patients report long delays to contact a GP and continuity of care is declining rapidly,^{7,8} while satisfaction with general practice is also dropping.⁹

The backdrop to this story is a 16% increase in GP workload between 2007 and 2014,¹⁰ accompanied by a fall in investment in general practice. GPs are retiring early, and fewer young doctors are willing to replace them, increasing stress on those who remain.

CONCEPTUAL FAILURE OR IMPLEMENTATION FAILURE?

So, what's going wrong? Is the idealised model of personal generalist care no longer sustainable? When I research new interventions and they do not work out as expected, I ask the question of whether it was conceptual failure or implementation failure. The problem in general practice is implementation failure — we haven't been able to deliver on our principles. But some recent policy initiatives imply conceptual failure and suggest that a different model is needed.

Since the QOF we've standardised disease management using protocols and care pathways, and computerised checklists, and treated people as commodities. Generalism has been weakened by segmented services in primary care, while a single point of contact and continuity of care have been undermined by alternative services, such as walk-in centres and primary care access hubs. The GP Forward View's description of the role of GPs seems inconsistent with a policy to encourage electronic consultations with different, unknown doctors.

PROBLEMS WITH SEEKING A DIFFERENT CONCEPT

Innovations that fail to recognise the fundamental principles of general practice lead to several problems. They are often not based on evidence of benefit, and pay

insufficient attention to the potential for unintended consequences. For example, e-consultations are at least as likely to increase GP workload as to reduce it.^{11,12} They disregard opportunity cost. Many alternative models of care intended to relieve pressure on general practice are considerably more expensive. A walk-in centre¹³ or a GP access hub consultation¹⁴ costs half as much again as a consultation in general practice. It is like going out to dinner at an expensive restaurant to save on your supermarket bill. Some of these innovations have failed to account for supply-induced demand.¹⁵ People change their expectations and behaviour according to the options available.

Segmenting care into different models or services for each disease leads to patients with multimorbidity having different clinicians for each of their problems, duplication of effort, and gaps in care. Skill mix in general practice needs to be managed carefully to ensure that it supports rather than undermines generalist patient-centred care.

The problem with many of these initiatives is that they are based on the misunderstanding that most consultations in general practice are for simple transactions and well-defined problems that can be managed by staff with limited training or by a computer algorithm. They are not — complexity and multimorbidity are the rule, not the exception. Of course, some people have simple problems. Walk-in centres and online consultations are more likely to be used by younger and healthier patients. We risk investing in initiatives targeted at people with the fewest health needs, draining resources from services for people with the greatest needs. It is an issue of equity as well as efficiency.

CONSEQUENCES OF UNDERMINING THE PRINCIPLES THAT UNDERPIN GENERAL PRACTICE

If general practice is no longer a single entry point to the NHS, we lose the advantage of a simple system that patients understand and that enables good use of expensive hospital care. Without continuity of care we lose that sense of understanding of context that allows GPs to work effectively as patients' advocates and we lose the trust that makes their advice so powerful. If we lose generalism, we will have too many patients receiving the wrong care in the wrong place at the wrong time.

If we lose the clear accountability between a doctor and a patient that comes from the registered list of patients, we will have lots of choice and a great service for those with simple problems, and a second-class safety net for the old, the ill, and the vulnerable.

DESIGNING HEALTH CARE FOR THE PEOPLE WHO NEED IT

How can we design health care for the people who need it? We need initiatives that reinforce rather than undermine general practice. We need to have the patients with the greatest needs at the forefront of our minds when we think about designing health care. Instead of efficient but impersonal care, we need person-centred care that is responsive to everyone's individual needs and priorities. We need to offer longer consultations to people with complex problems. We should innovate to improve access to care, using online systems to book appointments and new forms of communication such as video-consultation, but in ways that reinforce a continuous doctor-patient relationship rather than undermining it. Groups of practices should work together to provide back-room functions, such as policies and quality control, but front-line care should be based on a single point of contact with services that are small and local rather than large and impersonal. We need to make use of the goldmine of data held in GPs' record systems to understand population needs, to help us manage individual patients using expert systems, and to inform decisions about how best to provide services.

OBJECTIONS AND THE CHOICE

Many people will respond stating that we cannot offer the type of care I envisage because we do not have enough doctors. But, under the right circumstances, there are few jobs as rewarding as general practice; make it possible for people to do it well, and support new ways of working to encourage sustainable careers for GPs, and the recruitment problem will solve itself.

Others will say that I am harking back with rose-tinted spectacles to a past form of general practice that never really existed. I disagree. Has general practice ever been very accessible or patient centred? Have we ever looked after the housebound proactively? I do not believe that the model has failed and needs to be replaced. It is implementation failure, not conceptual failure.

Others will point out that improving general practice would require significantly more resources. That is true, but achievable. Because we start from such a low base, a 2% shift in NHS resources from hospitals

to primary care would increase funding to general practice by a quarter and have a massive impact.

We have a choice. We can continue to act as if continuity of care is no longer relevant and provide a range of fragmented services to ensure the fastest possible access and the greatest possible choice. The result will be fewer GPs, paradoxically longer waits for care, much higher costs for the health service, and an inevitable drift towards patients seeking primary care from emergency departments. There will be better care for those with the fewest health needs and worse care for those who need it most.

Alternatively, we work hard to develop and invest in comprehensive primary care. We do not accept a gradual decline by hanging on to outdated ideas. We embrace innovations designed to support the foundational primary care principles of accessibility, generalism, personal care, and coordination of care for a defined population. These ideas have not failed; they have just never been properly implemented.

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A video of the lecture is available at: <https://www.youtube.com/watch?v=Y1dydRE-WUA>.

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