Letters

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The global primary care crisis

January's Editor's Briefing[1] and the accompanying editorial by Darran Foo and colleagues[2] accurately diagnose the difficulties facing primary care. From the perspective of the NHS we might add fragmentation of working practices, leading to discontinuity of clinical care and difficulties for doctors, marked variation across the system in ways of working, and in quality of care and, in all sectors, less than inspiring management and leadership. In the UK the way that social care is funded and organised is nothing short of a national scandal.

The remedies for this very complex crisis must include not just more and better-targeted funding derived from increased taxation, but a complete rethink of how the NHS shows its staff that they are valued, rather than exploited, and a whole-system, long-term (and ideally cross-party) strategy for health and social care. Some of this could be achieved relatively rapidly by improvements in remuneration for low-paid workers and improved working conditions and amenities for all staff. Any impact of training more doctors will not be felt until far into the future, and the NHS has a dismal record in successful whole-system redesign. This makes the suggestions by Foo and colleagues of particular interest – a mechanism to identify, disseminate, and assimilate good practice at a manageable level. The Integrated Care Systems in the UK could provide a framework for doing this. Learning from success is a more appealing and relevant approach to system change than waiting for years for the (often unhelpful) results of large-scale health services research trials.

In all countries economies are damaged by ill health in the population, including in the healthcare workforce. Interventions that lead to better outcomes and are either cost-neutral or cost-saving deserve attention and investment.

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Who is your doctor?

Many patients simply don't know. If we are to realise the ambition of the Health and Social Care Select Committee, to provide *'continuity to all patients as much as possible'*,[1] we need to overcome current barriers and ensure patients know who their doctor is.

Many practising GPs (especially younger GPs) lack experience of relational continuity of care and fear that continuity metrics will be just another stick to beat GPs with. We need to change the narrative through widespread education. Only then will younger colleagues realise that continuity makes the job easier and more enjoyable.

The myth that continuity of care can only be delivered by 5-days-a-week working has led to intergenerational conflict. This has been debunked – GPs in Norway work 3–4 days[2] per week in their practice. In England, submissions to the Health and Social Care Select Committee show that continuity can be achieved with part-time working[1] by spreading working days across the week. Health Foundation research found 61% of patients will wait to see their preferred GP.[3] I work in a personal list practice and 'Who is your doctor?' is asked and reinforced throughout the patient journey.

Access models foisted onto primary care are weakly evidenced and need revaluation. Norway recently evaluated their national personal lists scheme (covering 4.5 million patients over 20 years) showing hard end points (fewer hospital admissions and lower mortality) and demonstrated a dose–response relationship.[2] We need to trust the evidence. Continuity is no longer just a nice idea.

The shortage of GPs mean we need to use them as efficiently as possible. Relational generalist care is the GP's 'scalpel' and should be front and centre in all our practices, primary care networks, and integrated care boards. To do this we must create the environment for GPs to flourish (ideally in partnerships) and keep them in the same community for as long as possible (most benefits >15 years).[2] Pensions and estates are relatively fixable problems, and should be urgently remedied. Then we can get to a place nationally where most patients can easily answer the question – Who is your doctor?

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Jacquet erosive dermatitis in an era of 'going green'

An 8-week infant male presented to paediatric dermatology with a 1-month history of a deteriorating perianal rash.