GPs can no longer claim to be the 'gatekeepers' of the NHS

According to the current European definition, GPs provide 'comprehensive and continuing care to every individual seeking medical care' and are 'normally the point of first medical contact within the healthcare system, providing open and unlimited access to its users, dealing with all health problems'.[1] Unfortunately this is no longer the case in the UK.

Since the inception of the NHS in 1948, GPs have been the first point of contact for members of the public. But the picture is changing fast. The focus of the primary care services provided by GPs has moved away from 'open and unlimited access' and from 'dealing with all health problems'.

Despite politically driven initiatives intended to make GPs more accessible, general practice has become a Monday to Friday, daytime service with increasing emphasis on health promotion, disease prevention and chronic disease management. *The NHS Plan*[2] included proposals to make primary health care more accessible but has had mixed results. 'Advanced Access' turned conventional appointments systems upside down, to the satisfaction of practices,[3] but not patients.[4,5]

GPs are no longer necessarily the first port of call when patients need or want to gain access to the NHS, particularly when they seek medical attention but have not planned it in advance. Patients are voting with their feet and electing to use other routes to obtain health care. Accident and Emergency (A&E) departments, minor injuries units, walk-in centres, NHS Direct (NHS 24 in Scotland), palliative care teams and the NHS Ambulance Service increasingly provide the advice, attention and care formerly given by GPs and primary healthcare teams.

For example, there are currently 17.8 million annual attendances at A&E departments in England, increasing by almost 8% per year.[6] Approximately 3.5 million patients are transported by ambulance services in response to emergency calls,[7] where demand is also rising by about 6–7% or 250 000 responses per year. However, only 10% of patients calling 999 have a life-threatening emergency.[8]

In terms of the 300 million GP consultations per year in the UK, these figures may be small beer, but the trend is clear. Increasingly providers other than GPs and their teams are providing primary health care, which includes responding to patients with social care needs, mental health problems and new symptoms associated with chronic conditions.

The Royal College of General Practitioners continues to argue the importance of GPs as highly skilled, generalist 'gatekeepers' of the NHS who are prepared to manage risk and uncertainty.[9] Without doubt, GPs are invaluable generalists, but they can no longer claim to be the only gatekeepers of the NHS. The reality is that while GPs continue to man the gate during the day, the adjacent fence has broken down and the gate is manned by others at nights and weekends.

Since the new GP contract in 2004, many GPs have given up out-of-hours care, most of which is run independently from day-to-day general practice. The principle providers of out-of-hours care are still GPs themselves working in cooperatives. But doctors are in danger of pricing themselves out of the market, charging £70–180 per hour and more — particularly over bank holidays.[10] Some would argue that these fees undervalue highly trained professional people working unsocial hours. However, in a market economy, the NHS cannot sustain payments of this magnitude when alternative providers such as nurse and paramedic emergency care practitioners already exist and more can be trained. Extended prescribing rights for nurses and pharmacists[11] will enable them to extend the ranges of their clinical practice.

The recently published strategic review of ambulance services in England and Wales[8] describes ambitious proposals for ambulance services to become '*the* [my italics] mobile health resource for the whole NHS — taking health care to the patient in the community'. New, large, regional ambulance trusts will provide more clinical advice and an increasing range of mobile health care including primary care, diagnostics and health promotion.

The Ambulance Service is already adapting to the changes in demand by training an increasing number of paramedics to become emergency care practitioners. By assessing and treating patients at home, emergency care practitioners reduce the number of patients referred to A&E departments or admitted to hospital.[8] Increasingly, their work is being integrated into existing services. Implementation of the NHS electronic patient record should soon mean that ambulance staff will have access to necessary information to provide patient care and that their records are shared with patients' GPs, hospital staff and others who need access to them.[8]

There does not appear to be any evidence that patients are harmed when they receive urgent medical attention from health professionals who have had a much shorter training than the minimum of 9 years served by GPs. They may not provide the same quality of care as traditional GPs and they may not turn out to be cheaper. But if they are safe and effective, the future role of GPs could be to assess and manage complex problems in the surgery, during working hours, leaving the management of acute problems and many of those that have already been diagnosed to nurses, paramedics, pharmacists and other professions.

Recent trends, accelerated by the new GP contract, mean that the European definition of family medicine no longer applies in the UK and is unlikely to apply

in the future. UK GPs now need to redefine their role, bearing in mind that they have little or no control over other professions who are expanding their roles and providing services that GPs have decided to give up. There is a strong case for a broad debate about the future role of UK general practice.

Jim Cox
Medical Director of Cumbria Ambulance Service NHS Trust

Competing interests

Jim Cox is Medical Director of Cumbria Ambulance Service NHS Trust, a role which involves some direct patient care. He is a former GP and member of RCGP Council.

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ADDRESS FOR CORRESPONDENCE

Jim Cox
The Barn, Caldbeck, Wigton, Cumbria CA7 8DP.
E-mail: jim.cox@btconnect.com

Care of patients with intellectual or learning disability in primary care: no more funding so will there be any change?

'Perhaps the unsuccessful treatment of these people and the hostility they face is a non-modifiable problem intertwined with the long-term outcome of learning disability and the inherent difficulty this disability poses on normal social functioning, rather than a problem with the institutions that provide health care and social services.' (Mary Sheridan, 1965.)[1]

'In the state of nature all men are born equal, but they cannot continue in the equality. Society makes them lose it and they recover it only by the protection of the law.' (Charles de Montesquieu 1689–1755.)

As the UK financial year comes to a close partners, associates and practice managers will join eagerly together in assessing their Quality and Outcomes Framework (QOF) figures and targets — practice, personal and national, financial, operational and clinical, and statistics and reports will enable us to make a final rush towards the March deadline. It is remarkable how some targets will drive us to intense activity while others lay forgotten. It would be interesting to know how many GPs reading this editorial work in practices where each of their learning disabled patients has had a health action plan composed for them with the help of a health action facilitator. It would be even more interesting to know how many practices are able to identify the number and names of patients on their lists suffering from learning disability.[2]

If intellectual ability were normally distributed among the population then those with an IQ 2 standard deviations below the mean would constitute 2.5% of the population. This would assume a polygenic multifactorial form of inheritance and a normal distribution. There are few people with IQs at the upper and lower end of the distribution with most of us clustering around an IQ of 100.[3] The effects of birth defects, birth trauma, chromosome disorders and metabolic problems may cause a skewing downwards of the tail of the normal distribution. The incidence of learning disability is therefore estimated to be about 2%. The prevalence increased by 53% over the years 1960–1995 and will probably increase by 11% over the years 1998–2008,[4] so that the prevalence will be in the same region as hypothyroidism or diabetes, disorders for which care is resourced and outcomes are subject to QOF scrutiny. Medical intervention has unusual effects — the incidence of Down's syndrome might decrease as the result of antenatal