Reforming primary care:

innovation or destruction?

The importance of primary care in any healthcare system is undisputed,[1] and many countries are currently engaged in system reforms that aim to strengthen the primary care sector. A variety of factors have triggered this need for reform, most driven by the need to address increasing health costs and the challenges of long-term illness. However, preoccupation on reducing costs may inadvertently reduce the role of the GP to that of financial gatekeeper, rather than the advocate of the patient, and in doing so, remove the very essence of its professionalism, that of trust between the patient and their doctor. Another concern is that short-term financial measures will curtail primary care in developing its full potential. This may cause downstream higher replacement costs: for example in access (with increased demand for emergency services) or in integrated care for people with chronic diseases, leading to higher use of hospital-based care. Such an approach is internally inconsistent with a main objective of health policy, to reduce hospital facilities — a policy built on strong primary care.

CONCERNS ABOUT THE DIRECTION OF HEALTHCARE REFORMS

The forces that drive healthcare reform include the need to deliver evidence-based public health and to address health inequalities, as well as the political imperative to create a market in health care. Healthcare reform may lead to substantially different, and unpredictable, outcomes for primary care; varying from a system of single practices providing comprehensive health care, to the creation of a more comprehensive and integrated system (for example the federated model proposed by the UK's Royal College of General Practitioners), or a model where multiple providers deliver specific packages of primary care (for example, care of older people or child health), in the context of liberal market forces. Even now in countries with traditional comprehensive primary care, individual providers (such as GP practices) or multidisciplinary consortia or cooperatives are providing services directed at specific health problems (for example diabetes mellitus or depression) or groups of patients (such as students or 'men's health').[2] These services often compete with more traditional existing primary care services. This paper analyses the potential consequences for primary care in different scenarios for healthcare reform.

CORE COMPETENCIES OF PRIMARY CARE

Recent years have seen a shift from the care of acute health problems, with short episodes of care, dominated by a single discipline, to the management of chronic health problems, where care over time is required and is directed at multiple health problems, as well as fluctuations in patients' perspectives. Rather than specialisation-in-depth, this new paradigm demands for specialisation-in-breadth,[3] providing the ability to integrate domains of expertise and to monitor the changing needs of patients over time. The competences required to achieve this can be summarised as: medical generalism, directed at all health problems, at all stages, and in all individuals, determined by need; a community orientation, focusing on social determinants of health and societal (family, household) factors; and working from a personal–professional relationship with patients (person-centred, integrated, continuous care).[4]

THE PARADOX OF PRIMARY CARE

The relationship between the strength of the primary care sector in a health system and individual and population health outcomes is not straightforward. Many studies have demonstrated that, for specific diseases, specialists are capable of achieving better standards of care than generalists,[5] and some proposals for reform have focused on improving access to specialist medicine as a means of improving health outcomes. Conversely, specialist care is recognised as being more expensive than generalist care, and there is a good deal of evidence to show that strong primary care is associated with better health outcomes at lower cost for the healthcare system overall.[6,7] This apparent contradiction has been described as the 'paradox of primary care' by Stange and Ferrer,[8] who also point out that optimum outcomes are generated when generalists and specialists collaborate. Unraveling the paradox depends on an appreciation of the limitations of relying on single-disease outcomes or costs to measure quality of care, and achieving a better understanding of the added value of 'integrating, prioritising, contextualising, and personalising'[8] health care across its many dimensions.

So, for example, when patients' functional health status (that is 'can I do what I want to do?') rather than disease-outcome (for example, blood pressure reduction) is measured, specialists and generalists achieve similar results — with generalists using fewer resources,[9,10] representing better value for money.[8,11] In line with this, stronger primary care is associated with better population health and life expectancy[12,13] and also better control of major chronic illness at lower cost.[1]

COORDINATION OF GENERALIST AND SPECIALIST CARE

To achieve better population health and functional status, primary care should be the key component of a healthcare system, within which disease specific expertise is provided and coordinated.[14,15] This raises the question of the very nature of primary care, its professional content, and organisational structure to pursue this function. That primary care is essential may well be beyond doubt,[1,5] but it is less well understood which of its characteristics[4] determine its effectiveness. This hampers the translation of the principles of primary care into a coherent primary care-led healthcare system. The development of

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disease management programmes restricted to specific health problems and/or groups of patients, should be viewed critically against this background.

'Single issue' programmes, such as those for diabetes mellitus, acne, menopause, cardiovascular and other preventive services, depression, drug dependence, well-man services, and so on, for which their providers seek payment under the prevailing health system fee for service arrangements represent a 'cherry-picking' approach to health care that is unlikely to be associated, in the longer term, with cost containment or improvements in population health. The superficial attraction of these programmes is in the provision of 'state of the art' care of the specific medical problem, complete with all technical and logistical support. Providing direct access in the community adds to the primary care flavour: it offers everything for patients. For example, a diabetes service will provide an entire suite of facilities, such as foot care, eye care, cardiovascular risk monitoring, and the like. Some current principles of health policy with their emphasis on health care as a market, consumer choice, and competition between providers, encourage developments of this kind. As a consequence, there will be diversification and fragmentation within primary care, with more and more single issue programmes or services, in particular ones that can be clearly defined. The success of such programmes is measured in numbers attending and in short-term outcome indicators, although, as argued above, these health gains will have only limited impact on the longer-term health status of individuals and of populations.

Cherry picking patients away from their normal primary care provider will result in disruption, duplication, and waste. Many primary care patients present undifferentiated symptoms and problems, often in the context of multimorbidity. Individual needs require an individual response[16] and demand a flexible approach to management, rather than a pre-defined care pathway. This is where the core values, deeply rooted in the professionalism of general practice and primary care, come into play:[4] comprehensiveness and continuity of care, focus on the persons with the disease, their psychosocial context, and in the physician–patient relationship over time. These are founded on the most powerful factor health care has to offer, a personal relationship of trust, that allows the generalist to take responsibility for the whole patient, irrespective of their health problem.

CONCLUSIONS

Primary care and general practice are needed — now more than ever.[17] Healthcare reforms should be directed at strengthening, not dismantling, the core of what determine their effectiveness. In as far as specialist expertise and managed care pathways are relevant, and there will be an increasing demand for these,[15,18] they should be integrated into and coordinated by comprehensive primary care, to support and empower continuity of care between GP and patient.

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