King's Fund

Modernisation and the Future of General Practice

Stephen Gillam
Geoff Meads

King's Fund
Publishing
avendish Square
W1G 0AN

Modernisation and the Future of General Practice

Stephen Gillam
Director, Primary Care Programme, King's Fund

Geoff Meads
Professor of Health Services Development, City University, London

King's Fund

Published by
King's Fund Publishing
11–13 Cavendish Square
London W1G 0AN

First published 2001

ISBN 1 85717 455 0

A CIP catalogue record for this book is available from the British Library

Available from:
King's Fund Bookshop
11–13 Cavendish Square
LONDON
W1G 0AN

Tel: 020 7307 2591
Fax: 020 7307 2801

Printed and bound in Great Britain

Cover illustration: www.johnbirdsall.co.uk

Contents

Acknowledgements

Thanks to all colleagues who provided feedback on this paper, and to Shanaz Islam and Trevor Anderson for support in its production.

Preface

General practice and the systems surrounding it are changing. General practitioners are struggling to make sense of 'modernisation'. They are disconcerted by high-flown rhetoric that does not accord with their sense of day-to-day realities. They know that what their patients want and some of the things they have always wanted – in particular, more time.

Change is painful and general practitioners are understandably reluctant to embrace change when it threatens their role. We risk replacing the best of general practice with '24-hour, Health'R'Us' services run by generic health professionals offering quick fixes less cost-effectively. Increasingly, the very term 'general practitioner' is being discouraged; we are being restyled as 'primary care practitioners'.

The challenge for future leaders will be to meet the public's expectation for excellence and increasing demands for care. The public wants family services that are accessible and local. When ill, they want to be seen by a super-specialist. Our clinical leaders have to strike a balance in changing circumstances and use them to our advantage. We need to find opportunities that policy-makers have not foreseen, to persuade others to follow, and to encourage them to take risks. As a profession, we must – as the final chapter suggests – 'behave as a profession: self-determining, independently practising but peer supported and, above all, ethically committed to public service'. I hope that those re-modelling our profession are aware of what they risk losing: the quality of general practice. The NHS used to be the envy of the world. This is no longer true, but other health care systems continue to try and learn from our primary care services. General practice is broad based – it manages the physical, the psychological and the social, and also offers continuous care over time. These must be the benchmarks by which we measure all future developments. If we compromise these, our patients will be the losers.

This extended essay attempts to unpack the meaning of 'modernisation'. It charts the roots of today's discontent, and the tensions inherent in the new roles being proposed for general practitioners. The final chapter outlines ways forward for the profession.

You may not agree with all it contains. But this is an 'ideas' paper, not a comprehensive review. In the last analysis, it seeks to reassure a beleaguered profession that those traditional strengths can be preserved, enabling GPs to tackle new challenges and new roles with confidence.

I commend these essays to politicians, policy-makers and GP leaders; the advice contained here may help save general practice from unnecessary harm.

Claire Gerada
MBE FRCGP MRCPsych
General Practitioner, Lambeth

Chapter 1

Changing perceptions of general practice

Introduction

The NHS is being 'modernised'. The word litters contemporary policy statements. Yet ask people in the NHS what is meant by modernisation and they struggle for coherence. Answers include child-like repetition of the five 'P's' in the Prime Minister's introduction to the NHS Plan. After 'performance', 'partnerships' and 'professions', the list usually runs dry. Curiously, 'patients' are still most often forgotten.

Ask NHS colleagues about the nature of primary care today and you get a similarly tentative response. The only current certainty is continuous change and the future is fluid. Primary care in the United Kingdom is no longer synonymous with general practice. An organisational revolution is taking place. Primary care is being modernised on the one hand; and on the other a modernised NHS requires a fundamentally new understanding of what constitutes general practice.

The purpose of this extended essay is to examine the implications of contemporary policy and organisational change for the future of general practice. Will the expanded roles and responsibilities afforded primary care by today's new policies and organisations subsume or supersede the individual GP? Conversely, will the underlying philosophy and principles of general practice be rolled out to embrace all parts of our health and social care system? Or will general practice-based primary care simply continue to muddle through, with its customary step-wise approach to strategic change? The past decade may have been a period of continuous structural revolution in the NHS, but at its close GPs continue to see nigh on a million patients on a (bad) day in the sanctuary of their surgeries as they have done for generations. Continuing public appreciation seems evident – but not to doctors themselves.

This opening chapter sets the scene, placing modernisation in context. The next two chapters examine the historical roots of the malaise and the profession's sometimes

dysfunctional response to current crises. The fourth chapter considers the nature of modernisation before a way forward is sketched out in the final chapter. Our thesis is ultimately optimistic.

General practice in retreat

Understanding the extent to which modern policy and organisational developments are simply 'froth' is a real dilemma. The literature of general practice is littered with publications auguring crises which failed to materialise.[1,2] Generations of commentators have asserted that the latest set of governmental initiatives represents 'the last straw for the family doctor',[3] or a critical 'cross-roads'.[4] General practice has ever been as much a local creation as a creature of central policy.

Sometimes these reactions have represented outright rebellion by the profession against the direction of national government. Witness the origins of group practice back in 1952, through the General Practice Loan Fund negotiated in the settlement of a bitter four-year-long remuneration dispute;[5] or the conversion of health promotion clinics and night duty rotas into chronic disease management programmes and multi-practice, local, out-of-hours co-operatives, after threats of contractual non-compliance and judicial reviews four decades later.[6] That government policy initiatives are frequently short term and overstated, we readily acknowledge.

But our experience of working with participants from hundreds of new primary care organisations since the Labour government was first elected in May 1997[7,8,9,10] confirms that GPs and other primary care professionals feel inadequacy, incomprehension and ignorance in relation to current primary care organisational developments. These feelings are a major hindrance to their implementation. They leave too many unanswered questions at the levels of personal meaning and professional behaviour.

Nowhere does this uncertainty apply with more force than to the traditional 'lead' profession of UK primary care: the general medical practitioner. This is not always obvious. No profession is better defended, at least in public, and a persistently

defensive/aggressive stance on almost any new political initiative is one of its (sub)cultural characteristics. But in closed workshops, action learning sets, mentorship sessions and development programmes for the newly emerging primary care organisations, truth will out. The GP is not sure who he or she is anymore or where he or she is going.

Society's implicit valuation of personal and pastoral care, with which general practice has been so intimately aligned, is no longer enough to guarantee its future. Other professions are laying claim to this territory. More disarmingly, so too are a new breed of politicians with the same creed of modernisation; they are bent on reforming other sectors of society and, in the process, on purging other professions.

So what does modernisation really mean? How does one understand its relevance to the NHS as a whole? Can modern policy and organisational developments actually improve patient care and public health? Or are these developments to which we should just pay lip-service and 'sit out'? The NHS Plan claims to be about 'reform and investment'[11] and yet the political need in general practice seems rather to be for leadership which champions the values of sustenance and survival. Can general practitioners respond positively to the new policy environment and look forward to a strong future as a profession?

A recent World Health Organisation survey of primary care development across Europe reached an affirmative conclusion:

> *The general trend in health care is to favour primary care in general practice. Evaluation of general practices such as the Netherlands, Denmark and the United Kingdom has not taken place without opposition, often from doctors themselves. It is nevertheless essential that a well-organised profession and well-trained professionals are encouraged. Their position has to be supported by positive regulation. A health care system based on primary care is more effective where a doctor (or practice) cares for a defined list of patients and controls access to secondary care. Such a model clearly*

> *may not be appropriate in perpetuity, but given the pressures and organisation of European society, this seems most appropriate.*[12]

These words are only three years old. The millennium has turned and so too has the conclusion. In the UK, the government-authorised publicity for the NHS Plan lists general practice in fourth place on the frontline of modern primary care. It now comes after the walk-in centre, NHS Direct, the various sources of self-care and even sometimes the revamped community pharmacy.[13] The days of fundholding, when everything seemed to be directed towards the all-singing, all-dancing purchaser-cum-provider GP, have passed. The illusion of omni-competence has shattered. For all their grumblings about the 1990 General Medical Services contract, GPs have been victims of their own success. Too many of them showed that it was possible to incorporate major resource management, community development and public health responsibilities into the practice of primary care in the UK.[14,15] Indeed, rather too many actually relished these new roles. They filled a professional void.

The myth exposed

The sense of a profession in search of an identity is, of course, partly derived from the very nature of traditional practice. Its key roles, as articulated by one of its most powerful advocates, are:

> *Firstly, to serve as interpreter and guardian at the interface between illness and disease and, secondly, to serve as a witness to the patient's experience of illness and disease.*[1]

This is the 'mystery' of general practice. It traces its origins to the psychodynamic school of GP writers and researchers who so influenced the profession in the 1960s. Their platform was Balint's pioneering work in distinguishing the distinctive features of general from specialist medical practice in terms of its wider framework of individual human relationships, and the potential these brought for harnessing energies in support of medical care.[16,17] The building blocks of the profession were the first university Departments of General Practice (appearing in 1963), the General

Practice Charter (of 1966) and the Royal College of General Practitioners (founded in 1967).[18,19]

As modernisation strategies take root through a range of new institutions (e.g. the National Institute for Clinical Excellence and the Commission for Health Improvement), concerns for the nature and value of general practice re-emerge. How should the mystery be solved? Clearly not through evidence-based medicine and the profusion of protocols and guidelines. These will enlighten only a small portion of the generalist's work. People come to surgery for something more and other primary care professionals are queueing up to provide it. Counsellors may be better listeners; osteopaths, chiropractors and physiotherapists can manage the majority of musculoskeletal problems; and nurses in their new professional guises claim to be able to do anything in the realm of community-based care from prescribing and public health to chronic disease management. Under such circumstances, claims on behalf of general practice can appear misplaced. Where lie the distinctive expertise and body of knowledge upon which general practice has rested its claims to the status of a profession?[20] Confined to the consulting room and its computer, the special status of the general practitioner can appear paradoxical,[21] even arrogant.

The second half of the old century witnessed the continuous rise of the profession. Its popular, paternalistic and individualistic style fitted well with society's stratification and sources of solidarity. At one point, by the early 1990s, the term 'general practice' could legitimately be applied not just to the profession and its clinical disciplines, but to its services, staff, buildings and structures as well. But it has over-reached itself. The primary care policies and organisations of the new millennium are geared to a different sort of society, where cohesion depends, for example, on the use of such terms as 'partnership', not to justify GPs' uni-professional legal status but to describe and promote inter-professional alliances.[22] They live in a different world, formed as much by global ideas and trends as by grass-roots innovations – and with little time for mysteries or myths.

For general practice this is a story of revolution. At such times roots become important. In looking to make sense of the future, we therefore begin in the next

chapter by examining how and why general medical practice became established in the first place.

References

1. Heath I. *The Mystery of General Practice.* London: Nuffield Provincial Hospitals Trust, 1995: 5–14.
2. British Medical Journal. *The Future of General Practice.* London: BMA Publications, 1992.
3. Gibson R. *The Family Doctor.* London: Allen and Unwin, 1981: 86–93.
4. Fry J. *General Practice and Primary Health Care, 1940s–1980s.* London: Nuffield Provincial Hospitals Trust, 1989: 106–15.
5. Godber G. *The Health Service: past, present and future.* London: Athlone Press, 1973.
6. Allsop J. *Health Policy and the NHS.* London: Longman, 1995: 203–13.
7. Gillam S, Brooks F, eds. *Towards Patient and Public Involvement in Primary Health Care.* London: King's Fund, 2001.
8. Levenson R, Gillam S. *Linkworkers in Primary Care.* London: King's Fund, 1998.
9. Ashcroft J, Meads G. *Relationships in the NHS.* London: Royal Society of Medicine Press, 2000.
10. Meads G, Meads P, eds. *Trust in Experience: transferable learning for primary care trusts.* Oxford: Radcliffe Press, 2001: 2–45.
11. Secretary of State for Health. *The NHS Plan: a plan for investment; a plan for reform.* Cm 4818-I. London: The Stationery Office, 2000.
12. Boerma W G, Fleming D. *The Role of General Practice in Primary Health Care.* WHO, London: The Stationery Office, 1998.
13. NHS London: *Know your NHS?* Croydon: Croydon Health Authority, 2001.
14. Audit Commission. *What the Doctor Ordered.* London: HMSO, 1996.
15. Williams S. *The Way Forward. Fundholding.* Beckenham: PI Books, 1996.
16. Balint M. *The Doctor, His Patient and the Illness.* London: Pitman, 1964.
17. Lane K. *The Longest Art.* London: Allen and Unwin, 1969.
18. Pereira Gray D. *A System for Training for General Practice.* London: RCGP, 1977.
19. Moon G, North N. *General Practice – policy and place.* Basingstoke: Macmillan, 2000.

20. Pereira Gray D. *Training for General Practice.* Plymouth: Macdonald and Evans, 1982.

21. Willis J. *The Paradox of Progress.* Oxford: Radcliffe Medical Press, 1996.

22. Ashcroft J. Releasing the dividend of 'new' partnerships. In: Meads G, Meads P. *Op. cit.*: 49–68.

Chapter 2

Continuous revolution – new roles, new responsibilities

Introduction

The profession of general practice derived over the course of the nineteenth century from the trade of apothecaries who dispensed medicines. In the growing industrial cities where GPs relied on patients' fees, nobody was seen in the outpatient clinics of charitable hospitals unless referred by a GP. This was the origin of the first of three fundamental principles of general practice in the UK, that of referral, whereby GPs became the 'gatekeepers' to secondary care.[1]

The second principle concerns non-specialisation, since most scientific advances and medical care took place in hospitals. The evolution of the 'expert generalist', able to co-ordinate the management of patients from the centre of a web of health professionals, is seen as a source of the NHS's efficiency. By the beginning of the twentieth century, GPs were increasingly being paid an insurance fee by patients as members of 'sick clubs'. These foreran the National Insurance Act in 1911, which covered wage earners. This was extended to the whole population with the creation of the NHS in 1948, which provided the basis of the third principle: that of capitation and a fee for everyone on a registered list of patients.

While the postgraduate training and professional development of British general practitioners became increasingly sophisticated, many countries saw the status of family practice decline. International comparisons of the extent to which health systems are primary care orientated suggests that those countries with more generalist family doctors acting as gatekeepers with registered lists are more likely to have better health outcomes as well as lower costs and greater satisfaction.[2] But these three key principles are increasingly seen as constraining.

Referral arrangements are now seen as monopolistic and restrictive. Many of this government's health policies have been designed to increase access to care through other routes. The generalist is under threat. How can any single health professional

stay abreast of advances in all branches of medical science? Indeed, some question whether qualifications in 'general practice' can still be offered with academic integrity. The personal list coupled with doctors' sense of 'womb-to-tomb', round-the-clock responsibility in the traditions of Dr Finlay has provided the bedrock of family practice for generations but is now seen as fostering paternalism. What were once virtues are now vices. This chapter examines recent health policy from the perspective of general practice.

Moving centre stage

The cost efficiency of the NHS has long been attributed in large measure to general practice. The tripartite division between hospital, community and family practitioner services, with open access to family practitioner services but controlled access to specialist services, has endured since 1948. However, the very existence of this tripartite structure, combined with the independent contractor status of GPs, contributed to a service criticised as poorly co-ordinated, unresponsive and of varying quality. The reforms introduced by the Conservative government in 1990 concentrated on controlling cost and quality through the introduction of an internal market.[3] A central policy instrument was fundholding, which capitalised on general practitioners' intimate knowledge of local services (derived from their 'gatekeeping' function), and their financial entrepreneurialism (derived from their autonomy as independent contractors). General practitioners were felt to be best placed, if not best equipped, to act as advocates for their patients.

Although the proponents of GP fundholding claimed great benefits from the scheme, the evidence to support these claims was equivocal.[4] Fundholding was ultimately rejected for several reasons. It was bureaucratic, involving high transaction costs. It was perceived as unfair; (successful) fundholders generated inequities in access to care (two-tierism). Above all, the internal market failed to deliver anticipated efficiency gains. Yet it did entrench political support for widening the involvement of general practitioners in resource allocation. And it empowered those same practitioners with a new sense of their political potency.

Stewards of the new NHS?

New Labour's first White Paper formally announced the demise of GP fundholding and the internal market.[5] It underlined the role of the NHS in improving health, renewed an ideological commitment to equity in access and provision, and tackled the need to ensure quality through clinical governance and accountability to local communities. Of fundamental importance was the move to loosen the restrictions of the old tripartite structure by moving towards unified budgets, and imposing a duty of partnership. The major structural change introduced to deliver these policy goals was the formation of primary care groups (PCGs), in turn to evolve into independent primary care trusts (PCTs).

That general practitioners would prove efficient as stewards of the NHS was largely an article of faith, and PCGs were saddled with heavy expectations. Predictably, they are moving at different speeds. Organisational development has consumed much early energy and many are only now translating priorities into clear local health strategies, targets and action plans – let alone delivering visible new services. They have made progress in developing and integrating primary and community care, but their commissioning and health improvement functions are as yet immature.[6] PCG/Ts have started to develop minimum standards for practice services and agreed plans for redistributing resources. In other words, they are beginning to intrude beyond the front door of their constituents' surgeries. Nevertheless, many practices remain disengaged from the work of PCG/Ts. And they lack the managerial capacity to deliver the local changes their constituents demand, let alone ever-mounting responsibilities as defined centrally.[7]

Independent contractors or local employees?

General medical services (GMS) and general practice as providers of services were left otherwise untouched by the internal market. The contract imposed in 1990 provided tools to increase the accountability of GPs but failed to address deep-rooted deficits in primary care and was criticised for its lack of local flexibility. *The Choice and Opportunity* White Paper of 1995 was in many ways a response to pressure for change from within the medical profession.[8] The British Medical Association (BMA)

was seeking to renegotiate the compulsory contractual requirement of 24-hour responsibility for care and to define more tightly the nature of 'core' general medical services. Recruitment and retention of doctors were problematic, and a growing minority of GPs were seeking salaried or alternative employment options.[9]

The NHS (Primary Care) Act 1997, passed in the dying days of the *ancien régime*, nevertheless marked a revolutionary change. The launch of personal medical services (PMS) pilot schemes effectively ended GPs' monopoly of primary medical care, with new market entrants in the shape of NHS trusts and nurses. The long-cherished national contract was no longer to apply universally with the development of alternative employment options to that of the independent GMS contractor. It also undermined the trades union as the BMA struggled to retain sole negotiating rights over GPs' terms and conditions.

After a slow start, PMS pilots proved unexpectedly popular. The financial risks of running a practice are reduced and, unsurprisingly, a reduction in the bureaucratic burdens of the job is welcomed by many GPs.[10] PMS provides entrepreneurs with some of the independence enjoyed by fundholders, but its success reflects in part its appeal to practices disaffected with other aspects of the current reforms. Paradoxically, many practices see PMS as a way of defining their own priorities and insulating themselves from the intrusions of PCG/Ts. Unfortunately, such has been the pace of change that many PCG/T boards have lacked a strategic position on local PMS. Nonetheless, PMS provides crucial leverage for the primary care trusts that will in future hold their contracts. For the first time, PCTs hold truly integrated budgets with the ability to commission local primary care.

Accessible or continuous carers?

At first sight, the raft of post-1997 policy initiatives designed to improve access to primary care appeared populist and reflexive. The purpose of NHS Direct was to provide 'easier and faster advice and information for people about health, illness and the NHS so that they are better able to care for themselves and their families'. More specific objectives for NHS Direct included the encouragement of self-care at home

and reducing unnecessary use of other NHS services – i.e. management of demand.[11] NHS Direct was unpopular with most general practitioners, who feared it would add to their workloads. Evaluations confirm that the new service has had little early impact on other emergency services.[12]

Already sensitive to threats to their professional monopoly over first contact care, the medical profession was therefore doubly wary of the introduction of walk-in centres. These were an explicit response to the apparent success of instant access primary care facilities established by the private sector, e.g. on railway stations serving time-pressed commuters. This sensitivity was heightened by an awareness that experience in other countries suggested that multiple access points with poorly co-ordinated record-keeping could result in fragmented care.[13] Nevertheless, the new centres did expose the limitations of conventional general practice in providing for groups who have not, for reasons of culture or convenience, gained satisfactory access to primary care in the past.

These innovations nicely crystallise the differences in priority that different players attach to access. Their apparent popularity with patients contrasts with their reluctant acceptance by health professionals. Concerns over their cost-effectiveness remain but the trade-off implied between personal continuity and modern care can be exaggerated. It is more often between small (more familiar) teams and large (more cost-efficient) ones. PCG/Ts may offer the opportunity to separate administrative and clinical functions that work best on different scales.[14]

Both NHS Direct and the new walk-in centres involve forms of nurse triage. Some of the new practices established using PMS flexibilities are effectively 'nurse-led'.[15] These innovations are changing the way primary care is perceived. In addition, a growing proportion of new entrants to general practice are women seeking to reconcile career aspirations with family responsibilities. Greater feminisation of the primary care workforce is altering the image – and possibly also the status – of family doctoring.

Externally controlled or self-regulating?

The invention of clinical governance heralded the latest of many attempts in the NHS to exercise greater managerial control over clinical activities. Governmental concerns over professional self-regulation – heightened in the wake of events at the Bristol Royal Infirmary – were about to be raised still more dramatically. Clinical governance has been defined as 'a system through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which clinical excellence will flourish'.[16] It draws together elements of quality assurance that are often ill co-ordinated. The corporate nature of this new responsibility requires, in the overused phrase, major 'cultural change'. For PCG/Ts, this implies sharing intelligence about quality across professional and practice boundaries, and health professionals seeing themselves as collectively accountable for the clinical and cost-effectiveness of their colleagues' work.

Clinical governance presents particular challenges for PCG/Ts, the most pressing of which is the management of poor performance. Complaints, colleagues' expressed concerns and financial audit are the main means of detection at present. The future is about compulsory annual audit and regular revalidation, with assessment and support centres for failing doctors.[17] A package of performance indicators to help identify sub-standard performance remains the holy grail. But the easily measurable is rarely useful and most indicators are influenced by factors outside the control of health systems.

PCG/Ts are trying to adopt a non-threatening, facilitative and developmental approach to clinical governance while setting up new local monitoring mechanisms.[18] In the wake of the Shipman verdict, engendering a 'no blame' culture has not been easy. The threats both to independent contractor status and professional self-regulation have increased doctors' feelings of vulnerability.

Information sources or knowledge managers?

Traditionally, medicine has been based on knowledge acquired during training and topped up from time to time from sources such as scientific journals, conferences and

medical libraries. These dated quickly, but clinicians nevertheless had more knowledge than their patients who were denied access to such sources. However, 'The World Wide Web, the dominant medium of the post-modern world, has blown away the doors and walls of the locked library as efficiently as semtex'.[19] Increasingly, patients will be more knowledgeable than their doctors.

The computer screen may threaten the interpersonal nature of the consultation but new tools should change clinicians from being repositories of facts to being managers of knowledge. Some clinicians are nervous of giving patients better information, and not all patients want it. However, most people want to be in charge of decisions about their health – for the default approach to be empowerment rather than paternalism. Giving patients more knowledge or a consultation style that facilitates involvement improves not only patient satisfaction but also clinical outcomes.[20] As people gain access to information about risk, a higher proportion may choose not to accept the offer of screening or treatment.

New information technologies are promoting the uptake of evidence but medicine is not an exact science. Guidelines and protocols may rob clinical practice of some of the responsiveness and flexibility that patients most value. (The growing popularity of complementary therapies is testimony to anti-rationalism and the importance attached to holistic models of care.) But new communications systems offer other prospects: direct booking of hospital appointments, e-consultations and a panoply of other telemedical advances.

Patients' champions or guardians of the public's health?

The last 30 years have been chequered with pleas for closer co-operative working between primary care and public health. Many of these envisaged the emergence of new hybrids. The best known of these is Julian Tudor Hart's 'community general practitioner' – 'a new type of physician engaged in local participatory democracy to maximise the population's health'.[21] While there have always been plenty of GPs who understand the central role of primary care in tackling health inequalities, the majority remains less supportive. It is no coincidence that the most trenchant commentaries on

the politics on health promotion have emerged from departments of primary care: from the pens, for example, of Petr Skrabanek, James McCormick and Bruce Charlton.[22,23]

Michael Fitzpatrick, a GP in east London, maintains the tradition. He is scathing of New Labour's elevation of social exclusion to the centre of policy and wittily ridicules coercive interventions designed to combat health inequalities. The activities of the Social Exclusion Unit around issues such as homelessness and teenage pregnancy do nothing to reduce inequality, he argues, but foster a dependency relationship between the State and recipients of welfare benefits. In his view, programmes such as Sure Start are nothing more than a sophisticated instrument for social regulation. He suggests that the high standing of general practice, which makes it such an attractive base for New Labour's role in engineering projects, is an asset that will be wasted rapidly if GPs continue to assume the 'shabby mantle of social work'.[24]

These authors eschew involvement in lifestyle modification for, back at the surgery, doctors face the consequences of such medicalisation of personality: enormously increased workload and failure to meet expectations raised by the indiscriminate application of medical labels to diverse forms of mental distress.

Fitzpatrick's plea is for a form of medical practice that treats illness rather than regulating behaviour, and puts the autonomy of the individual and the privacy of personal life before the imperatives of political correctness. But his challenge to the 'tyranny of health' amounts to retrenchment – withdrawal from a wider social role, a more restricted definition of medical practice. Patterns of behaviour are, after all, socially conditioned rather than pharmacologically determined. Fitzpatrick's arguments may seem as illiberal as those he reviles, but they are powerfully appealing to a constituency under pressure.

If primary care organisations are to drive forward public health goals, they need, as they corporatise primary care, to reinforce the culture of support for 'upstream' solutions. Can PCTs resolve these tensions? Can they provide a third way that

generates greater consensus? Clearly, they have an important role in helping to re-distribute resources within and between their areas. They are already investing in services that will improve access and reduce variations in quality of care. The impact of health services themselves on public health is increasingly well attested but their first steps towards effective commissioning have been more hesitant. As yet, they lack the budgetary clout, management infrastructure and information to pull their weight. But there are signs that these new organisations may yet make something of their health improvement role.[25] Health Improvement Programme (HImP) sub-groups are beginning to invest in health-promoting initiatives beyond the NHS that address social determinants of health. Surprisingly, they are led more often by GPs than by any other professional. And where GPs have neither the time, skills nor inclination to lead this work, primary care nurses, particularly health visitors, could be equipped to spearhead this role. A renewed emphasis on the development of public health skills across a range of primary care disciplines should further change the culture in support of population health.

Tackling the 'forces of conservatism'

Labour's was allegedly a ten-year project, but the development of effective primary care trusts was always going to take more time than the electoral cycle allowed. Similarly, the implementation of clinical governance was never going to keep health scandals from the national news. The NHS Plan was an implicit acknowledgement that Tony Blair's mission to modernise the NHS was foundering.[26] Public failures, particularly those of the medical profession, armed the Government to challenge entrenched medical interests and strengthened the case for reform.

The Plan was to represent a 'new deal' between the Government and the health sector (Box 2.1). In return for substantial new funding, the Government sought to challenge some of the long-established foundations of the NHS and, in particular, to revisit the settlement between organised medicine and the State. Alternative methods of funding health care (private insurance, co-payments, social insurance) were, however, explicitly rejected.[27] What does all this presage for general practice?

An expansion in hospital beds and consultant numbers with consequent reductions in waiting times, if realised, should ease the burden of containment in primary care. The expansion by 2000 of GP numbers over four years is less impressive, representing only a modest increase in long-term trends. Even allowing for investment in other community-based services, GPs will not easily be able to improve access to their services or extend consultation lengths.

Box 2.1: The NHS Plan – key points

- 500 one-stop health centres by 2004
- 3000 surgeries upgraded by 2004
- 2000 more GPs and 450 more registrars by 2004
- NHS Lift, a new private–public partnership, to develop premises
- 1000 specialist GPs
- Consultants delivering 4 million outpatient appointments in primary care
- 2100 extra acute and general hospital beds
- 5000 extra intermediate care beds
- Outpatient appointments to drop from six to three months
- Patients given copies of clinicians' letters
- Single-handed GPs to sign up to 'new contractual quality standards'
- Annual appraisals from 2002
- Mandatory audit from 2002 to support revalidation
- The GMC to be part of new umbrella organisation of regulatory bodies
- Assessment centres to oversee doctors' performance from 2001

Increasingly, patients who currently go to hospital will be able to have tests and treatment in one of 500 new primary care centres. Consultants who previously worked

only in hospitals will be seeing outpatients, in these settings, while 'GPs with special interests' will be taking referrals from their colleagues in fields such as ophthalmology, orthopaedics and dermatology. The model for these is untested. Similarly, the investment in intermediate care represents something of a triumph of ideology over evidence.

After nearly a decade of rhetoric in support of the 'primary care-led NHS', there is little evidence of a shift in the balance of NHS expenditure.[28] In absolute terms, it is the acute sector which continues to attract most new money. In many areas, PCG mergers give PCTs the aura and scale of the health authorities they replaced. Will PCTs have the critical mass they need to lever resources from hospitals into community-based services? Or will they fossilise as their bureaucracies burgeon rather than develop the agility needed for efficient commissioning?

NHS Direct opens up new approaches to demand management. The vision is of a single phone call to the one-stop gateway to all out-of-hours health care. Many primary care providers will be nurse-led and ostensibly more cost-efficient. The same substitution of less expensive human resources is reflected in new extended roles for pharmacists. Ten key roles for nurses equip them to take on hitherto medical tasks in line with their North American counterparts. GP sub-specialists similarly will take on work previously undertaken by hospital consultants.

Progress on partnership building at the level of the PCG/T is as yet patchy. The jury is out on whether these organisations can really work effectively beyond the health service to tackle the determinants of health inequalities. Though they are only slowly developing their commissioning functions, PCTs provide a vehicle for the increasing integration of health and social care. The proposed Care Trusts, bringing together health and social services funds, are unlikely to overcome all the long-standing barriers to joint working at this interface but they remain a logical progression.

The quid pro quo

If the Plan signals a major investment in new staff and facilities, the Government clearly expects more than just 'principled motivation' in return. The early emphasis by the Labour government on increased regulation of professionals is considerably strengthened under the Plan. The most significant change to the ways GPs work will be the elaboration of a new contractual framework building on the stipulations for improved outcomes that are supposed to be inherent in the PMS approach. Small and single-handed practices are an immediate focus for this.

New Labour has been repeatedly criticised for its centralising tendencies at the expense of local experimentation. Henceforth, subject to satisfactory performance, NHS bodies are promised considerable freedom from central supervision and interference ('earned autonomy'), but new accountability structures are being created. The Modernisation Agency and countless task-forces are overseeing implementation. The capacity of the Commission for Health Improvement ('Ofdoc') has been extended. Though couched in a vocabulary suggesting local discretion, the NHS Plan tightens central control. Whatever the Government's intentions, clinicians and managers fear they will be operating within an environment that is increasingly dominated by pre-determined clinical frameworks and an enhanced performance management framework.

Conclusion

For those of an apocalyptic disposition, general medical practice is ever on the edge of revolutionary change. The collectivisation of primary care under Labour marks a move toward managed care under UK-style health maintenance organisations. The PMS initiative heralds the end of the national contract and changes the nature of independent contractor status. Much generalist care will be provided not by individual practitioners but from inter-professional units under local contracts. As today's surgeries increasingly become the service outlets for larger primary care organisations, many 'corner shops' will disappear.

Demographic and other pressures on the primary care workforce carry their own imperatives. Persisting nurse shortages and the retirement of a cadre of overseas-trained general practitioners serving inner city populations determine the need for new networks of provision. Both within and out of hours, a plurality of nurse-led providers will form the first point of contact. In many respects, nurses *are* the future of primary care.

A key strength of UK general practice has been its comprehensive financing system. There are risks in unravelling the GPs' national contract – but potential gains too. Top-down governance is acknowledged as having failed to provide the innovation or responsiveness to deliver sustained improvement in patient care. The third way of a new post-PMS contract could yet liberate the local entrepreneurs. The enduring advances of the last 30 years must not be swept away by ill-judged 'modernisation'. How has the profession responded?

References

1. Hannay D, Mathers N. General practice, management culture and market ideology – bedfellows or culture clash? *British Journal of General Practice* 2000; 455: 518–19.
2. Starfield B. Is primary care essential? *Lancet* 1994; 344: 1129–33.
3. Secretaries of State for Health. *Working for Patients.* Cm 555. London: HMSO, 1989.
4. Le Grand J, Mays N, Mulligan J-A, eds. *Learning from the NHS Internal Market. A review of the evidence.* London: King's Fund, 1998.
5. Department of Health. *The New NHS: modern, dependable.* London: The Stationery Office, 1997.
6. Wilkin D, Gillam S, Leese B, eds. *The National Tracker Survey of Primary Care Groups and Trusts. Progress and challenges 1999/2000.* Manchester and London: National Primary Care Research and Development Centre/King's Fund, 2000.
7. NHS Executive. *Shifting the Balance of Power.* Leeds: NHSE, 2001.
8. Secretaries of State for Health in England, Wales and Scotland. *Choice and Opportunity. Primary care: the future.* London: HMSO, 1996.
9. Lewis R, Gillam S, eds. *Transforming Primary Care. Personal medical services in the new NHS.* London: King's Fund, 1999.
10. Huntington J, Walsh N, Barnes M, Rogers R, Baines D. This is your pilot speaking. *HSJ* 2000; 110 (5716): 30–1.
11. Calman K. *Developing Emergency Services in the Community. The final report.* London: NHS Executive, 1997.
12. Munro J, Nicholl J, O'Cathain A, Knowles E. *Evaluation of NHS Direct First Wave Sites. Second interim report to the Department of Health.* Sheffield: Medical Care Research Unit, University of Sheffield, 2000.
13. Jones M. Walk-in primary care centres: lessons from Canada. *BMJ* 2000; 321: 928–31.
14. Guthrie B, Wyke S. Does continuity in general practice really matter? *BMJ* 2000; 321: 734–5.
15. Lewis R. *Nurse-led Primary Care.* London: King's Fund, 2001.

16. NHS Executive. *A First Class Service: quality in the new NHS.* London: Department of Health, 1998.
17. NHS Executive. *Supporting Doctors, Protecting Patients.* London: The Stationery Office, 1999.
18. Wye L, Rosen R, Dewar S. *Clinical Governance in Primary Care. A review of baseline assessments.* London: King's Fund, 2000.
19. Muir Gray J A. Post-modern medicine. *Lancet* 1999; 354: 1550–3.
20. Florin D, Coulter A. Partnership in the primary care consultation. In: Gillam S, Brooks F, eds. *New Beginnings – towards patient and public involvement in primary health care.* London: King's Fund, 2001.
21. Tudor Hart J. *A New Kind of Doctor.* London: Merlin Press, 1988.
22. Skrabanek P. *The Death of Humane Medicine and the Rise of Coercive Healthism.* London: Social Affairs Unit, 1994.
23. Charlton B. Public health medicine: a different kind of ethics. *Journal of the Royal Society of Medicine* 1993; 86: 194–5.
24. Fitzpatrick M. *The Tyranny of Health – doctors and the regulation of lifestyle.* London: Routledge, 2001.
25. Gillam S, Abbott S, Banks-Smith J. Can primary care groups and trusts improve the population's health? *BMJ* 2001; 323: 89–92.
26. Lewis R, Gillam S. The NHS Plan – further reform of the British health service. *International Journal of Health Services* 2001; 31: 111–18.
27. Secretary of State for Health. *The NHS Plan: a plan for investment; a plan for reform.* Cm 4818-I. London: The Stationery Office, 2000.
28. Gillam S. Homeward bound? Just how far have we come in re-directing resources to primary care? *Health Management* 2000; November: 14–15.

Chapter 3
Feeling the pressure – how has the profession reacted?

Doctors' stock

The NHS remains popular as an institution for what it symbolises – a central part of the social fabric to which public and politicians alike remain committed. Yet the corporate altruism of the postwar period that gave rise to the Welfare State can no longer be taken for granted. Nor can a utilitarian commitment to universal coverage. Support for a state-controlled system and the notion of a 'public service' ethos has steadily eroded under a growing combination of pressures. They include rising consumer expectation, technological advance and demographic change – the forces that have ensured that demand for health services steadily outstrips supply. These pressures have faced the NHS since its inception 50 years ago; others have intensified more recently.

Doctors feel that, while they retain public respect, in terms of social status, pay and professional autonomy, they have been steadily losing ground. In an information-rich society, health professionals are struggling to come to terms with a shift in power relations with ever-more knowledgeable patients. Day to day, loss of trust is reflected in rising levels of complaints and increasingly frequent litigation. The public's expectations continue to outstrip the health system's capacity to deliver change and, in particular, to increase access.

On the other hand, trust is multi-faceted. The public seems able to distinguish wider societal concerns from the trust that derives from personal contacts moulded over time. Patients consistently attach highest priority to three particular facets of general practice.[1] They want a personal relationship with someone who communicates well and who understands them. Second, they need to know that their doctor is technically sound in clinical terms. Third, they want to be able to rely on their general practitioner as a source of information, as someone with whom they can share decision-making. Personal care and continuity are not necessarily the same thing but the latter provides the doctor with the contextual knowledge required for the former.[2]

And there is plenty of evidence to suggest that levels of satisfaction with general practice remain high. But surveys also reveal consistent generational differences with people aged over 65 years broadly more satisfied than younger people.[3] This may in part be a 'cohort effect', with greater support for the NHS evinced among those old enough to remember what preceded it. It is more likely to relate to changing needs. With age and the onset of chronic conditions, instant access may become less important than personal care. In other words, much of what both server and served value is shared – and enduring.

Old wars, new battles

The impact of the NHS Plan was always likely to hinge on the manner of its implementation and the Government well understood the importance of neutralising medico-political power bases. The document positively glowed with the endorsement of twenty-five high profile signatories from across the health service. The profession's leaders were, however, soon backtracking as the grass-roots made plain their ennui. The appeasement offensive began with cries for 10,000 more GPs in the run up to the 2000/01 annual pay bargaining round. The trades union has been brazen, but the Government for its part has been quite as tactically crude. As discontent mounted in spring 2001, the Prime Minister in one of his many paeans to general practice, doled out £100 million worth of 'incentives' (pre-electoral bribes) – assorted direct payments, golden handshakes and cuffs. None of this impressed the profession.

Ministers are frustrated that extra investment, more pay and power to primary care has so far yielded limited change. GPs are similarly short-termist. They attribute their burgeoning workloads to the Government's reforms. For this there is little evidence; demand has been increasing for decades.[4] Neither side seems to have understood the core of the other's concerns. This is ironic, for politicians and general practitioners share common burdens. Onto both is projected blame for all that is wrong in the lives of those they serve. They are buffeted by events beyond their sphere of influence.

The GPs' malaise is really about loss of control – living with the uncertainty of change, new primary care organisations intruding into the surgery, the imperatives of

clinical governance, greater external regulation and tightening professional accountability. Despite pledges to the contrary, more structural change and central directives generate new bureaucratic chores. All this is against a backdrop of media harassment post-Shipman. Contradictions in government documents – is it greater access they want or more continuity? – increase the feeling that no one up there understands them. Bearing daily witness to suffering is an exhausting business, but the Government appears to value glitzy walk-in centres and telephone helplines rather than traditional forms of care. Politicians have raised expectations that the profession feels powerless to deliver.

It is hard to articulate the cognitive dissonance experienced in an outer world where you are measured in terms of waiting times, prescribing expenditure, mechanistic indicators of activity and your contribution towards aspirational health targets you can be decently sure are meaningless. The world within, your place down the years across interlocking webs of human experience, is indescribably more complex. The coarse reductionism of the planners and politicians belittles both you and your patients' life experiences.

Doctors have therefore hit back – with threats of resignation and days of industrial action. The leadership are caught between a rock and a hard place but their strategy is high risk. Parallels are drawn with 1990, or even 1947, when the profession opposed other strong governments – and lost. The rank and file are divided. While many GPs clamour intermittently for charges, successive BMA reviews of different NHS funding options have reasserted the merits of the status quo. The majority of doctors claim commitment to the founding principles of the NHS. Thinking through the implications of mass resignation tends to amplify the hollowness of this threat. How many doctors really want to exchange the security (and income) of the status quo for the hazards of the market place? Furthermore, 20 per cent of GPs now work to local contracts under PMS. These doctors will think hard before dancing to the tune of an organisation that, while keen to represent them, remained until recently ambivalent about their very existence. This government's health spending may not match the average proportion of GDP spent in the rest of the European Union, but most health service employees appreciate that its largesse is unlikely to be repeated.

The union's position – threatening withdrawal from the very institution they claim to be defending on behalf of their patients – looks weak, but neither does the Government want vitriol poured into 6 million voters' ears each week. So, the two sides have come together to battle over the terms and conditions of a new contract. A variant on the current PMS core contract will not play well with the troops, but with a strong, new government, a divided profession, the spectre of salaried practice – compromise is likely.

New opportunities

Could the emergence of many more salaried non-principals create a new form of 'two-tierism' with less well-remunerated, peripatetic doctors providing more care in deprived areas? Will PMS inadvertently lead to the emergence of 'ghetto primary care' for under-served groups?[5] Or will these changes mean that personal care may be restricted to those with complex chronic diseases – from their specialist GP or community consultant – or for those private patients able to pay for extras?

Such visions are unduly pessimistic. The emergence of powerful GP managers and medical directors need not be accompanied by the relegation of their caring role. History suggests that health service users will continue to place a premium on these traditional virtues – and there is no reason to suppose that nurses cannot provide them as well as doctors. The trade-off implied between personal continuity and modern care can be exaggerated. A greater challenge both to the new primary care organisations and to the health workers within them is to meet the varying needs and demands of service users for the information they need to share decision-making. Creative use of IT, particularly the Internet to communicate with patients, will be central to future clinical practice. Fundamental redesign rather than ever-faster spinning of the 'hamster wheel' of health care is likely to be the only way to sustain the NHS and those working within it.[6]

Apothecaries and barber surgeons began working from their 'surgeries' nearly 200 years ago. Their descendants are reclaiming surgical skills, and the ambitious investment programme for NHS LIFT suggests that pronouncements on the death of

the surgery maybe premature. Practices are likely to remain the basic building block for the time being. A single electronic record will in time offer exciting opportunities to integrate information from different providers and to support more self-care from home. Primary care trusts offer an administrative and organisational model to support service integration, for example out-of-hours, more cost-effectively. PCTs are already realising, not the gulag, but opportunities for virtual integration (across networks of primary care professionals) and vertical integration (with colleagues in secondary care) around which to expand community-based services – a prerequisite of 'fundamental redesign'.[7]

Conclusion

New Labour has staked its reputation on reform of the NHS, but the election campaign underlined the dangers of continually fuelling public expectations. From the perspective of general practitioners, there is little in the NHS Plan that really tries to limit demand. Its proposals for modernising access are akin to continual road building schemes as an answer to traffic congestion. The more you provide the busier the routes.

If the NHS Plan is seen to be failing, more far-reaching reviews are inevitable. Can different forms of public involvement or doctor–patient relationships underpinned by decision-making that is properly shared really be fostered without changing the financial leverage at users' disposal? Many GPs have always been sympathetic to a wider range of incentives designed to rationalise (i.e. limit) the use of their services. The prospects of new forms of public–private partnership are perhaps less threatening to the culture of general practice, but GPs' ambiguous support for the NHS is likely to be tested as private sector involvement is extended.

Doctors are easily portrayed as part of the problem as they grapple with their responsibilities for modernisation. Once more they have appeared to 'dig in' – to resist central control and to assert financial independence. Echoes of 1911, 1948, 1966, 1991 ... History suggests that politicians underestimate the power of the profession's representative bodies but they may nonetheless be tempted to take the doctors on.

Many professions are under threat but, from the inside, the medical profession feels peculiarly vulnerable. Little wonder that GPs show little enthusiasm for the opportunities these reforms undoubtedly offer.

References

1. Roland M, Holden J, Campbell S. *Quality Assessment for General Practice: supporting clinical governance in primary care groups.* Manchester: National Primary Care Research and Development Centre, 1998.
2. NHS Executive. *National Surveys of NHS Patients. General practice 1998.* London: Department of Health, 1999.
3. Horsdahl P. Continuity of care – going out of style? *British Journal of General Practice* 2001; 51: 699–700.
4. Mechanic D. How should hamsters run? Some observations about sufficient patient time in primary care. *BMJ* 2001; 323: 266–8.
5. Lewis R, Gillam S, Jenkins C, eds. *Personal Medical Services: modernising primary care?* London: King's Fund, 2001.
6. Morrison I, Smith R. Hamster health care. *BMJ* 2000; 321: 1541–2.
7. Rutter I, Hill L. Primary Care Trusts – cut to the quick. *HSJ* 2001; 111 (5775): 24–5.

Chapter 4
Modernisation – the bigger picture

General practice and government

There are many aspects of general medical practice that are politically attractive. Successive governments have admired its capacity to absorb and divert health care demand; to balance the differential use of clinical resources according to particular individual circumstances; and to manage its own affairs, from education to remuneration, with relative equanimity. Out of general practice have sprouted, at a surprising pace, an extraordinary range of alternative primary care organisations: from multi-funds to walk-in centres.[1,2] The options for central policy development at the frontline of health and social care have become very rich indeed. Moreover, through all the organisational changes, and inevitable tensions associated with the profession of general practice, the latter has continued to retain enviable levels of public confidence. For the present Labour government, as for its predecessors, GPs represented a major political opportunity to install the kinds of leadership required to 'modernise' the NHS. Hence, despite the plaintive cries of other Family Health Services contractors, doctors have occupied the majority positions on primary care group boards and primary care trust executive committees.[3] The contemporary 'partnership' agenda may be about integrating a range of professional players into governance arrangements, but medical primacy remains a political fact of life.

Unlike its Conservative predecessors, however, the present government does not have a natural affinity with general practice. The self-employed businessman, employing staff on largely local conditions; selecting his own partners, in private; determining patterns of service delivery according to income profiles; and using the site of these services as a personal pension fund and capital investment – all this is not quite the new Labour image of a natural 'modernised' public service agency. But the problem is not membership of the independent sector *per se*. After all, this is the government that engineered a nation-wide concordat with the private health care industry as an affirmation of commitment to a mixed economy of providers.[4] The issue is rather what that independent status signifies. General practice seems to belong to the

hierarchic, male-oriented, single discipline structures of an institutionally based society that pre-dates post-modern communities with their more flexible boundaries, relative values, complex whole systems and political emphasis on engineering social solidarity. Peter Drucker's definition of contemporary citizenship captures beautifully, if not the spirit of the new age, then certainly its aspirations:

> *Every developed country needs an autonomous, self-governing social sector of community organisations. It needs it to provide the needed community services. It needs it above all to provide the bonds of community and to restore active citizenship. Historically, community was fate. In the post-capitalist society and policy community it has become a commitment.*[5]

This aspiration places general practice firmly on the side of 'fate'. It is seen, and has too often simply seen itself, as part of the predestined order. The forces of modernisation, according to the cluster of social scientists and political theorists whose writing and thinking underpins the present government's view of the world, are all about overhauling if not overturning this order.[6,7,8] Moreover, these forces directly impinge on general practice. Together they pose questions that compel the creation of a new model of primary care, in which the principles of general practice may prevail, but not much else (Box 4.1). These questions relate directly to the five forces of modernisation listed in Box 4.2. In essence they are those which today's students of contemporary primary care policy most often ask.

Globalisation is the most frequently cited of the five forces of modernisation. The revolution in information management and technology, new computerised communication systems and interdependent corporate developments across the international economy, *inter alia*, add up to a world in which conventional boundaries count for less. Effective organisations operating across continents are viewed as the essential prerequisite for political, social, financial and even personal coherence and standardised order. It is increasingly organisations like the World Bank, the G7 and the World Health Organisation that define the overarching policies within which

Box 4.1: Modernisation – the fundamental questions arising

1. Where should the future responsibilities reside for generalist care?
2. How can membership organisations be created to ensure wider ownership of modern primary care?
3. What is your franchise in terms of legitimacy to practise as a local primary care organisation?
4. Which partnerships count as most important for the delivery of primary care's changing roles?
5. (When) will the differences be real in terms of clinical and service quality, and community health?

members of the European Union exercise local discretion and powers of regulation. For example, they ensure that the growth of trans-national life sciences companies is geared to the goals of the WHO's Alma Ata Declaration on primary health care, and not just to the premium and profit requirements of the New York Stock Exchange, where Astra Zeneca, GlaxoSmithKline and their counterparts now often occupy places in the 'top ten'. It is at the European level now that national targets for screening, drugs misuse, immunisations and preventable morbidity are aggregated and aligned.[9] No single national model of health care seems sacrosanct. As nurses and doctors increasingly cross state boundaries to study and work, so too do service policies, models and standards.

For how long can any traditional professional monopoly elude the European tendering requirements of fair competition? How does the denial of direct specialist access square with the translation of global initiatives on human rights and public information? What forms of social market can ensure that it is patients themselves, actual and prospective, who determine what constitutes general practice in the future? With these questions the proponents of globalisation come face to face with the future of UK primary care and its main profession.

Box 4.2: Modernisation – a summary

Theme:	Social Justice	
Forces:		
	Globalisation	- multi and international corporate developments
	Individualism	- advocacy for new citizenship and consumerism
	Governance	- realignment of rights and responsibilities in response to new political relationships
	Ecology	- new scientific capability to shape and respond to the environment
	Radical Centre	- power to effect change by majority as a critical mass for positive developments
Outcomes:	Improvements in:	- participatory democracy
		- social solidarity and inclusion
		- professionalism and quality systems
		- regulated integration of health and social policies
		- sustained economic growth

Globalisation has compelled nation states to look to their laurels. The simple alignment of government with direct public services provision and management is no longer viable. When twinned with the new individualism that is the second modernising force, globalisation has ensured that the UK's political leaders have had to reappraise their roles.[10] Indeed, faced with the delegation of powers to continental levels on the one hand and regional devolution on the other (e.g. the Welsh and Northern Ireland assemblies each with their own health ministers), the Government is redefining its role. A new basis for its relationship with the electorate is critical to its continuing authority. This is frequently to the discomfort of such traditional professions as general practice.

Public health and public policy

Leadership of public health is a part of these new roles, as represented in the UK's two national health strategies over the past decade.[11,12] Public health is being ever more broadly defined and now includes socio-demographic inequalities not just disease profiles. It is reaching out to assume rights over the ways in which local relationships, especially at organisational levels, are structured and processed. The policy framework for the post-1948 NHS articulated the right to health care of the individual and the responsibilities of the State. In the post-1997 nation-wide health system, these are frequently reversed. To exercise political leadership (on public health and health care) government has to assert its rights over all sectors, whatever their status. It is the inspector of the nation's performance. Moreover, in defining what is required of the individual, both to raise awareness and maximise support for hard-pressed health care providers, the Government has no alternative but to emphasise personal responsibility.

In this context, the profession of general practice finds itself under more political pressure than ever before. The local and central boundaries of the modernised NHS are in conflict. GPs are being squeezed between the two. There are no protective intermediate tiers any more. The classic approach to public policy analysis, whereby each stage in the sequence of implementation dilutes the force of the political will, scarcely applies.[13] Without regional professional committees or district health authorities, it feels as if there is no facility to trade for more time, more local discretion or fewer national imperatives. There is now no hiding place from central government on the one hand or the informed, Internet-using, litigation-conscious consumer on the other. Independent contractor status is certainly no protection. Indeed, it seems increasingly to be a liability and an anachronism. Both the local and central agendas point to expectations of a new primary care that the general practitioner in his or her 'surgery', by definition, cannot fulfil. These expectations incorporate clinical expertise *and* population-wide prevention programmes plus, through primary care trusts, the accountability for managing the provision of specialist care as well. Individual, community and group responsibilities are now the multi-

layered framework for the practice of primary care. It is not only intrinsically about inter-professionalism, but about new professions as well.

Space, succour and smallness have long been important both conceptually and practically for GPs. They are not so much appreciated now. They are not financially valued. Their effects on clinical efficacy are unquantifiable. Modernisation is about the 'big picture'. Its third and fourth dimensions are directed at the new connections which shift accountabilities from exclusively hierarchic to multiple and often lateral and diagonal relationships, through governance; while the modern emphasis on ecology embraces an environment in which scientific knowledge is instantly international. Mechanical, agricultural and human engineering are increasingly interwoven, and environmental management itself is now regarded as a responsibility of primary health care because of its immense influence on both individual and public well-being. This is a far cry from the simple GP armed with antibiotics for the patient's infectious disease. It signifies the step change in which primary care in the UK is being joined to contemporary network theories of public policy development.[14]

Modernisation of primary care compels its professions individually and collectively to reconsider what is their franchise, and to assess priorities for their future working relationships. As Table 4.1 illustrates, the profile of these relationships is rapidly expanding and changing.[15] Which partnerships really count? What will be the terms of reference for a commissioning tender? These are not simply academic or rhetorical questions. Prospective European anti-monopoly legislation, the extended professionalisation of nursing, citizens' choice and managed care movements are all powerful 'modernising' mechanisms at play here. Increasingly, the profession of general practice is being required to demonstrate, and display, the real difference it makes.

So far, GPs have relied on popular support for their responses. In the latest general election campaign they produced the results of their own ballot about dissatisfaction with the NHS just days before polling day. Their thinking is still that 'the overwhelming majority are behind us'. Moreover, a basic professional tenet of GPs has been to advocate on behalf of their individual patients against the health-

impinging excesses of governments; whether they be on the left or the right. This position over the past century has led to many admirable instances of general practice campaigning for improved social and economic conditions, especially in areas of high unemployment, urban and rural deprivation.[16] Latterly, this led to our own involvement in the community-oriented primary care movement.[17]

Table 4.1: Primary care partnerships

Pre-PCGs		Post-PCGs
(1999/2000)		(2001/02)
Intra-Practice		Social Services Department
Health Authority		Community Nursing Team
(Hospital) Provider(s)		Clinical Management Groups
		Councils
		Local Media
		Key Community Groups
		NICE/CHI
		Health Authority
		Finance Brokers
		Pharmaceutical Companies
		IM & T Facilities/Suppliers
		NHS Direct
		Other PCG/Ts
		National PC Associations
Operational	→	Strategic

Based on survey of 50 primary care groups. In: Ashcroft J, Meads G (2000), *Op. cit.*, Chapter 1.

Modernisation, however, fundamentally realigns – in Drucker's words – 'the policy community'.[18] It is the pragmatists, of no particular persuasion, who are now legitimised, and expected to be the radical centre. This means 'you and I', not 'them and us'. Ordinary people, the majority, will shape public service systems in conjunction with their political leadership. Self-determination by professions does not get much of a look in here. It is no part of the political paradigm.

The impact of such thinking on the individual general practice of such perspectives is potentially devastating. The practice has been *the* unit of UK primary care for as long as we can remember. Automatically it has been the focus for development. Understanding its dynamics has been axiomatic to the effective formulation of policy. This psychological primacy has been reflected in national financial strategies and structures. All incentives, rewards and (few) penalties have been directed at harnessing the developmental energies of the individual practice. Modernisation requires a fundamental reappraisal of these national systems. The annual waves of PMS pilots and the shift to fewer strategic health authorities help prepare the way for such a review, but it will be more far-reaching than many yet realise.

Our concluding chapter therefore looks at the future of general medical practice as a profession. At present the danger is that it becomes defined only by and at its margins. The need is for a reinvigorated centre.

References

1. Mays N, Dixon J. *Plurality in Purchasing.* London: King's Fund, 1997.
2. Meads G, ed. *Future Options for General Practice.* Oxford: Radcliffe Medical Press, 1996.
3. NHS Executive. *Primary Care Trusts: establishment, the preparatory period and their functions.* London: Department of Health, 1999.
4. Higgins J. Let's drink to that. *HSJ* 2001; 111 (5737): 22–4.
5. Drucker P. *Post-capitalist Society.* Oxford: Butterworth-Heinemann, 1994.
6. Etzioni A. *The Spirit of Community: rights, responsibilities and the communitarianism.* London: Fontana, 1995.
7. Giddens A. *The Third Way. The renewal of social democracy.* London: Polity, 1998.
8. Seedhouse D. *Health: the foundations of achievement.* Chichester: John Wiley, 1995.
9. Boerma W G, Fleming D. *The Role of General Practice in Primary Health Care.* WHO, London: The Stationery Office, 1998.
10. Ham C. *Health Policy in Britain.* 4th ed. Basingstoke: MacMillan, 1999: 51–71.
11. Secretary of State for Health. *The Health of the Nation.* London: Department of Health, 1992.
12. Secretary of State for Health. *Saving Lives.* London: Department of Health, 1999.
13. Pressman J, Wildavsky A. *Implementation.* Berkeley: University of California Press, 1973.
14. John P. *Analysing Public Policy.* London: Continuum, 1998: 66–91
15. Ashcroft J, Killoran A, Cornish Y, Meads G. *Can Primary Care Organisations improve Health as well as deliver Effective Health Care. Mixing oil and water.* London: HEA Publications, 1999.
16. Tudor Hart J. *A New Kind of Doctor.* London: Merlin Press, 1987.
17. Pietroni P. The greening of medicine. In: Pietroni P, Pietroni C, eds. *Innovation in Community Care and Primary Health.* Edinburgh: Churchill Livingstone, 1996: 15–18.
18. Gillam S, Miller R. *Community Orientated Primary Care – a public health experiment.* London: King's Fund, 1997.

Chapter 5
The fall and rise of general practice

Moving forward

While the forces of modernisation may seem threatening, closer examination of the profession's frontline points to many positive opportunities. Its twentieth-century rise does not necessarily have to be followed by a post-millennial fall.

Training, professional development and the research base for the discipline are steadily developing. General practitioners are embracing computer technologies in ways that enhance quality of care and relationships with patients. Approaches to quality improvement are being slowly systematised and more clinical information is being shared within and between practices.[1] Primary care trusts are concentrating on strengthening their local community service infrastructures,[2] even at the expense of attention to their new commissioning responsibilities. The increasing contribution of community hospitals and health centres is, more often than not, driven by local doctors' desire to manage their patients in locations through which, in personal and financial terms, they share a sense of ownership.[3,4]

The early years of the twenty-first century have genuine echoes of those of the nineteenth century. Two hundred years ago, with a rather different threat of European dominion looming, English GPs were demonstrating their own Napoleonic spirit. Their new 'surgeries' then represented a radical departure, separating the general practitioner from the community pharmacist (apothecary) and the established hospital-based physician. Their surgeries took personal health care to the people and the people followed them.

Modern general practitioners need to emulate their ancestors if they are to sustain their position as the country's most popular profession. They should and can avoid the reductionist slide into managed care activities, particularly if this focuses financial incentives and quality assurance on the easily measurable.[5,6] They should hold firm to the conviction that the fundamental imperative for general practice as a profession is

not medical, but moral. By remembering their roots – providing care to communities, families and pre-eminently individuals – general practitioners can regain collective self-confidence.

Beyond a new contract

A new national contract alone is not enough. At best, it can provide a safety net for minimum service standards nationally. At worst, it may be a centralising mechanism for more prescriptive national control. Fortunately, general practitioners themselves are increasingly making these assessments for themselves. By April 2000, a quarter in England had expressed formal interest in personal medical services contractual arrangements. A year later, the British Medical Association was threatening mass resignations to support its negotiations for improved GP 'terms of service'. Clearly a climate for change exists, even if the PMS 'opt out' option and trade union-style tactics represent essentially negative impulses. The positive part of the present narrative is simply that conditions prevail in which there is the opportunity to revive general practice as a profession.

How can this happen? What would constitute a re-assertion of the moral imperative for personal and pastoral care in a modern context? If its rise over the past two centuries has depended upon being so in tune with grass-roots society and class cultures that most people came to accept, without questioning, their GP as a natural phenomenon, what could be the sources of a comparably empathic relationship in future?

The answers lie in the profession of general practice demonstrating the courage of its convictions. This means continuing to behave as a profession: self-determining, independently practising but peer-supported and, above all, ethically committed to public service through principal relationships of direct, reciprocal accountability with local people at an individual level. It means getting rid of the baggage of the past, where this no longer belongs to the present or the future. But it also means GPs recognising that they can, if they choose, control their destinies. The means are still theirs. For example, primary care trusts could easily ape past health authorities and

become bureaucracies. They could even see GPs end up as a mixture of local authority employees and NHS Trust outposts if the new NHS lateral and vertical integration agendas hold too much sway. It is naive to deny that some powerful local councils and large hospitals do not see, in these modernisation menus, political opportunities to absorb general practice into their extended management of social and secondary care. But these are not inexorable trends. General practice possesses the status, skills, staff, systems, sympathies and synergy for regeneration. In classic management terms, the two 'S's that are missing are strategy and structure.[7] The logistical questions of where?, when?, who? are a distraction if they lead to an excessive focus just on the details of operational efficiency and effectiveness. For general practice the focus now must be on the how? and the why? – the 'big issue' questions. Clarity of strategy and purpose is crucial to the survival and development of the modernised GP professional.

There is much old baggage to jettison, beginning with the national contract. It has no place for a self-respecting modern profession. Relying on an instrument of state to preserve a service simply as a tradition is an insult, both to its practitioners and the public today. It smacks of restrictive practice, of income protection, and, above all, of fearfulness in the face of contemporary changes. Education, housing, transportation and all other sectors of public service are accelerating down a road to new kinds of partnership, participation and public accountability. General practice needs to do the same. In the contemporary context, the personal and pastoral care GPs offer merits not crude, centrally administered contracts but the consolidation of co-ownership arrangements with community representatives, the commercial integrity of a (social) market sustained service provider, and the endorsement of patient-citizens. New mechanisms for framing personal health care include individualised accounts, covenants and electronic health records. Some practices have already experimented with forms of personal contract.[8] Gift-aid is not new to practices that enjoy close links with the communities they serve.

Reactionary notions of clinical freedom are redundant. Reform of the processes of professional self-regulation was long overdue. The profession's leaders at the BMA or RCGP have broadly supported the thrust of clinical governance, but too much internecine squabbling over the detail risks alienating the public. Ready co-operation

with new forms of scrutiny is another marker of professional strength. Future general practitioners will look back disbelievingly on the days before regular revalidation, when information on clinical performance was not freely shared with patients.

In practical terms, we need to move beyond just diversity of primary care organisations to their deregulation. General practice as an exclusive professional legal partnership is an anachronism. Its ownership and management now require different criteria and forms. PMS is more than just a safety valve allowing self-determination for the entrepreneurial. It has spawned new types of primary care organisation.[9] The more innovative PMS practices are delivering primary health as well as medical care supporting new forms of practice-based community development in areas of high need.[10]

Future personal care arrangements

Continuous personal care remains, and must remain a principle to die for, but the rigidities of individual GP-only registered lists, with their associated automatic rights of closure and fixed local limits, are no longer appropriate to mobile populations. Most people would be astonished if they knew how general practitioners are still paid: the extraordinary micro-economics of fees and allowances, taxable income, non-taxable grants and differential capitation scales. Even if they could understand the financial system, they could scarcely recognise any reflection of their current service needs. In vain would they search for the profession's monetary incentives to tackle back pain or stress management, long-term disabilities or mental health. They would see that consumerism has scarcely scratched the surface of UK primary care. Simply as service users and payers the modern public and its patients require different ways of sourcing and resourcing their kind of general practice. The parallels with social care and housing are obvious. The growth in domiciliary, respite and residential care has been unprecedented over the past 15 years. Charities, companies, community groups (both local and national), clients and collaborative ventures should all be allowed to play their part.

The personal and comprehensive care offered by general practice in this new context for future resource investment carries a premium. In all kinds of ways, people should be able to show their support – as shareholders, donors, trustees and subscribers. At present, tax-funded general practice is increasingly seen as of marginal value by central policy-makers. Only 8 per cent of the projected new professional resources in the NHS Plan are general practitioners and half of this increase will be swallowed up in the extension of new specialist roles (often in secondary care). Much debate currently surrounds the definition and regulation of 'General Practitioners with Special Interests'. This movement formalises long-standing role diversification in general practice and will strengthen its appeal as a career choice. But the public value and will invest in generalist care. Inevitably, this will increasingly be delivered by nurse (general) practitioners for which they should be supported.[11] They are paving the way for new forms of primary care management as did their forebears for domiciliary and residential care management a decade ago. A decade hence, pharmacists, social workers and others will have challenged GPs' monopoly over primary care leadership.

The new NHS is a difficult place for GPs to thrive in, while it remains centrally prescribed and proscribed. They are used to freedom, the licence to choose and decide for themselves; they rely for their sense of value and motivation on personal caring relationships. There are at least some signs that the need to allow more local self-determination is understood at the Centre.

New structures, new strategies – the rise of general practice

When organisations were simple and society stratified, general practice required respectively diagnoses and drugs, independent practices and the title of 'Family Doctor'. It now demands an altogether different set of combinations. As Box 5.1 seeks to illustrate, the gains outweigh the losses. What is lost is more than made up for by the range and resourcefulness of the replacements. In all senses, a richer future could beckon for general practice. Health care systems are shaped by the imperatives of macro-economics. General practitioners flourished in the days when simply sustaining a fit enough fighting force and efficient industrial labour were the economic

requirements. They can flourish equally in service-oriented, technically driven, leisure- and life-intensive economic circumstances.

Box 5.1: The fall and rise of general practice – as a profession

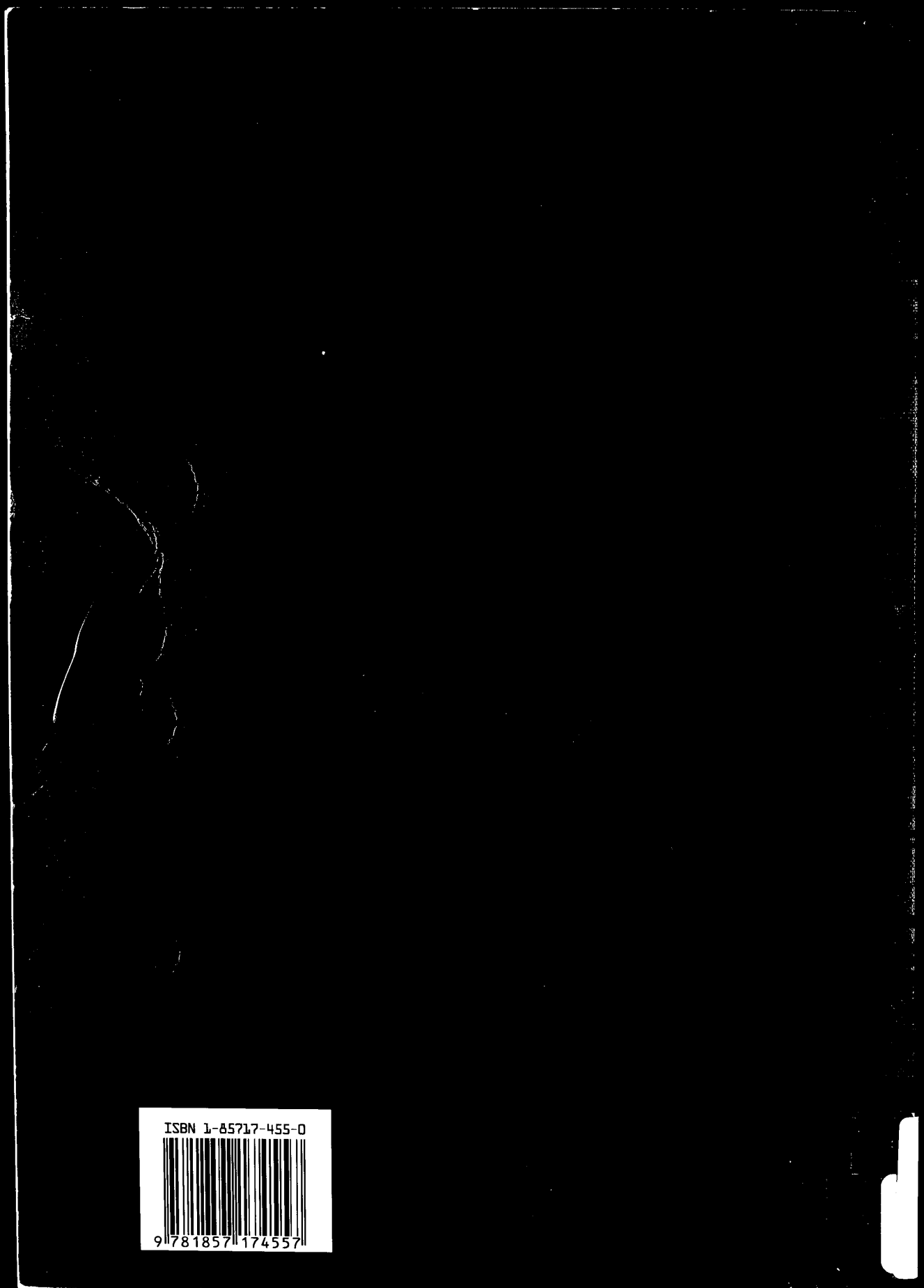
OUT	IN
Structures	**Structures**
– nationally government administered and negotiated GMS contract	– individually covenanted according to personal needs and services offered
– patient registration/local lists	– individual enrolment/membership bodies
– uni-professional, legal partnership monopolies	– multi- and non-professional organisation partnerships
– independent sector status	– multiple status, including voluntary/independent sector providers
– NHS exclusive commissioning (e.g. primary care trust)	– range of approved commissioners, including health care companies professional consortia, and corporate agencies (e.g. charities, employers) without geographic constraints
– Local Medical Committees	– Societies for Primary Care
Strategies	**Strategies**
– micro-medical services and expenses	– long-term, reviewable and renewable outcome/output-based franchises
– distinct medical education and accreditation	– leadership of personal health care course/curricula developments
– sole secondary care gatekeeper/commissioner	– multiple primary care access points with referral rights
– lead primary care organisational management roles	– facilitation/co-ordination of integrated health and social care team leadership models
– separation from social care	– local combinations of resource sharing and service development across public/independent and social services

The main point about Box 5.1 is that the power to reconstruct the profession lies principally with the professionals themselves. GPs alone have the power to both develop the new and depart from the old structures and strategies identified. To nobody else does this apply. Nurses, for example, have never had it so good in terms of both expanded clinical care and career opportunities. The increase in physiotherapists, likewise, is such that the demand for supervisors of the new recruits – especially those coming from other countries – has almost outstripped supply. Other professions are clearly doing well, but general practice remains the only profession of primary care with a body of specialist knowledge, expertise and relationships exclusive to this setting and of a comparable status to the specialist professions in settings such as hospitals, courts and cathedrals. And it still both owns and controls the assets.

Managing the transition will involve trade-offs – for the profession as a whole and for individual doctors – between collective and individual goals. General practitioners have no need to subvert the processes of modernisation. Long after today's structures – these trusts, those pilots – have disappeared, people will seek the personal care that tomorrow's general practice should strive to provide.

References

1. Wilkin D, Gillam S, Coleman A, Leese B. *The National Tracker Survey of Primary Care Groups and Trusts 2000/2001.* Manchester and London: National Primary Care Research and Development Centre/King's Fund, 2001.
2. Meads G, Meads P, eds. *Trust in Experience: transferable learning for primary care trusts.* Oxford: Radcliffe Medical Press, 2001: 2–47.
3. Seamark D, Moore B, Tucker H, Church J, Seamark K. Community hospitals for the new millennium. *British Journal of General Practice* 2001; 51: 125–7.
4. Tucker H. Turning community hospitals into assets. In: Meads G, Meads P. *Op. cit.*: 103–20.
5. Moore G. *Managing to do Better. General practice for the twenty-first century.* London: Office of Health Economics, 2000.
6. Roland M, Marshall M. General practice in an age of measurement. *British Journal of General Practice* 2001; 469: 611–12.
7. Iles V. *Really Managing Healthcare.* Buckingham: Open University Press, 1996. 48–54.
8. Pietroni P. The greening of medicine. In: Pietroni P, Pietroni C, eds. *Innovation in Community Care and Primary Health.* Edinburgh: Churchill Livingstone, 1996: 15–18.
9. Lewis R, Gillam S, eds. *Transforming Primary Care. Personal medical services in the new NHS.* London: King's Fund, 1999.
10. Carter Y, Curtis S, Harding G, Maguire A, Meads G, Riley A, Ross P, Underwood M. *National Evaluation of Primary Care Acts Pilots – addressing inequalities.* London: HMSO, 2000.
11. Lewis R, Gillam S. *Nurse-led Primary Care.* London: King's Fund, 2001.



ISBN 1-85717-455-0