PRIMARY CARE - A VIEW FROM ACROSS THE WATER

Background

There is a common wisdom that very few models for anything used in one country travel well - primarily because most evolve from different historical and cultural traditions. This is probably true, but in my own experience of the last three years in Europe, they can certainly help you reflect on your own system and perhaps develop new ideas about ways around or through apparent obstacles. I always start these comparisons with an important thought in mind from Robert Evans, the Canadian health economist to anyone working in health care :

> "When you think your health care system has got it right
> that's when you're really in trouble."

With that caution, it may be useful to start with a brief overview of the US system seen from the macro level by a foreign audience:

* The predominant characteristic of the US system is its heterogeneity. There is no central planning for facilities, services or health personnel. There is no uniform central financing of the service delivery function. The US Surgeon General's report of 1979, Healthy People (linked to the WHO "Health for All" programme initiative) did, however, articulate a set of central health promotion and disease prevention goals for the nation.

* Health insurance in the US has tended to be largely an employment based system with other programmes developed by Government to fill in the gaps for special population groups. Most notable are Medicare, a Federally funded health insurance programme for the elderly and disabled and Medicaid, a health insurance programme for certain categories of the poor financed jointly by the Federal and State governments with eligibility levels and benefit packages that vary by state.

* Health care financing programmes have tended to focus on institutional acute care and more recently, institutional long term care rather than community based services. The result is a delivery system that is badly out of balance (dominated by the acute hospital and technology) and very expensive. While it is estimated that 30-35 million Americans have no health insurance, there may be up to 70-75 million with inadequate insurance. Individuals are more likely to be insured for in-patient or emergency care than ambulatory or primary care and almost never for preventive services.

* Finally, with over 13% of the GNP going to health care costs, the major US health policy for the past decade has been cost containment. As a result, there is an alphabet soup of financing and organisational models - PROs, DRGs, HMOs/PPOs/IPAs - aimed at lowering costs and, to some degree, promoting quality control through regulatory

framework and financial disallowances for unnecessary services. The primary focus of all these efforts has been the reduction of acute hospitalisation.

While there have been scores of changes proposed to address some of the obvious problems in the US system and some incremental progress is being made, large scale change still seems very difficult.

The British government on the other hand, under Mrs Thatcher wasn't convinced it was getting value for money at slightly under 6% GDP in health and in December 1989 launched a full scale reform of the National Health Service (NHS) with only marginal new resources added.

The goal of the reform was to introduce an internal market to an increasingly decentralised state managed health care system in order to increase efficiency and consumer responsiveness.

When complete on 1 April 1994, in a little less than four years, government policy changes will have been largely implemented to change:

1) The basis for health service financial allocation.

2) The organisational structure and management for hospital and community nursing care.

3) Primary Care and general practitioner services to increase incentives for prevention and shift more power to a set of GPs - fundholders - to buy an array of hospital services on behalf of their patients.

4) The funding and delivery of community care for the elderly, mentally ill and learning disabled to increase de-institutionalisation and transfer management responsiblity from the NHS to local government.

Because, a picture is worth a thousand words, the biggest difference in the US and UK health care systems can be captured by a sequence of three diagrams comparing the "participants" in the US health care system and those in the British system.

[insert figure 1 - 1a,b,c]

The top diagram (1a) shows the basic transaction between a provider (the doctor) and a patient who pays for their own care.

In the pre-reform NHS, the State was the dominant provider with the NHS, administered by through 14 Regions and about 200 districts with GPs on contract to the government. Patients paid taxes in exchange for universal financial entitlement to services.

The second diagram (1b) shows a post-reform NHS in which government has delegated its purchasing authority to 177 (and decreasing) defined District commissioning agencies to buy services on behalf of the population in a defined geographic area. These services are purchased through contracts with

providers which were previously managed by districts but can now apply for quasi independent status as NHS "trusts" and will compete for contracts.

Patients are now, in a sense, the beneficiaries of the District based purchasing agency for acute care and registered on a list with GP or GPFH for primary care. There is now a single intermediary in the UK system. By contrast, one might characterise the current mature or post mature market in the US system by the images in the final diagram (1c). When you see the difference in the number of players involved, you begin to understand some of the reasons for differences in cost and in the pace of change that is possible.

Two additional features of the British system are worth noting - mainly because they were not changed in the reform. They are crucial strengths of their system and crucial weaknesses in ours: universal financial access to health services and primary care.

A final feature and perhaps the most radical is a recent report called Health of the Nation issued in July 1992 which calls for a renewal of the original goal of the NHS is to serve as an instrument for improved population health, not just individual patient care.

What is Primary Care?

One of the big problems in discussing primary care is clarity about what it is. Without this there are great difficulties in deciding who does it, how to teach it and how to strengthen it. Alpert and Charney's functional definition (1) complimented by that of the Institute of Medicine (2) covers the key characteristics of a definition for me.

Primary care services involve the provision of:

1) first-contact care at the patient's point of entry into the health care system

2) comprehensive care to the patient (including preventive, curative and rehabilitative care)

3) continuous care, in which the patient has an on-going, personalized relationship with a primary care provider or team for his/her health care

4) co-ordinated care, in which the primary care provider serves as the co-ordinator of all patient care, including hospitalisation and necessary referrals to specialists, including mental health specialists, and related health and social services.

   The primary care provider acts as the patient's advocate to assure that care received is appropriate to the patient's needs and that the patient is an informed participant in decision-making about the overall care plan and educated as to the appropriate use of the ambulatory care system.

There are two other features of adequate primary care:

5) Assuring access for the patient to needed health services (bars to access can include operating hours, geography, finances, culture, and language);

6) Assuring accountability of professional and administrative staff for the quality of services rendered, the ways in which they are provided, and the outcome of care. This involves accountability to internal and external review criteria as well as to the patient.

In revisiting this definition today, one might add the concept of "community oriented" with primary care providers assuming some role, if not responsibility, for improving the health of the community served (3). When trying to develop health policy mechanisms to support primary care service delivery and education, its important to be clear on your definition so that you can test the models you're developing.

How important is Primary Care?

Another important question to answer before tackling a complex policy problem is: how important is it? It's very important.

My favourite example is shown in an often quoted study conducted in the 1960's by Kerr White (4). In a classic paper using data from the "Survey of Sickness in England and Wales" and the US National Health Survey, he analysed the sickness behaviour of one thousand adults over 16 years of age during one month. He found that of this thousand, 750 experienced some health complaint, of which 250 sought medical attention; 9 of these were admitted to a community hospital, 5 referred to another physician and one admitted to a teaching hospital. Applying these findings to our evaluation of the relative role of components of the health service, we realise that the hospital, clearly the focal point of the traditional delivery and medical education system, is actually needed by less than 4% of individuals who enter the formal health care system. Most are treated in an ambulatory care or primary care setting. A similar review in 1983 showed even less initial use of the physician and, once the patient enter the service system, less use of hospital - a trend likely to continue.

What's So Different About Primary Care?

A key issue is what distinguishes primary care from the traditional dominant and, by virtually all external criteria, outstanding US system for acute service delivery and medical education? Why are so many different structural, financing and educational models needed? A few examples may give you a sense of the differences that must be addressed.

MAJOR DIFFERENCES BETWEEN ACUTE HOSPITAL AND PRIMARY CARE

ACUTE EXPERIENCE	PRIMARY CARE EXPERIENCE
1. Site and pace of work:	
hospital based ward medicine is major use of time, patients seen intensively for short periods of time	outpatient setting is a major focus; patient seen intermittently over long periods of time
2. Goals:	
disease centred problem-solving, disease classification and death prevention	disease prevention, problem management, reduction of discomfort dissatisfaction, worry; health promotion
3. Role Models:	
faculty "stars" in clinical research and high prestige areas of surgery, subspecialty medicine	primary care physician in pediatrics, general internal medicine, family practice (not always on the faculty so therefore low prestige in medical school)
4. Knowledge and skills:	
knowledge, skills, technology in medical "science" are the intervention central focus of training	knowledge and skills in general medicine psychosocial and problem management are central.
5. Diagnosis and Treatment:	
in-patient diagnosis is deterministic and treatment is controlled and closely observed	ambulatory diagnosis relies on probability derived from clinical experience and epidemiology. Treatment is frequently a "clinical trial", with many unknown variables
6. Doctor-patient relationship	
* hospital relationship is time limited and the ward ritual assures a "safe" distance between doctor and patient	relationship between doctor and patient is 1:1, continuous, close and extended in time
* "doctor" is in total control of the environment (med taking, information giving, degree of patient contact with family) while in hospital	doctor has little control over patients' environment, must deal with patient in complex social network
* assumption is made that any doctor can be replaced by any	nature of care creates 1:1 relationships and the individual

other at any time provided s/he has similar skills and experience (ward rotations)	"healing abilities" of the doctor are critical
* physicians are specialists, rarely in position to be criticized since they are solving "problem cases" referred by other MDs	physicians are first in line contacts by the nature of the referral system; are also in a position to be criticized by specialists.
* patient is acutely ill, totally dependent on MD	ambulatory patients are "functioning" at some level, are more self-reliant, may not comply with regimen, are subject to outsid influences
* gratification is immediate: patient survives the CAC; acute infection cured; surgical problem treated	gratification often delayed: chronic disease with long term management, psycho-social problems with ambiguous outcomes
* major need is scientific technology, so the doctor is the key figure, solo performer, autonomous in managing "medical problems"	because of the complex nature of problems, the doctor works on a team and makes decisions collaboratively

So, given these differences, what kind of progress has been made in the US to date in supporting the development of primary care service delivery and education and what are some of the key issues remaining on which the British experience might shed some light?

Primary Care – the US Experience

In many ways my own professional career mirrors the recent era of primary care development in the US and as we now may be moving, however tentatively, beyond the "demonstration" programme or "special project" phase of primary care education and service, it is important to reflect on the history of such efforts so that we don't find ourselves a decade from now, yet again rediscovering primary care.

While my experience is largely in New York, the principles apply more broadly and I know the examples of what has been done there are not unique but exist, sometimes better developed all over the country.

In many ways I "grew up" professionally in primary care in inner city New York. I arrived from Michigan as a pediatric resident in the Social Medicine Programme at Montefiore Hospital in the Bronx in 1971. It was the end of the golden age of the OEO Federal community health centre movement, in which interdisciplinary teams of doctors, nurses and community health workers with legal aid, social and mental health services worked out of a neighbourhood health centre to serve a geographically defined community. I received much of my training in one of these centres affiliated with the teaching hospital. There were several such models in New York City. These were based on a programme run by George Silver in New York City in the 1950's and models in New York in the 1930's described by George Rosen (5,6).

In the 1970's-80's this system, largely designed for the poor, grew to a network of nearly 800 primary care centres around the country. Considerable research on their effectiveness showed them to be models for comprehensive continuing care: accessible geographically and by time; capable of lowering rats of hospitalisation and emergency room use; and lowering State Medicaid bills. Much of richness of the multiservice centre concept was lost with the cost containment pressures of the 1970's, but it is still a vital network and, I note, now being targeted for reinvestment. During this same period of time the HMO movement was being launched as a primary care model for working people.

During the mid to late 1970's, we also saw the initial Federal investment in innovative models for primary care undergraduate and graduate medical education in General Internal Medicine, General Pediatrics, and Family Practice as part of the Health Professions Educational Assistance Act. Since that time, thousands of primary care residents have graduated from many such programs throughout the country and many are now in leadership roles in our major health care institutions.

The National Health Service Corps is another programme of that era which provided mechanisms for financial support of these young doctors and other health professionals to work in medically under-served communities. Again, massively shrunk during the 1980's, the Corps is also receiving renewed attention.

In the early 1980's as President of New York City Health and Hospitals Corporation, we assembled a team charged to put primary care on the corporation's agenda. Ironically, this often meant rebuilding and expanding health care centres and programmes that had existed in the 1970's but had been dismantled during the city's fiscal crisis. It also meant the City assuming financial responsibility for investment in capital and staffing costs, as there was no other source of financial support due to inadequacy of reimbursement and the number of uninsured.

Between 1986-89 eight new primary care and community mental health centres were opened and a new series of hospital linked primary care networks were established around most HHC hospitals. Other academic medical centres around the country were doing the same - some to provide community service and some as good marketing mechanisms to assure full beds.

I've seen some enormous successes and some frustrating loss of ground during what is now over 15 years.

What have we learned from these experiences?

1. US health professionals know how to set up excellent primary care models that can deliver comprehensive services to a defined community:

    * group practices;
    * hospital based primary care services;
    * neighbourhood health centres;
    * primary care networks linked to hospitals;
    * physician homesteading;
    * managed care programmes of all kinds

    They have all been tried and those that have received sufficient resources (human and financial) over a sufficiently long period of time have succeeded in delivering quality care, reducing hospitalisation, and providing effective services to some of the most medically deprived communities in the country as well as to groups of the population with private insurance.

2. We know how to train residents and medical students in primary care settings in both a hospital base and in the community. Since the mid 1970's, graduates of primary care programs in General Internal Medical and General Pediatrics with significantly more primary care and ambulatory care experience, and often less in-hospital experience than their traditional counterparts, have performed well on their board

exams and as clinicians and faculty in our teaching hospitals and medical schools and in the community. Family Practice residents are trained in excellent primary care "teaching health centres" and have been increasingly important primary care service providers all over the country. Similar teaching models have been developed in HMOs and large group practices.

3. We know that the primary care service and training programmes that work are the result of long term partnerships. These partnerships are between the primary care systems, the community served and, in urban or isolated rural settings especially, a back-up hospital or medical centre that can offer specialty support for clinical care and academic continuing education support, including academic appointments to physicians and nursing staff. It has been hard to sustain such partnerships due to the historical priorities of medical education and tertiary care hospitals.

4. We know that primary care programmes are a financial liability because of:

   * the lack of health insurance for large segments of the population in need;

   * inadequate financing of primary care services related to cost, especially when provided by individual primary care physicians;

   * The expense of capital infrastructure for primary care in urban environments

   * inadequate financing of graduate medical education in primary care settings.

   Those institutions with a commitment to such efforts have subsidised them directly or lived off grants and special program funds for years, trying to fill the gaps and keep them running. Some States are beginning to develop financing mechanisms within existing public insurance frameworks to address these issues.

Some of the most talented and committed primary care experts in service and education in the world are in the US and, interestingly are very involved as consulting experts in health reform projects in Western, and East and Central Europe and the former Soviet Union. All of these countries see a strong primary care system as the foundation on which to build reformed health care delivery systems. To achieve this in the US we need the mechanisms to ensure that the kind of on-going financial support enjoyed by hospital based secondary and tertiary care services and graduate medical education in past years is extended to primary care. This support must be institutionalised as part of "the way we do business" if things are to really change.

Reflections from the British Experience

So what are a few of the key policy issues and how could the British experience help us think about them differently? I've selected four for special focus.

* There is a lack of consensus on a single universal paradigm for primary care

This was the major problem cited in the final report of a recent National Primary Care Conference sponsored by HRSA (7). The definition I read earlier would probably satisfy most people on the what. The real issue is, I think, who does it; this is especially an issue in the US because on the answer rests the issue of who gets paid and how much.

The nominees are: Family Practitioners (FP), General Internists (GIM), General Pediatricians (GP) or specialists. In the US, a debate for funding educational programmes has been resolved by the very useful Federal definition that distinguishes Genaral Internal Medicine (GIM) and General Pediatric (GP) graduate medical education programmes from traditional internal medicine and pediatric programmes which most often lead to further specialty training and practice. Family Practice was accepted as a primary care specialty without debate.

An on-going US debate on the role of specialists in providing Primary care, especially in the face of the diminishing number of medical school graduates enterning these primary care specialties, is best captured by Gordon Moore of Harvard in his review article "The Case of the Disappearing Generalists" (8). He examines the arguments for just letting the specialists do primary care because: we don't seem to be able to attract students to it and there are already more than enough specialists and they do primary care anyway. His analysis of the data on the quality and adequacy of comparative practice seems to favour the argument for the primary care physician but he does raise the need for strengthening of training and practice in primary care to realise its full potential.

This debate is a non-issue in most European countries, certainly the UK where there is very clear differentiation between the specialists who are "hospital based" and the GPs who are "community based", In actual fact, specialists have office based private practices and GPs in some parts of England do follow patients into the hospital. But the key to the distinction is the clarity of the so called referral system (a less pejorative and economically driven label than the often used gatekeeper).

The GPs are the first contact doctor provider and patients only get to specialists and hospitals through referral. GP's also control access to most of the social welfare benefits of society - disability, sickness funds etc.

This distinction has an interesting history in the UK as recounted by Rosemary Stevens (9). In 1518, the Royal College of Physicians (RCP) was established to regulate medical practice within seven miles of London. The "physicians" were the elite, served royalty, and were rich. Surgeons and apothecaries were

restricted to practice outside urban areas. In the 1700's, a hospital system started; physicians made all the decisions but the surgeons and apothecaries did the work. Bed control in more established hospitals was restricted to physicians; so surgeons and medical specialists (eye, ear, other) began to set up their own hospitals and increasingly do outpatients. As the middle classes increased and demand soared, surgeons and apothecaries also started outpatients and keen competition lead to an agreement. The Medical Practice Law of 1858 determined that the physician and surgeon consultant specialists "got the hospital" and the apothecaries who later became GPs "got the patient". With the 1915 National Insurance system, the GP list began and, shortly after, hospital doctors were salaried.

The burgeoning number of GPs was not a threat to specialists because they were mutually dependent for referrals. In the current reform, the creation of GP Fundholders has strengthened this interdependence through their increased purchasing power.

In Canada in the 1970's, the Royal College of Physicians and Surgeons decreed that specialists function as consultants and designated family practitioners as responsible for primary care. This was further reflected in the payment system under which consultants were paid less for "non-referred "patients.

A further issue in defining the "who" is that of non-doctors. By our earlier criteria for primary care, non-doctors, especially nurses, can do significant amounts of primary care. Expanded roles for non-physicians are much more developed in the US as Nurse Practitioners (NP), Physician Assistants (PA) etc. but there is a lively debate over payment and scope of practice. By contrast, in England, there is a much more extensive service infrastructure in community nursing and allied health linked to acute and primary care. More recently, practice nurses and other health professionals can be hired by GPs and included in the practice allowance. Because all are salaried through the NHS, there is no competition for finance. There is some difficulty in co-ordination, but the general focus is on patient needs and how to develop the teams to meet them.

In the US the simplest mechanism to start developing a primary care sector would be a designation of recognised "primary care providers", including non-doctors. They would be eligible for enhanced payment for primary care and one would need to create financial disincentives for specialists who do the same work. Because of pluralistic financing, we may need a uniform definition of service to do this and all providers are paid the same. Current systems including RVUs still seem to be procedure vs. transaction oriented. Finally, we may not be ready to develop a full "referral system" but clearly, the HMO and other managed care approaches have the beginnings built into the model. If "managed competition" seems a favoured approach there are real opportunities to reinforce the role of primary care.

* The need for a medical education and manpower planning policy for primary care.

As noted earlier, the US has no central planning of health manpower. There is some self regulation by specialists by limiting the numbers of residency slots they will approve, but this has most often been market driven.

Generally, medical students are free to select their specialty and hospitals/academic medical centres can train the number and types they wish, subject to quality review. The subsequent location of practice is similarly open.

In the 1970's, there was a national awareness of medical specialty and geographic distribution problems, and it was decided to take a market approach: double the number of medical school graduates and they would trickle down into the needed specialties and locations.

This theory worked about as well as trickle down economics and there are still major problems of excess specialists: more than 70% of US graduates in the recent National Resident Matching Programme chose non-primary care specialties and 64% of practicing physicians self identify as specialists. Persistent geographic maldistribution lead to a recent Fortune magazine article describing "a national physician shortage" and blaming protectionist attitudes of physicians.

While financial incentives for practice are obviously a problem (and one we have not been prepared to address), we have tended to believe that an educational strategy might work - the proper medical education experiences in primary care would increase the numbers of these physicians.

In his classic study of Medical School graduates between 1958-1976, Funkenstein (10) concluded that the greatest influences on a physician's career choice were: economic incentives and ideology (the social values of the time). The reason for the upsurge in primary care interest in the 1970's was, he believed, a perceived excess of specialists with threatened income loss and Federal interest and investment in primary care.

Another body of research shows the clear influence of new primary care medical schools and special programmes geared towards primary care in proportionately increasing the percentage of graduates selecting and remaining in primary care fields. Special graduate medical education programmes in primary care have even more compelling results.

While federal investment has been a critical incentive, it has been variable and most medical institutions have not picked it up as part of mainstream funding. There is also a confusion between giving students more ambulatory care experiences - in emergency room and 8 specialty outpatient clinics - and primary care experiences meeting the definitional criteria outlined above.

Interestingly, in the UK with over 60% GPs, undergraduate medical education is, by US standards, rather traditional and rarely involves out of hospital experiences. Graduate medical education (GME) is even more hospital biased and GP specialty certification only began in 1982. Clearly the major influence on specialty

distribution and geographic practice location in the UK and other European countries are national or regional systems of manpower control.

For UK specialists, the central Department of Health controls financing for all training funds (Graduate Medical Education positions). They are allocated to Regions in line with the available number of consultant posts that will be needed. Previously the districts, but now the new trusts bid to Regions for posts. An Advisory Committee (the Joint Consultants Committee or JCC) with membership from the BMA, the Royal Colleges and Department of Health officials act on applications - "shaping" the system. Occasional problem areas where requests are not properly balanced will lead to an intervention.

For GPs, there is a national system through the Medical Practice Committees where agreed population and practice size limits are used as benchmarks for self regulation of practice location which is monitored by the Department of Health.

In Canada with about 50% Family Practitioners, provincial governments fund the majority of GME positions influence the mix of number and type being offered. New York State recently began a policy of "up weighting" primary care residencies under State methodology for funding the indirect costs of GME. Using the Federal definitions residency positions in GIM, GP and FP, received 1.5 weights and others 1. The plan next year is to phase out direct support for Fellowships and all run primary care residency slots will be weighted at 0.9.
Specialty choice and geographic distribution of doctors is an area in which years of effort to self regulate has failed. It is time to revisit a national or State planning or "shaping" mechanism. Medical education is a necessary but not sufficient strategy to achieve the goals of sufficient primary care development.

* A third issue is the increasing voice of the patient and the public and their role in relation to health professionals and those managing the system.

In the US, we have always had high patient demand and high expectations and in a litigious environment, the response has been - when in doubt, treat (often refer to the specialist).

In the UK, patients have historically been relatively passive, reliant on the doctors advice, and with lower expectations from the system due to an acceptance of resource limitations. The tendency has been: when in doubt, not to treat.

With the introduction of the internal market in the British reforms, patients are becoming more activated - sometimes around more superficial hotel services which is the first tendency in the market, but again the government has set a framework for citizen involvement and performance standards to guide expectations for all public services. For the NHS, this is called the Patient's Charter. It lays out service expectations on waiting times that would not be particular advances for US health consumers, but direct patient access to one's chart is certainly more radical. The point is that there is a national

effort to raise the level of citizen involvement.

Purchasing authorities are also charged with ambitious goals for public participation in choices about how money should be spent. As patient's become increasingly well informed they begin to ask substantive questions about the effectiveness of procedures, and the quality of doctors and hospitals. This is obviously a long-term process but the approach is an interesting example of a large scale policy initiative to involve/empower individual citizens to hold doctors accountable for their 1:1 care and purchasers accountable for decisions on resource use for the larger community.

It seems very different in style from US proposals to set up yet another "third party entity" like Health Insurance Purchasing Corporations to represent the of patients in the financial transaction. The US Public Health Service "Healthy Community" initiative uses more of a community development approach to citizen actuation around health issues in general.

An obvious issue is the distinction between a public health care system like that in the UK which is by its nature accountable if the level of public awareness is raised and mixed or predominantly private systems like those in the US that may need "organisational forces" to have an effect. It does raise the question in the US about the proper role for government as advocate for or proxy for the citizen or patient in a system when public funds are already paying in excess of 50% of health care costs.

* The final issue I'd like to analyse is the question of a vision for what a health service can be.

Again, from across the Atlantic, the only vision that seems to be articulated for the US health care system is that it must provide everything to those who can pay and cost less.

One British observer marvels at the US information systems, utilisation review techniques and protocols for care but sees these as tools for micro-management of processes to compensate for the failure to macro manage by a global budget mechanism or a clear policy framework for the system.

The initial vision for the NHS was to guarantee universal financial access and distribute those health care resources that were available as equitably as possible. As such, and especially post Thatcher, the NHS has enormous symbolic value as one of the few, if not the only, remaining public services available to all citizens regardless of income and publicly accountable to them for its performance.

This is seen by policy analysts to be a critical feature of most well supported state welfare programmes - the extent to which the middle class benefits from it.

This reality is now appearing in the US - as increasing numbers of middle class citizens are beginning to be affected by costs of health care and problems in the health care delivery systems, there are increasingly serious demands for change and increasing activity by politicians to respond.

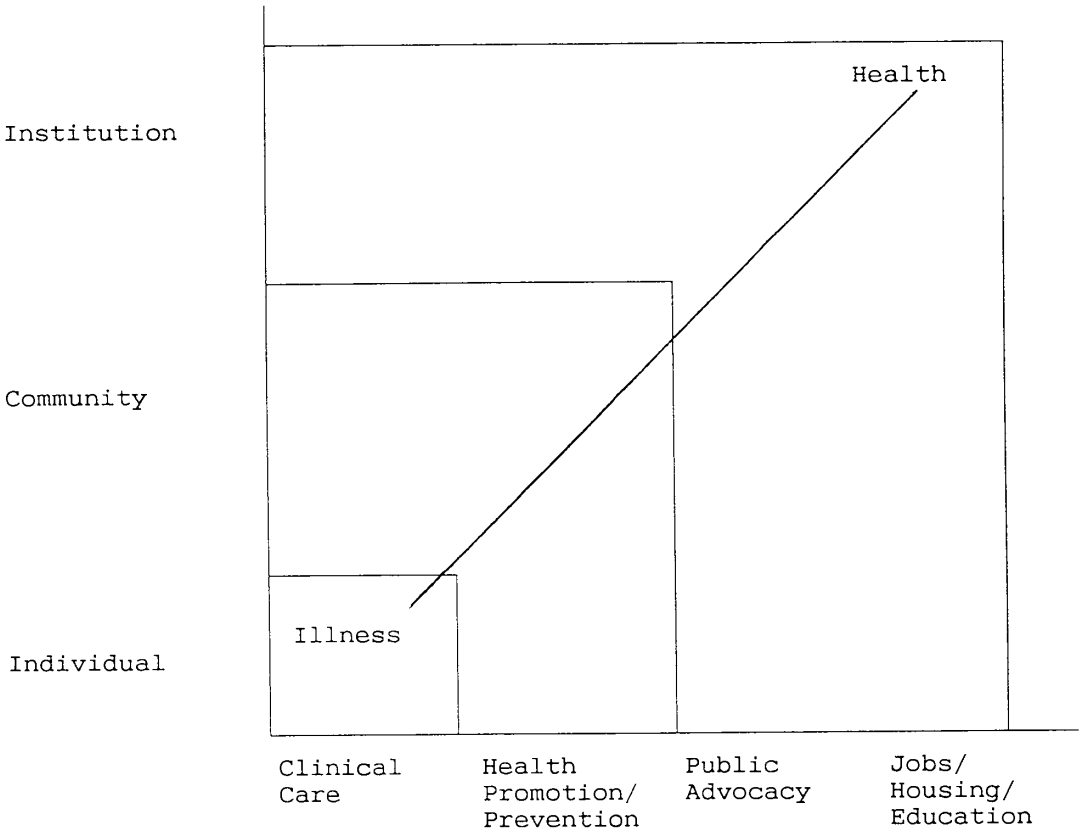
Responding to cost control in a zero sum game by definition means taking something away, imposing limitations and loss. Reaction to these negatives leads to entrenched institutional or public resistance.

Alternatively, the development of a vision of what the health care delivery system is supposed to do can at least provide a framework for tough decisions taken towards a purpose.

The post-reform NHS has revitalised an additional feature of the initial vision for it - that it should be an instrument for improving the population's health - a responsibility beyond caring for and curing the individual patient.

There is considerable debate about the appropriateness of such a goal. Some see it as a cynical attempt to deflect attention from the problems of a service that is underfunded for its current responsibilities; others see it as unrealistic because health care exerts only a small influence on overall health. But it has become a framework for a series of policy decisions that have shaped the reforms and is giving health service managers a clearer sense of direction.

TARGET OF INTERVENTION



TYPE OF INTERVENTION

This diagram represents a way of thinking about such a vision which identifies the type of intervention needed to promote the community's health on the horizontal axis; the potential targets of the intervention - the individual, the community or the institution, shown on the vertical axis; and the impact of these interventions on the third dimension of this diagram, the continuum from illness to health. Institutional and individual purchasers and providers are in a position to act at each of these levels, if they are aware of their potential and are provided with the proper incentives - financial, regulatory, or political - to do so.

If we only provide traditional clinical medical care in the hospital setting, even if we assure the effectiveness of each intervention, we limit our ability to significantly influence the health of the larger community though we may save enormous resources.

If we can unlock the financing of primary care and the use of primary care practices as a base for health promotion and disease prevention as well as treatment, then we can begin to reach out into the larger community and take better advantage of the power of the health care system as a broader instrument for improving community health.

UK government health policy reinforces this vision by further strengthening the historically strong role of primary care in the reform. Part of it is very pragmatic. With limited resources, the government needs the GP to minimise unnecessary use of services (only about one tenth of all GP visits are referred on for specialty care). But elements of this importance vested in primary care have been in the system for some time.

Overall physician income scales in the UK in 1990-1 show an estimated net income of £42,000 for GPs and £45,000 for specialists without merit awards, though 2/3 of consultants eventually receive merit awards and this disparity is under negotiation in the new GP contract (11).

When the number of GPs was declining in the 60's, a new Family Doctor Charter was written to change the basic financing of general practice and address premises costs, staffing costs and targeted incentives for night call and home care. The recent reforms have added incentives for prevention activity and the GPFH initiative shifts even more power into the hands of certain GPs to purchase an array of services for their patients.

Once primary care services can be adequately financed, the next challenge is bringing the services currently provided more in line with the health needs of the community, rather than with pure market demands. In a resource restricted environment, we must achieve the closest match possible and perhaps make some hard choices.

In the UK, the purchasing authorities have been charged with the responsibility of "purchasing for health gain" - looking at the epidemiological data, the service utilisation data from acute and primary care providers and involving the public in decision making about priorities for maximum positive health effect.

The Oregon Experiment with all its flaws, has caught the imagination of health policy leaders throughout Europe because they understand financial limitations and see it as an effort to involve the public in an open debate about what the health system should do. However, the real challenge for the future is the need for the right incentives for health service providers to use their institutional resources and influence for improved community health as a major purchaser of goods and services and as a major employer in a community.

In the UK Secretary of State for Health is charged to work with other cabinet departments in government to assess the health impact of various policies for education, housing, environment and trade. An example of a volatile issue now facing the Minister is permitting tobacco advertising.

A number of US providers have seen it in their self interest to take on more of a responsibility for the health of the communities they serve - some receiving financial benefits through special state rate setting. With a new administration, there is an opportunity for a new vision - a goal statement for the health services in the United States that could provide a framework within which States, insurers and providers could shape their behaviour with national policy leadership to facilitate the process and a mechanism to monitor it.

If a vision could be developed that sought to address the health needs of the community, it would still be a challenge to implement. Such changes confront long-standing vested interests in the delivery system - often the medical politics within powerful acute care institutions or organized medicine. For example, a community health needs assessment that demonstrates greater need for maternal child services, perhaps at the expense of specialty surgery, places the decision maker squarely at odds with traditional interests and ways of doing things.

Another problem is that primary care and other efforts to achieve improved community health are interdisciplinary undertakings. They require collaboration across professional disciplines (medicine, nursing, social services etc.); across sectors (acute, primary and community care); and across units of government; and with the public. It's hard to work at interfaces; it's lonely and there are few rewards for it. Traditional treatment and care services are a little neater; they'd be more effective if there was more collaboration, but the patient can still get the services from a series of relatively independent sources.

Leadership for primary care and community health improvement is about building systems of care, not institutions. This is perhaps the most difficult and threatening step of all. The kinds of interdependence, fluid boundaries between levels of care, and collaborative focus on patient and community needs, rather than control and institutional survival are very difficult to realize.

Finally, a risk that is more acute for the public sector policy maker and manager is running out of time. The politician's attention span tends to run in electoral cycles. Usually two to four years. It's very hard to make fundamental institutional change in such a time frame, especially in the face of resistance and constrained resources. The advice you often get is not to do any strategic thinking or acting.

Health systems change will be one of the major challenges to a new administration but the time is never better than at the beginning. Eli Ginsberg's recent article in the New England Journal of Medicine (12) indicates that we have little choice as we cannot sustain the costs of our current health care system to the end of the century.

Conclusion

A few final reflections on the feasibility of this task when viewed from the perspective of another country. First, viewing the US system from the European perspective, in sharp contrast to the other systems in the world, health care in the US is not seen as a public service or a right of citizenship. It is profoundly embarrassing that the US spends 30%-50% more than any other country and can't assure financial access to all our citizens.

I don't think it is a money issue, it's a values issue, because the cost keeps going up as we delay. If there is in fact a developing values consensus that all of our citizens should have financial access to health care - that becomes a linchpin in a new vision for the health care delivery systems of the future, and a key element in appropriate use of services will be effective primary care development.

Second, no matter how difficult the financial situation, the United States has enormous resources in its health care system, unheard of in other countries. The issue is how we use them and, as always, our will to make change. Sometimes institutions have to re-invent themselves. A sense of history can be important. St Bartholomew's Hospital was founded in the 10th century and is potentially hard hit by recent NHS reforms which will cause its traditional referral base for tertiary care to shrink dramatically. While most are fighting the change, one consultant physician said thoughtfully "Well, you know we've only been a tertiary care hospital for the last 30-40 years, maybe we should consider what we need to be for the future." There must be a vision of a future to make that change easier rather than a reflex "digging in of heels" to resist the loss of something we've had.

Finally, the energy and action orientation of Americans is incredibly unique. Many other countries struggling to make change in their health care systems know what they want to achieve but they don't have the skill, managerial or organizational. We do, if we have the will and the vision. That is one of our gifts as a people. We must use this gift to begin and sustain a process of change that can assure the best health care delivery system and the best health for all our citizens.

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