

Editorial

Keep primary health care personal!

In the fifties and sixties a rebirth for primary health care (PHC) took place in the United Kingdom and The Netherlands. New scientific journals started: the *Journal of the College of GP's* (now the British Journal of General Practice) in the UK and *Huisarts en Wetenschap* in The Netherlands. In 1966 in both countries reforms took place to reinforce General Practitioners within the health care system. In Holland, 1966 was the start for the development of the world famous GP- standards and for many multidisciplinary health care centres. Also in that year, the first Dutch chair in general practice was inaugurated [1]. In the UK Richard Scott had been appointed to the first GP chair in the world in Edinburgh in 1963. In 1966, after bitter negotiations, the government and the GP political leaders agreed the so-called GP charter. This notably rewarded GPs for improving their practices (previously this had been at their own personal expense), it also included incentives for GPs to practice together in groups and to undertake postgraduate education. A second key UK landmark was the nationwide introduction of three years compulsory vocational training for GPs in 1979.

By the eighties Fry was able to [2] publish five common features of PHC: (1) Access and availability on a round-the-clock basis. (2) First contact assessment and ongoing management of complaints, demanding an intimate understanding of both the patients and their problems. (3) Care provision to a relatively small, static population of around 2,000 individuals. (4) The type and nature of illnesses and conditions seen in primary care practice reflects the specific needs of each patient population. (5) Long-term continuity of care is possible.

Since the sixties, in European and North American countries PHC became a success story. The United Kingdom, Finland, Denmark, The Netherlands created strong PHC systems with family doctors at the core of it. Since 1980, in the United States the Health Maintenance Organisations were growing at a fast speed. In the centre of the HMOs the primary care physicians play the key role. Nowadays, more than 50% of the Americans are insured through an HMO system. In Canada, General Practitioners are at the centre of the system. Recently, Germany and France decided to adopt some features of the PHC system from their neighbouring countries. Important principles for a strong PHC system were and are: (1)

Listing of patients, which means that patients have to sign up to one particular family doctor or practice. (2) Gate keeping for patients who want to visit a medical specialist. These two principles are organisational conditions to make PHC personal care in which long standing relations between patients and their GPs flourish and patients are seen as long as possible in their own environment and by the same health care provider.

Three arguments explain the success of PHC. First *local context*, the paradigm that it is better to treat patients in their own environment. Only there can important health determinants such as housing, life styles, food habits and exercise be changed and many patients prefer to stay at home as long as possible. Second *PHC is more personal*, patients, in their own environment have more power and are more equal in relation to the clinician. The third argument is related to cost saving. Medical treatment and nursing care can be provided *more economically* than in hospitals. This is because more personal care in a local context can be more appropriate and particularly the greater element of trust encourages 'wait and see' policies rather than early medicalisation and investigation.

For these three reasons hospitals in many countries shortened their average length of stay. Mental health care became community based with PHC and ambulatory care for psychiatric patients as long as possible. Long-term care was more and more provided by PHC professionals behind the front door of the private houses of the elderly.

For the last few years there has been a growing impression that PHC is threatened by a perception of increasing workload. Family practitioners and other PHC staff felt exhausted because of it. The workload appeared to grow because of increasing emphasis on better prevention and care of chronic disease and the growth of chronic and psychiatric, non-institutionalised patients within the community. (Other aspects of work such as care of minor self-limiting conditions have reduced, however.) Hospitals responded to their own cost pressures by pushing for early discharge of inpatients. At the same time PHC practitioners tended to practice in ever larger and more professional groups. This had two consequences. Firstly, PHC became less personal: Answering machines became popular in PHC offices and GP's assistants in these larger settings became remote and apparently

reluctant to make appointments. The number of home visits declined because they were time consuming and hard to fit into an increasingly structured care process. The second effect was a shortage of family doctors, which threatens countries as the United Kingdom, The Netherlands and the United States. This is so partly because of a negative image of the profession within the group of medical students and partly because the workload got higher and the annual revenues did not increase with the same speed. The same shortage is the case for other parts of PHC: District nursing and home help services also encountered growing workloads combined with budgets which grew slower than the demand for their services.

Primary Care Organisations (PCOs)

To answer the new problems for PHC with less personal care, growing workloads and less revenue, we see in many countries the creation of special PHC organisations which hope to combine the principles *small is beautiful* with *big is powerful*. In the United Kingdom they are called Primary Care Trusts [3] (PCTs), in New Zealand Primary Care Organisation [4] and in Italy Nuclei di Cure Primarie (NCP). The PCTs are responsible for 80–150 thousand patients and manage individual practices (led by GPs), which average 8–12 thousand patients with a range of 3–30 thousand. PHC organisations in other countries are made up of GPs, family paediatricians, nurses, and midwives responsible of a population of at least 15/30,000. In the USA they are named IPAs: Individual Practitioners Organisations which cover a variety of primary care physicians: family practitioners, internists, paediatricians, obstetricians and gynaecologists.

The PCOs take over from the individual PHC physicians and other PHC providers many back office tasks: bargaining with the financial agencies, the organisation of night duties, bookkeeping, technical, housing and ICT support services, quality assurance management and standardising of care processes. Indeed, these new PCOs integrate many back office tasks of PHC. They also create a fruitful bottom for new PHC tasks as health education, promotion of self-management by patients and support to informal carers. However, do they make PHC more personal on the front office, i.e. in

the consulting room of the GP and the district nurses? We are not sure about the answer because of several reasons. First, the scale of the individual practices is no longer small. In New Zealand and Italy for instance they serve at least 15,000 patients, far larger than the scale of 1500–2500 patients described by Fry (himself a single handed practitioner with one assistant). Second, the new PHC organisations encourage new professionals such as nurse practitioners and physician's assistants who may relieve the workload of family doctors. However, delegation from doctors to nurses may create less personal contacts between patients and doctors, even while it substitutes more personal ones with nurses. Third, the new organisations create an environment in which part-time working doctors and quick staff changes may flourish: these are counter productive for continuity in personal care. Fourth, the PHC organisations may create patient doctors encounters, which are better prepared on both sides by foregoing internet contacts. However, this might be also negative for personalized PHC, especially for those elderly who did not grow up with the Internet.

We are not sure that PHC organisations will save the old tradition of personal PHC for the future. Of course the PHC organisations will integrate many back office tasks which family doctors and other PHC professionals dislike. They will promote the quality of these back office services. However, that is not enough to keep PHC personal. For that, smaller PHC teams are necessary, serving a small population and working within a network of informal and formal carers inside and outside the health services. Here IT can well be harnessed for more personal care, using telephone and email as well as websites. In a following editorial we will discuss in more detail these additional conditions for a modern PHC with its vital potential to integrate care personally for the benefit of the individual patient.

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