

MANAGING TO DO BETTER: General Practice in the 21st Century

Gordon T Moore MD, MPH



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Abstract

Health systems the world over are striving to manage their available resource to deliver the best value for the public's health. For most nations, the general medical practitioner (GP) is the keystone of their organizational approach to achieving the best mix of quality, public and individual satisfaction, and cost. England's latest reforms point towards a national health system that employs GPs – individually and in groups – as the micro-managers of resource and of care. GPs are close to the individuals and populations that are the target of improved health and sit at the interface between community, social, and medical resource. Consequently, GPs are in an excellent position to determine needs, manage care, and direct spend so that it does the most good. Yet it is not clear that GPs want the job. They are not adequately prepared or supported for this expansion of their traditional role. Nor is it certain that this role is theirs for the asking; others might step in to fill it, leaving general practice in a narrower medical role in future. New knowledge, skills, and, especially, attitudes will be needed if GPs are to carry out these functions well, win this work, and enjoy satisfying and personally sustaining careers. Medical education and continuing professional development must change if general practice is to undertake this critical role in the 21st Century.

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1 INTRODUCTION

The UK National Health Service (NHS) is a remarkable medical organization, better esteemed by its public¹ than most other systems and probably achieving the best value for money in the world. But the NHS is in trouble. Like most other national health systems in the developed world, it suffers from growing demand for medical care outstripping funding growth, and variable quality and productivity. Accelerating advances in medical care are widening the gap between what is on offer in the NHS and what is potentially available to those wishing the highest world standards of care. The government's response is built on a large increase in funding (from taxes) and a new national plan to modernise the NHS. Many observers have called for a sweeping re-think of the terms and organization of Britain's health services.

Objectives of a 'new' national health system

Some of the features of a blueprint for an ideal health service are already clear. It must become a 'system' that is built upon but goes beyond the current NHS. It must be viewed as equitable and fair by the British public if it is to be socially and politically acceptable. The new national health system should maximize the population's health (how 'health' is defined is a critical factor in itself, since it drives the level and direction of investment) with whatever national financial resource is available in the health sector, both public and private. To achieve the highest possible yield from the nation's spend, the new national health system must be efficient and effective, with services as productive and appropriate as possible. Quality and productivity should be measured, improved, and rewarded. If money for health care is limited (as, ultimately, it must be), the new system

10 must set priorities and allocate its public spend wisely. The mix of services must shift, rationing some potentially worthwhile individual medical benefits in favour of preventive and population interventions of greater cost-effectiveness. If some medical services are rationed and unavailable in the public programme, it would be good for these to be of high quality and easily available to those willing to pay privately. Finally, the new system must encourage and support individuals to take responsibility for staying well through preventive medicine and the adoption of health-enhancing personal behaviours.

The NHS struggle to reform

The last two Conservative and the current Labour governments have struggled to move the NHS in this direction, albeit with an emphasis on efficiency and cost reduction. First came efforts to improve efficiency (the provider-purchaser split and fund-holder purchasing, now shifting to accountable Primary Care Groups (PCGs) and eventually to Primary Care Trusts (PCTs)) and reduce costs by hiving off or restricting payment for some services (downsizing NHS dental services and raising patient copayments for medicines, for example).

Efforts are underway to raise quality and reduce inappropriate care. Among these are better documentation – improving data collection, producing league tables, examining for small area and regional variation – and the introduction of quality improvement, audit, and evidence-based medicine. The formation of the National Institute for Clinical Excellence (NICE), the Commission for Health Improvement (CHI), and national measurement systems (the Performance Assessment Framework) add further infrastructure to improve clinical care.

In addition, the General Medical Council is becoming more proactive in policing doctors' performance.

The balance between treatment and prevention and the mix of individual care and population interventions are also being shifted. Incentives for GPs to meet immunization and screening targets began this effort. Now the introduction of the Health Improvement Programmes to be addressed jointly by PCGs/PCTs and Health Authorities further shifts general practice towards population health improvement. Integrating community services, as well as public health, into PCTs represents a substantive shift in the direction of shaping the 'primary care led' NHS into a strategy that attempts to put more resource and manpower into population and community needs.

These policy initiatives begin to define a way forward to improve the NHS and, indeed, the whole national health system. Both Labour and the Conservatives appear prepared to set health outcome goals and organize primary care into accountable business units to manage resource investment to achieve these targets. Services delivered will include, but not be limited to, traditional individual medical care. Preventive, public health, social, and community approaches will be in the armamentarium of services available to the PCTs. To facilitate the deployment of these new capabilities, multi-professional health workers are being integrated and budgets consolidated under PCGs or PCTs. A management framework is emerging for directing PCGs or PCTs. Accountability is being built in through programme budgeting as well as process and outcome measurement. System enhancements to support primary care, improve service and communication, and measure performance are part of the scheme.

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While current policy appears to be moving in a largely consistent strategic direction, Britain is still far from having a health system fit for the future or even from agreeing what it would look like. There are four overriding, interlocking issues that are barriers to achieving even these early planned changes as well as further advances needed for a new national health system. These barriers, embedded in the design of the NHS from its inception, are:

1. The government's position that the NHS will deliver individual medical services as the country's major approach to improving the health of the nation, and the concomitant lack of public and medical understanding and agreement about the right trade-offs between individual medical care services and population health improvement;
2. The public's expectation that virtually all care is to be provided, making it extremely difficult for the medical profession openly to implement, and the public to discuss, rationing of medical care;
3. GPs' strongly held position that they operate as independent contractors who function autonomously, creating real resistance to a model in which they become the lead agents of the state's efforts to change the delivery of health care;
4. The narrowness of medical education, producing GPs poorly prepared to carry out the new tasks and the management of a system that needs to be efficient, effective, and capable of change.

1. Lack of public and medical understanding of the trade-offs between individual care and population health programmes

Basing its national health system on an individual acute care, disease-orientated model is hardly unique to the UK; but it creates a true dilemma today as the NHS struggles to reform. The British public generally expects individual medical care of high standard, free at the point of use. Medical professionals are committed to and trained for this model. But individually orientated medical care is not the most effective future route for improving the health of the public within the limited resources that are available.

Today's personal care orientation becomes increasingly problematic as new drugs, treatments, and diagnostic technologies drive up the cost of individual medical services with diminishing marginal improvements in health for both individuals and populations². Thus, additional resource spent on an NHS that remains as currently structured will deliver progressively less value for money over time.

While experts do not doubt that advances in individual medical care have contributed to improving health³, they agree that further gains can most cost-effectively be achieved by investments in prevention and population- or community-based approaches to improving health^{4,5}. Personal prevention, as currently delivered by GPs, features immunization against illness, early detection of disease, and adoption of healthy living behaviours. Personal prevention cannot be fully realized without population approaches such as health education, public policy initiatives, and community outreach programs. Additional gains and efficiencies are possible through other population-orientat-

ed approaches such as disease management, and community-based interventions to mitigate the adverse effects of violence, community disruption, and social and economic deprivation.

Although public health and general practice have long been separated, many believe that bringing the two closer together would improve health outcomes^{6,7}. This concept has been experimented with in many settings, starting with the innovative Peckham Experiment in London over half a century ago⁸. A more recent approach to a mixed model of individual and population care was proposed by Kark⁹ and summarized in a US Institute of Medicine report¹⁰. It describes Community-Oriented Primary Care (COPC), a model that deploys primary care doctors in both medical care and public health and community roles. This approach is ‘the provision of primary care services to a defined community, coupled with systematic efforts to identify and address the major health problems of that community through effective modifications in both the primary care services and other appropriate community health programs.’ The design for PCTs looks to be moving in this direction.

The government’s plans take some operational steps to make this model practical. These include: ceding to the PCT the control of almost all of the consolidated budget for their patient population; integrating community care funding and personnel into the PCT’s budget; assigning social service and public health manpower to the PCT’s team; and encouraging collaboration between the PCTs and their local Health Authority in design and implementation of health improvement plans.

As long as the public and doctors view individual medical care as the *sine qua non* of the NHS, it will be very difficult to optimize a preventive- and population-oriented model. For the government’s primary-care-led strategy to work, PCTs must

manage the available funds to ‘buy’ health. The PCTs, and their individual practitioners, must be able to allocate available resources as needed to achieve population based health improvement and clinical performance targets. Much of this reallocation will favour prevention, community, and population interventions over individual acute medical care. Neither GPs nor their patients are likely to support this trade-off, and it is unlikely that there will be sufficient funding to do both.

To overcome public and professional resistance, at least three additional steps will be needed. First, the mixed model integrating individual and population approaches must be clearly described and marketed. The public and the medical profession need to be educated as to the advantages of a national health policy that strikes a better balance between acute medical care, prevention, and public health at the primary care practice level. Second, national and regional priorities must be clearly set out, so that primary care practitioners can operate within a publicly agreed framework that lends authority to their new tasks in integrating medical, preventive, and population care. Finally, the attitudes and skills of primary care practitioners need to be upgraded, so that they can make this approach work in their practice and community.

These seem formidable tasks. But forging a new social contract is not impossible. There is mounting pressure for change in England and elsewhere. The 20th Century model separating public health and medical care and preferentially funding the latter in a country’s national health insurance programme is not sustainable. All nations will need to move their public systems closer to a mixed individual and population approach in the 21st Century. The UK is closer than most to a working model that the public could accept. Offloading expensive and

16 marginally useful personal medical care to self-pay status in exchange for programmes that lift the health of all is a message that the public, especially those who are older, could possibly come to endorse at this challenging time for the NHS. Wait longer and a growing personal consumption orientation may make it impossible to change.

2. Rationing and its effects on social solidarity

In the future, more rationing of publicly funded personal medical services is inevitable. Supply and demand for specific services will grow; public and private resource available to pay for medical care is limited. Even though the government is increasing its NHS investment now, the NHS will ultimately confront funding limits because of public and individual priorities that compete with health for available funding. Moreover, as discussed above, spending more on personal care, even in a maximally efficient NHS, is not the wisest use of available public resources to gain additional health at the margin.

Also as outlined above, PCTs, pushed by the need to meet health improvement plans and health outcomes performance targets, will allocate less of their available resource to personal care and more to cost-effective approaches meeting health improvement goals. GPs and other primary care providers will thus be tasked explicitly with making decisions that deny or ration some services of low cost-effectiveness.

Such an approach creates tremendous tension for primary care. Rationing on an individual basis is not unfamiliar to GPs in the NHS, but making this approach a cornerstone of policy is new. Will the profession undertake rationing in this context and to the needed degree? Heretofore, GPs have rationed hid-

den from view; the public's ire has not been raised, and the prevailing medical ethic of advocating for individual care has not been challenged.

Some would hope that doctors could continue to ration by stealth. Such an approach would be appealing to government, since it would theoretically allow the social contract to stretch and, hopefully, not break. Nevertheless, I believe this is wishful thinking. The scale of rationing is likely to be too great in future to enable either doctors or patients to bury its existence. Growing restiveness of the public, documented by the media and fuelled by doctors chaffing under medical funding restrictions, will almost assuredly force rationing into the open.

How can this painful conflict be overcome? Placing the responsibility for rationing exclusively at the practice level would be difficult. It flies in the face of the generally espoused medical and public view that the GP's job is to provide, or advocate for, all the care needed by an individual. Another approach to rationing is that it should be nationally led so that GPs would be told exactly what rationing decisions to take. Under this approach, primary care would be told to follow national rationing rules, so that some other agent appears responsible when services are denied or withheld.

Practically, however, this is not likely to occur. Government, for both political and methodological reasons, is unlikely to want to publish clear coverage exclusions. Such a process would be politically unpopular, and it would be hard to develop guidelines that could fit the wide variation in circumstances of individual decisions.

A shared model of responsibility for rationing may be more feasible. While difficult to accomplish, priority setting is being undertaken in many countries. In an editorial accompanying

18 three articles describing approaches to setting medical care limits, Klein¹¹ concludes that priority setting ‘is inevitably messy and difficult,’ but that ‘the challenge everywhere is about how to organise and orchestrate what, for the foreseeable future, will be a continuing dialogue between politicians, professionals, and the public about the principles that should be invoked in making decisions about rationing and about how best to reconcile conflicting values and competing claims.’ One messy, but ultimately successfully implemented, approach is illustrated by Oregon’s effort to determine medical benefits coverage in its Medicaid program.¹² A priority list of covered services was developed in an open process and then applied locally by doctors, albeit not as rigorously as its initiators had hoped. In England, a similar national and regional course of action could lead to publication of broad clinical guidelines of coverage that would then be interpreted and applied on a case-by-case basis. The creation of the National Institute for Clinical Excellence (NICE), which will take responsibility for developing guidelines and making some rationing decisions, is already a step in this direction.

This approach devolves considerable responsibility to the primary care practice level while sharing the onus of rationing. It still is most likely that GPs will be heavily involved in micro-managing clinical care decisions and in making rationing determinations. In fact, making a cost-effective medical decision has always required striking a practical balance between general guidelines and local interpretation. Clinical decision-making is highly dependent on the characteristics of the individual under consideration, as reflected in Bayesian approaches to diagnosis and treatment. Thus, GPs must undertake difficult decisions on an individual basis if evidence-based guidelines are to be sensi-

bly and fairly used. No rule-based system can cover the infinite variations of multitudinous medical care decisions; local management will prevail. Since PCTs will hold the budget, practitioners will have some freedom to transgress guidelines to deliver services as most appropriate to their patients (although they may need to be prepared to defend their decisions to the group).

An equally difficult readjustment faces the public. If rationing is to take hold and free up resource to be put to better use in improving overall health, patients must also understand this. Without this general understanding, patients' trust in their doctors will diminish and the traditional doctor-patient relationship will be placed in jeopardy. Patients will need to understand that the role of the GP has shifted perceptibly from that of an exclusive advocate for an individual's medical interests to balancing the interests of the individual and the health of the PCT population of which the individual is a member.

The first tension point in a new social contract is public acceptance of private financing of healthcare. As the gap widens between what is available medically in the world and what is on offer and covered from public funds within the NHS, unmet demand will be created. Since the UK already countenances private insurance and payment for medical care, the nation's proportion of private care will surely increase from its current level of 16 per cent of total health sector expenditure.

A rising level of private paying patients thrusts the two-tiered system of care into public visibility, undermining the national social contract and values of the NHS that medical care should be equitable, accessible, free, and comprehensive. These values were expressed by Aneurin Bevin in 1948: 'the purpose of the NHS is to assure that no one will ever again worry about

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receiving all the medical care they need when they need it'. The tensions created by a two-tiered system, with one tier based in large part on ability to pay, could be formidable. It strikes at the heart of the notion of equity. Tremendous pressure will be placed on government to roll back its population approach to improve overall health in order to concentrate resource on individual medical care.

The best response to these problems, in my view, is to 'come clean,' proposing to both the public and the medical profession that such a change is both necessary and for the best. A determined, articulate leader enjoying a large parliamentary majority at a time of an extraordinarily strong national economy could do this. If not now, when would the circumstances for such a debate be better?

The message would be simple. A new charter for health care is needed: the purpose of public expenditure on the new national health system is to enhance the health of the public; rationing of expensive personal care of low benefit is necessary; that such care is still available for those who wish to pay; a safety net of basic, proven, effective personal medical services for all will be in place; and the public's good health is best achieved by combining individual medical care with preventive medicine, public health, and health education initiatives based on population approaches. This will win the greatest gains in health.

3. GP resistance to serving as agents of the state

GPs are accustomed to working on their own and for themselves. Their relative independence was granted at the time of the formation of the NHS and has been zealously guarded since then. Suspicious of any attempt to control them, GPs will be

doubly concerned with a system that forces them to change and moreover asks them to take the lead in doing so.

GPs are to become the chief operatives of the new health system. But in this system, the game played by primary care and general practice will change. In the new game, resources are limited, rationing is to occur, and resources are to be allocated to the mix of individual and population services that does the most good. The PCTs and GPs are being given enhanced authority to carry this out and asked to be responsible for achieving the results.

This is not general practice's agenda or wish. Most GPs would simply want more of the country's money spent on the NHS. It is an agenda of the state, forced upon them by the circumstances of an aging public, modern medicine's costly successes, public sector financial limitations, and their obligation as leaders to assure that England has a system that creates as much health for the public as possible.

How can general practice be persuaded to work to an agenda that is not their own? Ultimately, they must either be forced or convinced. The government does not directly control GPs. But since the government determines the available spend (inputs) and sets the outcome measures (outputs), they have considerable power to make PCTs do their bidding. If they mandate health improvement plans and set hard health outcome targets, they leave little choice to the PCTs but to comply to meet these goals, especially if achievement is linked to rewards or sanctions.

On the other hand, it is not in the government's interest to have an open revolt among doctors. Convincing general practice of the importance of their participation is a far more desirable approach. A case must be made that, whatever the value of their autonomy and independence in the past, general practice

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must now adopt a new way if they are to help the country find a way forward. The alternative is a failed system. Without the leadership, involvement, and support of general practice, the public system simply cannot perform its job – to maximise the health of the public within available resource.

Persuasion works best if it is matched with incentives as a means to change behaviour. If GPs can be brought to agree that this should be the goal of the new health system and that only they can make it work by managing the process, it may just be possible to convince them to consider this responsibility. Providing adequate resource to carry out the change and rewarding doctors for their effort and results would undoubtedly facilitate the transformation.

4. GPs are poorly prepared to function in a new system

The fourth major barrier is the relative lack of capability to operate in this new paradigm at the front lines – in the PCTs and the doctors' surgeries. If PCTs are to be jointly accountable for achieving clinical care goals and improvement targets within a capped, all-inclusive budget, they must accomplish at least three goals. First, the PCTs must see to it that new, collective, organizational responsibilities are defined and carried out effectively. Second, PCTs must become virtual (if not real) group practices. Each practice must begin to see itself as one of a group of interdependent franchises for the PCT, working to common approaches and common purpose. Third, the PCT must operate efficiently and effectively with as little variation and waste as possible. Thus, each of the GPs within the PCT must contribute locally at the level of their practice and surgery to agreed performance targets.

To improve on current performance and to deliver to new accountabilities requires enhanced capacity from top to bottom in the PCTs. Centrally, the PCT will need to commission services, define goals and objectives, develop collective plans, and allocate resource. Some management activities at leadership level within the PCTs will fall to business specialists, although experience with group practice management in America suggests that clinicians should be among them¹³. Running a good group practice (or group of practices) is a complicated process requiring group organization, cultural competence, systems support and management skills. As new entities, PCTs will need organizational structures to determine how decisions are taken and communicated, functions assigned, authority given, and rewards and sanctions handed out. Rules, policies, and procedures will need to be developed and adhered to by the practices in the PCT. A good group develops shared values, mutual respect, and willing collaboration. Information systems must be used by all for supporting communication and decision-making as well as for collecting and analyzing data. At the local level, GPs will also need new skills in such areas as practice administration, teamwork, data analysis, and quality improvement.

These competencies are not widely available today at the local practice level. Medical training does not currently prepare GPs well for these activities. Also working counter to these objectives is the tradition of independent provider status of primary care doctors; GPs are accustomed to functioning independently of one another. Collective planning is rare and training programmes rudimentary. Nor do clinicians fully understand and agree the need for these changes. Without explanation and buy-in as well as systems support and training, local practitioners will not be able to take these new models very far. In fact,

as accountability shifts to the PCTs and their constituent primary care practices, doctors could easily become overwhelmed, disillusioned, and angry.

These are not new problems, however, and much can be done to anticipate and ameliorate their impact. First, adequate resource must be in place. Any new enterprise needs capital to prime the pump – extra funds to cover inefficiency associated with transitioning and learning new skills. Second, some assistance may be needed to reduce the patient load of GPs. There are many ways to accomplish this, from hiring in extra nurses or more GPs to offloading work. In the long run, as the PCTs become better at reducing cost and improving results, the additional cost of doing this ought to be recouped. Third, consultative assistance will be needed. Seconding experienced administrators to new PCTs to set up and train staff would help, as would the preparation of example procedure manuals, organizational charts, and other administrative tools. Finally, training schemes for these new competencies can be begun at medical school, in general practice training programmes, and in continuing professional development.

3 WHAT LIES AHEAD?

A period of considerable strain lies immediately ahead. The changes described in recent White Papers need to be realized. PCTs are a new structure with new responsibilities. Implementing the government's plan will not be easy, and public and medical resistance is to be expected. Further, as described, even more daunting steps are yet to be taken if Britain is to move to a new national health system.

In the near term, however, the greatest challenge is to the doctors in the PCGs or PCTs. A new structure – a group of practices – is to be created. It will have new responsibilities and accountabilities. Doctors will need to learn how to function effectively in such a group. They face uncomfortable prospects, from learning how to deal with variation – practices that are performing significantly differently from each other – to case-by-case rationing and managing interventions for populations of patients. They will face new obligations in staying within the available resource and being accountable for their results. Funding will probably not be adequate to cover all needs, and the requirement to ration and shift resource to population and community interventions will escalate. Incentives to do the work and rewards if it is done well will be patchy and slow in coming as the system learns how to function. In short, as has happened before, general practice will need to take on a new, ill-defined, unstructured, under-funded system and make it work. What skills will help them do it?

4 WHAT JOB SKILLS ARE OF VALUE IN THE NEW NHS MODEL?

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In this section, I propose to examine the set of competencies that would enable GPs to practise effectively and satisfyingly in the new primary care led system. At the outset, let me emphasise my view that these skills are not just for those in charge in the PCTs. In the new primary care model, virtually every GP who provides care for a list of patients will need to prepare for new responsibilities. The needed changes cannot be achieved simply by adding new managers, medically trained or not, to direct them from the head office of a PCT. Health care improvements along the lines we have described need to be part of each practice and results must be built from the individual front line practices up to the PCT management level.

My central assertion is not that all GPs must practise this way; many will not or cannot. Rather, my argument is that new responsibilities and skills that add value will be preferentially valued. Those GPs who take on this challenge, learn these skills, and apply them to make the PCTs and their practices work better will earn status and authority and, ultimately, be satisfied practising in this model. Sooner or later, material rewards also will reflect better performance in this primary care led system.

Many of the necessary skills are already included in training for general practice, but simply need to be done better.¹⁴ Some of these time-tested competencies are:

- good communication with patients;
- a solid knowledge and skill base for handling primary care illnesses;
- disease prevention and health promotion;
- the ability to integrate biologic, social, and psychological factors in the care of patients; and
- appropriate attitudes and abilities in undertaking their own continuing professional development.

A portfolio of advanced capabilities is needed, however, if primary care clinicians are to fulfill their responsibilities in the new national health system – managing the resource for a population of patients to achieve agreed performance targets. The managed care movement in the US (similar to the emerging English model in many of its elements, such as its use of a fixed budget to manage the benefits for a population) provides some object lessons about skills that are needed in general practice. One view of the necessary competencies has been outlined in the US literature, where several surveys and empirical studies have postulated the kind of curriculum needed to prepare doctors for managed care medical practice. These studies^{15,16} emphasize (in addition to the traditional basic primary care clinical skills):

- understanding how and why the health care system works and funding decisions are taken;
- using evidence to assess literature and apply it to clinical decision-making;
- employing methods to measure the quality of practice activities and improve it;
- understanding and participating in disease management programmes that focus on improving results for designated conditions;
- working effectively in multidisciplinary teams; and
- employing epidemiologic methods to assess needs and outcomes of populations of patients.

One area – handling the ethical conflict arising from being personally at risk financially for managing a capitated budget – is not directly applicable to the UK, where the clinicians stand neither to gain nor lose income by undertaking to manage budgets.

A second view of new responsibilities was presented in the 1996 Working Party Report on The Nature of General Medical Practice,¹⁴ albeit prior to Labour's revised model of GP budget-holding. While little detail is given, the Report sketches out the enlarging responsibilities of the GP in the 1990s and concludes that these call for skills in teamwork, management, teaching, learning, research, audit, and evaluation.

Six core functions and required competences

Another view of the new capacities needed in Britain, however, arises from my analysis of needs created by the new system. These fall into six categories representing core functions if the new model is to work optimally. Although these are described as responsibilities of a GP in a Primary Care Group or Trust, these functions are properly those that a primary care practice must undertake and could be shared by other personnel. The functions are:

1. In order to achieve the greatest possible efficiency and effectiveness of individual medical care in their practice, a GP must be effective as the case manager and coordinator of care – in effect, serve as the general contractor of care for the practice and individual patients;
2. In order to meet the PCT's health improvement plan goals, the GP must be able to assess the overall needs of the practice population in the context of health improvement targets and to design and implement plans that reach the target at-risk populations in the practice – in effect, carrying out descriptive epidemiology, clinical care process improvement design, and project management;
3. In order to put available resource to work in the practice where it does the most good in achieving population health

- outcome targets, the GP will need to make cost-effective rationing decisions (hopefully applying agreed guidelines) about medical care resources appropriate in individual cases, and allocate available resources to individual and population interventions in order of their cost-benefit in achieving the desired outcomes – in effect, become the triage officer integrating population health and individual medical care;
4. In order for patients to understand the decisions made about their eligibility for cover by the NHS and to know the benefits and risks of buying services on their own, GPs must function as a trusted advisor to patients in a shared decision-making model – in effect, to become a trusted personal advisor and investment counsellor on medical care decisions and chief communications officer about the health initiatives and outcomes for the practice population;
 5. In order for practices to assess their performance and improve their clinical processes, GPs must collect data, interpret results, monitor process and outcomes and serve as the local centre of quality improvement – in effect become the Director of Quality Assurance and Improvement for their practice;
 6. In order to achieve the above in a cost-effective and satisfying manner, the primary care team itself must be managed well – in effect, the GP must become a leader in managing the practice and its suppliers to produce the desired results.

Table 1 presents these and other new functions and relates them to some underlying competencies that a clinician would need to carry them out. I now discuss these functions and competences in more detail.

Table 1 **Competencies of the General Practitioner as Care Manager in Primary Care Trusts**

| Responsibility of the New Clinician Manager | Examples of competencies |
|--|---|
| <p>1. Serves as general contractor:</p> <p>Provides primary access for patients</p> <p>Participates in system design and purchasing</p> <p>Provides first line medical services</p> <p>Manages episodes for best timing and outcomes, and lowest cost</p> | <p>Cultural competence, to understand patient and population barriers to seeking help</p> <p>Systems design, to set up responsive and efficient systems</p> <p>Basic accounting and budgets</p> <p>Excellence in managing the 2-3 most common problems in each major specialty</p> <p>Project management</p> <p>Referral management</p> <p>Survey methods to measure patient satisfaction</p> |
| <p>2. Implements population health improvement plans</p> | <p>Cultural competence</p> <p>Descriptive epidemiology</p> <p>Preventive medicine and health education</p> |
| <p>3. Allocates resource between individual and population interventions</p> | <p>Critically analyse literature from an evidence-based medicine perspective</p> <p>Understanding of cost-effectiveness and cost-benefit analysis, number needed to treat, epidemiology, biostatistics, and probability</p> <p>Understanding of NHS Executive Regional Office, Health Authority, and PCT's financing, goals, accountabilities – the context for managing care</p> |

| Responsibility of the New Clinician Manager | Examples of competencies |
|--|---|
| 4. Advises patients about what is happening and why, and participates in shared decision-making | Communication for understanding and trust Able to explain guidelines and decision trees using understandable lay language Present decision choices as unbiased options Understand and explain uncertainty and probabilistic reasoning Understand and incorporate patient's preferences in decisions |
| 5. Monitors and improves quality | Use information systems Knowledge of data collection methodologies Programme and performance evaluation and continuous quality improvement Understand elements of good service experiences Knowledge of systems design and process improvement |
| 6. Manages the team and the system | Supervision Human resources management Project management Small business skills Knowledge of organizational theory |

1. Serve as the general contractor of care

The general contractor responsible for a building project serves as a useful analogue to the primary care manager. A general contractor, like the managing clinician, is the general manager of

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the building project, responsible for bringing in the job on time and within budget. They must understand the needs of their clients and the capacity and performance capability of the sub-contractors that they use. They determine who will carry out the work, plan the timing, and oversee the work as it is carried out.

The general contractor must be generally knowledgeable about the work of the subcontractors and specialists. They should keep up with new technical developments and be able to decide when these new approaches can be useful. They need to be able to help the client (patient) assess their options.

A general contractor must collaborate with subcontractors, yet oversee their work. The general contractor monitors and manages costs and quality. The medical general manager will follow the care of patients through care episodes involving hospitals and consultants to assure that it is as efficient and appropriate as possible. They will also retrospectively assess the performance of these services. Process monitoring, data collection, and reporting frameworks for this will likely come from hospital Trust level or higher. GPs must be able to collect data reliably and accurately, understand performance reports of quality, cost and patient satisfaction, and compare and interpret these data against the performance of other practices in the PCT.

2. Implement health improvement plans at the practice level

PCTs, in conjunction with Health Authorities, will identify and agree to achieve health improvement targets for the PCT's population. While intervention plans may be set collectively, GPs will have to work to implement the plan in their individual

practices. Because of the unique nature of individual practices, no overall health improvement plan or set of guidelines can accommodate perfectly the special mix of patients and the environmental, economic, and community forces that shape the needs of each practice's registered patients. While overall plans for the PCT will be necessary for shaping development, training, communication, and resource mix, the plan is only a guideline at the individual practice level where it is applied. Implementing health improvement plans is a contact sport.

A new set of population capabilities will be needed to implement improvement plans. If each practice is to contribute maximally to the overall success of the PCT, each must be able to adapt PCT-wide health improvement plans to local needs and circumstances through micro-management by the primary care team. In other words, regional or PCT planning may produce a programmatic basket of plans and procedures but the practices must draw from the basket and fashion the most appropriate local responses. The required tasks include the ability to characterize the list of patients they are responsible for, identify those at risk for the specified conditions, adapt or develop a plan, mobilize the necessary personnel inside and outside the practice, organize and then coordinate the process, and measure the results. Practical skills in epidemiology, programme design, project management, and evaluation will be needed.

In addition to meeting specified health improvement targets, a practice might use its budget to respond to other community needs. For example, a practice with a larger proportion of elderly patients or with a subgroup with high rates of diabetes might emphasize these programmatic aspects and might resource these interventions in preference to others – say asthma or cardiovascular control. The clinical manager will need to understand the

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needs of the practice population, the programmatic and manpower resources that are available in the community, and the outcome targets to be achieved.

The best primary care practices would reach out to establish community-wide goals and programmes. Interventions are often multifactorial, encompassing public health, social, occupational, religious, and other modalities. Such an approach has been advocated in COPC, as described earlier^{9,10}. Many types of community or population interventions are described in a recent book on community-based medical education written by Boaden and Bligh¹⁷. These fall under the rubric of community medicine and public health. The authors emphasize the importance to general practice of community-based activities and describe an educational model that takes place in community settings and draws upon teams of professionals addressing social, community medicine, environmental, workplace and public health issues. These skills will clearly be needed, and the authors draw attention to the deficiencies of health system organization and design, as well as to inherent limitations in the preparation of doctors to undertake these activities.

3. Triage officer for the practice

The care manager will balance and make trade-offs in resource use between individual medical care and population interventions. This will require that the GP makes cost-effective decisions with individual patients, determines when outcomes for specific conditions would be more cost-effectively achieved by participation in a group programme rather than by individual care, and decides when resource is best used on a community or population intervention (as described in the previous section).

At the level of the individual patient, the care manager will need to apply research evidence to decision-making about individual care and, further, to translate general clinical pathways and guidelines to the problem at hand. Some of these guidelines – such as those promulgated by NICE – will set forth rationing decisions about how resources should be used in the NHS; but these guidelines will need to be interpreted and applied by the care manager. In some cases, a restrictive guideline may need to be overruled because of characteristics unique to the specific patient. In other cases, as they may do now, GPs and patients may agree that individual social or community nursing care offers more benefit than further diagnostic or treatment services.

Money that is earmarked for individual care of specific conditions may be better used by the care manager to provide a population type of approach. Common conditions (examples include asthma, congestive heart failure, diabetes, chronic pain) are often better cared for by managing groups of patients at risk. In this approach, interventions are planned for the whole population with the condition, including those who do not generally come to the surgery for care. These programmes, called disease management¹⁸, are growing rapidly. Services may be individual or in groups. The process is engineered carefully and usually employs outreach, education, self-care, and an integrated approach to the services. The GP's role may range from designing and participating in such programmes to selecting, enrolling, and coordinating the care of participating patients.

4. Trusted personal advisor

The role of the care manager in the new model of care puts considerable responsibility on the GP to reshape the doctor-patient

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relationship. In the old model, the relationship between doctor and patient drew its strength from two elements that figure strongly in the ethical codes of medicine: beneficence and non-maleficence – the ethical principles that guide physicians to promote the patient’s well-being and to do no harm. The assumption that the physician will act only on the patient’s behalf for the patient’s benefit has been an essential element in the implicit contract that underlies the trusting doctor-patient relationship.

In the new model, the GP is responsible for stewardship of a population as well as care of individuals. Some degree of rationing of individual care, albeit to agreed guidelines, will take place. Not all the personal care that could be available will be covered by the NHS and sponsored through the GP. It is probably true that much of the British public already understands that care is restricted today. However, in the new system, such restrictions will be more obvious, especially if efforts are made to educate the public about the new approach. Therefore, for many patients, a new population element will have been introduced and the unquestioned advocacy of doctor for patient diminished. This will undermine the traditional relationship.

Doctors will need to learn how to reconstitute the trust their patients have in them. In the new model, decisions in which a service has been denied will need to be handled in a way that patients can trust. Doctors will have to learn how to say ‘no.’ In contrast to ‘informed consent’ about risks of tests, treatments, or procedures, doctors will need to become skilled at ‘informed dissent’ – how to inform their patient of a service that has been withheld.

We do not know much about the dynamics of ‘informed dissent.’ There are similarities with giving patients bad news about

a prognosis. At the least, it will require a new approach. There is no simple answer to the question of how much a patient should know. If private payment for the denied service is possible, then all patients must be informed in order for them to have the choice. If a patient cannot pay, then we can expect that some patients might want to know about a withheld service, while others would not.

This is a subject worthy of research. In a world where resources are limited, we need to know more about how to have doctors in a position to use those resources where they do the most good, but also to be able to establish and maintain trust from their patients.

A second issue of trust and advice arises around the choices to be made about private care. By design, the services not covered by the NHS will be those of relative high cost and low benefit. Thus, although benefit might be expected, individuals must make a decision about just how much they are willing to pay for. Patients will need to know exactly what benefits they can expect, what risks might be entailed, and what care might cost. They will want to know who can best deliver this care at a price they can afford.

Shared decision making is growing in medicine. Much has been learned about the ways in which clinical evidence must be presented for patients to be able to understand their choices. Individual patient preferences are often different than doctors expect; skills to elicit such preferences need to be learned. Doctors need to see themselves as partners in the decision process, a consultant type of model significantly different than the traditional hierarchical 'doctor knows best' roles that many have employed heretofore.

5. Director of quality assurance and improvement for their practice

The British medical audience is no stranger to the issue of quality improvement. Many articles and conferences have pointed out the progress made in achieving rising levels of quality in industry and suggested that similar approaches have much to offer medicine. Medical audit, employing quality improvement methods, has long been advocated and taught. In the new model, where a budget must be deployed to maximum effect in reaching planned outcomes, excellent design and implementation are fundamental. Quality improvement methods can facilitate planning and implementation and then aid in analyzing data about performance that can be used to upgrade performance.

Current educational approaches still fall short of teaching medical graduates the practical practice-improving skills they need. Many US training programmes now expose medical students and housemen to the methods of quality improvement by having them carry out a project in which they identify a problem and undertake a quality improvement assessment and plan. The approach that these trainees learn is quite basic and practical. With such skills, graduates should be able to assess the processes in play in their practices and PCTs, pick an area in need of improvement, gather data, analyze the problem, and institute changes. These are not processes that require an administrator or business manager to carry them out. In fact, the issues are often as much clinical as administrative, and these skills merely prepare GPs to design and organize their surgeries better than in the past.

6. Managing the practice

The GP in the primary care led NHS must know how to manage a small enterprise. The skills required include such things as managing people, running meetings, planning and implementing projects, budgeting and following cost and performance reports, and leading a team. Working in groups, dealing with conflict, and negotiating agreements are important skills. There are many training models for such competencies in academic, industrial, and medical settings.

GPs will need to integrate professionals from different disciplines into their team. Many doctors believe in a hierarchical model of leadership: the leader gives orders and others follow. The complex, multifunctional teams in which GPs do, and will, work are not easily led in a military model. Professionals want and expect more. They need to understand the goals and objectives, participate in discussion about approaches, and contribute their expertise to the enterprise. Primary care and community-based teams will need flexibility, not rigid hierarchies. Learning to lead in this way calls not only for new skills but also for new styles and attitudes.

A specialised competency: leadership of Primary Care Trusts

An additional, specialised skill will be needed by PCTs. Medically qualified managers will be desirable. These managerial clinicians will take part in commissioning services and negotiating health improvement plans, will participate in budgeting and developing work plans, produce guidelines and procedures, guide audit and care improvement activities, monitor and man-

4 WHAT JOB SKILLS ARE OF VALUE IN THE NEW NHS MODEL?

40 age the PCT's work, and provide administrative support to individual practices.

At higher management levels in the PCT, and in the primary care organizational structure that relates to Health Authorities, those GPs who participate will clearly need advanced skills. Generalist clinicians, such as GPs, are well suited to participate in this kind of role. These positions will require strategic planning, operational, clinical, epidemiologic, community medicine, and public health competencies. These leadership roles will be key, and there are currently only a small number of appropriately trained doctors to fill them. In the US, many doctors are taking business degrees to prepare them for such roles. Alliances between schools of medicine and business are developing in the US to prepare such individuals.

5 WHAT ARE THE STRENGTHS AND WEAKNESSES OF GPs AS GENERAL MANAGERS OF CARE?

'The GP of the future, with adequate auxiliaries and working closely with the social services, should have a wonderful chance to organize the complete care of the community. It is to be hoped that he will rise to the opportunity.'

(AL Cochrane, 1971¹⁹)

The system of general practice in the UK is widely admired around the world. Many believe that Britain's accessible NHS and its unrivalled value for money are largely a function of two decisions. First, the NHS was structured so that primary access was through geographically distributed GPs. Second, the traditional deployment of the GP as the gateway to hospital specialists created a system that was parsimonious in its use of expensive secondary and tertiary resources.

Over the years, general practice has continually improved itself, as documented in a recent history²⁰. The establishment of the Royal College of General Practitioners (RCGP) and the training and accreditation scheme were central to this improvement of what, previously, was a fragmented and unregulated system. Successive reports, starting with the Future General Practitioner in 1972²¹ and progressing to the recent iterations of responsibilities and calls for improvement in the 1996 Working Party Report¹⁴, have defined the elements of general practice and the areas in which it has needed to improve.

General practice has considerable strengths to commend its centrality in the management of the new national health system. It is a generally well-trained work force, distributed relatively homogeneously across the country. Its practitioners are true generalists, with working knowledge of most specialist services with which they and their patients relate. They largely under-

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stand and know the cultural, social, and environmental influences on the registered patients and communities for which they are responsible. They are close to their patients and populations, certainly more so than the Department of Health or NHS Executive and probably substantially closer than the Health Authorities. GPs are accustomed to making allocational decisions about referrals, drugs, and community and social services in short supply. GPs have adapted well to the use of incentives to improve preventive practices and create multidisciplinary teams, suggesting that they are quite capable of achieving targeted changes. Most surgeries are either on, or moving towards, computer-based information systems. General practice provides adequate first access cover 24 hours a day and seven days a week.

However, there are weaknesses remaining to be overcome, should general practice wish to take on a central role (rather than have others responsible) for the management of care in the new national health system. The first problem is the declining numbers of new GPs. Medical school graduates are decreasingly likely to choose general practice as a career. Among the other deficiencies of general practice are:

- the relative autonomy of individual GPs and the resulting weakness of disciplinary organization and control;
- the variability with which individual GPs keep up with their continuing development as doctors;
- their resistance to change; and
- the reluctance of GPs and other doctors to police themselves aggressively. The consequence, of course, is tremendous inter-practice variation in performance, not all of which can be for the good.

These are potentially remediable deficiencies. Attention is

already being directed towards the declining uptake of general practice by newly qualified doctors. Many efforts at continuing professional development and other initiatives undertaken by Health Authorities, the Royal College, and the post-graduate programmes of medical schools have demonstrated that GPs can learn, adapt, and change. GPs' strengths outweigh the negatives, in my view, making them prime candidates to manage the new national health system.

6 WHAT ARE THE ALTERNATIVES TO GENERAL PRACTICE? WHICH OTHER GROUPS COULD UNDERTAKE THIS WORK?

If primary care doctors are to lead the new NHS and if excellent management is the *sine qua non* of such leadership, it follows that each individual or PCT practice must be well run. I have presented strengths and some weaknesses in the performance of general practice if GPs were to undertake to be the managers of such an enterprise. While tradition as well as their strengths would argue that GPs serve as the leaders of a primary care led NHS, there are counter arguments and alternatives.

There are several potent arguments against GPs leading practice management. First, one could argue that they already have too much to do in providing individual patient care, delivering preventive services, running surgeries, and referring to and from consultants. Managing budgets, coordinating care, and thinking about their population of patients would be a substantial additional burden added to their traditional role.

Second, one could argue that doctors were meant to advocate only for individual patients. If they undertake rationing and reallocation, their traditional relationship with patients will be undermined and patient trust will disappear. In this line of thinking, it would be better that GPs continue to advocate for their patients and let others make the rationing decisions.

Third, GPs lack the skills to undertake this work. They are not trained in the basic methods of management, epidemiology, decision-making, and quality improvement that would be needed.

Finally, doctors are selected and acculturated to be in charge clinically. They are not team players. Therefore, they will be unable to take up leadership styles that enable multiprofessional teams to function effectively.

Others could be considered as primary care leaders. Business graduates might be hired in to take on management roles, leaving the professionals to do medical work. While this might work at the higher levels of management in the PCTs, it is an unlikely model at the practice level. The problem with this model is that so much of the decision-making is clinically based and takes place in the flow of patient care in the surgeries. A business manager is removed from this action and would have to involve the doctors under any circumstance.

Some might suggest that nurse practitioners take on the leadership function. Many of the advanced practice nurses have a deep understanding of the clinical issues in general practice, and nurses are trained to view the patient in social and community context, a perspective central to the coordination and integration of services. While some nurses might very well be excellent at leading in the management functions of the primary care practice, my concern is that it would be difficult for nurses to be the major source of labour for this function. The nurse practitioner pool is small, other jobs will compete for this pool (nurse advice lines and hospital nursing), nurses would require considerable advanced training, and the dominant, doctor-led culture of general practice might make it difficult for them to delegate sufficient authority to enable nurses to lead.

7 WHY SHOULD GENERAL PRACTICE UNDERTAKE THIS CHANGE?

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GPs' future economic and leadership success will depend on their capacity to add value to a national health system. The more GPs add, the greater their worth to the system; if their contribution decreases or is taken over by less expensive methods of achieving similar outcomes, their value, and rewards, will decrease commensurately.

The value of traditional general practice is under threat from several sectors. In a recent book²², Peckham paints a bleak picture of both general practice and the NHS if GPs do not adapt to external forces and begin creating more health. Among the threats are that specially trained nurses, other types of doctor extenders, and nurse advice lines could largely substitute for the GP's primary medical care services in the surgery. Pharmacists can replace other services, especially as treatments for common problems are freed from prescription status. New technologies, such as home pregnancy and strep throat testing also eliminate the requirement that a doctor be seen. Technology can be expected to substitute more self-care for traditional doctors' work over time. Computer-based information systems and web materials are rapidly providing medical information and advice to sophisticated users and can compete effectively with doctors for speed, accessibility, personalization, and reliability of such advice. Consultant sector care of many disease entities also handled by GPs has been shown to be superior to that provided by the GP. Furthermore, community and social services have professionalized many of the services that formerly were provided by GPs out of their surgeries.

All this is to say that the traditional roles of GPs are being changed and challenged. Without substituting some activities of higher or at least equal value, GPs will find that fewer of them are needed and that a smaller proportion of the available spend will come in their direction.

The role of care manager, as described above, provides a natural opportunity for GPs to enhance their worth to the health care system and to move to a higher and more unique contribution. If they can successfully add the care manager role, GPs will be able to withdraw from other traditional activities but still make a significant, and well-rewarded, contribution. If general practice fails to adjust and move 'upstream', its future is certainly challenged.

8 WILL THESE BE GOOD NEW CAREER ROLES? WHAT IS IN IT FOR GPS?

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Whatever arguments there are about capacity building and the need to adopt a new role in the future NHS, general practice will face an uphill battle if this role is not satisfying, rewarding, do-able and sustainable over time. This will entail appropriate preparation, adequate support and infrastructure, sufficient levels of resource to do the required job, and time to carry out the tasks. All of these are feasible and, in fact, if this new model can deliver better health, a growing share of money, control, and status should go with this role. But past history, as well as current financial and political constraints, raise worrisome concerns about the government's capacity to support and sustain the planned transition into a new health system built around primary care.

General practice is already suffering from declining medical student interest. While the causes of this downturn are not clear, some observers ascribe it to fundholding and a new market orientation that students view as increasing commercialization of primary care. Others believe that diminishing interest relates more to the difficulties inherent in doing primary care work and its relatively poor status and financial rewards as compared to that attained by consultants in secondary and tertiary care.

Regardless of the aetiology, recruitment of adequate numbers of well-trained GPs is crucial to the success for the new health service. Consequently, some hard questions need to be asked and answered about how these career roles can be made attractive.

The satisfaction of such a role depends in part on its activities, work effort, status, and remuneration. The activities comprising these expanded roles are not foreign to GPs. There is

nothing in these new responsibilities that has not, at one time or another, been done by some GPs at some time in some setting. Many of the activities that are envisioned for the new role were included in the Royal College's 1996 description¹⁴ of future roles for GPs. While the proportion of higher level decision making, population analysis and community orientation, and quality and process improvement will increase, there should still be plenty of challenging, satisfying medicine to deliver.

The effort required of GPs in this new role should be reasonable. A critical dimension is whether the value added (and the resulting benefits in outcome for a given resource input) can support a reduced list size for the GP. New care management responsibilities cannot merely be added on to all others, as so often happens when special interests identify yet another activity to be taken on by general practice. In this proposed model, many activities are delegated to others and the work retained by the GP is of a higher order and supported by a reasonable workload consisting both of medical as well as preventive, public health, organizational, and community activities. Large lists, unless services are offloaded to other primary care providers, are not compatible with accomplishing the necessary care management tasks. Finding the proper balance of work activities is essential and is a subject that warrants operational research.

The new leadership roles must enhance the status of general practice. For many years, the consultant sector has enjoyed a reputation (whether deserved or not) as the higher status, better trained group. In a new managed system, the GP becomes the more pivotal resource and, ultimately, probably will be in a position to deliver more health, albeit through different methods, than most consultant specialists. How this can be turned into status and respect is not clear, but at least part of it must come

from developing role models and sending students out to the PCTs where they can gain first hand experience of the new functions of GPs.

Material rewards should be available as incentives for those undertaking the care management function in the PCTs. While I do not favour directly rewarding GPs for saving money by restrictively managing the care of individual patients (as has, sadly, been accepted by many US doctors), I do believe that it is feasible to reward achievement of overall outcome goals for their population – to pay for performance. The US system has taught us that GPs will take on more work as care managers if rewarded for it. It has also taught us that the public rightly worries when their doctors are rewarded directly for clinical decisions made about resource use for individual patients. British general practice has wisely generally avoided that conflict of interest in the way that fundholding was instituted and operated. Nevertheless, there is a case to be made that GPs should be rewarded for meeting performance targets that are based on the populations for which they are responsible. This principle has already been incorporated in the pay for prevention targets. A similar mechanism should be developed to encourage the effort and innovation that will be needed for the PCTs to achieve the targets that they and the Health Authorities set.

Moreover, if a higher level of training and responsibility are a requirement, GPs should be paid at higher rates than they are now. These are high level roles that require more training and ask more of the doctor. These efforts should be recognized by raising compensation levels. Managerial roles in industry generally draw higher remuneration than technical specialists; there is no reason to believe that such high level general managerial functions in health care should be different.

9 WHAT IS NEEDED IN THE WAY OF TRAINING AND SUPPORT?

Training and systems and infrastructure support are crucial to satisfaction of general practice with these new roles. The GPs need to be confident that they are prepared to carry out the work well. Systems to support the work will make it easier to do and sustain over time.

New competencies will need to become part of the curriculum in medical school, post-graduate training, and professional development for those already in practice. Medical education does not currently prepare medical students or general practice trainees adequately for the role as care managers. As Boaden and Bligh¹⁷ explain, medical school education emphasizes disease and individual illness, not the disciplines that underpin managerial, preventive, or population orientations. In future, all students should acquire a better working knowledge of epidemiology, biostatistics, and clinical study design; be able to read the clinical research literature critically; and understand how to apply such findings to clinical care. At medical school, community-based experiences in which students learn how to characterize the needs of populations, the influence of social, cultural, and economic factors on health, and the uses of epidemiology now are often not viewed as core activities. Not only must greater priority be given to exposure to GPs' surgeries, nursing, social and community care givers, and public health activities, but also rigorous curriculum and teaching must be in place to extract the maximum in learning from these experiences. It should be an essential outcome objective for students to acquire practical knowledge and skills (and positive attitudes) from a broad exposure to the professionals and programmes involved in health and the community.

Trainees in general practice need to broaden their clinical experiences to include those that they will need in managing

care later. These include responsibility for handling community- and population-based interventions, regular opportunities to make individual allocational decisions based on evidence and guidelines, participation in data collection and performance measurement, and an understanding of the core principles and elements of quality improvement.

The action learning orientation of post-graduate training should be maintained. Trainees learn best when they have patient responsibility coupled with reflection, and coaching, and critique from a knowledgeable preceptor. A competency-based orientation should be preserved; registrars should understand the skills they need to acquire and be given opportunities to test their acquisition, design their own remedial learning plans, and be given the chance to move on once the desired level of performance has been achieved.

The field of continuing professional development has recognized how important adult, action learning methods are to the acquisition of new competencies. The model of continuing professional development issued recently by the Chief Medical Officer²³ contains a framework that applies to trainees in training practices as well as to their teachers. It espouses a continuous process of audit, assessment, and improvement that maps well into the skill set that practitioners will need in future.

Assessment drives learning. Consequently, the competencies needed for future practice should be translated into measures of performance that can be used in assessment. Such assessment can be both formative – used to enable trainees to measure their progress, identify gaps, and refocus their learning approaches – and summative – to determine when a trainee has mastered the objectives in an area and is ready to move on.

General practice has proven its ability to design and imple-

ment such training schemes in the past. Once competencies and assessment methods have been identified, continuing professional development can be laid on for practitioners and faculty development programmes introduced. Problems and cases can be developed by the Royal College of General Practitioners as a national effort and distributed as part of prototype curricula. Web sites and intranets can be developed as a means of increasing consistency and making materials available to decentralized trainees and tutors.

The role of care manager will not be easy to do; more than individual skills will be needed. Support for this role will be necessary as well. There is every reason to expect that the NHS will provide it. Computer systems will soon provide internet and email access for all GPs. This channel will soon provide much that will make the role of care manager easier. This will, or should, include:

- routine publication of new evidence relevant to the management of primary care problems;
- updated clinical standards, guidelines, and algorithms;
- emerging best practices for a range of conditions and problems;
- performance data for hospitals, laboratories, radiology, and consultants;
- patient-specific data, including electronic data transfer of transactions such as prescriptions, test ordering, referrals and results of emergency care;
- patient and population data bases complete with ongoing reports and summaries of progress towards health targets.

Similar web based methods will be used to provide advice and information to patients.

10 A DOZEN NEXT STEPS

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At this critical transition point in England's health services, the concept of a primary care led health service is emerging. General practice's role in this model is critical. To facilitate this transition, I suggest the following action steps.

1. The Royal College of General Practitioners should convene a process explicitly to explore and define the future role of GPs in the new health system. While there are many models that have been used to carry out such a process in the past, one that might serve well is exemplified in the recent report issued by the Nuffield Trust and Cambridge University's Judge Institute of Management Studies entitled 'Policy Futures for UK Health: Pathfinder'²⁴. The process utilizes commissioned papers and a summary draft report as a mechanism to draw out varying viewpoints and refinements. This would be well-suited to involving the wide range of parties who would be interested in participating in a redefinition of the role of general practice.
2. The new pilots of PCTs that started at the beginning of April 2000 should be closely monitored along agreed areas of performance and their experience reported out for discussion earlier rather than later. Useful reports of this type have been published by the OHE²⁵ and others²⁶ on the first models of collective purchasing.
3. As a matter of priority, examine the range and determine a programme of incentives – financial and others – that could attract doctors into this new model of general practice, stimulate them to undertake the advanced training and acquire the skills that will be needed, perform the necessary work well, and remain happily practising for many years.
4. Convene commissions, working groups, and conferences by the Royal Colleges, the medical schools, and the General

Medical Council to discuss the objectives of the new medical system and to define the attitudes, skills, and knowledge needed by their graduates to enable them to practise competently and happily in such a system.

5. Define the research and development agenda for improving clinical care processes in the new system and commission competitive research to develop and trial new ideas.
6. Create regionally based practice development training schemes so that practitioners can retrofit their competencies to the skills and knowledge needed to be successful in the new paradigm.
7. Begin the public education campaign by developing a public-orientated forum on television for presenting and discussing alternative scenarios and visions of the new national health system.
8. Begin teaching new skills and attitudes in the nation's medical schools, teaching hospitals and practices and report and discuss these experiences at the annual meeting of educators (Association for the Study of Medical Education).
9. Bring in leaders to present PCG/PCT development ideas from countries that are implementing new approaches, especially Australia, New Zealand, The Netherlands, the US and Scandinavia. Since these issues are central to the health system development of many countries, request that the World Health Organization sponsor an annual meeting to present and discuss new developments in this arena.
10. Commission or in other ways encourage through a targeted policy the development of systems and software to enhance and support clinical care practice efficiency and effectiveness.
11. Lobby the government to provide adequate incentives, operational funding, and capital development to support the

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- new primary care roles. Explore the entry of private investment in developing PCTs but regulate it carefully. This model might be a way to increase the capital funding available to PCTs in a manner similar to the private finance initiative for hospital Trusts.
12. Assure that the private care industry, which will grow, is monitored and quality assured to at least the same standard as the publicly provided health service.

11 CONCLUSION

A quarter century ago, a small group of leaders transformed general practice.²¹ They found general practice to be in a parlous state, described in explosively critical reports by Collings in 1950²⁷ and Hadfield in 1953.²⁸ Following on the formation of the Royal College in the 1960's, these leaders widened the remit for GPs, expanded training requirements, strengthened the educational process, and instituted periodic accreditation. General practice emerged greatly enhanced.

The concept of a primary care led NHS represents another significant step in a decade-long shift in the roles and responsibilities of GPs. These changes point towards a future in which general practice will need, once again, to reexamine its role in health care.

In this paper, I have attempted to draw the implications of such a change. In order to prepare GPs for these new roles, leaders need to begin now to discuss what GPs will do in future, how they will be prepared, what support they will require, and how they will keep up.

Much has changed to prepare general practice to undertake this challenge. The Royal College of General Practitioners is now a vital institution quite capable of hosting workshops and other forums for discussion, commissioning reports, and implementing agreed findings. The General Medical Council has recently shown considerable resolve to improve the training and continuing practice of doctors and has published an admirable series of papers about preparing doctors, outlining guidelines for their education and continuing professional development. The academic resources now available in primary care and general practice are considerable.

As always, however, leadership will be needed to bridge the gap between today's issues and the role of GPs in the next cen-

58 tury. There is always a gap between what is understood about practice now and the competencies that will be required for practice in the future. Leaders bridge that gap and identify the changes needed to prepare those in training to be ready to undertake those new roles. This ‘long range radar’ is especially important, since the lead time needed to prepare graduates ready for new responsibilities is often the better part of a decade, even if one knew today exactly what attitudes, knowledge, and skills such GPs would need.

The leaders of general practice need to begin today to identify the gaps in competency that will need to be filled. They must lobby their colleagues to work with them in defining a new model that works. With a vision of the future in hand, plans for education, training, accreditation, and support can be developed and begun. In the model of ‘do it and fix it’, it is less important that the programme to prepare GPs for the next century be perfect than that it begin and improve over time. Now is the time to start.

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