General practice of the future

Can general practice retain its best features while adapting to the demands of a changing health service? David Colin-Thomé and Brian Fisher argue the case for new models.

By Professor David Colin-Thomé, Independent Healthcare Consultant*, and Dr Brian Fisher, a semi-retired GP and Patient and Public Involvement lead for the NHS Alliance.

General practice has proven resilient, flexible, popular with patients and entrepreneurial over the years. However, the requirements of the next few years may put general practice under strain. The current organisational form of general practice is unlikely to be able to deliver the kinds of services to the quality and quantity required. The question, then, is how do we keep the best while changing the rest?

General practice has many strengths, notably in providing continuity of care, the registered list system and a payment system that, at its best, allows innovators to respond quickly. It is an important local resource in many communities and an important component of local social capital. It is much loved, the producer of most value in the NHS and fiercely local in a world of centralism and distance.

But in a changing world it has many weaknesses. Today primary care is expected to develop more effective health improvements not just for individuals but also for communities; it is supposed to create clear frameworks for the management of long term conditions; to line up health and social care; and to provide many of the services traditionally provided in acute care including diagnostics, outpatients and minor surgery.

General practice in its current form is unsuited to deliver these tasks, mainly because of size. Yes, it is legitimate to ask why should patients have to go to hospital for x-rays or ultrasounds? But how can a small general practice in a small space provide these?

Apart from size, the quasi-business form of general practice may not be the best model for the future either. The financial incentives can support innovation but often they work in the other direction and encourage inertia with a focus on the financial bottom line that restricts innovation and change. There is little incentive for practices to listen or respond to their patients’ needs or wants. Quality is variable, perhaps because there is little incentive to improve, as a quasi-autonomous provider. The business approach and the incentives means that every change has an opportunity cost that needs to be paid for – and it looks to the outside world as though GPs will not do anything new without payment.

There can be a loneliness of practices cut off from each other, although that is rapidly changing. The business aspect of general practice breeds a commercial confidentiality that lacks transparency and makes it difficult to compare and work effectively with some practices.

It may be that the Commissioning Board’s oversight of general practice will improve consistency of quality. It may be that the collective interest of the CCG in achieving the goals set out above will drive change.

At any rate, general practice cannot but respond and it may be that we shall see the business basis and the size of practices changing over time.

One proposal has been to create groups or federations of practices. The move to clinical commissioning will undoubtedly be important in this. Clinical Commissioning Groups for the first time in the history of the NHS grant GPs a say in the NHS and improving primary care in quality and scope has certainly emerged as one of their key priorities.

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As we move from managerially-led commissioning we can expect that localities of GPs and federations will become far more commonplace and that such federations will include not just general practice but also our other community-based colleagues. CCGs, led by GPs, will seek to devolve more responsibility and finances to willing practices/localities/federations.

The question remains as to whether such federations would actually deliver the change we need – or just produce larger organisations doing more of the same while losing the strengths of general practice in its current form?

Little and big

It is not, in fact, an either/or choice. For general practice to fulfil its potential it must be both “little and big”, both local and strategic. We need a new model of care provision that moves away from provision centred on the hospital to one centred on primary care.

A “Primary Care Home”¹ would be an integrated, population-based provider organisation commissioned on a devolved, population-based, holistic NHS budget to disburse on the “make or buy” principle – either it provides the service the patient needs or refers them to another provider.

It would be a home not only for general medical practitioners and their teams but also for all primary care independent contractors and their staff (pharmacists, dentists, optometrists), community health service and social care professionals. And potentially a home for many currently working in hospitals, in particular those who have a responsibility for long term conditions care, for rehabilitation and re-ablement and for the surgeons who specialise in procedures that do not usually require an overnight stay.

The Primary Care Home is not an NHS hierarchical model but a more sophisticated wider and comprehensive provider than GP federations. Constituent organisations would retain their autonomy, subject to two-way accountability. It could be managed by whoever is the suited to the task locally. It could compete with other NHS-funded organisations.

So general practice can be big and small, strategic and locally operational, working together and alongside community providers to change the way health services are delivered to populations.

As joint authors of this paper, we are not in fact in agreement on the way forward. There are merits on each side of this debate. Yes, we need change – but we also need to be mindful of what we might lose and what we might gain in the process.

¹ The Primary Care Home’, Colin-Thomé, D. 2011. www.dctconsultingltd.co.uk