



Debate & Analysis

Reorganisation of general practice: be careful what you wish for

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INTRODUCTION

With the recent publication of the NHS *Long Term Plan*¹ and the renewal of the GP Contract,² it is timely to consider what we value within general practice. In this article we consider normative ways of thinking about general practice and the implications for primary healthcare organisation and funding. We examine some of the opportunities and challenges that current 'common sense' thinking produces, shaping ways in which particular 'problems' and 'solutions' are constructed and accepted.³ We discuss potential 'gaps' or 'alternative' ways of thinking and their potential contribution to future policy and practice.

CONSTRUCTION OF A CRISIS PROBLEM

Many have referred to NHS general practice as being in crisis.^{4,5} Debate about this crisis has included discussion of GP retention and recruitment in relation to capacity and service demand. The difficulties experienced in primary care have been exacerbated by factors including rising patient numbers and changes in the nature of work.⁵ For these reasons, general practice provided under the conventional principles of comprehensive care (that is, a patient can attend with any problem) to a universal set of patients, while maintaining a supportive and continuous relationship,⁶ is frequently described as unsustainable.⁴ In the short term, within current models of working, there are not enough GPs to meet the demand to treat patients with increasingly complex problems.

The naming of a general practice ‘crisis’ has led to a number of initiatives attempting to address this. Policies have promoted IT, mixing of skills, role expansion, and delegation of tasks to allied healthcare professionals.⁵ While not undermining or devaluing the value many of these initiatives provide for patients, this article seeks to explore some of the unintended consequences and underpinning assumptions of these changes.

WAYS OF THINKING ABOUT GENERAL PRACTICE WORK

Currently, healthcare organisation is oriented towards disease-based conditions, exemplified by current secondary care hospital services; primary–secondary referral pathways; and medical education curricula. Similarly, many primary healthcare professional groups have well-defined and deliberately narrow professional scope and responsibilities. General practice, however, challenges this way of thinking: led by patient encounters oriented towards experiences and problems. A principle strength of general practice is the opportunity for patients to attend with any problem, regardless of the particular pathological pattern, or professional disciplinary scope of practice. A key area of GP expertise is the ability to appreciate and deal with this breadth of patient engagement.

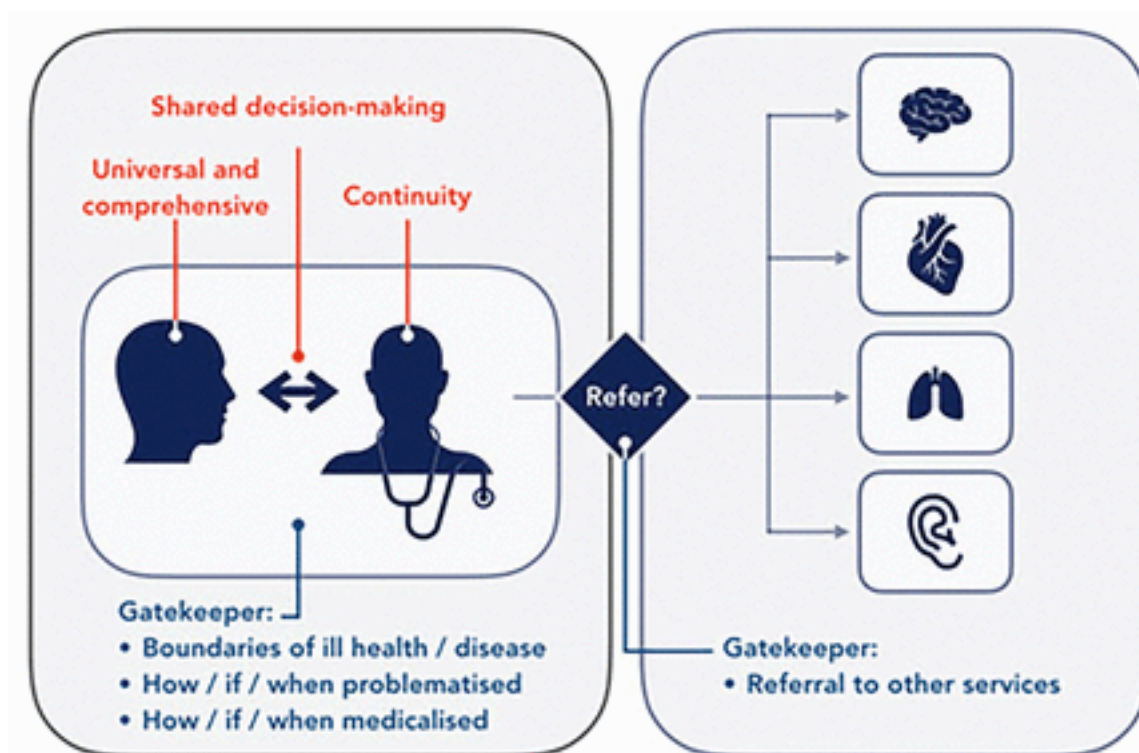
A central but often forgotten function of general practice is a gatekeeping role, contributing to healthcare cost-effectiveness, for example, through an ability to selectively refer to secondary care services.⁶ Expert negotiation with patients of boundaries between stressful life experience, illness, and disease,⁷ shapes the potential medicalisation, investigation, and treatment of symptoms, and their subsequent clinical and economic impact for patients and society. Some have, for example, highlighted the importance of early recognition of medically unexplained symptoms and improved management of patient symptoms.⁸ This process involves constant intellectual challenge for GPs to consider a range of differential biomedical diagnoses with patients, in combination with a patient’s social, psychological, and contextual experiences.⁹ A GP’s role therefore requires that they have the knowledge, attitude, and opportunity to fulfil these role requirements.

RECENT GENERAL PRACTICE AND PRIMARY CARE POLICY TRENDS

A variety of approaches to work distribution has been proposed in the UK as solutions to an apparent GP shortage and relative work overload, such as employment of community pharmacists, paramedics, and physiotherapists to undertake ‘GP work’.^{1,2} Evaluation of these initiatives is in its infancy and it is unclear the extent to which they are cost-effective or reduce GP workload. However, a number of challenges have been made visible through their introduction.

One emerging challenge has been the repositioning of GPs within healthcare provision. A range of primary care models exists. **Figure 1** illustrates one end of the spectrum, which reflects the way GPs have

traditionally functioned in the NHS. In this model, a patient will consult with a GP as a first point of contact. This will likely involve negotiation about how and if an issue is problematised, alongside consideration of a range of possible pathways or outcomes. This may include a 'watch and wait' approach; investigation; trial of treatment; follow-up; or possible referral to other services dependent on need (for example, neurology, cardiology, respiratory, ENT).



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Figure 1.

Expert generalism model of general practice.

Many new service 'innovations' have been initiated to increase speed of patient access to a healthcare professional. These new services change the function of a GP, as illustrated in **Figure 2**. This illustrates the expansion in patient interface options. While these increase the potential speed whereby a patient can access a healthcare professional, this inherent 'choice' requires a patient (often when feeling unwell) to be able to work out what is wrong with them and so which healthcare professional or service they need to see. A number of new services, such as paramedic home visits or 111 triage, are positioned instead or ahead of a GP consultation, alongside 'care navigator' programmes, to support access and navigation of care pathways.



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Figure 2.

Selective model of general practice: distributed primary health care.

These services therefore shift the nature of the GP–patient consultation from expert generalist, to engagement with a more selective patient group with a potentially higher incidence of pathology or complexity. General practice therefore moves from being a ‘primary care’ to ‘secondary care’ service, with a range of other healthcare professionals providing the initial patient interface and possibly serving as the ‘new’ gatekeepers to NHS services.

Figure 2 demonstrates how a GP–patient interaction (bottom, middle column) becomes one of a number of specialist options. This in principle makes better use of a GP’s biomedical knowledge as ‘complex multimorbidity expert’. However, the implicit compartmentalisation of services available to patients increases the potential for health inequalities. For example, those who are relatively well and/or have knowledge of the ‘system’ may find it easier to access appropriate care. Unsupported and vulnerable patients are more likely to fall through the net even before accessing appropriate primary care services. Patient continuity is also

potentially reduced by providing different primary care services in different institutions and settings.

SUMMARY

So how might we consider the future organisation of primary care differently? First, as healthcare professionals alongside policymakers, we should reconsider how and why certain issues have been named as ‘problems’. For example, has the normalisation of austerity measures minimised debate about adequate funding of primary health care (rather than reorganisation of care within existing funds)? Could increased visibility of the scholarship and intellectual challenge of general practice enhance the attractiveness of GP posts?¹⁰ Might greater support for models of care that promote high-quality comprehensive care within a continuous relationship (rather than short-term transactional consultations) increase GPs’ job satisfaction and reverse the problems with recruitment and retention? And might an emphasis on the definition of ‘good-quality care’ be shifted from consumer-type priorities such as speed of access, to a fresh and critical curiosity with patients about what they most value and need from primary health care and general practice services? Important questions remain about the position and nature of multidisciplinary support (for example, before or after GP–patient consultations); whether the additional services are provided within or outside existing healthcare structures; and the amount of responsibility disseminated to patients in order to access suitable healthcare services.

Notes

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