

The future NHS:

time for another change?

In 2008, on the 60th birthday of the NHS Don Berwick, then President and Chief Executive of the Institute for Health Improvement in the US, wrote:

*'Reinvest in general practice and primary care — these, not hospital care, are the soul of a proper, community oriented, health preserving care system. General practice is the jewel in the crown of the NHS. Save it. Build it.'*¹

GP vacancies were at a low level² and morale was relatively high.³

CRISIS IN GENERAL PRACTICE

What has happened since then to create headlines about doctors leaving general practice in droves, a service on its knees, patients flocking to accident and emergency departments, a Royal College of General Practitioners (RCGP) petition, and a major recruitment crisis? Chronic underfunding and maldistribution of resources within the NHS is partly to blame. Reports of lost jobs in general practice and surgeries closing are clear evidence of this, but, despite the rhetoric — 'a primary care-led NHS' — many politicians don't really understand general practice. They are sceptical about claims for the clinical and cost effectiveness of the gatekeeper role, the small business model, and the independent contractor status, and are unclear about where new resources would go. The RCGP and British Medical Association have responded with campaigns to provide additional funding for general practice, which now seem to have political traction.

In this issue of the *BJGP*⁴ two junior doctors tell us why general practice is not seen as a desirable career choice in medical school, with little being done in the later years of medical education to encourage applications to GP training schemes. This is particularly dispiriting, given the greatly increased, and generally well-funded, proportion of undergraduate curricula

now being taught in general practice. Are students picking up on the negativity that is beginning to characterise discussions about the future of general practice, and is this spilling over into postgraduate career choices? Have the research-driven agendas of the medical schools demoralised the teaching workforce and undermined what once looked like a commitment to more community-based undergraduate education?

NHS PROBLEMS

There are deeper problems in the NHS where, with varying degrees of success, generations of doctors and managers have succeeded in papering over the cracks. The structure of the NHS as we know it was an accident of history: a healthcare system created when little was known about healthcare systems. The 1948 National Health Act formalised the ancient distinctions between apothecaries and physicians, and drove a wedge between generalist and specialist medicine. GPs were given self-employed status with no proper career structure, and a payment system linked only to patient numbers and a handful of procedures, without any recognition of teaching, research, and professional development. GPs were also given 24-hour responsibility for their registered patients. Hospital doctors secured a much more 'professional' contract, which recognised time spent in educational, academic, and administrative work, but did not include responsibility for population health and no incentives to work collaboratively with GPs to improve it. Instead, an unhealthy and sometimes destructive tribalism developed, with consultants feeling entitled to make disparaging comments about GPs being inferior, or playing too much golf, and GPs being equally free with comments about the hauteur and smugness of hospital specialists. How can people who have trained and worked together become so antagonistic? Some elements of the

Lansley reforms have made things even worse.

It really has been a miracle that the system has worked as well as it has. Shortly after the NHS was founded the Collings Report⁵ revealed that much of general practice was unfit for purpose and often a danger to public health, yet we still cling to the model of general practice that underlay the problems Collings identified. Following the 1966 Family Doctors' Charter, when group practices and partnerships were in their heyday, general practice was regarded as an attractive career option. This may have been the golden age of general practice, with well-staffed practices integrated into the community, partnerships of GPs offering a wide range of services, and with excellent connections to hospital medicine and to social care; but that is long gone in most parts of the country and little has changed in the longstanding cold war between generalists and specialists. The primary-secondary care interface is often a conflict zone.

HOW TO MOVE ON?

How can a fragmented, demoralised, and underfunded system of general practice, in which standards of care remain uneven, be rehabilitated and developed, so that its undoubted core strengths are retained and enhanced while its weaknesses and vulnerabilities are dealt with? How can recruitment and retention of general practitioners be supported in ways that acknowledge the changing demography of the patient population and of the medical workforce? How can an integrated approach to the promotion and protection of the health of individuals and communities be created by primary, secondary, and social care working together instead of pulling apart? How can the NHS improve some of its health outcomes that lag well behind comparable European economies, without breaking the bank?

INTEGRATION OF TRAINING AND SERVICES

Some of the weaknesses of general practice, such as its small-scale units of care and heterogeneous management arrangements, can also be its strengths: the ability to respond with speed and agility to a changing environment and a capacity for reinvention. However, the formula

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for the future is unlikely to be more of the same: the small business model of general practice, the primary–secondary care divide, a commissioning system that generates antagonism, and a remuneration system that encourages exploitation and does not adequately reward high quality. Instead, it may now be time to seriously consider the creation of more genuinely integrated organisations in which doctors in training and in practice, in hospital specialist medicine and in community-based primary care, are encouraged to share employment, human resources, contractual and estates infrastructures, and management systems, with more porous professional boundaries between training posts in generalist and specialist medicine. A more attractive career structure for primary care clinicians could be devised that could address the recruitment problems faced by general practice. Collaborative care provided across the interface could be a solution to difficult clinical and service problems, such as out-of-hours care and the management of multimorbidity. Economies of scale achieved by more centralised management, procurement, and workforce planning could genuinely free up resources within general practice. Shared accountability for patients at all stages of their illness trajectories, supported by a common electronic health record, would begin to address the lack of coordination of care that is so frustrating and time-wasting for patients and clinicians.

INTEGRATION: OF A SORT

There are already examples of ways in which integration can be fostered and maintained, and it will be important to share experiences and success factors between organisations that have managed to develop such arrangements. Emerging models of primary care collaboration include managed networks, federations, and super partnerships. However, many, if not all, of the integrated care pioneer sites are focused on integration among social, primary, and community care services and stop short of more complete service integration and of tackling the professional problems described above. There can be a sense of rearranging the deckchairs and

renaming the foundering vessel. These schemes are also a far cry from some of the integrated models in the US, where many traditional professional boundaries have dissolved almost completely, and in parts of New Zealand where there are examples of extensive service integration. Additional guidance may well emerge from the developing Academic Health Science Networks (AHSNs), in which partnerships between clinical academia, secondary and tertiary hospital care, community and primary care services, social care, and the private and third sectors are created.⁶ One of the London AHSNs, UCL Partners, sees a major part of its mission as improving the health of the 6 million or so people in the catchment areas of its constituent hospitals. The success of the venture will be judged by its effect on the health of this population, turning the old model on its head, looking out from the hospital to the community beyond its walls.

MAJOR CHANGES

These are introductory sketches of what may be considered; there are of course major, but tractable, issues of governance, professional boundaries, esteem, and money to negotiate. General practice would need to be an equal partner in any new scheme. In a *BJGP* editorial last month,⁷ Stephen Gillam looked in more detail at the future of funding for health and social care in England and offered some new ideas about how we can shake off the ‘unaffordable’ label from the NHS and start doing things differently — and better — including realigning the uneven relationships between health and social care. In doing so he set the scene for the recently published King’s Fund report from the Barker Commission entitled *A New Settlement for Health and Social Care*.⁸ This report and its recommendations are focused on the delivery of health and social care but not on the underlying educational, professional, and governance factors that also need to be dealt with. It describes possible ways of identifying new resources and defraying costs, against a backdrop of a projected increase in healthcare expenditure in the UK to 11–12% of GDP. These are important proposals aimed at

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improving the equity and effectiveness of medical and social care but we need to do more; we need to have the courage to try to heal the fractures between all parts of the NHS and social services, and this means a radical rethink of the present structures in which GPs and hospital doctors train and practice. This may be one NHS reform that we cannot afford to avoid.

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