At a Time of Change

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> **"General practitioners are on the "front line" of medicine. They are the patient's advocate in the health system."**

"In its most highly developed form, primary care is the point of entry into the health services system and the locus of responsibility for organising care for patients and populations over time. There is a universally held belief that the substance of primary care is essentially simple. Nothing could be further from the truth."[1]

This quote is from the recently deceased Barbara Starfield, Professor of Health Policy and Management at the Johns Hopkins Bloomberg School of Public Health, who advocated for excellence in primary care programmes both in America and all over the world.

In an ideal world, the health system would be structured in the way Barbara Starfield suggests. The general practitioner is the "gatekeeper", the first port of call, preventing unnecessary hospital visits and providing continuous and personal health care. In an ideal world, the general practitioner is a separate entity to any administrative or government body and advocates for patient care alone. In an ideal world, the general practitioner charges an appropriate fee for the private consultation and in an ideal world, everyone can afford this bill. Unfortunately, we do not live in an ideal world.

From a purely economic standpoint, however, general practice has shown its virtue. The higher the percentage of primary care physicians, the lower the cost of health care in a country. 70% of UK doctors work in primary care and only 6% of the British gross domestic product (GDP) is spent on healthcare. This compares to only 30% of doctors in the USA, Barbara Starfield's native land, employed in primary care and the resultant 12% of the GDP allocated to healthcare[2]. The more general practitioners there are providing a community service and an alternative to the hospital for many conditions, the better the chance of keeping healthcare expenditure in our country lower.

This, however, says very little about the inefficiencies and inadequacies of the Irish healthcare system. Far from this ideal world, there are those in the community who cannot afford to visit their doctor: those who fall just short of the requirements needed for a medical card. Severely disadvantaged areas are short of general practitioners and those patients who cannot afford to, or otherwise cannot access a GP, are the same people at a higher risk of developing chronic disease and multiple morbidity. They are the same people who will inevitably show up in A&E again and again, presenting at a later stage of disease and therefore at a more difficult stage to treat, diminishing their chance of a good prognosis and, in the most cynical way of thinking, costing society more to treat them.

In 1971, Dr Julian Tudor Hart coined the phrase "The Inverse Care Law"[3]. Interpreted simply, this states that those in most need of health care in society have the least access to it. It is a well-known fact that the less well off individuals in the community are also those with poorer health due to many contributing factors. These include income inequality, lack of government spending, lack of social supports, lifestyle factors such as smoking, poor diet and lack of exercise and other non-medical factors such as housing and transport. Those in deprived areas are less likely to complete their secondary education or progress to third level, limiting their career opportunities and income. Many are left unemployed and those who have work often have poorer training and working conditions which in themselves are health risks.

Drug abuse is more common, as is alcoholism, and the social support is not in place to encourage change or even prevention of these serious issues. Along with these factors comes poor nutrition. As healthy food is becoming more expensive and processed food comparably cheaper, obesity is rising in the poorer communities in Ireland. An in-depth report by Combat Poverty Agency in 2008[4] revealed that due to these factors, "almost half (47%) of those who were consistently poor (ie. in income poverty and experiencing deprivation) and 38% of those who were income-poor reported having a chronic illness, compared with 23% of the general population".

Not only did they describe the health effects of poverty on those of low income, they also outlined the health issues facing the marginalised groups in society, including the travelling community, asylum seekers, those suffering from mental health issues, those of a different sexual orientation, those with disabilities and the homeless. These people, while affected by many of the issues facing those of a low income in a disadvantaged area, also have distinct health issues of their own. For example, asylum seekers may not have had the privilege of vaccinations that we are so lucky to receive and may be more at risk of infectious diseases, whereas homeless people have a higher incidence of tuberculosis and those with Down syndrome commonly suffer with cardiac issues. Many in these groups will also by stigmatised due to prejudices in society, such as those who suffer with schizophrenia or those in the travelling community.

General practitioners are on the "front line" of medicine. They are the patient's advocate in the health system. If an issue can be dealt with in the practice, the doctor can put worries to rest, instilling trust and furthering the doctor-patient bond. Thus, if an issue needs a more specialised opinion and the patient must delve deeper into the health system, they will know that their GP is their navigator and with them 100% of the way, charting their journey and hopefully their recovery. Luckily in Ireland, I believe we have such GPs. I have seen first-hand, while on placement in primary care, GPs taking the necessary time, listening closely to what really concerns the patient and then speaking on their behalf, all the while with an interest in the patient's well-being above all else.

Currently, the Irish government is bringing in changes to improve healthcare as part of the Programme for Government 2011. With regard to the plans for primary care alone, plenty of changes

are sought. Universal free health care is to be implemented. GP fees will be eradicated for all. GPs will have greater access to diagnostic equipment to alleviate pressure on the hospitals. The number of places on GP training schemes will be increased to allow greater numbers of GPs in practice. Similar measures will be implemented for primary care nurses and other professionals in the sector, including psychologists and counsellors, to aid in the management of mental health in the community.

There will be four phases to this plan. First, those with long-term illnesses will be granted free health care. Then, claimants of free drugs under the High-Tech Drugs Scheme will receive free health care. Thirdly, health care for everyone else will be subsidised and finally, primary care will be free for all. Under this plan, GPs will be expected to work in a multidisciplinary primary care team. GPs will then be financed entirely by the government[5].

Doctors from areas of deprivation seem to welcome these changes. Dr Edel McGinnity, whose practice is in Mulhuddart, Co. Dublin, stressed how much help being part of a primary care team has helped her practice and how her patients would benefit from a greater access to healthcare[6]. Advocacy for her patients is her simple underlying conviction. She also stated how important it is for general practitioners to advocate for themselves. The Irish College of General Practitioners has welcomed many of the recommendations made by former junior minister for primary care, Roisin Shortall, such as ring-fencing a primary care budget and access to diagnostics for GPs[9]. Suggestions have been made in relation to the restructuring of general practice into primary care teams, a change welcomed by Dr McGinnity and other GPs in areas of deprivation. The ICGP report suggests, however, that "engagement at local level planning and developing services needs to be undertaken and it must be acknowledged that one size does not fit all"[7].

This perhaps applies to many primary care physicians who do not practise in disadvantaged areas, who may have invested a huge sum of money into setting up efficient and well-run practices and who have developed the same trusting, personal relationships with their patients, who have connected with other healthcare professionals in an informal way, finding this as effective as the proposed structured primary care teams. These GPs have systems in place for long-term care management and prefer to be autonomous. They worry ablout being entirely under the authority of the HSE. This, I believe, is completely reasonable and healthy. The Programme for Government is aimed at helping those less well off in society and this is very desirable. However, some GPs fear these developments will actually diminish the level of health care currently available. Some GPs feel that attending public care team meetings will reduce patient contact time by 1.5-2 hours per week and that this is an inefficient use of GP time and resources, increasing inpatient admission rate by 2.5%, outpatient visits by 2%, emergency department attendances by 4% and surgeries by 3%, thus costing more and putting more pressure on the hospital services, reversing the desired effect of this reform[8].

There are fears among GPs of how disenfranchised they could potentially become with the HSE (or whatever new body would be set up under the Programme for Government) taking over the regulation of primary care, which has traditionally remained quite independent of government management. This will severely limit the GP's role as an advocate for their patients. A worrying element of the planning of these changes is that the implementation group involved in coordinating the logistics of universal healthcare is made up of those with experience in public service administration or academics but only one doctor, a pathologist, has had an input[8]. It is understandable for many GPs to be anxious about a major upheaval of the current system, which does work effectively in many areas, without any consultation from those with a background in general practice. It is especially unsettling to see rifts within the Department of Health that have led to Ms. Shortall's resignation. With such an extensive remodelling of primary care

in prospect, it would be far more reassuring to see a united team working together for the good of the patients and the GPs rather than internal strife and controversy. Much of the focus seems to be on the policy-makers rather than those who will be affected by the end result.

These fears are supplemented by reports from the IMO that these new developments are not in the patients', or indeed in the GPs', best interests. Recent reports that the primary care centres planned to be opening in the south of the country show no signs of new diagnostic developments, no improvements of the current primary care facilities, no signs of a shift of hospital services to the community and that the doctors who enter into the new system would have no tenancy rights and be in constant danger of the HSE dismissing their services[9]. There seems little sense in reshuffling GPs from perfectly good practices they have set up to properties rented by the HSE if there are no advantages to patient care, especially if their livelihoods become more precarious and they are under the authority of a body which has no GP representation. Additionally, if the government is the only financier then the system becomes a cartel and GPs lose their independence and advocating role. What the government also has to be careful with is the future recruitment of newly qualified primary care workers. In recent times, we have seen a dramatic increase of junior hospital doctors leaving Ireland for better working conditions and pay abroad at the expense of hospital services here. The work of general practice should attract the brightest and best of the qualifying doctors to continue to improve primary care for the citizens of Ireland.

In order to do this, the first step the government needs to take is to involve the general practitioners to a greater extent and listen to their opinions on reform and universal healthcare. As worthwhile and commendable project as it is, it cannot be blanketed all at once across a country with such varying socio-economics. Any developments made need to be made at a local level, rather than a national level, in places that need and welcome change. Universal free health care is a wonderful idea but the implementation of primary care teams and actual improvements in services require more co-ordination between those proposing the change and those on whose livelihoods it would impact, who continually provide excellent primary care facilities and services to their patients. General practice in Ireland has extremely short waiting lists, there is no two-tier approach to public and private patients and they resist medical inflation, so rather than restructuring primary care the government should perhaps build on the good, albeit not perfect, system which already exists.

In a country as developed and progressive as ours, it is deplorable that there are some who will not seek medical advice for financial reasons. For the good of any individual and for the country as a whole, this is a situation that badly needs to be rectified and few can argue against free healthcare. It is a commendable step that our country is taking to eradicate this problem. However, the Programme for Government is such a broad and ambitious strategy that I am afraid this worthy undertaking will be lost in favour of a different, more easily implemented task. I believe primary care teams are, in theory, a wonderful way for the various aspects of health care to interact and help each other, and in many situations would be extremely welcome. But for this to be the first step in our healthcare reform, before universal health care has been brought in and without primary care input, seems like poor prioritising. It is oversimplifying the situation to reroute every GP into primary care teams when many doctors work out of perfectly functional centres with unforced arrangements with their local physiotherapists, counsellors etc. already in place. Perhaps it is time for the government to listen to those at the front line, who know how primary care should work and what is needed at a local level, and then perhaps money can be spent where it is needed and to do away with the inverse care law in Ireland.

References

1. Starfield B., Primary Care: Concept, Evaluation and Policy (Oxford University Press: Oxford) 1992.

2. Taylor R. J., McAvoy B. R., O'Dowd T., General Practice Medicine (Churchill Livingstone) 2003

3. Julian Tudor Hart, "The Inverse Care Law", The Lancet, Volume 297, Issue 7696, Pages 405 - 412, 27 February 1971 doi:10.1016/S0140-6736(71)92410-X url:< http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(71)92410-X/abstract> Accessed 22/09/12

4. Farrell, C., McAvoy, H., Wilde, J. and Combat Poverty Agency (2008) Tackling Health Inequalities – An All-Ireland Approach to Social Determinants. Dublin: Combat Poverty Agency/Institute of Public Health in Ireland.

5. Programme for Government url:< http://per.gov.ie/wp-content/uploads/ProgrammeforGovernmentFinal.pdf>

6. McGinnity E. (2012, Sep) General Practice in Disadvantaged Areas: Addressing the Inverse Care Law. Speech presented at the Albert Lecture Theatre, Royal College of Surgeons in Ireland.

7. Irish College of General Practitioners Primary Care Teams: A GP Perspective ICGP PCT Report 2011

8. Behan W., Shackleton F. "No love in a cold climate" Forum, Volume 29-Number 8(ISSN 0790-9977) August 2012

9. Cuilltom G., "HSE charged with 'edifice complex'" Irish Medical Times Volume 46 No. 33(ISSN 0047-1476) 14/09/12