Primary care: political favourite or scientific discipline?

Chris van Weel

Primary care has become a favourite of politicians, who regard it as a mechanism for containing technology-driven demand for medical care, for balancing the costs and consequences of care, and for fostering self-reliance in individuals. It is seen as the way to provide medical care to everyone in the community, irrespective of income or social class.1 Primary care is promoted throughout Europe, although formal organisation of services varies from one country to another. The present state of affairs is a welcome change from the days when general practitioners were regarded with disdain—as drop-outs from the career race for hospital consultant status.

Although the high expectations of politicians are fostered by the discipline of general practice,2,3 the medicopolitical promotion of primary care fuels ambivalence as well. How much of this promotion is political rhetoric, and how pleased the public will be once primary care sets the pace, remains to be seen. Cheaper healthcare is not necessarily better healthcare, and a supposedly more patient-friendly medical approach cannot be expected to result in universal improvements in care outcomes while simultaneously reducing expenditures. Because of this tension between professional and political expectations, general practice, as a medical discipline, must exert control over its own development. How may general practice in Europe develop under these circumstances?

Since primary care is an issue throughout Europe, there is a general trend throughout Europe to support general practice. For example, the new scientific organisation of the discipline—the World Organisation of National Colleges and Academies-Europe/European Society of General Practice—held its first conference in Stockholm in July, 1996. Communication among Europe's general practitioners is aided also by three primary care journals aimed at international readerships: Family Practice, the Scandinavian Journal of Primary Health Care, and the European Journal of General Practice. The European infrastructures provide for exchanges of empirical data of relevance to the care of patients in general practice. Such data help us to look through the processes and structures of care provision, with large differences between countries,1 into the outcome of the care for patients. For many years general practice was bewildered by remarkable country-to-country variations in everyday procedures, good examples being preferences in the prescribing of antibiotics, and numbers of home visits accommodated. These variations contrast with the similarities in the morbidity spectrum5 and invite questions about the effectiveness of care.

Effectiveness of care refers to the extent to which the needs of the population are met. Variations from defined norms in clinical procedures can be observed, particularly in those countries where the structure of health care promotes competition between general practitioners; such competition may encourage interventions that aim to satisfy patients' demands rather than their needs. The essential point is that primary care must be directed at the needs, rather than the demands of patients.

Evidence of the effectiveness of primary care has been presented by Starfield2—the greater the orientation towards primary care, the better the outcomes of care in relation to costs. At the Stockholm conference Badia5 expounded on economic mileage to be had from the "gatekeeper" role and the personal list: the best cost-benefit balances in Europe are found in the UK, the Netherlands and Denmark, countries where general practitioners have personal lists of patients and refer for specialised care. Spain and Portugal, with primary care centres but no personal lists, come second in the cost-benefit league. Those countries without any formal primary care have less favourable cost-benefit balances. An example supportive of a cause-consequence relation between structure and outcome of care comes from Portugal, where statistics show a clear increase in life expectancy, and a decrease in infant mortality, since the introduction of national health programmes structured on primary care in the 1970s.6

The findings of Starfield2 were welcomed by protagonists of primary care, but what do they imply? Experience of modern life tells us that the best buy is usually from the specialist, and we find it hard to imagine that what is true in general would not hold also for medicine. The conclusions of Starfield, supported by the observations of Badia, depend on how quality is measured, and who, in the final analysis, may be deemed the specialist. The implication is that the quality of care is not so much determined by single interventions or technologies, important as these may be, but by their appropriate application to patients. Assessment of needs is the specialty of general practice and that is where the structure of the health care system can frustrate or facilitate exploitation of the specialty.

Achievement of the full potential of primary care medicine requires strengthening of the general practitioner's ability to cope with all health problems in the community, irrespective of stage, severity, or the economic circumstances of patients.1,4 The dissemination of up-to-date information about common diseases, in particular their natural history and the long-term outcome of interventions, will help to improve decision-making by general practitioners. However, their decisions must also take account of patient-related factors, such as family medical history, and the patient's expectations and values. The long-term relationship with the patient facilitates...
orientation in this sense; practitioners treat a variety of illnesses in any one patient in contrast to secondary care, where many patients are treated for the same disease. This contrast explains why comorbidity, the cultural norms and values of patients, and the social context of illness, are key issues for general practice research. Such research should be conducted in various cultural settings, and cooperation within Europe can offer this facility to general practice.

The provision of home care for patients with chronic illness, and arrangement of terminal care, are examples of settings in which individual needs and the support of a social network can be combined. Patients cherish the hope of remaining as long as possible in their trusted home environment, but the involvement of a social network for 24 h care is crucial. The heavy burden of providing care often rests upon elderly shoulders. An even more decisive factor for the quality of care than the physical condition of the caregiver is the relationship between the latter and the patient. General practice has developed effective interventions to foster coping by the social network.

The variation in sociocultural backgrounds in Europe provides a good base for research into primary care but may have the disadvantage of impeding implementation of new developments. Primary care is essentially egalitarian in its outlook. Thus, new expertise developed in one centre will be relevant for the discipline as a whole only if it can be transferred to every practitioner. Another factor that increases the complexity of introducing new developments is the variation in background and training among general practitioners, who in each country form the single largest group of medical professionals. Implementation is a key to the development of general practice. It requires postgraduate professional training, continuing medical education and quality control. The professional training of general practitioners has been institutionalised (a minimum 3 years of training after graduation has been endorsed for the European Union). Impressive progress has been made in continuing medical education, discussed at the Stockholm conference. Educational skills in general practice are widely available, as is expertise with audit and quality assurance. These skills provide the stepping stone to large-scale programming of continuing medical education in small groups, catering to the needs of local practitioners and directly related to analysis of their performance.

General practice means medical practice in the context of everyday life, of which hospital-based secondary care is a part. Research and continuing medical education touch on that context, and partnerships between experts from both sides of the hospital wall are vital if progress is to be made in primary care delivery. Hospital specialists will discover that they might benefit in such partnerships, since general practice has much to offer in terms of clinical judgment, teaching, and quality assurance.

The countries of eastern Europe might gain much from good primary care, but in those countries attempts to restrict access to secondary care, or to restrict the prescription of drugs to evidence-based use, encounter stiff resistance in people, and professionals, who cherish recently won freedom. This experience emphasises the importance of developing and promoting throughout Europe general practice to serve the needs, rather than the demands of the community.

References

2. KNAW (Koninklijke Nederlandse Academie van Wetenschappen) General Practice Research in Dutch Academia, Amsterdam, 1994.