VIEWPOINT

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Learning from UK primary care

The Australian Government is wise to examine other health care systems as it strives to improve the quality of care and address rising costs to both governments and individuals. Focus is currently on the United Kingdom, whose National Health Service (NHS) stands out as one that delivers good care at a reasonable price to all who need it. The Australian and UK systems have many similarities: universal access, tax payer support, no or low cost at point of delivery, and good population health outcomes. They also face similar pressures on services from aging, increasingly unwell yet expectant populations. However, there are also differences, largely in the way that health care is funded, organised and delivered. The NHS is a huge system for 60 million people in four home countries with diverging policies. Within England, the system is managed through 10 strategic health authorities, each responsible for about 5 million people and having the right to interpret national policy. Population based health care, including tertiary care, is funded locally via primary care trusts.

The differences are greatest in primary care. Primary care in the UK is better integrated within the health care system and probably further advanced in providing increasingly complex care through multiprofessional primary care teams. The shortage of GPs is being tackled by giving 'simpler' roles to other health professionals, both existing and new. Targets are widely used to drive service improvement, facilitated by defined practice populations, information management systems designed for this purpose, and devolved accountability for targets. Patients have fewer choices in health care provision, but increased choice is being offered, at least about location of services.

Yet despite these positive developments and the increased investment, all is not necessarily well with the NHS. General practitioners and nurses are unhappy with their contracts,[1] real patient choice may not exist,[2] and the media commonly report difficulties obtaining appointments, delays in investigations and referrals, and concern about non-GP prescribing.[3] Consultations are shorter and focused on only one presenting complaint, GP morale appears low amidst change fatigue, and access to expensive treatments (eg. newer cancer drugs) varies by region.[4] Costs have risen such that in 2006, 9.3% of gross domestic product was spent on health.[5]

Based on my experience working in general practice in both systems, the two could learn from each other. The UK may benefit from developing an Australian style combination of public and private health care. Australia may benefit from a means of defining practice populations; a common, interoperable core patient health database in all practice record systems; and the judicious use of some targets. These may improve the monitoring and management of chronic disease, the major challenge facing the health care system.

However, there are risks. Defining practice populations may reduce the access and choice strengths of the Australian system. Targets do not always work and can have unintended consequences. For example, to meet the current 48 hour appointment target, appointments beyond 48 hours are hard to get and 18 week referral targets are met by diverting as many patients as possible to nurse practitioners and GPs with special interests. Most clinical targets (eg. blood pressure readings, HbA1c levels, Pap test rates) are relatively easily achieved. However, these tend to be process rather than outcome measures and there are risks that enormous effort is placed on collecting huge amounts of information that may not make much difference to patient outcomes.

The Australian health care system could certainly be improved, and the UK offers alternatives. However, the UK road, if travelled too far, may increase the level of bureaucracy and data gathering and place further barriers between patients and GPs. Process targets are particularly risky, as it is possible that access and pathways for some would improve at the expense of others. Would Australians accept this?

We should choose carefully features that will be successful in the Australian system, ideally piloting them before widespread implementation to avoid mistakes based on theory and dogma.

References

1. McGregor W, Jabareen H, O'Donnell C, Mercer SW, Watt GCM. Impact of the 2004 GMS contract on practice nurses: a qualitative study. Br J Gen Pract 2008;58:711–9.
2. Barnett J, Ogden J, Daniells E. The value of choice: a qualitative study. Br J Gen Pract 1008;58:609–13.
3. Available at www.telegraph.co.uk/news/newstopics/politics/health/3204594/ [Accessed December 2008].
4. Cancer Research UK, 2008. Available at http://info.cancerresearchuk.org/news/archive/newsarchive/2008/august/18738769 [Accessed December 2008].
5. Griffin A. UK nears European average in proportion of GDP spent on health care. Available at www.bmj.com/cgi/content/full/334/7591/442 [Accessed December 2008].

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