

The best of both worlds: How primary care can save lives *and* money

David Haslam

Just imagine, for a moment, that you receive a request from a newly independent country, anywhere in the world, appointing you to devise a health care system. You have an absolutely free hand to design it as you wish. Where would you start?

Most of us would start by determining exactly what outcomes we wanted for our system. It is hard to believe that many thinking people would opt for anything other than improved health outcomes for their population, and a reduction in health inequalities. What else could be more important?

And so it is mystifying that so very many countries have healthcare systems that do the very opposite, that appear to have as their main reason for existence the provision of jobs for clinicians, or the acquisition of increasing levels of high technology equipment. Do their populations realize this? More importantly, do the health ministers, and their civil servants realize this? Sadly, one suspects that they do not.

Because the evidence is remarkably clear that high quality primary care is the secret to effective health care. Primary care is the first point of contact for the majority of people who need to access health services, and is able to meet 90-95% of all health and personal social service needs. In 1978, the World Health Organisation, at a meeting in Alma Ata, in Kazakhstan, set out a broad, visionary definition of primary care. The definition says primary care should:

- Be an integral part of the whole health system as well as the wider social and economic development of community
- Ensure greater community participation
- Act as the first point of contact for health and social needs
- Be a process which also provides on-going care
- Be scientifically sound, practical and affordable.

The high tech world of hospitals always looks more glamorous, but the work of Barbara Starfield from Johns Hopkins in Baltimore shows remarkable benefits from having a focus on primary care. Her work demonstrates that countries whose health systems are more oriented towards primary care achieve

- better health levels
- higher life expectancy
- better health outcomes
- higher satisfaction with health care among their populations
- lower overall health care costs
- lower medication use

One has to wonder what else would really matter to any healthcare system, particularly when her evidence also shows that:

- countries with strong primary care systems have better health outcomes and healthier populations
- health systems based on effective primary care with highly trained generalist physicians practising in the community provide more cost-effective and clinically effective care
- the higher the ratio of family physicians to the population, the lower the hospitalisation rates

Barbara Starfield's findings would – you would think – be meat and drink to everyone involved in health care. After all, what could be more desirable than reduced costs and improved health outcomes? But despite these findings, the attention of most policy makers around the world tends to be focussed on secondary care – the high tech units that look as if they must be more important and valuable.

Both the World Bank and the World Health Organisation have also been very clear about the value of Primary Care. According to a paper in the British Medical Journal in June 2007 – “Primary Care systems seem to offer important advantages within healthcare systems in terms of cost containment and the health of the population. Those that focus on secondary care offer the least in terms of benefits to the population overall.”

In the United Kingdom, public pronouncements by politicians about education and health until very recently almost always use the same shorthand headline phrase – “schools and hospitals”. Perhaps this isn't entirely surprising. After all, about 80% of any health care budget goes into secondary care, and the potential for dramatic glory as well as disaster is frequently concentrated within hospitals.

However, secondary care is not health care in the UK or anywhere else in the world. Far from it. In the United Kingdom approximately 90% of the work of the Health Service is carried out in primary care. In one recent year there were 268 million consultations with general practitioners, and satisfaction rates with general practitioners are high

This under-valuing of primary care is puzzling. I have been privileged to meet doctors in many countries around the world, and in every single one it is clear that recruitment of doctors is rarely focused on primary care. It is worse than that. Medical students and doctors who want to become GPs often feel looked down on by their hospital colleagues. People talk about “ending

up as” a family doctor in a way that they would never refer to “ending up as a neurosurgeon”. Indeed, despite all this evidence for how important primary care is, in the UK, for instance, over one recent ten year time span, the number of hospital doctors in the UK increased by 60%, whilst the number of Family Doctors was almost static. But research has shown that even hospital mortality rates are even more closely related to the number of family doctors than to the number of hospital doctors, as shown in a major study which showed that in order to reduce deaths in hospital by 5000 per year, the NHS would need either 9000 more hospital doctors or 2300 more GPs, which makes current workforce priorities all the more puzzling.

I suspect the reason is that much effective general practice is based on prevention. If a family physician offers advice and treatment that prevents a heart attack, nothing happens. There is no story. But if someone has a heart attack, and is saved by a skilful hospital physician, there is a story. There is drama. There is credit. It’s very difficult for politicians to see that something not happening is better than a dramatic success – but I am absolutely certain that you would much prefer not to have a heart attack than to be successfully resuscitated after one.

In the USA studies have shown that areas in which primary care is stronger, as measured by primary care to population ratios, have much lower total healthcare costs than other areas. This has been demonstrated to be the case among the elderly in the US who live in metropolitan areas for both total costs (inpatient and outpatient) and for the total population in the US – as well as in international comparison of industrialised countries.

Why should general practice have such a major effect on the national health? There can be little doubt that keeping patients away from hospital, except when it is essential, is generally good for them. Minimising risk for patients is key, and general practice can be described as the risk sink of the healthcare system.

Within every computer there is a device known as a heat sink. The heat sink appears to do little other than absorb the heat in the system. It doesn’t compute, or calculate, or display. But if you take it away, the system crashes.

Family Doctors have a similar effect. They not only see huge numbers of patients but they absorb huge levels of risk and uncertainty. In the UK General Practice is the heat sink of the National Health Service, absorbing both risk and workload. Generally, referral rates are low. On average, family doctors only refer five patients to secondary care services for every one hundred consultations. An experienced General Practitioner is likely to know when a headache needs an urgent investigation, and when it is a result of disease or unhappiness in the patient’s life. No doctor will always get this right every time, but the high satisfaction rates, and low complaint rates point to a high level of skill.

Indeed this beneficial effect can be detected elsewhere. Family doctors working in emergency rooms are significantly less likely to investigate or admit patients compared to junior

hospital doctors – a classic example of the risk sink in action again. In a study in the USA, men aged over 55 and over were randomised to primary care with or without continuity of provider. For those who were randomised to continuity of provider there were fewer emergency hospitalisations, shorter hospitalisations, and greater satisfaction.

It appears likely that the reason that family doctors are so effective at managing risk is that they are more likely to know their patients. Continuity of care matters, and is probably linked to trust. Part of the traditional success of Family Medicine has come from the long term relationship that is built up between patient and doctor. Indeed a major study from the US and UK showed that continuity of care is perceived by many patients to be deeply important, and is associated with the development of trust by patients.

Levels of trust in family doctors can be quite extraordinary. A study carried out by a committee of the UK parliament known as the Committee on Standards in Public Life showed Family Doctors absolutely as the most trusted people in British Society – at an astonishing 92% yes response to the question “which of these professions would you generally trust to tell the truth?”

Doctors who know their patients are less likely to admit or investigate them, and there is, of course, a great deal more to the therapeutic relationship between GPs and their patients than simply the avoidance of risk. Indeed, there is a real likelihood that the very thing that has kept the British Health Care system – the National Health Service – running for all these years is trust.

Trust means that when a patient asks a doctor if an X-ray or referral or scan is needed and the doctor says that it isn’t that the doctor is believed. Starfield shows that keeping people away from secondary care services is generally good for them, unless it really is necessary – and that is the most difficult judgement any of us have to make.

None of this is in any way a criticism of doctors working in secondary care. Because of the risk sink effect of primary care, they see a different population. The population with headaches who sees family doctors is a different population to that seen by hospital specialists – at least in a system with strong primary care. And because of these different populations of patients, these different types of doctors can take a different approach, and the major difference between generalists and specialists relates to the tolerance of uncertainty.

- Family doctors try to exclude the presence of serious disease
- Specialists aim to confirm the presence of serious disease.
- GPs accept uncertainty, explore probability, and marginalise danger.
- Specialists reduce uncertainty, explore possibility, and marginalise error.

These are important and complementary skills, and working together can be of real benefit to the patient. In addition, part of the skill of family physicians comes down to a word first used by Aristotle, and which has many definitions. *Phronesis* has been described as “the art of knowing what to do when you don’t know what to do”, and this is an extraordinarily high level skill. Much of the work of primary care doctors dealing with new presentations involves patients whose symptoms and signs don’t fit any clear diagnostic label, so knowing what to do when there are no guidelines and algorithms is vital, and not easy.

In addition, as increasing numbers of patients suffer from multiple comorbidities, the generalist focus becomes even more essential. Almost all guidelines are based on research that excludes patients with comorbidities; for fear that these confuse the results. But huge numbers of our patients living in the real world have comorbidities, and the guidelines may not be appropriate. Over-focusing on the disease, rather than the patient with the disease or diseases, may not always be the optimum form of care.

In a report published by the World Health Organisation in January 2004 on restructuring health care, the conclusion was reached that international studies show that the strength of a country’s primary care system is associated with improved population health outcomes for all-cause mortality, and that increased availability of primary health care is associated with higher patient satisfaction and reduced aggregate health care spending. Studies from developed countries demonstrate that an orientation towards a specialist-based system enforces inequity in access. Health systems in low income countries with a strong primary care orientation tend to be more pro-poor, equitable and accessible.

Some years ago a notable Welsh General Practitioner, Julian Tudor Hart, proposed his now famous Inverse Care Law that the availability of good medical care tends to vary inversely with the need for the population served. There seems good evidence from international studies that a primary care focus reduces such inequalities, has better health outcomes, and is much more cost effective. But the dilemma is that it does not lead to headlines – health rarely does.

The evidence is remarkably clear. Primary Care really can save lives, and money. If ever I heard of a win:win situation, this is it.

Further reading

1. The effectiveness of Primary Healthcare. Chapter in “A celebration of General Practice” Ed: M Lakhani, Radcliffe Medical Press, 2003
2. Campbell, J. Provision of Primary Care in different countries. *BMJ* 2007;334:1230-1
3. Office of Health Economics. Compendium of Health Statistics, 2002. Table 4.19
4. Roland M. Contract needs to enable doctors to give first class care. *BMJ* 2002;325:1241
5. Jarman B, Gault S, Alves B, Hider A, Dolan S, Cook A, Hurwitz B, Iezzoni L. Explaining differences in English hospital death rates using routinely collected data. *BMJ* 1999; 318: 1515–20.
6. Shi L, Starfield B, Kennedy BP et al. Income inequality, primary care, and health indicators. *Journal of Family Practice*. 1999; 48 : 275-84
7. Haslam D. “Schools and Hospitals” for “Education and health”. *BMJ* 2003; 326: 234-5
8. Murphy AW, Bury G, Plunkett P, Gibney D, Smith M, Mullan E, Johnson Z. Randomised controlled trial of general practitioner versus usual medical care in an urban accident and emergency department: process, outcome, and comparative cost *BMJ* 1996;312:1135-42
9. Wasson, Sasuvigne AE, Mogielnicki P, Frey WG, Sox CH, Gaudette C, Rockwell A. Continuity of outpatients medical care in elderly men: a randomized trial. *JAMA* 1984; 252 : 2413-7
10. Mainous AG, Baker R, Love M, Pereira Gray DJ, Gill JM. Continuity of care and trust in one’s physician: evidence from primary care in the US and UK *Family Medicine*. 2001; 33 : 22-7
11. http://www.public-standards.gov.uk/upload/assets/www_public_standards.gov.uk/researchsummary.pdf
12. Hjortdahl P, Borchgrevink CF. Continuity of care: influence of general practitioners’ knowledge about their patients on use of resources in consultations. *BMJ* 1991;303:1181-4

Professor David Haslam CBE, FRCP, FFPH, PRCP
President, Royal College of General Practitioners
London, UK