Primary Care in England
Its strengths, weaknesses and Future

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President Elect – British Medical Association

Focus for this presentation

• The function of the NHS
• Historical context
• Why primary care is effective
• Why primary care needs generalists
• Why generalists need specialists
• The changing role of generalists in an information-rich world
• Recent Governmental proposals
The Primary / Secondary Divide

• Care is provided to people who are ill or believe themselves to be ill –
• The doctor-patient relationship is founded on mutual trust
• Care is personal, focused mainly on the individual patient
• General Practice is an integral part of the whole NHS system
Just a GP?
World Health Organisation - Alma Ata - 1978

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.

STARFIELD EVIDENCE (1)

• 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
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

STARFIELD References

- The Contribution of Primary Care Systems to Health Outcomes within OECD Countries, 1970–1998
  
  James Macinko, Barbara Starfield, and Leiyu Shi

- Primary and specialty care interfaces: the imperative of disease continuity
  *British Journal of General Practice* 1993:
  September Volume 53, Number 494 pages 723-729
Choose Any Two..

• Affordability
• Easy Access
• Quality

If you choose..

• Affordability
• Easy Access

You may miss out on the
• Quality
If you choose...

- Quality
- Easy Access

*You may miss out on the*

- Affordability

If you choose...

- Affordability
- Quality

*You may miss out on the*

- Easy access

Explaining differences in English hospital death rates using routinely collected data,


Family Practice

The Risk Sink of the National Health Service

“Schools and Hospitals” for “Education and health” – Haslam D.
BMJ 2003; 326: 234-235
GPs / Family Physicians

Accept Uncertainty, explore probability, and marginalise danger

Specialists

Reduce uncertainty, explore possibility, and marginalise error
The Risk Sink in the Emergency Room

BMJ: 1996: 312: 1135-1142

The Risk Sink in the USA

JAMA 1984: 252: 2413-17
Continuity of care and trust in one's physician: evidence from primary care in the United States and the United Kingdom.


<table>
<thead>
<tr>
<th>Profession</th>
<th>Yes</th>
<th>No</th>
<th>Net trust*</th>
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<tbody>
<tr>
<td>Family doctors</td>
<td>92</td>
<td>7</td>
<td>+85</td>
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<tr>
<td>Head teachers in schools</td>
<td>84</td>
<td>12</td>
<td>+72</td>
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<td>Judges</td>
<td>80</td>
<td>16</td>
<td>+65</td>
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<td>Local police officers on the beat in your area</td>
<td>77</td>
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<td>Senior police officers</td>
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<td>26</td>
<td>+42</td>
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<tr>
<td>Television news journalists</td>
<td>49</td>
<td>46</td>
<td>+3</td>
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<td>Your local MP</td>
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<td>45</td>
<td>+2</td>
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<tr>
<td>Senior managers in the National Health Service</td>
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<td>49</td>
<td>-5</td>
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<td>Local councillors</td>
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<td>-11</td>
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<tr>
<td>Top civil servants</td>
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<td>53</td>
<td>-16</td>
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<td>Journalists on newspapers like the Times, Telegraph or Guardian</td>
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<td>56</td>
<td>-18</td>
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<td>Top newspaper in local area</td>
<td>46</td>
<td>52</td>
<td>-6</td>
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Note: Public office-holders covered elsewhere in this research are shown in italics.
• Ageing Population – changing demographics
• Mobile populations
• The problem of co-morbidity
• The hazards of polypharmacy
• The information explosion & the internet
• Time pressures – Increasingly complex consultations
• The importance of personal care and trust

<table>
<thead>
<tr>
<th>Comorbidity Trends in the Most Common Chronic Conditions, by Age Group</th>
</tr>
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<tbody>
<tr>
<td>Most prevalent chronic conditions by age</td>
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<tr>
<td>------------------------------------------</td>
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<td>Age 65 and older</td>
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<tr>
<td>Hypertension</td>
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<tr>
<td>Diseases of the heart</td>
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<tr>
<td>Eye disorders</td>
</tr>
<tr>
<td>Disorders of lipid metabolism</td>
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<tr>
<td>Diabetes mellitus</td>
</tr>
</tbody>
</table>
The Big Picture

- 1900-50 Infectious diseases
- 1950-2000 Acute diseases
- 2000- Chronic diseases (LTCs)
The structure of the NHS

**Current**

- Dept of Health
- 10 Strategic health authorities
- 162 Primary care trusts
- Hospitals, GPs, mental health units, dentists, community services eg. district nurses
- Patients

**Proposed**

- Independent board
- 500 GP consortiums
- Hospitals, GPs, mental health units, community services eg. district nurses
- Dentists, specialist services eg. intensive care
- Patients

**Key**

- ▼ overseeing role
- ▼ flow of money
- ▼ caring role

(Source: OECD Health Data 2007)
Headlines……

- Proposed transfer of commissioning function of most services from PCTs to GP consortia
- GP consortia will hold around 80% of NHS budget
- PCTs and SHAs abolished
Key Points

• Delegation of responsibility
  – Accountability passed from Secretary of State to NHS Commissioning Board
• Clinically lead, reduction in costs
  – GP commissioners -
  – 45% reduction in management costs
• Public Health budget
  – “Ring-fenced” with “health premium” to reduce inequalities
• Opening up the market
  – Services can be provided by ‘Any willing provider’

Timescale

• Consortia fully responsible from April 2013

• SHAs abolished 2012-13, PCTs from April 2013

• SHAs replaced by NHS Commissioning Board, April 2012
Consortia Responsibilities

• Determining healthcare needs
• Determining what services are required to meet these needs
• Ensuring the appropriate clinical and quality specification of these services
• Entering into, managing and monitoring contracts with providers
• Improving quality of healthcare provided through these contracts
• Providing oversight of health care providers’ training and education plans
• Holding constituent practices to account
• Driving up quality of primary medical care and improving use of NHS resources
• Consortia will be statutorily responsible for commissioning the vast majority of NHS services

Not Consortia Responsibility

• Commissioning and holding contracts with individual practices for primary medical care

• Other primary family health services (dental, ophthalmic and community pharmacy)

• National and regional specialist services (e.g. heart transplant, spinal, burns), or prison/custody health services.
Functions of NHS Commissioning Board

- Will develop commissioning guidelines, design tariffs and model contracts, and hold consortia accountable for outcomes & financial performance
- Promoting public involvement and choice, including personalisation and personal health budgets
- Ensure development of GP commissioning consortia
- Commissioning services outside remit of consortia, e.g. dentistry, specialised services
- To allocate NHS resources, accountable to Secretary of State - managing financial risk

Unintended Consequences
Most want standard treatment available across the country

And thinking of the treatments that are available on the NHS, which of these statements most closely matches your opinion?

- 73%: Treatments should only be available on the NHS if they are available to everyone and not dependent on where you live.
- 23%: The availability of NHS treatments should be based on local need rather than a 'one size fits all' approach across the country.
- 4%: Don't know

Base: 999 English adults (18+), November 2008
Source: Ipsos MORI/Social Market Foundation
Ipsos MORI
Thankyou

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