An Analysis of PRIMARY MEDICAL CARE – An International Study

W. J. Stephen

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Primary Medical Care

AN INTERNATIONAL STUDY

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To my long-suffering wife and children

FOREWORD

The British National Health Service is in difficulties now, partly for lack of money, partly for factors in the administrative structure, partly because of defects in the structure of the professions, especially of medicine, but most of all because these things together have greatly undermined morale. Nevertheless the public generally believes in the Service and receives from it a high standard of care with fewer gaps than could be found in most other countries. The Service is not at the point of dissolution, as occasional disgruntled doctors have been announcing for the last twenty-five years, and its very real defects can be remedied. The real reason why it was viable in 1948 and has been only moderately damaged by the dissensions of recent years is the stability and effectiveness of the primary care system which is its main support. General medical practice has evolved a long way since 1948 and primary care in Britain has become mainly group medical practice of doctors with nurses and other professionals. As at the time of the Collings Report, it is uneven in quality and still requires continuing effort to raise its standards. Other countries organise primary care in other ways and some of them provide examples which could assist development here. Dr Stephen's study covers more countries than any other now available and his book will, at the least, suggest opportunities for closer examination of such differences.

Dr Stephen has not only read widely about his subject but has devoted much time and energy, with only limited outside help, to visits which have given him uniquely wide personal acquaintance with primary care in other countries. He has some personal convictions which influence his assessments of other countries, as his chapter on

the United Kingdom reveals. There is much in that chapter with which, in common with many others, I would disagree. That does not invalidate the large amount of factual information he has brought together from other countries, though it may influence his assessment. Because the area covered is so wide it is inevitable that there should be evidence of some misinterpretation of local situations – for example, full investigation by Danish general practitioners is said to have produced a low rate of hospital use. In fact the admission rate in Denmark is well above that in Britain where availability of diagnostic services has been wider and earlier than the text implies. There is a problem, too, with the reconciliation of statistics from widely differing sources and with their interpretation. It is nonetheless remarkable to find so much collected together in one volume.

One reservation about the views expressed must be made. The author himself writes 'Primary care cannot be considered in isolation from the rest of the health service and without good secondary care in hospitals it will founder'. This is the underlying truth of the British NHS; but he goes on to say later that primary care must do better than hospital, when its real object is to do best with whatever contribution is best made by 'hospital'. It is quite artificial to judge what has been done for one side or the other by comparing the proportions of total expenditure and changes in them over the years. The fact is that the lesser needs of general practice for capital in absolute terms have been preferred to the far greater needs of secondary care ever since British doctors have come round to acceptance of health centres. In general his emphasis on the greater need of primary care, especially in developing countries, is justified but the even greater urgency of providing safe water supplies and safe disposal of human wastes could have been given even stronger emphasis. Any reader will surely regard this as a small matter only to be expected in so large a single-handed achievement.

This book is an important contribution to the review of primary care and its relation to secondary or specialist care in any country. Relationships within medicine and between medicine and the other professions have changed much in the last thirty years and must change much more under the pressure of both scientific and social advance. Shared responsibility, rather than autocratic medical control, must be the pattern of the future and the general practitioner of medicine with his other professional colleagues in primary care is at the focal point.

The most important relationship of all is the continuing family doctor relationship with patients in health as in illness, whether minor or major. The answers we have now in Britain are far from perfect and there is much in Dr Stephen's book from which we can all learn. It is a special feature of this study that it has been made by one who throughout has been engaged in primary care himself. To have encompassed the review of the relevant literature alone is a considerable achievement; to have undertaken the travelling, with a valuable contribution from Eric Gambrill, and surmounted the language problems as well makes it monumental.

At the end of my reading of this book, despite the inevitable reservations on points of emphasis, I was left feeling that my own knowledge of health care in other countries – even those well known to me – had been enlarged. There is nothing quite like it in print now. If it is written from an essentially general practitioner point of view, that is in its favour for it brings with it a deeper appreciation of the health care needs of people than a writer with an administrative or hospital background might have. Yet the historical perspective, so often ignored in descriptions of health service organisation, and the statistical background are there. This is an achievement in a class of its own.

Sir George Godber
Formerly Chief Medical Officer,
Department of Health and Social Security

PREFACE

> The health of any given population depends more on the availability of good primary health care than on the advanced technical resources of modern hospitals; and it is generally accepted that a properly organised system of primary care can deal with a very large proportion of all demands for health care: a figure of 80 per cent is commonly quoted, and many would put it a good deal higher. It has been claimed also that the treatment of illness through a primary care system leads to economy of money and resources, though in a situation of potentially unlimited demand for health care services, this represents a better use of resources, rather than an actual saving of money. A contrast is, however, sometimes drawn between the high cost of providing hospital and specialist services for a relatively small number of people, and the relatively much lower expenditure on the provision of primary care required by the great bulk of the population. In consequence, there has, not unnaturally, been a tendency to question the disproportionate amount of resources made available for the institutional forms of care, particularly hospital care, compared with the much smaller amount devoted to primary care.

No independent, fair-minded observer could disagree with this extract from a report of the World Health Organisation, following a meeting in Moscow in July 1973 on 'Trends in the development of primary care'.

During the last twelve years, I have been studying the difficulties and problems of primary care in a world-wide context. This has not been easy, as I have found little interest in universities, medical schools or the Department of Health and Social Security, and certainly no

financial support has been available from these organisations for this type of research.

Between 1966 and 1968, I spent five weeks in Eastern Europe, visiting Bulgaria, Czechoslovakia, Hungary, Poland and Romania, followed by two weeks in Canada in 1969, and a further five weeks in the USSR during 1971/2. This was organised under the auspices of the Anglo/Soviet Cultural and Scientific Agreement, with the help of the British Council. In 1972, I spent two months in Japan, which was made possible by a Nuffield Foundation Travelling Fellowship. Three-week visits to Cuba and Chile in 1974, followed by Norway, Sweden and Finland in 1976 and the USA in 1977 completed my studies, except for brief visits to Belgium, France, the Netherlands, Italy and the World Health Organisation in Geneva. I have also collected material through the European office of the World Health Organisation in Copenhagen, and its headquarters in Geneva, and from official sources in many countries. Since 1960, I have been in active general practice, working in the National Health Service which, while it has made me acutely aware of our own domestic problems and difficulties, has also made me aware of our strengths.

Throughout the last twelve years, I have felt the need for a book which would give an account of the different methods of organisation in operation throughout the world. None is available. This book is, therefore, an attempt to fill the gap; it includes many of the major industrialised countries and one chapter considering in general principles the problems of the developing world. It is obviously an incomplete and personal account, and has dealt almost entirely with the structure and organisation of primary care, rather than with its clinical and technical aspect. I hope I have not fallen into the trap of drawing too many facile conclusions from such a comparative study, as the organisation of any country's health service depends on so many variable factors – political, social, historical, educational and financial – each specific to the country under consideration, that it makes direct comparisons almost meaningless. Rather, my aim has been to collect the facts, in the hope that, in spite of all its defects and limitations, or perhaps because of them, it may stimulate a much more detailed and comprehensive study in the future. It is intended for anyone who is interested in improving health care – politicians, patients, doctors, health service administrators, journalists, university departments of community medicine and general practice, students and other health

workers – so that, by illuminating and focusing on each other's problems and dilemmas, a rational discussion can take place and progress can be made.

John Stephen

Wells, Somerset 1978

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Space does not allow me to mention by name all those people who, during the last twelve years, have helped to plan my visits and arrange programmes of study, or those who have given so generously of their time, knowledge and hospitality, or those who have willingly given advice and letters of introduction. A list is, therefore, included in an appendix: inevitably this has omitted many people whose views and opinions have helped to formulate this book. I would ask them to accept my apologies and I hope that they will realise how much their assistance has been valued.

The suggestion that I should write this book came from Dr František Ošanec, Department of Foreign Health Services, Prague, who encouraged an idea which I had been pondering for several years. His encyclopaedic knowledge of the organisation of health services is known in many parts of the world, and to him I readily express my thanks and admiration, and acknowledge his influence.

To Dr Eric Gambrill, who has not only written Chapter 9, but has also read the manuscript, I am extremely grateful. His sound and helpful comments on the initial draft have proved invaluable. Also I wish to thank Mr Alan Quilter, Headmaster, Wells Cathedral School, for his advice and suggestions regarding style and grammar. The guidance I have received from the Cambridge University Press has been greatly appreciated. The considerable knowledge and pertinent criticisms of Dr John Fry have been of particular value. Finally I owe a special debt to Mrs Susan Record and Mrs Lisbeth Bull, assisted by Mrs Pauline Penney, who have miraculously converted my illegible scrawl into an orderly typescript.

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1

INTRODUCTION

The need to provide medical care has stirred the imagination of man throughout the world from the earliest records of history, but the organisation of medical care is an activity which has only interested governments, patients and doctors since the end of the nineteenth century, and only seriously since the end of the Second World War.

What are the reasons for this? European culture and tradition have been based on the Christian ethic, even if, at the present time, most countries in Europe and throughout the rest of the world are largely secular. Basic to this belief is the absolute importance of man as an individual, and this idea was reinforced by the concept of 'post-Renaissance man', which was also fired by the same philosophy. For nearly two thousand years, at least, in Western Europe, and subsequently in those parts of the world which came under the influence of European civilisation, the best in medicine was always closely associated with the Christian tradition. Consequently, the highest standards in medicine and nursing have been synonymous in most people's minds with devoted attention to individual patients. Paradoxically, this compassionate caring for the individual has tended to obscure the needs of the community, at least from the eyes of many doctors and nurses, even if not from patients. There has been a delay in understanding, or even appreciating, the issues involved in providing health care for large numbers of people, and this failure to recognise the problems has been a major obstacle to progress.

Of course, no-one would pretend that this is the whole story, and to many it is merely a reflection on the nature of society. The USSR has succeeded in providing a comprehensive service for its entire popula-

tion, virtually starting from nothing, following the revolution of 1917, while the USA is still debating about a health service. The different philosophies of health care in Cuba and Chile, or India and China, also highlight the political nature of the problem. But equally, in Scandinavia, New Zealand or the UK, the organisation of medicine has altered to a considerable extent, without any fundamental change in the structure of government or society. But what would seem certain is that in countries which fail to provide appropriate care there is a danger that medicine may become a political issue and nothing else.

A great responsibility thus lies with the medical profession, at least to try to meet the needs of the people, and thus prevent a polarisation of opinions and a general atmosphere of distrust, which imposes an impossible strain on patients, government and doctors. Patients have the right to be treated with the highest ethical and clinical standards; governments have the right to expect the cooperation of doctors in providing a fair distribution of care and resources to the benefit of all, and doctors have the right not to be used as a political tool. It will require the highest standards of integrity and motivation between government and profession, also considerable understanding and cooperation from patients, if a satisfactory solution is to be found.

A new force has recently entered into the arena of health care, whose advocates claim that medicine in fact does more harm than good! (Illich, 1975) Many people would agree that much modern, sophisticated therapy is of doubtful value, and may sometimes be harmful; that much aggressive, heroic surgery produces very little benefit for the unfortunate patient; that medicine has fostered and encouraged an overdependence on the part of many patients; that the value of early diagnosis, and therefore the hope of better treatment, is often illusory, and that many investigations and treatments are an expensive luxury, even a total charade. But to claim, as some do, that poor people who cannot afford any health care are probably better off than those who are rich enough to run the risk of seeing a doctor, is surely a perverted view of medicine. It is not without interest that such views are often paraded by those people who, in reality, live in the secure knowledge that medical care is at hand for them should they need it. And so it is accepted that there is a demand and need for people to have some form of health care, and to argue otherwise is to ignore reality and to misinterpret their expectations. But where should the emphasis be placed and the resources allocated? There is no health service in the

world today which can meet all the demands made on it, and it is in this context that resources must be allocated. How necessary, therefore, is primary care and how should it be organised? This surely will be the essence of much deliberation on the future planning of health services. If, of course, universal care for the entire population is not accepted, then medicine can remain a commercial enterprise, governed by the rules of the market place. In such a situation, only the rich or privileged can afford the luxury of medical care and others will have to rely on chance or patronage.

It is a fact that in all developed countries hospital services take a very much larger proportion of money than primary care; this is inevitable. It is also true that the number of physicians employed in the hospital service has increased greatly compared with the number of general practitioners; this is inevitable with the present-day emphasis on technological medicine. Even in the UK, where it is claimed there is a strong primary care sector, the figures show only too clearly the magnetic effect of the hospital service and its dominant role (Table 1).

TABLE 1 *Increase in number of hospital doctors and general practitioners in the National Health Service*

Category	Number of doctors		
	1959	1973	Increase (%)
Consultants	5 322	8 988	+69
Senior registrars	931	1 821	+96
Registrars	2 787	4 408	+58
Senior house officers	2 315	6 292	+172
House officers	2 436	2 351	− 3
Total hospital doctors	13 791	23 860	+73
General practitioners	22 091	21 358	− 3

Based on DHSS statistics

Governments and health service administrators, encouraged and advised by the medical profession, still expand the hospital service at the expense of primary care, even though it is realised that there is a definite need for an effective system of first-contact care. It is difficult to believe that this situation can continue for much longer, and in the near future personal long-term continuing care, as far as possible

within the context of the family, will be seen as one of the major priorities of medicine today. Minor ailments, self-limiting diseases, the problem of incurable disease and the inevitability of the ageing process all require help and advice from a physician (or medical auxiliary) working in the community. But the advocates of primary care or general practice must be able to demonstrate that their claims are attainable, desirable and necessary. The next chapter will attempt to describe the aims, requirements and essential ingredients of good primary care and the differing methods of organisation.

What is a good health service and how can it be measured? Can good health care be provided without a sound organisation of primary care? What is a sound pattern of organisation and who should provide the service: a family doctor or specialist, working individually or in a team? Are doctors prepared to carry out general practice which is *accessible*, *available* and provides *continuity*, and are they capable of carrying it out? Is there a satisfactory method of paying doctors? Does the method of payment influence the quality of service received by the patient? How appropriate is the medical education of most primary care physicians?

Subsequent chapters will focus on individual countries in an endeavour to answer these questions and to show how successful or unsuccessful they have been in organising their own system of first-contact care within the context of their differing political, economic and social backgrounds.

2

PRIMARY MEDICAL CARE

Function, requirements and special features of primary care

The role of the general practitioner, both now and in the future, has been the subject of endless conferences, working parties and reports, both nationally and internationally, over the last twenty years. Speculation and controversy have raged, regarding not only the differing approach of various countries – the specialist or 'specialoid'* in the USA and USSR (Fry, 1969) as compared to the firmly rooted family doctor philosophy of the Netherlands, Denmark, New Zealand, the Republic of Ireland and the UK – but also whether primary care might disappear from the medical scene altogether; this seemed a distinct possibility during the 1950s. Since then there has been a renaissance of general practice throughout most of the world and to quote Professor James Knox (1970), Department of General Practice, University of Dundee, 'For too long general practice has been considered to be an ailing patient whose demise is expected hourly. The patient has refused to die. The severity of the illness is no longer at issue, but the crisis is passed and the patient is on the long road to recovery, even if the understanding of the complex aetiology is still important.'

An all embracing definition of general practice or primary care and of general practitioners/family physicians/primary physicians is difficult, particularly when considered in relation to the differing political, economic and social structures of the countries involved. There have been many attempts of which the following are examples.

* See footnote on p. 246.